

prophylaxis. 2 patients (18%) were started on prophylaxis and in 1 patient it was continued.

**Conclusion** The documentation of decision making regarding VTE prophylaxis in RH was initially poor. Following implementation of the assessment tool there has been improvement in documenting and discussion around VTE prophylaxis.

Data collection is still ongoing. The next step will be to assess if VTE prophylaxis prescriptions are reviewed, e.g. monitoring platelets, reviewing the duration and appropriateness of treatment.

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### THE DEVELOPMENT OF AN ENHANCED NURSING HOME BEDS SERVICE PROVIDES AN ALTERNATIVE TO HOSPITALISATION FOR PEOPLE APPROACHING THE END OF THEIR LIVES

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**Background** In 2013 the Palliative Medicine Department at Derby Hospitals launched an initiative within care homes with the aim of reducing unwanted hospitalisation and offering an alternative place of care for people approaching the end of their lives.

The Enhanced Beds Service consists of 10 beds within 5 Nursing Homes across a commissioning locality. They are available to patients who reach a crisis point, needing 24 hour care, where hospitalisation is undesirable. Day to day care is delivered by the Nursing Home staff, overseen by three specialist nurses who provide support and additional nursing care to patients and those important to them, as well as training and support to the Nursing Home staff.

Referrals are taken from all care providers including the hospital and community palliative care teams. Patients are assessed in their current location and, if admitted, are usually transferred within hours. A patient and carer experience survey and an audit are completed for all referrals. These measures monitor the service impact and direct improvements to the service.

**Results** In the last 4 years 466 patients have been transferred into an Enhanced Bed, 63% of which would have otherwise been admitted to hospital the same day – potentially saving 3500 acute bed days. Overall, 96% of admissions avoid further hospitalisation. The experience survey reports a high level of satisfaction in the care received. Informal feedback from colleagues in health and social care is positive, with increasingly more complex patients being referred.

**Recommendations** The Enhanced Beds service has demonstrated measurable improvements in patient experience and outcomes. Future developments include a 'roaming bed' to increase choice of location.

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### THE PRIDE OF WEST MIDLANDS PALLIATIVE CARE RESEARCH: WM CARES

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**Background** Research is key for speciality development and higher medical training but there are well recognised barriers

to participation in research within palliative care. The West Midlands Palliative Medicine Registrars recognised that lack of local structure and collaboration was contributing to trainees' difficulties in participating in research.

**Methods** The West Midlands Palliative Medicine Registrar group initiated a trainee-led collaborative, 'West Midlands Collaborative Actioning Research in End-of-life and Supportive Care' (WM CARES), which was launched in September 2016 with local stakeholder support. We hold monthly meetings at registrar training days, involving partners including the National Institute for Health Research (NIHR), local universities, palliative medicine consultants, speciality doctors and local providers of palliative care. We regularly update the wider palliative care community via newsletters, website and social media.

**Results** WM CARES has developed four research questions into working groups under consultant supervision. The WM CARES network enables larger, multi-site, high quality research which crosses the boundaries of any individual registrar's placement. To date, the group has presented six posters at national conferences and two journal articles are currently being prepared for publication. WM CARES has a mission to share local work, with collaboration being a central focus. This year the collaborative organised an inaugural conference, WM CARES PRIDE (Presentations in Research, Innovation, Development and Excellence) which showcased multidisciplinary research, audits and service developments from the region. There has been buy-in from the registrar body who recognise the opportunity to meet curriculum competences and explore research interests within a structured framework.

**Conclusion** WM CARES is an innovative and collaborative trainee-led network conducting high-quality research and raising the profile of research. It enables and enthuses Palliative Medicine Registrars and the wider multidisciplinary team to learn about and be involved in research activities, which will ultimately improve patient care.

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### INTEGRATED ONCOLOGY AND PALLIATIVE CARE: ANALYSIS OF A NEW SERVICE FOR CANCER PATIENTS

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**Background** There is growing evidence to support the benefits of early integrated palliative care (PC) for patients with advanced cancer. Within a tertiary referral cancer centre we started a new Integrated Symptom Control and PC service. The aim of this service is to proactively identify patients who would benefit from PC review and to offer earlier support. The aim of this study is to assess the feasibility and outcomes of this service.

**Methods** This pre-post design study was approved locally, and is part of a national programme to develop Integrated PC. Two tumour groups were selected due to their poor prognosis; renal cell cancer (RCC) and gynaecological cancer (GC). The study was conducted between October 2016 and September 2017. 316 patients (RCC 111/GC 205) were assessed as part of the new service. 286 of these patients (RCC 100/GC 186) were formally assessed for PC needs using the validated Integrated Palliative care Outcome Scale (IPOS). Descriptive statistical analysis was conducted.

