

Methodology Using Shropshire Doctors Co-operative Ltd (Shropdoc's) recorded data we have collated a representative picture of the palliative care practice over a year period from 161 OOHGP patient interactions.

Results 31% of home visits (HV) had documentation of potential reversible factors and out of those 72% were with the patient's estimated prognosis greater than 48 hours. Infection being the most common (57%) reversible factor, the majority being a lower respiratory tract infection. Overall 5.7% of OOH GP palliative HV's resulted in hospital admission, however this decreased to 0.6% adjusting for an estimate of the patient's prognosis to be less than 48 hours. 16% were admitted if the patient had a potentially reversible co-existing condition. 33% of consultations had documentation regarding a continuous subcutaneous infusion (CSCI), 86% of CSCI interventions were made with a prognosis of less than 48 hours. There were CSCI infusion issues requiring an OOHGP 3.4% of the time. Overall anticipatory medications were prescribed 39% of the time.

Conclusion The OOHGP deals with a wide variety of scenarios for a heterogeneous population. The symptoms and treatments instigated are on the most part expected within emergency palliative care. This data begins to quantify and describe the role being performed by OOHGP and has implications for service provision and potentially the necessity of 24 hour specialist palliative provision.

113 THE SWINBURNE SLOT: A CLINIC-BASED SERVICE FOR DETERIORATING PATIENTS WITH INTERSTITIAL LUNG DISEASE

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Introduction and objectives Patients with interstitial lung disease (ILD) can deteriorate quickly. It can be difficult to determine whether this is due to disease progression or other potentially reversible processes. Such patients are often known to multiple services; carer feedback in 2016 highlighted it is difficult to know who to approach. In response, the Newcastle ILD team introduced a weekly 30 min rapid access clinic slot (Swinburne Slot, SS) with the aim of determining reversibility and to support patients in their preferred place of care. Our objective was to evaluate this service, which may have practice implications for other teams.

Methods We collected data on how the SS was utilised between 12/09/2016 and 21/03/2017. This included appointment outcome; for example, further imaging or referral to specialist palliative care. Additionally, we collected data on acute hospital admissions within 30 days. Data were obtained using electronic medical records and telephone calls to General Practitioners.

Results The SS was utilised 24 times during the 28 week evaluation period. The most frequent clinic outcomes were adjustment to medication (n=19) and same day palliative care review (n=12). There could be multiple outcomes per patient. Six patients were admitted to hospital within 30 days with an ILD-related problem. Six patients died between the start of the evaluation and the end of data collection.

Conclusions Carer feedback highlighted a deficiency in our service. Our response, the SS, was well utilised, resulting in

adjustment to patient management and improved access to palliative care. We present the SS as a workable model which could be replicated by other multidisciplinary teams.

114 PALLIATIVE CARE AND THE ACUTE STROKE WARD: NEW BEGINNINGS?

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Background Despite advances in managing stroke, death and severe disability are common outcomes. Many patients unfortunately have profound irreversible damage on a background of multiple co-morbidities. However there is also a group of patients where the extent of irreversibility is unclear and the likelihood of survival may be longer, which leads to complex issues around capacity and decision making, whether clinically assisted nutrition and hydration is appropriate and ongoing symptom management. Difficulties can arise in recognising dying when the trajectory of the disease is not easily predicted.

Method Since May 2016 a member of the palliative care team has attended the board round on the acute stroke ward on a weekly basis to provide direct advice or take referrals while discussing all ward patients.

Results Over 12 months the palliative care team was involved in the care of 37 patients. The average Karnofsky Performance Score (KPS) of patients seen was 20. 57% referrals were related to managing patients in the last few days of life with 76% needing advice regarding symptom management. Nearly a third of referrals involved supporting the team in appropriate decision making around escalation of care in particular use of artificial feeding in patients who lack capacity.

Conclusions Stroke patients do have palliative care needs. The acute stroke team valued having regular input from the specialist palliative care team in particular with regard to recognising and managing the last few days of life and help in decision making around long term feeding in patients with an uncertain prognosis who lacked capacity. Funding has been approved to develop this work further with a pilot project enabling a palliative care CNS to have designated time to work on the general stroke wards from 2018.

115 EVALUATION OF THE USE OF A PATIENT HELD RECORD IN SPECIALIST PALLIATIVE CARE

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Introduction The Royal College of GPs in Northern Ireland created a Patient Held Record (PHR) for patients with progressive, life-limiting illness and their families. This study evaluates its usefulness in the specialist palliative care context.

Methods A prospective longitudinal cohort study through a hospice community service. Patients were given questionnaires with the passport and after 4–6 weeks. Hospice Healthcare Professionals (HCPs) completed a questionnaire and focus group after 8 months.

Results From September 2016–June 2017, 550 patients were screened, 347 (63.1%) were offered a passport and 259