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 although two (3%) had one episode of hospital admission with spontaneous bacterial peritonitis from which they recovered.

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

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.)