40 VTE PROPHYLAXIS IN A PALLIATIVE CARE INPATIENT UNIT AND BEYOND: GETTING OUR MESSAGE STRAIGHT

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Background Recently published evidence[1] highlighted high bleeding risks in palliative care (PC) cohorts. Evidence supporting venous thromboembolism prophylaxis (VTEP) generally comes from acute medicine or oncology.

Local trust guidelines mandated urgent VTEP assessment, recommending VTEP for most medical inpatients. No local guidance existed for PC. Anecdotally, practice within the attached specialist PC inpatient unit (IPU) varied.

Aims To audit VTEP assessment and administration against trust and NICE guidelines.

Methods Trust audit approval was obtained. Electronic and paper notes were examined for IPU stays between May-Aug 2017. Results were anonymised, using Excel for analysis.

Results Notes were available for 86/96 identified patient episodes. Thirteen patients receiving anticoagulation treatment were excluded, leaving n=73 episodes for analysis (including repeat stays). Most patients were elderly and had cancer. 86% of episodes had recorded VTEP initial assessments; 100% had VTEP prescribed (or a documented clinical reason), accordingly. Only 6/7 patients with potential VTEP complications had their VTEP re-assessed.

73% episodes included terminal care. Where death was unexpected (n=48), most patients stopped receiving VTEP either when dying was diagnosed (n=31) or at another time before death (n=8). This was not always a formal medical decision.

Actions Results were presented at the PC audit meeting. A departmental VTEP policy was drafted, which provided input to the trust thrombosis committee and future trust-wide policy. Holistic assessment of VTEP appropriateness and re-assessment at key clinical points were emphasised through teaching. IPU consultant ward-round stickers were created, encouraging formal re-assessment. Re-audit 2018 confirmed widespread improvement of targets.

Conclusions Variation in VTEP practice reflected lack of clarity about PC in the trust's policy. Changes to departmental policy and engagement with trust policymakers helped effectively align practice with NICE guidance, prioritising patient-centric care, shared decision-making and minimising potentially harmful medications.

REFERENCE

1. Tardy B, *et al*. *The RHESO study* 2017.

41 DESCRIBING THE END OF LIFE EXPERIENCE OF PATIENTS SUPPORTED WITH A LIFE-SUSTAINING LEFT VENTRICULAR ASSIST DEVICE (LVAD) AS BRIDGE TO TRANSPLANTATION IN THE UK – CAN WE HELP?

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Background In the UK, patients with severe heart failure suitable for heart transplantation may be managed with a life-sustaining LVAD as a bridge to transplant. Many will not undergo transplantation, due to lack of donor organs or clinical deterioration rendering them unfit for surgery. These patients are at risk of LVAD-related complications and will die with their device *in situ*. We describe the end of life for this patient group.

Method Retrospective case note review of 40 deceased patients who underwent LVAD implantation between 2010 and 2016 at a single UK centre.

Results Within this cohort, mean age at death was 57 years, with a median interval between LVAD implantation and death of 18 months(range 6–76). Death was described as sudden in 17 patients; this group commonly died at home(65%).

Serious LVAD-associated complications were seen in 35 patients (87.5%), namely VAD thrombus (30%), intracerebral bleed (30%), GI bleed (27.5%) or driveline infection (25%). These complications were often fatal. This group had frequent (median 5, range 0–35) and lengthy (median 57 days, range 0–267) hospital admissions to their specialist centre, which for the majority (87.5%) was not in their local area.

Where dying was identified and death expected (n=19), patients were most likely to die in hospital (84%), but transfer to local hospital (5%) or hospice (16%) was achieved for some. Anticipatory SC PRN medications were prescribed for 68% and symptom assessment undertaken in 84% of cases. Overall, preferred place of death was documented for 12 patients and achieved in 10/12 cases.

Conclusion The last days of life for patients with LVAD support, were commonly spent in hospital following active management of a LVAD-related complication. Early specialist palliative care input is recommended to improve quality of end of life care, support exploration of future care wishes and consideration of practical device management.

42 THROMBOPROPHYLAXIS IN THE LAST DAYS OF LIFE

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Background Venous thromboembolism (VTE) is a well-established cause of in-hospital mortality. Consequently, prevention is a vital part of patient care. Nevertheless, in patients approaching the end of life, VTE prophylaxis should be reviewed daily, with decision-making taking into account the views of the patient and carers. NICE advises VTE prophylaxis should not be offered to people in their last days of life.

Methods We undertook a retrospective review of the case-notes of all patients who died at a district general hospital in the month 17th September – 17th October 2018.

We aimed to assess whether patients dying in the acute hospital were:

1. Commenced on VTE prophylaxis during admission;
2. Recognised as dying;
3. Commenced on the hospital's individualised care plan for the last days of life;
4. Receiving VTE prophylaxis in the 72 hours before death.

Results 96 patients died within the review period. 5 deaths in the emergency department were excluded. Of the remaining 91, the median age was 82.

47 out of the 91 patients (52%) received VTE prophylaxis during their hospital admission.

68 patients (75%) were recognised as dying, and of these, 40 (59%) were commenced on the hospital's individualised care plan for the last days of life.