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MAKING EVERY DAY COUNT FOR PATIENTS IN AN ACUTE HOSPITAL AT THE END OF LIFE: SILVER TO GOLD BED DAYS

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Background Wirral University Teaching Hospitals NHS FT serves a population of 330,000. Patients who subsequently die in hospital spend 21 days (mean) of their last 100 days of life in hospital. When time is so precious, it is crucial that every day spent in hospital 'counts'.

Inpatient specialist palliative care and end of life care provisions was fragmented. The aim was to improve care and cohesiveness by putting patient's wishes at the centre of clinical process.

Methods The 'red to green days' concept (developed for Safer Patient Flow) was adapted to focus on patient experience of care. At the start of the day a board round assesses 'what matters most today' for each patient, with agreed actions across the team. The patient's day starts as silver and is then recorded as 'gold' only if progress is made against the patient's expressed wishes. A silver day means a patient receives high quality care, but no action to achieve wishes. The team applied 'Plan Do Study Act' methods to develop this approach from concept to practice.

Results Patients' wishes were more consistently understood and met. Examples include: obtaining a wig, a urinary catheter, complex spiritual care, wedding ceremony, rapid discharge, hospice bed, physical symptom control. The focus on 'what matters most' to patients increased team cohesiveness, greater peer support and shared responsibility rather than individual caseloads.

Performance was monitored using Statistical Process Control and ongoing analysis of barriers to achieving a gold day. There is an association between patient flow and the ability of the SPC team to meet patient wishes.

Conclusions A single focus on patients' wishes and what matters to them helps team working together to meeting these goals. Collecting evidence on why patients are unable to achieve their wishes supports thematic learning to guide future commissioning and service developments.

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DATA SHARING PROJECTS IN END OF LIFE CARE – EASIER, HARDER, OR JUST AS FIERCELY COMPLEX AS ANY OTHER?

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Background Electronic Palliative Care Coordination Systems (EPaCCS), enabling data sharing across care settings, have been under development in England for over nine years and are expected to cover all areas of the country by 2020. Data sharing (technically termed 'health information exchange?', HIE) projects are, however, amongst the most difficult projects of health information technology (HIT) implementation. We report on a sub-study of 'Prepared to Share?', a mixed methods realist evaluation of The Cambridgeshire and Peterborough

Project for Data Sharing in End of Life Care, nested in broader research on data sharing and EPaCCS.

Methods 44 participants were interviewed using principles of realist and episodic interviewing. Preliminary analysis of nine interviews and four existing reviews on HIE and HIT, covering 135 studies, contributed to an initial analysis framework. Framework and thematic analysis principles and 'pluralist' coding informed by the philosophy of science of J. Dupre were applied in the analysis.

Results We identified >460 challenges and >300 drivers to implementing EPaCCS and data sharing projects more broadly, the majority of them richly described in the interviews. The main sources of challenges were: the existence of 'alternatives', i.e. primarily well entrenched and thus easier ways of working, but also other data sharing solutions; generic resource constraints within the health system; information governance issues; generic IT infrastructure challenges; insufficient adaptability, capacities for personalisation and flexibility of the solution; and generic features of the health system, such as its fragmentation. 'Expected benefits' and 'training, education and awareness raising' were the only higher-level categories where drivers outweighed challenges.

Conclusions EPaCCS projects and research need to draw on and contribute more to existing HIE and HIT research. EPaCCS teams and users are learning the hard way many lessons which are already described in this broader research literature.

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TRIGGERS FOR REFERRAL TO PALLIATIVE CARE

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Background Benefits of early palliative care (PC) referral for oncology patients are well-documented. The development of PC referral 'Triggers' may help identify which patients should be referred. A number of 'Triggers' have been proposed, but are currently not commonly used in clinical practice. This project aimed to evaluate a number of published referral Triggers through a retrospective note review of PC team involvement with patients who died during a non-elective hospital admission.

Method All patients admitted to the oncology hospital non-electively during one year who died during that admission were selected, excluding patients admitted to CCU (N=159). The timing of referral to PC, and whether patients met any published PC referral triggers before and during their terminal admission was assessed.

Results 88% (140/159) of patients would have been eligible to 'trigger' a PC referral during their terminal admission, no matter which Triggers tool was used. Information relating to disease and symptom-related 'Triggers' are most commonly documented in medical notes. Psychosocial factors were less well-documented.

46.5% of patients were known to PC prior to their final admission. All but 3 of the remaining patients were referred during admission, with a median time (range) between admission and referral of 4 days (0–58 days), and between referral and death of 9 days (0–90 days).

