

**Data Sources** We searched the following databases: CINAHL, Cochrane Library, Embase, MedLine, PsychInfo and Web of Science followed by reference and forward citation reviews of included records.

**Results** 18 research studies were identified and included: 14 qualitative, 3 quantitative and one mixed methods study. Five key themes were identified: navigating the views of other stakeholders; clinician experiences and attributes; clinicians' interpretation of events; the perceived adequacy of the current setting and the alternatives; system factors; continuity of care and a perceived lack of choice.

**Conclusion** This review illustrates the number and complexity of factors influencing how Primary Care clinicians make hospitalisation decisions. The views of other stakeholders take great importance, and may be a source of conflict, and it is unclear how this should be navigated. Clinician factors, such as experience with palliative care and clinical judgement, are also important. There is significant geographical and system variation in approaches to decisions. Future research should focus on how the different aspects of the decision are balanced and to consider if, and how, this could be improved to ensure hospital admissions at the end of life are appropriate.

56 **EXPLORING THE IMPACT OF PROACTIVE IN-REACH BY THE SUPPORTIVE AND PALLIATIVE CARE TEAM (SPCT) IN THE EMERGENCY DEPARTMENT (ED) OF MANCHESTER ROYAL INFIRMARY (MRI), A CITY CENTRE TEACHING HOSPITAL**

Sarah Shipton, Gurs Purewal, Zoe Ashton. *Manchester University Foundation Trust*

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**Introduction** ED attendance during the final year of life is a significant challenge (Marie Curie, 2018). Models providing palliative care in the ED have shown numerous benefits (Wang et al, 2015). We embarked on a 6 month test of change providing specialist palliative care support to the MRI ED.

**Methods** The SPCT ACP proactively in-reached into ED two afternoons a week for 6 months. Quantitative and qualitative data was collected to demonstrate our outcomes and compared with retrospective data collected prior to this intervention.

**Results** Identifying patients presenting to ED who would benefit from SPCT input improved during the test of change with more than three times as many being identified by the SPCT ACP. Retrospective data showed 23.1% of patients had been identified in the last year of life by ED staff in comparison to 68% of patients by the ACP using prognostication tools. Patients presenting to ED often had a poor performance status (AKPS) of 50% or less, an initial median iPOS score of 24.5 and had an average of 3.13 admissions in the previous 12 months. Whilst many patients presented to ED appropriately with acute illness, SPCT input earlier on in their journey demonstrated reduction in symptom burden and improved quality of life reflected by a reduction of median iPOS score from 24.5 to 15.5 and patient experience stories. We were able to influence goals of care and subsequent hospital stay at an earlier point, demonstrated by a median reduction in length of stay of 17 days. The change also had positive impacts for ED staff, demonstrated by findings of the staff survey.

**Conclusion** Proactive SPCT input into our ED positively impacts on patient experience and outcomes, supports an often stretched department and can reduce length of stay. Further exploration is needed to provide a sustainable model.

57 **ATTITUDES OF STAFF TO CONDUCTING RESEARCH IN A HOSPICE INPATIENT UNIT**

Shannon Milne, Emily Sills. *Princess Alice Hospice*

10.1136/spcare-2024-PCC.75

**Introduction** Hospices are encouraged to be research active and contribute to the evidence base. Participating in research studies requires engagement by staff to assist with recruitment and implementation. During participation in a research study requiring recruitment of inpatients on our hospice inpatient unit (IPU), we sought to understand the views of IPU staff members about research being conducted on the ward.

**Methods** An anonymous online survey hosted on Survey Monkey was sent to nurses and doctors working on the IPU. Responses were collected between April and July 2023. Questions focussed on their own experiences of contributing to research and their views about research taking place on a hospice IPU.

**Results** We received 24 responses (8 doctors, 16 nurses) with a range of years of experience working in a hospice. 12.5% (3 nurses, all with less than 5 years' experience) had not yet contributed to research in their careers. 79% (19) had undertaken an audit including all 8 doctors. The majority (85.7%, 21 respondents) were supportive of research and most (75%, 18 respondents) felt it was extremely or very important that research is undertaken in hospice IPU settings. 18 (75%) respondents stated that patients and families were usually happy to be approached about participating in research. Barriers to engaging in research included lack of time, concerns about burdening patients and families, lack of staff confidence in undertaking research, paternalism, causing potential harm to patients if implementing an intervention, 'lack of understanding about how research could actually benefit the patients and their care' and resistance to change.

**Conclusions** Nurses and doctors working on our hospice IPU are supportive of research taking place on the ward but note a number of barriers to research engagement. Having a better understanding of these challenges will help the research team to support colleagues in future studies.

58 **FRONT DOOR PALLIATIVE CARE: DEVELOPMENT OF A MACMILLAN SPECIALIST PALLIATIVE CARE PRACTITIONER ROLE IN THE EMERGENCY DEPARTMENT OF A TERTIARY HOSPITAL IN THE UK**

Sophie Rayner, Alison Griffiths, Shaen Milward, Douglas Hooper, Martin Thomas. *University Hospital Plymouth, St Luke's Hospice Plymouth, Macmillan*

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In recent years attendances to the emergency department (ED), and consequently patient waiting times have skyrocketed. This combined with increasingly stretched community services has led to growing numbers of patients presenting at

end of life (EOL) and dying in ED. ED staff describe huge dissatisfaction in their ability to provide good end of life care to patients in the department. A big factor in this is the lack of ability to rapidly discharge a patient from ED to die in a more appropriate setting. In May 2023 a Macmillan funded Specialist Palliative Care Practitioner role (band 7 specialist nurse) was created with the aim of improving the experience of patients at EOL, increase the early identification of patients in the dying phase, change departmental culture, provide education and reduce the number of deaths within the department.

