

The effects of cancer and its treatment can have major adverse effects on the women it has affected and their families. This service has been set up with the support of Sutton Breast Friends and St Giles Hospice and will enable patients to discuss issues which were previously unrecognised relating to the impact on their altered body image, well-being and sexuality in a comfortable and open environment with a specialist nurse who has the skills to empower these patients to live their lives well, when suffering from the adverse effects of cancer and its treatment. Focus groups were utilised at the start to ensure that the service was set up how women wanted to ensure its success.

By developing this service and delivering this model of care, our aim is to:

- improve the wellbeing of women suffering with cancer and the adverse effects of its treatment
- enable women to take control and manage a range of problems impacting on their body image, sexuality and wellbeing
- enable wives/husbands/partners to discuss the issues and concerns relating to how cancer and its treatment may impact on their relationship
- prevent relationship disconnect linked to cancer and its treatments

There will continue to be an unmet need and these issues will remain unresolved for patients affecting their quality of life, and their ability to reconnect with their relationships. Evidence shows increased risk of relationship breakdown when suffering from the adverse effects of cancer and its treatment.

Due to this being a new service outcome measures will be collected and will be used to demonstrate the effect the intervention has had on patients self-worth, confidence and state of mind.

149 INVESTING IN QUALITY IMPROVEMENT IN A HOSPICE – HOW IT HALVED WAITING TIMES AND IS CREATING A NEW CULTURE!

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Over the last 2 years St Luke's Hospice has invested in the use a Quality Improvement Framework – The Model for Improvement (IHI), across the whole organisation.

This involved an investment in a QI lead, back filling the clinical time, actively supporting staff to participate and investment in a partnership with NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC).

There have been 3 key interventions.

- Delivery of a QI programme to 3 cohorts of staff and volunteers.
 - 33 people have attended the programme (2 doctors, 7 nurses, 4 Patient support, 1 therapist, 7 clinical support, 8 non-clinical and 4 volunteers), and 20 QI projects have been undertaken.
 - The course has evolved and now has a more theory into practice, peer support, and trialling incremental improvement
- Investment in a partnership with the CLAHRC to improve service in our Woodgrange Centre

- We will show how we have improved our data collection
- Halving waiting times in Our Woodgrange Centre
- Invested in setting up the use of Care opinion as a way of improving the way we use patient stories to appreciate our staff and improve services.

This has been a process of parallel continuous learning. We will also share what we have learnt about leading such a process and what our staff have learnt along the way.

This will be helpful for anyone in a leadership role wanting to follow a similar approach.

150 HOW WE HALVED THE WAITING TIME FOR HOSPICE SERVICE THROUGH IMPLEMENTING QI METHODOLOGY

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As part of a wider QI programme St Luke's Hospice invested in a Partnership with NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) to assess the impact of applying Quality Improvement methodology to the Woodgrange Centre (WGC). The WGC is our Daycare and outpatient Centre.

The presentation will present the series of Quality improvement methodologies used and what we learnt from each step: These include:

- Initial engagement with patients, carers, staff, volunteers and referrers
- Touchpoint Mapping
- Using an action effect diagram to develop a shared aim and prioritise first steps
- Use of process mapping to engage staff in the change idea
- Introducing and supporting staff to try tests of change through PDSA cycles
- Learning to use measurement for improvement to demonstrate the improvements

We will show how this has changed the culture, enthused and developed our staff and amongst other improvements halved the average waiting time from referral to 1st visit from 20 to 11days.

We will share the added quantitative data to patient feedback. We now know that as well as patients reporting that the 'service is wonderful', 43% believe the WGC has prevented a hospital admission.

151 MONITORING CORTICOSTEROIDS: AN IMPROVEMENT PROJECT IN A SCOTTISH SPECIALIST PALLIATIVE CARE UNIT

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Background Corticosteroids are frequently prescribed in patients with advanced cancer for a wide range of indications. Many undesirable adverse effects are frequently reported including steroid-induced hyperglycaemia. For patients commenced on corticosteroids, without prior diagnosis of diabetes, twice weekly monitoring of capillary blood glucose(BM) is

advised. Previous studies have shown poor documentation of indication, monitoring and side-effects of corticosteroids in a palliative setting.

Aims

Primary Aim Within 3 months, 90% of patients treated with steroids in Roxburghe House (RH) will be screened for hyperglycaemia with twice weekly BM monitoring.

Secondary Aim Within 12 months, 90% of steroid prescriptions in RH will have documented weekly re-assessment.

