of the prescription of steroids. A sticker has been developed and after multi-disciplinary team discussion it was added to the admission documentation with the aim of improving practice at the time of admission. Work to evaluate this intervention is on-going.

REFERENCE

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99

RE-AUDIT OF IMPROVEMENTS MADE TO THE MULTI-PROFESSIONAL ELECTRONIC HANDOVER IN A SPECIALIST PALLIATIVE CARE UNIT

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10.1136/bmjspcare-2019-ASP.122

Background Sheffield Teaching Hospitals, including the Macmillan Palliative Care Unit (MPCU), is now using a system of handover via the electronic whiteboard (e-handover). Handover is essential for effective sharing of information but is a potential source for errors. The e-handover was initially audited and a standard operating procedure (SOP) was subsequently produced by a multi-professional team of allied health professionals, nursing and medical staff and the ward pharmacy team. This SOP was introduced in August 2017 with the intention to ensure accuracy and a consistent approach in sharing of information. Re-audit in September 2017 showed significant improvements in all domains and this further re-audit in September 2018 aimed to assess if these improvements had been sustained.

Methods 17 patients' notes and e-handovers were audited by two independent members of the MDT against standards developed by The Academy of Medical Colleges, local nursing guidelines and against palliative care outcome measures. Results were then directly compared to earlier audits in 2017.

Results One hundred percent of patients had an accurate primary diagnosis on their handover and all documented in the correct place. 66% of patients had a documented preferred place of death (PPD), 100% had a documented and accurate escalation status (ES), 71% had a documented phase of illness (PoI) and 82% had Australian Karnofsky performance status (AKPS) documented. 32% of handovers were easy to read and 92% used trust approved acronyms. This confirmed deterioration in some domains, particularly PPD, PoI and AKPS, all of which were recorded as 100% in September 2017.

Conclusion One year after implementation of the SOP there has been deterioration in some of the information on the e-handover. Further work is needed to identify factors involved, such as changeover of staff, and to then re-educate ward staff in the completion of the handover.

100

THE QUEST TO BE A RESEARCH ACTIVE HOSPICE

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10.1136/bmjspcare-2019-ASP.123

Background In 2013, the Commission into the Future of Hospice Care published 'Research in palliative care: can hospices afford not to be involved?' It identified the importance of hospices becoming research active. St Margaret's Hospice in

Somerset includes inpatient and community services and has a history of participation in research. A potential was identified to develop the structure and focus of the research process and to widen participation further to increase research activity going forward.

Methods

- Identifying staff with a research interest and promoting GCP training.
- Developing links to facilitate involvement in collaborative projects.
- Forging links and seeking support from the NIHR locally.
- Developing a more robust research governance structure.

Results A Research group was created with quarterly meetings, involving core members from different disciplines. The aim being to increase awareness of research projects within the organisation, provide a forum for discussion of future projects and promote evidence based practice.

A Research booklet was created with a plan to update a paper copy yearly with continuous online updates. Participation in several portfolio studies including GAS, Hydration at the end of life, and presently STOIC; 32 patients recruited so far.

Conclusion It is feasible to become a research active hospice, even without the infrastructure of an R and D department and a local academic unit.

Key facilitators were the identification of staff members with the interest and enthusiasm to develop research further, seeking local support and collaboration where possible and choosing collaborative projects which the majority of staff felt looked at an important issue and were engaged with. Also with more staff GCP trained, the more opportunity there is for participation.

Next steps

- Forming a collaborative body with the local acute and community trusts.
- Looking at funding options for regular research nurse support.
- Development of in house research projects.

101

A REPORT ON THE BENEFIT AND ACCEPTABILITY OF A NEWS BASED ACUTE ILLNESS MANAGEMENT PLAN IN A HOSPICE INPATIENT UNIT

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10.1136/bmjspcare-2019-ASP.124

Background Over recent years we have had increasing numbers of acute admissions, with potentially reversible conditions, as well as noticing increasing use of intravenous antibiotics, without any structured monitoring of progress. We have introduced an Acute Illness Management Plan (AIMP) including regular observations with triggers for medical review, based on the Royal College of Physicians National Early Warning Score (NEWS). This change was introduced alongside improving oxygen prescribing and administration, and an education programme, and is being followed with ongoing quality improvement work. It is important to ensure staff feel a change is worthwhile and important to ensure they are motivated to develop this further.

We aimed to assess acceptability of an acute illness management plan in a hospice setting.

Methods We undertook a mixed survey with both quantitative and qualitative sections. This was analysed using a narrative approach.

Results All respondents feel the AIMP represents an improvement in the care offered to acutely ill patients in the hospice setting.

The Majority (60%) felt the AIMP is acceptable in the hospice setting and (40%) felt it is sometimes acceptable. No staff felt it was inappropriate in a hospice setting.

