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FROM HERE TO THERE: WHAT ARE THE SPC NEEDS & OUTCOMES OF PATIENTS ADMITTED FROM HOSPITAL TO HOSPICE IPU AND COULD THEIR NEEDS HAVE BEEN MET BY HOSPICE ADMISSION AT OUTSET?

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Introduction Visits to the Emergency Department by cancer patients are increasing but are associated with poor outcomes and capacity concerns. Current strategies aim to decrease hospital admissions and manage needs in community e.g. home/hospice. However it is not known whether needs of patients admitted from hospital (HA) to hospice could have alternatively been met by hospice IPU admission at outset.

Methods Cross-sectional retrospective analysis of consecutive HA to Hospice IPU (14 bed unit) August 16–March 17. Data collected: Demographics and outcome data from hospital/hospice admission. Two clinicians assessed whether management could have been met in hospice IPU at outset. Data anonymised and treated confidentially. Results analysed and descriptive statistics utilised.

Results Data from 50 consecutive transfers collected. Mean age 71.3 years (SD 13.7) and 60% male. 82% had a cancer diagnosis (Lung (22%) most common). More than half (52%) of patients were known to SPC Services prior to hospital admission. 38% (19/50) of patients self-referred to A and E. Half of admissions were in working hours (52% admitted 9 am-5 pm Mon-Fri). Most common phase of illness on hospital 1st assessment was unstable (n=22, 44%). Mean AKPS 38.9 (SD 22). Mean acute hospital inpatient length of stay was 14.7 days (SD 11.2; range 1–49 days). In 38 cases it was assessed that hospice IPU could not have met immediate needs at outset. Reasons: needing procedure/operation/hospital specialty review 9/38, needs acute investigations 9/38; acute sepsis treatment 9/38; chemotherapy related problems 3/38, patient previously not known to have palliative diagnosis/unknown to hospice 8/38. The majority of HA (90%) died during that hospice admission, 4 (10%) discharged. Total length IPU stay 13.2 days (SD 16.4) but range broad (1–73 days).

Conclusions Most HA patients needed initial acute hospital admission at outset (rather than direct IPU admission). Findings will guide 24/7-service development and future planning of hospice beds.

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THE CHANGING LANDSCAPE OF ADVANCE CARE PLANNING: A MULTI-CENTRE STUDY COMPARING PRACTICE IN 2014 TO 2017

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Background Advance care planning (ACP) is an important part of holistic care for palliative patients. Previous studies suggest that engagement in ACP improves patient and family satisfaction with care at end-of-life.

Methods Ten specialist palliative care organisations across Birmingham contributed data to a retrospective study – designed and co-ordinated by the local Specialist Palliative Care Audit

and Guideline Group (SPAGG) – across all settings including hospice inpatients, community and hospital. Data from 166 patients known to these services was collected using an electronic data collection form. The results were compared to a similar sample taken in 2014, and conclusions were drawn.

Results This study found the number of patients with a documented resuscitation status, preferred place of care and death had increased from 2014. Specifically, 81% had a preferred place of death documented in 2017 compared to 58% in 2014. Preferred place of death was achieved for 66% of patients in 2017 compared to 30% in 2014. In contrast, the number of patients completing a hand-held document of their wishes was 14% in 2017 which had fallen from 24% in 2014. Also, documented information was less likely to be shared with other health professionals including ambulance and out of hours services in 2017 compared to 2014.

Conclusions Rates of discussions of resuscitation, preferred place of care and death have increased since 2014. As a consequence, an increased number of patients achieved their preferred place of death. This is likely due to increasing organisational and political focus on avoiding unwanted hospital deaths and staff training to improve skills and confidence in these areas. The decrease in the number of patients with a hand-held document and lack of data sharing suggests opportunities for SPAGG to focus on supporting consistent implementation of a hand-held tool and improved communication across the locality.

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VTE PROPHYLAXIS IN A SPECIALIST PALLIATIVE CARE UNIT

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Introduction NICE recommend considering VTE prophylaxis for palliative care patients with potentially reversible acute pathology, taking into account potential risks/benefits and the views of patients and families. In Roxburghe House Specialist Palliative Care Unit (RH), NHS Grampian, there is no formal decision-making process around VTE prophylaxis.

Aim To assess the current level of documentation of decision-making regarding VTE prophylaxis in patients admitted to RH. To subsequently introduce a VTE assessment proforma as part of the admission pack to prompt decision-making and documentation of VTE prophylaxis decisions.

Methods The notes of 19 inpatients in RH were reviewed. The following data was recorded: diagnosis, VTE prophylaxis on admission/at time of data collection, documentation of decision as well as potential risks/benefits from VTE prophylaxis.

Following this, a VTE assessment proforma was introduced in the admission documentation for RH. The notes of patients admitted following were subsequently analysed.

Results Initially, only 8 patients (42%) admitted to RH had a documented decision regarding VTE prophylaxis. 10 patients (53%) were receiving prophylactic or treatment dose Dalteparin. Of the remaining 9 patients (47%), it was felt that 6 would not benefit from VTE prophylaxis (4 had active bleeding, 2 had cerebral tumours), and that 3 may benefit.

Following the implementation of the VTE prophylaxis proforma, Preliminary results show that 11 patients (100%) had a documented decision in the medical notes regarding VTE