Abstracts

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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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.

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

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Results 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