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

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Background Recently published evidence 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

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.