P-101 A RENAL PALLIATIVE MULTIDISCIPLINARY APPROACH

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Background Patients with end stage renal failure on dialysis have a high symptom burden (Murtagh, Addington-Hall & Higginson, 2007) and survival on dialysis can be comparable to some cancers (Nordio, Limido, Maggiore *et al.*, 2012). Increasingly it is recognised that patients with advancing age and comorbidities may benefit from a conservative approach rather than dialysis (Chandna, Da Silva-Gane, Marshall *et al.*, 2011). Patients with non-malignant disease often receive palliative services late or not at all (Allsop, Ziegler, Mulvey *et al.*, 2018).

Aims To improve renal palliative integration, education and support for patients with End Stage Renal Failure (ESRF), including those on renal replacement therapy and those opting for conservative kidney management.

Methods Development of a monthly renal palliative MDT meeting alongside a biannual two-day renal education programme.

Results From April 2017 to April 2018, 36 patients were identified and included in multidisciplinary discussion. Average age 74 (range 44 to 88 years). Majority included were haemodialysis (HD) patients (27). Six patients had cancer in addition to ESRF. There were 19 deaths during the period. In 71% of patients who died on HD, dialysis had been withdrawn prior to death. 74% of patients died at home or in the hospice. In 52% there was documented advance care planning (escalation decisions and DNAR).

Conclusion A monthly MDT improved access by identifying patients earlier. The referrals have been appropriate and controlled in number. The majority of patients died out of hospital. In our population, HD patients seem to have greater need for referral. Delegates attending the education programme reported an improved confidence in approaching end of life issues and a recognition of the benefits of a collaborative approach. A greater understanding of the population we support and mutual education has resulted in closer working relationships and increased referrals.

Further development of a joint Nephrology/Palliative clinic is planned. A focus group to identify patient and carer needs and experiences is planned.

P-102 INTRODUCING CORNEAL DONATION WITHIN THE HOSPICE SETTING: A QUALITY IMPROVEMENT PROJECT

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Within the UK, there is currently a transplant shortage of approximately 500 corneas each year. Since corneal transplant is a sight-saving procedure, corneal donation (CD) can be empowering for end of life patients who are otherwise unable to donate their organs. Within our organisation, it was felt that more could be done to promote CD.

To achieve this, we invited a specialist team from Moorfields Eye Hospital to train and educate hospice staff on the process of CD. Following this, changes were implemented on the initial patient assessments to facilitate conversations with patients, including a guide for both staff and patients on the

process of CD. Staff were also afforded the opportunity to observe the corneal retrieval process to build confidence during discussions with patients.

Prior to our intervention it was unclear what proportion of our patients were engaged in a conversation regarding CD, with only one donation occurring in the preceding five years up to November 2017. Between November 2017 and February 2018, CD was discussed with 93 of the 106 patients admitted to the inpatient unit. Four of these patients were referred to Moorfields, resulting in two donations. Reasons for non-donation following referral were (i) contraindication for donation and (ii) a change in the decision to donate following discussions with next of kin.

These preliminary results demonstrate that our intervention has been successful, and data will continue to be collected to confirm this. Guidance on CD will now be covered in the induction process for new staff to ensure consistency in approaching CD with patients and their relatives. Future aims include expanding this project into our community teams. To facilitate this, CD champions will be nominated to raise the awareness of CD, ensure that patients' wishes are addressed, and maintain momentum on raising the profile and benefits of CD.

P-103 RECOGNISING DELIRIUM IN HOSPICE INPATIENT UNITS: A QUALITY IMPROVEMENT PROJECT

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Background Delirium is a common yet serious condition, affecting up to 50% of all terminally ill patients (Smith & Adcock, 2011). It can be distressing for patients, carers and staff. Clinical evidence suggests that screening for delirium on admission can help improve outcomes for these patients. However, screening can often be omitted which may adversely affect patient care at the end of life (Baird & Spiller, 2017).

Aims To ascertain the current level screening for delirium in our hospice inpatient unit. To identify a validated tool for screening for delirium within a hospice setting. To implement the use of a screening tool and formally evaluate its impact on delirium screening rates.

Methods Retrospective case note review to ascertain the current rate of delirium screening on the unit. A literature review to ascertain the most appropriate validated screening tool to be used. A formal quality improvement plan (QIP) using the Plan-Do-Study-Act (PDSA) cycle with the implementation of the valid screening tool.

Results A retrospective case notes review identified that no admissions were being screened for delirium. Initially there was no improvement in screening rates by staff education alone. The literature review highlighted the 4AT as a rapid and user-friendly screening tool. The 4AT screening tool was formally introduced into the admission examination template. By November 2018 we hope to have formal data from our QIP. However, initial data has highlighted the difficulty in sustaining improved rates of screening with a validated tool alone.