Conclusions Currently, many patients are not known to palliative care until their last hospital admission, and therefore until their last days of life. In this patient cohort, a palliative

referral Triggers Tool would have proactively identified most or all patients who died during their non-elective hospital admission. The inclusion of disease and symptom-related parameters in a PC referral Trigger tool appears feasible as these are often documented in oncology records, whereas oncologists may not routinely identify psychosocial factors.

143 **CREATION OF GUIDELINES FOR MANAGEMENT OF PATIENTS UNDERGOING ABDOMINAL PARACENTESIS FOR MALIGNANT ASCITES AT JOHN EASTWOOD HOSPICE**

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Background The inpatient unit at John Eastwood Hospice (JEH) is increasingly providing care for patients with malignant ascites, allowing the relief of symptoms via paracentesis. With no established local or national guidelines to follow for peri procedural care, we felt there were varying approaches used for our patients. We set out to create a local protocol for patients undergoing paracentesis, and audit practice against this.

Methods A thorough literature search alongside review of guidelines uploaded to palliativesdrugs.com, and those publicly available on the internet, identified eleven established UK guidelines for management of malignant ascites.

These were used to construct a protocol for use at JEH. Audit standards were then established alongside this, allowing for retrospective analysis of the management of patients who had undergone paracentesis at JEH.

Results 8 patients had undergone this procedure in the preceding 12 months at JEH, giving a total of 10 completed procedures. Peri procedure management in several areas was variable.

A set of baseline observations was documented prior to the procedure in only 10%. Documentation of observations post procedure varied significantly, ranging from half hourly to none at all. 60% had documentation of drain clamping at some point but in none of the cases was there any further detail of the clamping (e.g. length of time). For the 7 drains which were temporary, the length of time they remained in situ ranged from 31 hours to 195 hours.

Conclusions This retrospective audit demonstrates significant variability in the management of patients undergoing paracentesis at JEH, which strayed from that suggested by the newly created guidelines. These guidelines will now be rolled out in the hospice, alongside education to staff, and re-audit completed to ascertain whether there is more uniform practice.

144 **QUALITATIVE COMPONENT OF A LONGITUDINAL, MIXED METHODS PROGRAMME EVALUATION USING IN-DEPTH INTERVIEWS**

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Background Macmillan Specialist Care at Home seeks to enhance patient-centred care through community and home-

based palliative and end of life care services. This article reports a qualitative study that formed part of a larger evaluation of a multi-site implementation of the specialist palliative care community service.

Aim To examine caregiver, patient and carer experiences of service implementation and identify how its key features: early referral; clinical interventions at home; avoiding hospital admissions; and facilitating patients to die in their preferred place of death, worked in practice.

Methods Qualitative component of a longitudinal, mixed methods programme evaluation using in-depth interviews (n=49 [Health professionals (n=18), volunteers (n=14), patients (n=9) and lay carers (n=8) from six community-based sites]) supported by a visual research method 'Pictor' to facilitate dialogue about experiences of care. The data were analysed using thematic analysis.

Results Effective partnerships between generalist and specialist teams improve the overall quality of community and home-based palliative and end of life care. The collaborative approach instils confidence and empowers patients and carers, principal factors in crises-prevention and enabling home deaths. Key themes were:

1. Early referral and rapport; Benefits of seamless care.
2. Averting crises situations;
3. Community consultant as catalyst; Home-based clinical interventions
4. Attending to wider aspects of care; Managing expectations through patient and carer education.

Conclusions Macmillan Specialist Care at Home is a complementary resource for community-based palliative and end of life care that can extend and greatly enhance the quality of care experience for people with life limiting illnesses and their families. Joint education, training and continuing professional development for specialist teams and existing community staff is advocated to promote shared knowledge and to forge and strengthen bonds between specialist and generalist health and social care professionals. Further testing of the mechanisms involved in implementation will improve transferability potential.

145 **IMPLEMENTING EDINBURGH COGNITIVE AND BEHAVIOURAL ALS SCREEN (ECAS) IN PALLIATIVE CARE IN PATIENTS WITH MOTOR NEURONE DISEASE (MND) – EXPERIENCE FROM PHYLLIS TUCKWELL HOSPICE CARE (PTHC)**

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Background PTHC has a longstanding interest in neuro-degenerative conditions (NDC) and hosts bi-monthly NDC multi-disciplinary team (MDT) meetings on its two sites. Despite other robust care pathways, assessment of cognitive and behavioural function was not standardised. ECAS was identified as the most suitable tool to improve this aspect of care.

Methods A 12-month hospice project was designed to:

- Raise awareness of cognitive and behavioural impairment in MND and ECAS