

P25 STANDARDS OF END-OF-LIFE CARE IN PATIENTS WITH NON-MALIGNANT RESPIRATORY DISEASE

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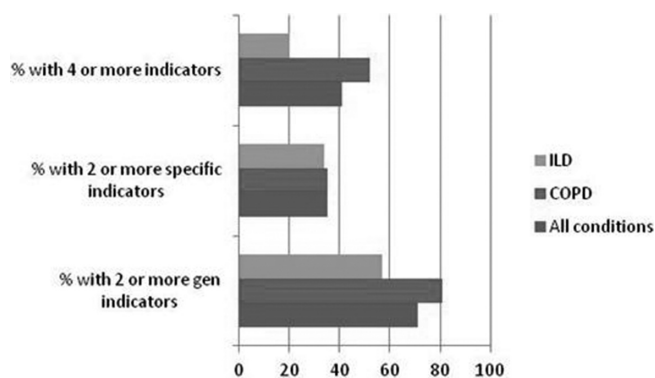
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Objectives Recognising the end of life phase in chronic non-malignant lung conditions remains a challenge which has been proposed as a major barrier to ensuring effective end-of-life care in this population.¹ Our aims were threefold. Firstly, to establish whether patients who died of causes related to their lung condition could have been predicted to have been in the last 6–12 months of their lives. Secondly, to evaluate the standard of care they received leading up to their death. Finally, to compare end-of-life care received by patients with chronic obstructive pulmonary disease (COPD) and interstitial lung disease (ILD).

Methods A retrospective review of deaths due to COPD and ILD over a 26 month period in two acute hospitals in South Wales using paper and electronic health records. Gold Standards Framework (GSF) prognostic indicators of poor prognosis were identified, and ‘standards of care’ evaluated in the 12 months preceding death.

Results 119 cases were analysed. 83% of patients could have been identified as ‘approaching end of life’ (AEOL) using GSF criteria. ‘Standards of care’ were variably met: do not attempt cardiopulmonary resuscitation (DNACPR) forms were completed in 93% of cases. Advanced care planning, establishing preferred place of care and use of specific end-of-life care documentation took place in <1%, 7% and 14% respectively. COPD patients had more indicators of poor prognosis than patients with ILD but received fewer ‘standards of care’.

Conclusions The majority of patients in our study could have been identified as AEOL and therefore ought to have been in receipt of the ‘standards of care’. There is a need to improve recognition of patients that are AEOL in order that they receive better end-of-life care. Further investigation to confirm or refute the discrepancy in care between COPD and ILD patients is necessary. Research into the best means of identifying, and subsequent provision of care, for patients with non-malignant respiratory disease is also required.



Abstract P25 Figure 1 Clinical indicators of severity

REFERENCE

- 1 Boland J, Martin J, Wells A, Ross J. Palliative care for people with non-malignant lung disease: summary of current evidence and future direction. *Palliat Med.* 2013;27(9):811–816

P26 MEASURING THE VALUE OF A CONSULTANT-LED COMMUNITY RESPIRATORY (CORE) MULTIDISCIPLINARY TEAM (MDT) IN A DEPRIVED INNER CITY AREA: ACHIEVING PARITY IN RESPIRATORY CARE FOR HOUSEBOUND SICK PATIENTS

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Introduction The shift of chronic respiratory disease management to the community has stimulated development of multidisciplinary community respiratory services (CORE-MDT). Measuring the value of these services is challenging but is important for quality improvement and commissioning. This retrospective analysis of the activity of an inner city community respiratory service documents the nature of the caseload, interventions made and their impact on usual care provision.

Method The CORE-MDT, accepting referrals from GPs and three acute hospital trusts, is based at three localities and includes respiratory nurses, physiotherapists, quit-smoking advisors, clinical psychologists and respiratory consultant support. Care is delivered at home with hospital in-reach during every admission. A bespoke iPad App database (HandBase) was designed for information documentation and sharing from case management and consultant-led MDT discussion of patients. A retrospective analysis of records was made of sequential referrals from Sept 2014 to March 2015. Demographics, disease severity, comorbidities, social deprivation, duration of management, nature of intervention and healthcare resource utilisation over 6/12 were documented. Hospital data allowed estimation of bed-day savings based on average length of stay for acute exacerbations of COPD (AECOPD).

Results Records from 83 patients (most with COPD) were reviewed. Mean [SD] FEV1: 0.98 [0.38]L. Patients had multiple comorbidities, high smoking prevalence, deprivation and isolation (Table 1). Mean[SD] duration of CORE team management: 5.2[4.9]months. ~50% of patients were then discharged to usual care. 17/34 (50%) completed pulmonary rehabilitation, 11 saw a psychologist and 6/12 (50%) achieved smoking cessation. Mortality was 6%. Hospital bed-days usage ($p = 0.001$) and GP visits ($p = 0.02$) were reduced during active case management compared to the year before referral. Domiciliary management of 105 AECOPD reduced GP workload with an estimated £58 000 savings in admission avoidance for ($n = 30$) patients with baseline hypoxia <92% or >2 admissions in the year prior to CORE management HRG DZ-21K: £2000/admission).

Conclusions The service has improved quality of care for these complex sick patients and generated significant savings in GP workload and admission avoidance which should underpin service commissioning and provision. The use of Handbase has facilitated consistency in evidence-based care and record-keeping, information sharing and evaluation of CORE-MDT activity.