The practitioner worked closely with the regional Ambulance Trust, the hospital Frailty Team and Medical Assessment Unit and was based full time Monday – Friday in the ED. The role was patient both patient facing and strategic, with the aim of developing processes to reduce time spent in ED for EOL patients and improve discharge processes.

Early data has shown a hugely positive impact from the role. In the first 21 weeks 99 patients were reviewed; of these 76 had Treatment Escalation Plan (TEP) documents updated, 6 died in ED with support from the post holder, 24 were admitted to hospital and 64 potential acute potential admissions were avoided and instead successfully discharge to their own home, nursing home or hospice directly from ED.

The joint role of having a specialist palliative practitioner embedded in ED has been hugely successful so far and the Hospital Trust is now looking to expand the role further to provide a 7 day service to support pre-conveyance decision making.

## Posters 59–64: Supportive care

### 59 HOME PARENTERAL NUTRITION IN PALLIATIVE CARE: EXPERIENCE OF A REGIONAL NUTRITION SERVICE

Corrie Bowers, Hugo Penny, Ching Lam, Jenna Mynett, Siu Hin Poon, Amber Webb, Susan McLlroy, Jennifer Wood, Ellie Smith, Mark McAlindon. *Sheffield Teaching Hospitals*

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**Introduction** The role of parenteral nutrition (PN) in the palliative care setting remains controversial due to limited data on outcomes. Guidelines suggest patients with a prognosis of greater than 2–3 months are most likely to benefit from home (H)PN. However, predicting prognosis is difficult in patients with advanced malignancy. We assessed experience within our regional nutrition service to inform the outcomes of palliative HPN.

**Methods** We performed a retrospective evaluation of patients referred to our service for palliative HPN between January 2015 and June 2023. Palliative patients were considered as those with malignancy without any curative treatment option. Case notes were reviewed and data at the of start of HPN was extracted and analysed.

**Results** Of the 46 patients referred, 30 (65%) were female and the mean age on referral was 57 years (range 27–81). Indications for HPN are listed in Table 1. Median time from referral to discharge with HPN was 25 days (range 3–68). Central line complications occurred in 12 (26%) patients (5 infections, 8 other complications). Median time from the start of HPN to decision to stop PN or death was 97 days (range 9–617); timings for malignancy subgroups are listed in Table

1. 6 (13%) patients died during the same admission HPN was being arranged; 15 (33%) died within two months of starting HPN. There was no association between albumin nor c-reactive protein at the start of HPN and time to death following HPN ( $p>0.05$ ). However, patients with an albumin  $<30\text{g/L}$  at the start of HPN ( $n=11$ ) had higher 30-day mortality than those with an albumin  $\geq 30\text{g/L}$  ( $n=33$ ; 45% vs 14%, respectively;  $p=0.03$ ).

**Conclusions** The burden-outcome balance of HPN in palliative care settings needs careful consideration before treatment is started. Albumin levels may help inform on 30-day mortality. Further studies to help refine patient selection for palliative HPN are warranted.

### 60 INCLUDING ONCO-GERIATRICS IN ENHANCED SUPPORTIVE CARE: SERVICE EVALUATION THEMES FOR QUALITY IMPROVEMENT

David Allcock, Charlotte Chamberlain, Eleanor Courtney, Anna O'Brien, Emily Gear, Ciara Wynne-Gallagher, Catherine Dennis, Frances Parry. *University Hospitals Bristol and Weston NHS Foundation Trusts and North Bristol Trust, Southmead*

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**Background/Introduction** Enhanced Supportive Care (ESC) manages challenging symptoms resulting from an individual's cancer or their cancer treatment through early multidisciplinary care<sup>1</sup>. The population served and model of service provision in ESC varies between cancer centres. In 2023, Cancer Enhanced Supportive Care (CESC) was introduced at the Bristol Haematology and Oncology Centre serving a population of almost one million (Bristol, North Somerset and South Gloucestershire). Patients with incurable Upper Gastrointestinal and Hepato-Pancreato-Biliary cancers having systemic anti-cancer therapy (SACT) are eligible. Weekly virtual multi-disciplinary team (MDT) meetings highlight patients in need of geriatrician input, using patients' IPOS score (Integrated Palliative Care Outcome Score), AKPS (Australian Karnofsky Performance Scale), and Clinical Frailty Score (CFS).

**Methods** Onco-geriatricians provide advice at the MDT and follow-up medically complex or frail patients (telephone or face-to-face). Follow-up clinics rely on the Comprehensive Geriatric Assessment (CGA) to optimise patients' quality of life (QoL). The CGA has been shown to improve patient outcomes (length of stay, readmission rate, mortality) in medical and surgical specialties and current European wide work on the role geriatricians in oncology is underway<sup>2</sup>.

**Results** During the first four-months, 43 patients, with a median age of 65 years, have been formally discussed with a mean frailty score (CFS) of four (ie vulnerable), (range: 2–9). The Onco-geriatric team have provided input across the following main themes: medical complexity (eg. anaemia and anticoagulation decision making); chronic disease management (eg. diabetes); deprescribing; advanced care planning (in regards to frailty) and input into psycho-social complexity. Patient and health professional feedback has been overwhelmingly positive following geriatric-oncology input.

**Conclusions** Onco-geriatricians play a vital role in the multi-disciplinary care of patients with incurable cancer, alongside disease-targeted treatment. More work is needed to quantify the impact on QoL and any associated cost savings through deprescribing and admission avoidance.