Additional comments include:

- Concerns about stopping treatment when a patient is felt to be clearly in the last days of life;
- Concerns about documenting individualised goals or triggers for medical review, to avoid frequent observations not leading to changes in treatment;
- A need for improved recording of urine output;
- A desire for more training in acute illness management.

Conclusions The AIMP acceptable in a hospice setting. Future work will include incorporating NEWS2 guidance, and an ongoing quality improvement programme to look at areas where it could be used more effectively. This will allow us to determine the efficacy of the AIMP along with ensuring staff feel empowered in the process of its introduction.

102 ULTRASOUND GUIDED PARACENTESIS IN A HOSPICE SETTING: A CASE SERIES

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10.1136/bmjspcare-2019-ASP.125

Background Ultrasound guided paracentesis is a safe and effective methods of managing ascites caused by malignancy or cirrhosis. It has traditionally been performed in hospital and often requiring admission for one or more nights. Following training in ultrasound and gaining experience in ultrasound guided paracentesis at our local hospital trust, we evaluated the introduction of a hospice based paracentesis day-case programme.

Methods We undertook a prospective evaluation of the service over 3 years in specialist palliative care patients referred for assessment of possible ascites and where indicated draining ascites in a hospice setting, including patient feedback collected approximately a week after the procedure.

Results 85 assessments were performed for possible ascites (58% non-hepatocellular cancer, 31% cirrhosis ± malignancy, 1% other), in 58 different patients. 45 patients were assessed as having paracentesis suitable for drainage in the hospice setting. This led to 36 successful ultrasound guided paracentesis procedures performed in the hospice inpatient unit (9 patients did not have paracentesis as not very symptomatic and/or too unwell). 21 were performed on a day case basis, 11 as part of a longer admission for symptom control or end of life care, and only 4 (16% of admissions for paracentesis) requiring an overnight stay for the procedure. There were no complications

64% of patients completed feedback a week later. 23/23 (100%) patients would be happy to have the procedure repeated in the hospice setting if required. 16/23 (70%) said paracentesis greatly helped symptoms, and 6/23 moderately (26%)

Conclusions It is practical and useful to include ultrasound in assessment of possible ascites in a hospice setting, and to use ultrasound guided paracentesis for day case, and existing inpatients in a hospice setting. This leads to reduced hospital attendance/admission, and it is an acceptable alternative to patients.

103 INDWELLING PERITONEAL CATHETER INSERTION FOR MALIGNANT ASCITES; SERVICE EVALUATION AND GUIDELINE PRODUCTION

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10.1136/bmjspcare-2019-ASP.126

Background Conventional management of malignant ascites is recurrent inpatient paracenteses. Patients have high associated morbidity. Alternative management is insertion of an indwelling peritoneal catheter (IPC) supported by NICE, reported to have infrequent complications and associated with estimated cost saving of £1051 per patient. Our trust has an established indwelling pleural catheter service. In order to provide symptomatic benefit pleural and surgical consultants with ultrasound training started inserting IPCs in operating theatre under strict asepsis. The palliative care team is crucial to patient selection and follow up.

Methods We performed a retrospective trust-wide service evaluation followed by dissemination of results and clinical guideline production. A prospective service evaluation is ongoing.

Results From January 2016 to April 2018, 11 patients had an IPC inserted. Median age was 67. Diagnoses were pancreatic cancer (3), mesothelioma (2), breast cancer (2), colorectal cancer (1), gastric cancer (1) and oesophageal cancer (1). Mean paracenteses prior to IPC was 3.45 and mean time from initial drainage to IPC and from IPC insertion to death was 53 and 55 days respectively. 1 complication (migration of the IPC precluding drainage) arose. Following the implementation of local guidelines, 8 IPCs were inserted between April and September 2018 with no complications. Median age and diagnoses were similar. However mean paracenteses prior to IPC was 1.25 and mean time from initial drainage to IPC and from IPC insertion to death was 19 and 12 days respectively. In all cases IPC insertion was associated with significant symptomatic relief.

Conclusions IPC insertion for malignant ascites is a feasible, safe and effective method of management of malignant ascites. A proactive service reduces patient's hospital visits and procedure rate significantly. Formal guidelines meant that IPCs were inserted sooner in patients who previously would have likely died with significantly symptomatic untreated ascites.

104 MODIFIED EARLY WARNING SCORE (EWS) TO AID IDENTIFICATION OF THE DETERIORATING PATIENT AT ST GEMMA'S HOSPICE

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10.1136/bmjspcare-2019-ASP.127

Background On admission to St Gemma's Hospice (SGH), patient escalation status is determined, guiding decisions when acute deterioration occurs. In August 2018, a modified early