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.

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.

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. One complication (migration of the IPC precluding drainage) arose. Following the implementation of local guidelines, 8 IPCs were inserted insertions 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.

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