

made to have one education program and provide a regional day of teaching on alternate months. Attendance is mandatory for trainees, but open to all doctors working in the specialty.

We designed a 4 year program of topics based on the specialty curriculum. Each half day covers one topic and is organised by a trainee from either NW or Mersey with consultant support. The program is overseen by SpR leads who manage the email account, registration for each day and support for session organisers. Trainees organising each half day are encouraged to lead a session, enabling them to get formal feedback and a teaching observation completed.

Methods We ran this program for 12 months before completing a review. 2 surveys were sent out using survey monkey. One was sent to all attendees and another to those who had organised sessions. The demographics of attendees were also analysed.

Results Sessions have been attended by a mix of trainees, consultants and SAS doctors, with 30–35 attendees per day. 84% of attendees said the sessions met their learning needs either well or very well. 92% rated the sessions as good or excellent. 92% of session organisers felt they had enough support and information. The main challenge was finding speakers, which 58% reported to be difficult or very difficult.

Conclusions Feedback has led to the creation of a checklist to support those organising sessions. Senior SAS doctors will be more involved, making the most of expertise in the region. The new program has been well received. It provides education that meets the needs of the training program whilst supporting other doctors working in the specialty.

27 IMPROVING END OF LIFE CARE IN NURSING HOMES

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Background There were 716 deaths in Royal Hampshire County Hospital and Andover Ward Memorial hospitals (including hospice) in 2016. With no hospice beds in Winchester 25% patients die in a care home opposed to 18% nationally. The team felt that the quality of care homes was variable, staff lack confidence and competence, symptom were not always well controlled, and lack of advanced care planning resulted in inappropriate hospital admissions.

Method One year quality improvement project carried out by a cross-organisational team including a commissioner, a community pharmacist, two care home managers, a specialist palliative care team Consultant, and two palliative care clinical matrons from acute hospital and hospice. The project was supported by NHS Wessex. The PDSA cycle used mapping of existing discharge processes, stakeholder analysis, a driver diagram, and a risk chart. Quantitative and qualitative interview data was collected. Changes were implemented at regular intervals throughout the year and education was provided. Initial syringe driver usage was also measured.

Quantitative results Each care home rating out of 10 rose from 7.6 and 8.6, to 9.5 and 9.6 respectively. One received

an 'outstanding' CQC rating for end of life care. 3 core qualitative questions were asked to measure confidence and competence. At the start of the project 67% responded positively, which rose to 100% by the end. Staff and family feedback was overwhelmingly positive and there were no inappropriate hospital admissions. There were several unintended benefits including better inter-rational working for between hospital and care homes, increased levels of trust, better quality of information, and staff felt empowered to influence care provided by GPs.

Conclusion The study showed that this had been a successful project with several additional unintended benefits. The team are planning to replicate the project in further care homes and fund raising is well underway to open Winchester hospice next year (2019).

28 THE USE OF SUBCUTANEOUS FUROSEMIDE FOR THE SYMPTOMATIC MANAGEMENT OF PATIENTS WITH END STAGE HEART FAILURE IN THE COMMUNITY; A GP SURVEY

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Heart failure (HF) is appropriately described as an epidemic with recent estimates suggesting there are more than half a million people living with this syndrome in the UK alone.

For patients with end-stage HF (ESHF), diuretic therapy is the cornerstone of treatment. These patients frequently require escalation to parenteral diuretics for symptom management; this can be a challenging option for patients who wish to be cared for at home. Continuous subcutaneous infusion (CSCI) of medication via a syringe driver (SD) has been used for over 30 years, revolutionising the care of dying people. Administering furosemide via this route can be an effective alternative to intravenous (IV) therapy.

An electronic survey was sent to General Practitioners (GPs) across the five Health and Social Care Trusts in Northern Ireland (NI) to determine if subcutaneous furosemide was being prescribed for patients in the community with ESHF. The survey was disseminated via email and private social media sites.

63 GPs completed the survey. 86% of GPs did not know that furosemide could be given subcutaneously with only 5% of GPs having ever prescribed it. 90% of GPs felt that there was a role for subcutaneous furosemide and under specialist guidance 86% of GPs would be willing to prescribe it. 44% of GPs felt that they would need additional training to feel confident in prescribing subcutaneous furosemide and expressed concerns, such as, availability of medication, training for district nurses, additional GP workload, anxiety relating to blood monitoring and choosing the appropriate dose.

Subcutaneous furosemide can be beneficial in the symptomatic management of patients with ESHF. With specialist guidance, training and support GPs in NI would be willing to consider this as a treatment option, which could prevent unnecessary hospital admissions and allow patients with ESHF to die comfortably in their own home.