

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.

discussions in medical notes. Information obtained from this audit will help guide development and implementation of new, combined DNACPR/TEPP forms in relation to new nationwide schemes.

**154 WORKING IN PARTNERSHIP IN THE COMMUNITY: OUR EXPERIENCE AND OUTCOMES OF THE LONDON AMBULANCE SERVICE CALLS TO ST LUKE'S HOSPICE (HARROW AND BRENT) SINGLE POINT OF ACCESS SERVICE**

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In May 2015, St Luke's Hospice launched a Single Point of Access (SPA) telephone and triage service. The aim of this service was to provide a coordinated 24/7 telephone service to provide specialist advice and assistance to patients in the last year of life. The SPA is also available to health and social care professionals, including paramedics from London Ambulance Service (LAS). The SPA service also provides access to a rapid response team to provide direct care to patients in need between 7 am-to-11 pm.

All telephone calls made between the SPA and LAS paramedics were logged onto a clinical database (iCare). By searching for the appropriate call code, relevant calls from the first 20 months of the SPA service were identified and analysed.

There were 130 telephone calls; 90 were regarding patients known to the SPA (67 individual patients), and 40 were about patients previously unknown to the service. Taking into account multiple calls for the same event, 74 separate clinical events were analysed. The most common outcome of a call from LAS was to arrange a call/visit from a GP (usually out of hours) or by a district nurse (DN) (in or out of hours) 28%. A further 12% of the calls required a visit from the hospice rapid response team, and only 11% of patients were escorted to hospital.

Analysis of these calls highlights the importance of the SPA as a liaison service, with over 25% of calls resulting in call-outs from community services (GP, DN, community palliative teams), and a further 12% requiring a call-out from the SPA rapid response team. We believe this is the first collection of data to show the impact of a palliative SPA service on the LAS, facilitating clinical decision-making, and improving confidence in leaving patients at home with community support.

**155 THE IMPACT OF AN INTEGRATED RENAL SUPPORTIVE CARE SERVICE ON SYMPTOM BURDEN, ADVANCED CARE PLANNING AND PLACE OF DEATH FOR PATIENTS WITH ADVANCED CHRONIC KIDNEY DISEASE MANAGED WITHOUT DIALYSIS**

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**Background** We redesigned a Renal Supportive Care (RSC) service in 2012 for patients with chronic kidney disease

(CKD) managed without dialysis. We audited the service to evaluate impact on symptoms and care pathways.

**Methods** The RSC service allows consultations over a wide geographical area and includes a RSC nurse, a Renal consultant and a Palliative Medicine consultant. The main focus is continuing care of CKD, symptom management and Advanced Care Planning.

A retrospective case-note audit was performed from April 2012 until October 2014 on all known patients who had chosen non-dialytic management. Data collected included demographics, RSC input, Palliative Care Outcome Score (POS), anticipatory care plan (ACP) information and mortality data.

**Results** 98 patients were managed with non-dialytic care during the audit period. 72% (71/98) received RSC consultations. 72% (57/79) of patients who received a RSC consultation had a full assessment of symptoms using the POS with an improvement in total symptom burden from a median score of 11 to 8, between the first and last consultation ( $p=0.03$ ).

For patients with RSC input, 79% (56/71) had an ACP compared to 19% (5/27) without ( $p<0.001$ ). Preferred Place of Care (PPC) was documented in 68% (48/71) and 26% (7/27) in each respective group ( $p<0.001$ ). PPC was community in 100%. DNA CPR was documented in 84% (57/68) of patients with RSC input and 47% (8/17) without ( $p=0.001$ ).

During the audit, 62% (61/98) of patients died. 29% (11/38) of patients with an ACP died in an acute hospital versus 43% (10/23) of those without ( $p=0.25$ ). 24% (8/34) of patients with documented PPC died in acute hospitals versus 48% (13/27) without documentation ( $p=0.04$ ).

**Conclusions** The Renal Supportive Care team achieved symptom management and Advanced Care Planning for many patients with CKD managed without dialysis and may help achieve preferred place of care.

**156 A PROSPECTIVE AUDIT OF SYMPTOM BURDEN AND PALLIATIVE CARE REFERRAL AMONGST IN-PATIENTS WITH DECOMPENSATED LIVER DISEASE**

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**Aim** Previous studies have suggested an unmet symptom burden in patients with decompensated chronic liver disease (DCLD). The Bristol Prognosis Score (BPS) has been designed to identify patients with DCLD likely to be in the last year of their life, who may benefit from Specialist Palliative Care team input. We aimed to audit the prevalence of symptoms appropriate to trigger referral to the Hospital Specialist Palliative Care Team (HSPCT), (using the Integrated Palliative care Outcome Score (IPOS)), rates of recognition of these by physicians, and rates of referral to HSPCT according to BPS status.

**Methods** A prospective audit of all inpatients with DCLD admitted over 3 months was conducted. Patients completed IPOS questionnaires. Demographic data were collated in order to calculate BPS. Case notes were reviewed following discharge to assess if significant symptoms (regarded as scoring  $\geq 2$  on IPOS) were identified by the medical team. Referral rates to HSPCT were also recorded.

**Results** 40 patients with DCLD were included. 36 (90%) scored  $\geq 2$  in at least one IPOS category. Most patients (20 (55.6%)) had only some of their significant symptoms