

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

¹Aaron Coats, ¹Catriona Young, ³Stephen Fenning, ^{3,4}Joanna Bowden. ¹Public Health UK; ²University of Glasgow; ³Fife Health and Social Care Partnership; ⁴University of St Andrews

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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

Sue Sutton, Helen Bonwick. *Liverpool Heart and Chest Hospital, Marie Curie Hospice Liverpool*

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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.

REFERENCES

1. Kochovska S, et al. Earlier multidisciplinary palliative care intervention for people with lung cancer: a systematic review and meta-analysis. *Translational Lung Cancer Research*, 2020;**9**(4):1699–1709.
2. Nottelman L, et al. A new model of early, integrated palliative care: palliative rehabilitation for newly diagnosed patients with non-resectable cancer. *Supportive Care in Cancer*, 2019;**27**:3291–3300

3. Chin C, Booth S. Managing breathlessness: a palliative care approach. *Postgrad Med J* 2016;**92**:393–400.

143 NURSE LED PARACENTESIS FOR PALLIATIVE CARE PATIENTS IN THE HOME SETTING IN A LOW- AND MIDDLE-INCOME COUNTRY: A CASE SERIES

Sunitha Daniel, Sheeba Jose, Vipin Paul, Sofi Johnson, Sarika Sanil, Athul Manuel, Geetha Vijayan, P Annie. *York and Scarborough Teaching Hospitals NHS Foundation Trust, UK, General Hospital, Ernakulam, India*

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Background Ascites in palliative care is associated with numerous distressing symptoms and can affect the quality of life of patients. Management of ascites-related symptoms is challenging especially in cancer patients due to the lack of evidence of response to diuretics. Abdominal paracentesis offers quick symptomatic relief but generally requires transfer to hospital for outpatient interventional radiology which is not easily available or financially feasible for patients in low- and middle-income countries.

Methods We present the results of the retrospective analysis of case notes of patients referred to our palliative care unit for nurse led paracentesis from November 2018 till date. These patients have an ultrasound confirmed ascites and first paracentesis in hospital setting. They are then referred for continuation of paracentesis at home.

Results Out of the eighty patients with median age of 65(38–96) seen by palliative care team at home, 59% were male, 47% had cancer (Hepatocellular 37%, Ovary 11%). Fifty-five (69%) of patients had less than 5 interventions while two (3%) had more than twenty interventions. The median number of days under the care of palliative care team was 29(3–712) were. Out of the twenty (25%) patients who are alive at the time of reporting, 75% are continuing with procedure while in 15% it was stopped as ascites resolved. There were no immediate post procedure complications though two (3%) had one episode of hospital admission with spontaneous bacterial peritonitis from which they recovered. Among the patients who had died, the median duration of referral to palliative care service before death was 33 (8–494) days.

Conclusion Nurse led home-based palliative paracentesis is a safe, effective, and convenient intervention for hospice and palliative care patients with symptomatic ascites.

144 SPECIALIST PALLIATIVE CARE INREACH TO THE EMERGENCY DEPARTMENT

Suzie Gillon, Faith Jacob, Lorna Fairbairn, Katy Nunn, Sarah Higgins. *Leeds Teaching Hospitals NHS Trust*

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Background Emergency departments (EDs) are under unprecedented pressure due to multiple factors including: a rising and ageing population; rising bed occupancy in hospitals; reduced capacity in social care and community services and high levels of staffing attrition. Attendance of patients known to, and suitable for, palliative care in the last year of life is common¹, 2, 3. This project sought to assess the impact of a proactive Specialist Palliative care (SPC) in-reach service into the ED within current resource.

Methods From November 2021 a SPC doctor and Clinical Nurse Specialist (CNS) visited the ED every weekday morning following the ED departmental handover meeting, where patients were identified as ‘may benefit from palliative care input’. Patients were reviewed in the department, verbal advice given to the ED team or followed up later in admission.

Results Referrals from ED to SPC increased from 10 in the 6 months pre-project to 60 in the following 6 months. Patients were often elderly (mean age 76, range 42–101); with a high proportion of non-malignant diagnoses (58%), many from 24 hour care (26%) and with a poor prognosis (80% of first 50 patients had died within the study period). SPC input included: advance care planning; symptom management and prescribing; supporting dying patients in the ED; goals of care decisions; assisting with challenging conversations; enabling rapid discharge, and referral to community and hospice services. High levels of satisfaction with the service were found when surveying ED and SPC staff, although the increased number of referrals has implications for SPC workload. Ongoing work aims to further define most useful SPC impact, and develop stronger links with Acute Medical teams to best influence hospital admissions. (Further up to date results will be supplied at PCC if submission is successful)

Poster Nos 145–155: Supportive Care

145 OBJECTIVE ASSESSMENT OF CANCER-RELATED FATIGUE, CARDIAC MUSCLE AND AUTONOMIC NERVOUS SYSTEM FUNCTION IN A PALLIATIVE POPULATION: A FEASIBILITY STUDY

Bernadette Brady, Michelle Barrett, Gerard King, Rory Wilkinson, Ross Murphy, Declan Walsh. *Our Lady's Hospice and Care Services, Dublin; University College Dublin; St James's Hospital, Dublin; Levine Cancer Institute, Charlotte, North Carolina*

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Introduction Cancer-related fatigue is a common symptom whose pathophysiology may involve dysfunction of cardiac muscle & autonomic nervous system (ANS).

Aim Assess feasibility of objective measurement of fatigue, cardiac muscle & ANS function in a palliative population.

Methods Consecutive participants with cancer recruited from palliative outpatient clinic. Fatigue measured subjectively (brief fatigue inventory [BFI]) & objectively (grip strength, timed-up-and-go [TUG], sit-to-stand [STS]).

A 2D transthoracic echocardiogram assessed cardiac function (systolic: ejection fraction [EF]; diastolic: isovolumic relaxation time [IVRT], LV filling velocities [E/A]. Myocardial strain analysed using EchoPAC software.

Heart rate variability (HRV) recorded for five minutes each of spontaneous & paced breathing. SDNN: standard deviation of RR intervals; RMSSD: Root mean square of successive differences. Active stand identified postural hypotension. Participants completed an acceptability questionnaire.

Results 10 participants, 7 female. Mean age: 66 years (57–71). Cancer types: Lung, colorectal, breast, gastric, ovarian. Metastatic disease: n=10. BFI ≥3 (indicating fatigue): n=7

Median (Range) BFI 4.2 (0–8.9). Grip strength (kg force) 18 (9–39). TUG (s) 9 (7–23). STS (no. in 30s) 10 (0–15)

Ejection fraction normal 67.5%. Grade I diastolic dysfunction present (E/A 0.8, IVRT 96ms).