Methods The Plan Do Study Act method of quality improvement was used. Baseline data was collected for all inpatients in December 2016 from medical notes and medication administration charts (Kardex). Documentation of indication, PPI prescription, twice weekly BM, evidence of re-assessment and response was reviewed. Baseline data was re-collected following interventions over 12 months.

Interventions: A new steroid form was created with input from all grades of medical staff. Form revised and re-printed on brightly coloured paper. Education given to nursing and medical staff about steroid-induced hyperglycaemia. Reminders displayed in doctors' room. Senior charge nurse implemented set days for BM monitoring. Progress discussed at quality meeting. Included in junior doctors' induction. Patients on corticosteroids highlighted in doctors' room board.

Results Between 45–76% of inpatients were prescribed corticosteroids. Documentation of BM monitoring improved from 0% at baseline to 43% at 3 months and 100% at 8 months. No trend identified in documentation of indication (33–86%), re-assessment (23–83%), response (0–43%) or PPI prescription (80–100%) over 12 months.

Conclusions Regular monitoring of BMs has become successfully imbedded. Documentation of response and re-assessment remains poor. The rotation of junior doctors is a likely influencing factor to achieving sustained improvement, highlighting the importance of induction and education.

Methodology The review was conducted using Cochrane and PRISMA guidelines. Outcomes that were identified amongst patients undergoing treatment for MUO included prognosis, quality of life (QOL), complications, morbidity and prognostication tools.

Results The initial review found 169 papers. A total of 56 papers were included. Median survival was 6.4 months in the 50 papers that stated this outcome. The average reported complication rate was 41% with one fifth of patients never leaving hospital post procedure. Significant predictors to poor outcomes included low serum albumin, hyponatremia, the number of malignancy related events, and performance status of 2 or worse on the European cooperative cancer group. For those patients with 2 or more risk factors, median survival ranged from 1.7–2.6 months and 12-month survival ranged from 0%–12%. QOL using several measures ranged from 41–88%.

Conclusion In this post Montgomery era with the concept of the 'reasonable patient', can we continue to justify discussing decompression without stating the evidence-based risks from the emergent body of literature? We propose a multi-centre review of outcomes to enable evidence-based consultations for patients and their families.

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AUDIT OF THE USE OF TREATMENT ESCALATION PERSONALISED PLANS IN UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

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Background Treatment Escalation Personalised Plans (TEPPs) were introduced across the Trust in 2014 to record ceilings of care for patients who fulfil specified criteria. TEPPs aim to encourage clinical decision making by senior clinicians familiar with the patient, in discussion with the patient and/or their next of kin (NOK). An initial audit was completed in 2015.

Methods We performed a re-audit of case notes on 12 medical, surgical and oncology wards over 5 weeks in early 2017. The criteria for a TEPP were: patients with a DNACPR, those meeting poor prognostic criteria for long-term conditions, or those deteriorating despite active treatment. Documentation of TEPP discussions with patients and/or NOK was also examined.

Results Of 268 notes reviewed, 126 met criteria for a TEPP (47.0%). Of these, 59/126 (46.8%) had a TEPP, and a further 6 had ceilings of care documented in their medical notes. 75% of TEPPs were completed within 48 hours of admission. Appropriate completion of TEPPs varied between specialities, from 80% in Stroke to 0% in Surgery. Evidence of TEPP discussion was present for 93% of patients with capacity and 89% of those without (discussed with NOK).

Conclusions Completion of appropriately indicated TEPPs was stable across audit cycles. Documentation rates of TEPP discussions with relatives had improved, but the extent of documentation varied significantly. The variable rate of TEPP completion between specialties is worthy of further investigation. Further work is required to reinforce the indications for TEPPs, raise awareness of formal poor prognostic indicators and emphasise the importance of full documentation of

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MALIGNANT URETERIC OBSTRUCTION DECOMPRESSION: HOW MUCH GAIN FOR HOW MUCH PAIN? A SYSTEMATIC REVIEW OF THE LITERATURE.

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Background Over the last thirty years, the management of Malignant Ureteric Obstruction (MUO) has evolved from a single disciplinary decision to a multi-disciplinary approach. Careful consideration must be given to the risks and benefits of decompression of hydronephrosis for an individual patient. Though there is some recommendations within cancer specific guidelines, both the European Association of Urology and the American Urological Association guidelines recommend drainage or de-obstructing the urinary systems, there is a lack of consensus of opinion as well as strong evidence to support the decision process.