Conclusions Screening for delirium on admission to hospice is important to minimise distress at the end of life (Hosker & Bennett, 2016). Formally implementing the 4AT into our admission process should increase our screening rates. Initial

data suggests a difficulty in maintaining improved screening rates and therefore we will need, in addition to the 4AT, strategies to ensure consistent increased screening rates.

P-104 CHC FAST TRACK FUNDING: WHO, WHAT, WHEN?

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Background NHS Continuing healthcare [CHC] is the name given to funding of care which is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing health care needs; the 'fast track CHC pathway' is a tool to enable the immediate provision of this care for patients who are deteriorating rapidly or who are actively dying (NHS Website). There is no timeframe for prognosis in the National Framework when considering eligibility for NHS Fast Track Funding.

Aims To review diagnostic trends in patients referred for fast track funding, the appropriateness of applications made by the hospice community team and the impact on place of death.

Method We recorded all fast track CHC funding requests made by the hospice community team between 1st June 2017 and 31st May 2018, recording date of request, date of death, place of death and diagnosis. We compared this to the whole population of patients referred to the service in that time.

Results 71 patients had a fast track CHC funding request made. 68 had a cancer diagnosis. 63 have died. Of those who have died, the range [in days] from application to death was 1–109 days. 36 [57%] died within two weeks of the application, and four were still alive at 12 weeks. 36 died at home, 17 in the hospice inpatient unit, three in an acute hospital, one in a community hospital and six in a nursing home.

Conclusions and discussion When compared with our annual data, more patients died at home [57% vs 44%] and fewer died in hospital [6% vs 17%]. Nearly all of the patients had died within 12 weeks [the standard review period] indicating an excellent assessment of likely prognosis. However, with over half dying within two weeks of completing the request this raises the question: should we be requesting funding earlier?

P-105 DEVELOPMENT OF A SINGLE ASSESSMENT PROCESS FOR INITIAL PATIENT CONTACT WITH A HOSPICE

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Background Feedback from patients indicated that they were often seen by multiple different people after referral to the hospice, with duplication of processes. To address this, the hospice wanted to develop a 'single point of access' for patients and clients, to reduce duplication and provide more co-ordinated care for our patients. Part of this included developing a single assessment form for initial patient contact with the hospice.

Aim The primary aim was to develop a single assessment process for patients for their first point of contact with the hospice, in order to streamline and improve patient care and experience.

Methods A 'task to finish' group was set up in February 2017 to review the hospice referral form, and develop a single assessment process to be used for patient referrals. The group consisted of representatives from different departments within the hospice, including an independent group member from Healthwatch and a critical friend. A new referral form was developed with basic demographic details, including patient consent, any safety concerns, and six main questions (an initial question of 'what has prompted you to phone today' and questions covering physical, social, psychological, spiritual and functional domains). After a successful pilot with several local GP surgeries, and hospital nurse specialists, it was introduced to all referrers in April 2018. Referrals now come in to a dedicated co-ordination centre via telephone, email or the electronic notes system.

Results Feedback about the new referral form has been good. Referral information is of a higher quality, particularly for telephone referrals. The process for patients is more streamlined with less duplication.

Conclusion Higher quality information is obtained from the referrer, which supports MDT decision making over who is the most appropriate first point of contact. Patient experience of the hospice is improved.

P-106 RECOGNISING DISTRESS AND BODILY CHANGES IN THE LAST HOURS OR DAYS OF LIFE

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Background Between 56%–74% of the Great British public report their preference is to die at home (National Audit Office, 2008). Around half of all deaths occur in hospital although there are few clinical reasons for admission, (National Audit Office, 2008; Berry, Brink, Harris *et al.*, 2017) suggesting the need for greater community support to avoid inappropriate hospital admission.

Aims Ambitions for Palliative and End of Life Care (National Palliative and End of Life Care Partnership, 2015) set a framework for action; six ambitions to urge change at the end of life for individuals and those important to them to enable a good home death.

Method The leaflet guides them through symptoms which their loved one may experience. It offers education and practical information; helping the relative feel useful at a time when they perhaps feel helpless. The subjects cover those 'normal' symptoms considered to be the most distressing in the dying process.

Results The patient information leaflet will support and educate all those involved in the care of the dying person. The Community Palliative Care Specialist Nurse focus on prevention and relief of symptoms, in a prompt and timely manner to improve the quality of life for the patient and their family (World Health Organization, 2002). Continually assessing the signs and symptoms which may suggest that a person is in the last days of life will allow for compassionate and responsive care provision (NICE, 2015).

Conclusion There is scope for more people to die at home by improving training and understanding of end of life care needs. In May 2015, The Parliamentary and Health Service Ombudsman identified palliative care failings in the report 'Dying without dignity' suggesting that the ability of health