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143 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 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

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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

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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).

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

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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.

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USING AN IMPLEMENTATION STRATEGY TO IMPROVE GUIDELINE-ADHERENT DELIRIUM CARE IN HOSPICES: EMERGING FINDINGS OF THE DAMPEN-DELIRIUM FEASIBILITY STUDY

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Background Delirium is a complex condition, distressing for patients, family members and staff, and associated with poor outcomes. Despite high prevalence in the palliative care setting, it remains under-diagnosed. Delirium guideline-adherent care may both prevent and alleviate delirium. The best way to improve delirium-guideline adherence, and whether better adherence is reflected in reduced delirium, is not known. Prompt dissemination of feasibility findings is critical to avoid research waste.

Methods To inform a definitive large study, working closely with Patient Public Involvement members, we conducted a co-design and feasibility study (ISRCTN55416525) to assess the feasibility of collecting data (delirium diagnosis; guideline-adherence) from clinical records. Clinical record data (evidence of: delirium using a validated chart-based instrument; guideline-adherent delirium care) was collected from 50 consecutive in-patient admissions at three hospices pre- and post-implementation of a co-designed implementation strategy (data collection completed 3 December 2022). Analysis: Pre-post comparison of percentages for continuous data (delirium outcomes); nominal data (raw count of guideline-adherent metrics).

Results Target clinical record data collection ($n=300$) was achieved within timeframe, despite data collection during COVID-19. Delirium prevalence was comparable pre-and post-implementation with two-thirds of patients having a delirium episode during admission. There was a reduction in the proportion of delirium-days during admission 62% to 49%. We observed modest post-implementation improvements in most guideline-adherent metrics: delirium diagnosis as documented by the clinical team 15% to 26%; evidence of reversibility 33% to 36%; delirium risk assessment 0% to 12.5%; screening on admission 21% to 35%.

Conclusion Data collection about delirium outcomes and guideline-adherence from hospice clinical records is feasible. Our findings show the disparity between need (high delirium-incidence) and documented action (low guideline-adherence). However, there is a signal of patient benefit even with small documented improvements which needs to be formally evaluated in a multi-site study of effectiveness of an implementation strategy for improving delirium guideline-adherence.