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

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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 intervention. 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 bacteraemic 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.

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SPECIALIST PALLIATIVE CARE INREACH TO THE EMERGENCY DEPARTMENT

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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 common. 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.)
HRV reduced SDNN & RMSSD very low: 21.3, 11.5ms spont; 27.2, 19.2ms paced, normal >50, >42 respectively
Strain significantly different (19.1, 24.3, p=0.02) in groups with/without fatigue.
BFI correlated with HRV, TUG with Strain (0.875, p=0.001), & HRV.
All found study acceptable No participant withdrew. One participant each:
• unable to complete STS
• felt echo interfered with privacy
• found paced breathing ‘bothersome’
Conclusions
1. Objective assessment of fatigue, cardiac muscle & ANS feasible, acceptable & warranted in palliative populations
2. Majority of participants fatigued subjectively & objectively
3. Significant diastolic dysfunction & loss of HRV present
4. Correlations between subjective & objective fatigue, myocardial strain & HRV
5. These bedside tests can be used in palliative populations to guide symptom management

THE IMPACT OF A NEW INTEGRATED SUPPORTIVE CARE SERVICE FOR PATIENTS WITH INTERSTITIAL LUNG DISEASE
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Background Interstitial Lung Disease (ILD) can have a prognosis of 2–5 yrs with symptom burden comparable to lung cancer. Advance Care Planning (ACP) is poor and dying is often unrecognised. Funding was obtained for a Palliative Care consultant and ILD nurse to provide a fortnightly clinic, alongside the ILD consultant. The aim of the service: to improve symptom control and ACP, alongside routine respiratory care.

Methods Outcomes were reviewed for the first 50 patients attending clinic within 6 months of the service commencing. Patients were selected by the ILD consultant. Symptoms were assessed using the Integrated Palliative Outcome Scale (IPOS). ACP conversations were documented electronically to the GP with a request to update the Scottish Key Information Summary (KIS). The IPOS scores and information on the KIS were compared from first to last consultation.

Results First and last IPOS scores were available for 33/50 (66%) patients. Symptom burden was high: breathlessness (90%), Fatigue (80%), Anxiety (78%), Depression (60%), Pain (30%). Cough (20%) and insomnia (15%) were mentioned (not routinely measured by IPOS). Most symptoms improved; pain (p=0.035) and anxiety (0.040) reduced significantly. Pre-service 11/50 (22%) patients had ACP documented on KIS with DNA CPR documented in 4/50 (8%). Post-service, 31/50 (62%) had ACP documented (p=0.003). ACP was uploaded to the KIS in 25/31 (81%). DNACPR discussions were documented for 19/50 (38%) (p=0.008) with 17/19 (89%) of these uploaded to the KIS.

Preferred place of death (PPD) was documented for 29/50 (58%) patients. 19/29 (66%) stated a PPD for home, 10/29 (33%) for hospital.

11/50 (22%) patients died within the 6 months. Of these, 7/11 (64%) had documented PPD for home. This was achieved in 6/7 (86%).

Conclusion The integrated ILD Supportive Care service improves symptom burden for patients, improves ACP and may reduce unwanted hospital admissions at end of life.