**Results** 12 months after initiation of the new integrated service, the proportion of patients with GC and RCC reviewed by PC at diagnosis of incurable disease had increased from 26% and 16% to 80% and 93% respectively. 79% (RCC) and 72% (GC) had severe or overwhelming psychosocial needs. 18% (RCC) and 25% (GC) had severe or overwhelming physical needs.

47 patients had died at time of analysis (16 RCC and 31 GC). Median time from review to death was 134 days (range 20–318 days). This compares to a median time between PC referral and death in the baseline cohort of 98 days (GC) and 83.5 days (RCC).

**Conclusions** The Integrated service proactively identifies patients with PC needs earlier and has highlighted the high burden of psychosocial needs. This study will underpin service development and improvement to include proactive intervention.

132 **IMPROVING THE PRESCRIBING IN A GENERAL HOSPITAL OF 'AS REQUIRED' ANTICIPATORY MEDICATIONS FOR END OF LIFE SYMPTOMS, FOLLOWING THE INTRODUCTION OF AN ELECTRONIC PRESCRIBING 'ORDER-SET'**

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**Background** Availability of anticipatory medications for common end of life (EOL) symptoms is a quality indicator measured in recent hospital care of the dying audits. Local results from the 2013 audit demonstrated poor uptake of anticipatory prescribing. In 2014, the Trust moved to electronic patient records and prescribing across the acute trust. Working in partnership with the informatics leads for pharmacy and medicine, the palliative care team utilised the capabilities of 'Cerner's' electronic patient prescribing system to develop an 'order-set' of 5 medications, commonly needed at the end of life. The system went live in May 2015 and an early induction session to the new junior doctors was delivered in August 2015.

**Aims** To evaluate prescribing of anticipatory 'as required' EOL medications, following the introduction of the palliative care 'order-set'.

**Methods** A retrospective review of anticipatory, 'as required', prescribing for a 1 month period was undertaken 12 months after introducing the prescribing 'order-set'. Criteria applied as for the 2013 National Hospital audit.

**Results** were compared with local results from 2013. Baseline information from 2013 showed that the Trust under-performed for prescribing for all symptoms: (Agitation- 23%, Breathlessness- 20%, Nausea- 14%, Pain- 27%, and Secretions- 7%).

Twelve months after implementation of the 'order-set' the results were: (Agitation- 68%, Breathlessness- 74%, Nausea- 68%, Pain- 74%, and Secretions- 65%). These results are all above the national average from the 2016 RCP: National End of life care audit.

**Conclusions** Introduction of an electronic palliative care prescribing 'order-set' for anticipatory EOL medications, has demonstrated considerable improvement in the uptake of anticipatory prescribing for dying patients. This in conjunction

with an early palliative care induction education session for junior doctors has demonstrated significant improvements in the quality of prescribing in the end of life phase of life for patients in an acute hospital.

133 **ASSESSING THE MANAGEMENT OF HEART FAILURE PATIENTS IN THE INPATIENT HOSPICE SETTING: A RETROSPECTIVE AUDIT**

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Approximately 900,000 people in the UK have heart failure (HF) with 30–40% dying within a year. The incidence of HF is increasing. Patients have a high symptom burden; patients with HF will have similar numbers of symptoms to cancer patients. As UK life expectancy increases palliative services will need to provide more support to this patient group.

This retrospective audit assessed care from Severn Hospice to HF patients admitted to the hospice since November 2015. NICE guideline 'Chronic Heart Failure in Adults: Management' was used as the gold standard.

Of 962 patients admitted to the hospice, 13 had a diagnosis of HF. 9 had a primary diagnosis and 4 had HF as a comorbidity. The majority of patients were referred for symptom control. At admission patients had a mean of 4.38 (range 1–7) symptoms. 9 patients had symptoms not in the NICE guideline including constipation, diarrhoea, anxiety, agitation and hallucinations. The majority had more symptoms at admission than at initial referral (mean 4.84). 9 patients had syringe drivers during their admission; 3 were furosemide infusions.

All patients had some advance care planning (ACP). All had a 'do not resuscitate order'. Preferred place of death was documented in 12 patients (1 had no capacity). 9 had a preferred place of care. No patients had an advance directive to refuse treatment. Most ACP was done on admission.

Surprisingly few patients with HF are admitted to the hospice. These patients have a significant symptom burden including some symptoms not always associated with HF. This suggests that the needs of HF patients are not being met. As a result efforts are being made to set up a joint HF and palliative care MDT. With this and increasing numbers of patients the hospice will continue to gain expertise in managing these patients.

134 **STAFF VIEWS ON CHANGES TO THE MULTI-PROFESSIONAL ELECTRONIC-HANDOVER IN A SPECIALIST PALLIATIVE CARE UNIT: SERVICE DEVELOPMENT PROJECT**

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**Background** Introducing change to service can be challenging. Following an audit of electronic handover (e-handover), a multi-professional group of palliative care doctors, nurses and allied health professionals, developed a Standard Operational Procedure (SOP) to guide staff and ensure e-handover consistently addressed patients' specific palliative care needs. As part