

Results Forty-eight participants completed the course in November 2015, with 43.8% (n=21) completing both phases of assessments across 3 European sites. Average knowledge scores improved significantly from 47.7% to 66.1% (p=0.0005). Self-efficacy (p=0.00005) and overall confidence (p=0.0005) also improved. Twelve HCPs participated in two focus groups across two sites, which identified the overarching theme- the ECHDC enhanced participants practice.

Conclusion This study demonstrated that a multidisciplinary distance learning course significantly improved the knowledge and self-efficacy of HCPs in delivering end of life care to patients with dementia and their families. The course was felt by participants to improve the care they provided for patients.

P-74 ABSTRACT WITHDRAWN

P-75 IMPROVING TIMELY ACCESS TO SPECIALIST PALLIATIVE CARE, USING QUALITY IMPROVEMENT (QI) METHODOLOGY

Emma Barclay, Sian Burgess, Philip Lomax, Lisa Corbett. *St Ann's Hospice, Heald Green, UK*

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The aim of the project is to enable more people who are triaged as appropriate for admission by the Multi-Disciplinary Team, to be admitted and receive timely specialist in-patient palliative care.

Background The rationale behind the project was that:

- Data indicated an increasing demand on specialist palliative care beds.
- There was evidence of the impact of delayed discharges on achieving timely access.
- There is need to educate society about the changing role of specialist palliative care.

Aim The aim is to increase the number of appropriate admissions from 70% to 75%.

Method The project uses Quality Improvement methodology as the mechanism for improving practice. The driver diagram below demonstrates how we structured our project.

Small change ideas are being used to slowly make improvements that are effective and sustainable. An example of one change was to review the referral form and admission documentation to ensure from the point of referral that patients understand the reason for their in-patient hospice care and the potential for discharge.

The project is based on the Model for Improvement tool.

Results We are using a measurement strategy to map and evaluate our progress. We are making significant progress as for the last eight months we have surpassed our original target and reached 79%. There are further change ideas that we intend to explore to help with sustainability and spread. One of these is holding a round table discussion with external partners to look at ways they can support the discharge process.

Opportunities We are intending that this project will enable us to maximise available resources whilst at the same time improve access to specialist palliative care to more people in a more timely way.

P-76 A SERVICE EVALUATION OF UTI ANTIBIOTIC STEWARDSHIP IN A UK HOSPICE: TWO AUDIT CYCLES SPANNING 2 YEARS AND MORE THAN 500 INPATIENTS

^{1,2}Paula Cook, ^{1,3}Craig Gannon. ¹Princess Alice Hospice, Esher, UK; ²Epsom and St Helier NHS Trust, Epsom, UK; ³University of Surrey, Guildford, UK

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Background Despite high antibiotic prescribing rates for urinary tract infection (UTI) at the end of life, the evidence suggests little or no symptomatic benefit in >50% of patients. This leads to concerns around the rigour underpinning UTI diagnosis in hospice inpatient settings and the lack of an applicable evidence base, with clear but conflicting antimicrobial guidelines in other populations.

Methodology Two matched retrospective audits of hospice inpatients over six-month periods in 2014 and 2016. Notes were analysed for symptoms consistent with a UTI, clinical investigations, results and management against local antimicrobial prescribing guidelines and checked against the corresponding microbiology laboratory database. To compare any findings, the audit was extended in 2016 to include one month of community patients in their last 30 days of life.

Results The inpatient UTI incidence was 11.4% in 2014 (n=33/290), 11.3% in 2016 (n=25/222) and 10.4% for community patients in 2016 (n=10/96). Correct management of patients with positive urine cultures increased from 56% to 100%. Correctly not prescribing antibiotics (when bacteraemia without symptoms e.g. catheterised patients) increased from 38% to 75%. The percentage of patients on antibiotics at death was 1% (n=3) and 1.4% (n=3).

Conclusions Incidence of UTI at the end of life, at 10%–11%, remained consistent over time and across setting to suggest reliability. There was a marked improvement in appropriate and targeted antibiotic therapy; qualitative analysis showed improved rigour in assessment of key symptoms, and more targeted investigations and antibiotic therapy (e.g. Ertapenem, Fosfomycin). It appeared that a UTI was associated with a poorer prognosis and delayed discharge. Further research is needed, particularly around the symptom benefits of patients receiving antibiotics for UTIs at the very end of life.

P-77 WEIGHING PATIENTS IN A HOSPICE SETTING

Jan Codling, Alison Phippen, Jennie Pickard, Becki Singh, Samantha Kay, Emily Wade, Niall Byrne, Dave Waterman. *St Ann's Hospice, Cheshire, UK*

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Background Standard practice at our hospice did not encourage routine weighing of patients on admission, which potentially limited ability to meet best practice standards for medicine management and nutritional assessment.

This project measured if patients were weighed at or soon after admission. Many were prescribed medication where dose was dependent on weight. The opinions of staff and patients towards routine weighing was investigated.

Method An audit of 40 patients measured if patients were weighed on admission or a reason for not doing so recorded and whether weight dependent doses were in line with the British National Formulary or other specialist advice.

A staff questionnaire gained the opinions of 79 clinical staff towards weighing patients, their understanding of the reason for weighing, and the rationale for their opinions.

A patient questionnaire gained the opinions of 38 patients on being weighed and their understanding of the reason for being weighed.

Results 97% of patients did not find being weighed distressing. However, 51% of staff members were opposed to routine weighing.

13% of patients had a weight recorded. 13% were prescribed low molecular weight heparin, 80% of these patients were weighed and 60% were on the correct dose.

Implications Routine weighing has been introduced for all patients where appropriate. Clinical staff now receive training that demonstrates the inaccuracy of estimating body weight. An alert sticker is now attached to the medicine chart, for patients prescribed weight dependant medication and a prompt on the shelves where the medication is stored acts as a reminder to check body weight.

P-78 USE OF AUDIT IN MEDICINE MANAGEMENT AT ST ANN'S HOSPICE

Jan Codling, Kath Mitchell, Jennie Pickard, David Waterman, Elaine Sigsworth, Suzie Doe. *St Ann's Hospice, Cheshire, UK*

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Background Medication errors can lead to patient harm including death. Prescribing error rates of 7% and administration errors of 8% are recognised. Effective systems and processes can minimise the risk of preventable medicine-related problems.

Methods A four monthly audit of prescribing standards contained in the hospice medicine policy was undertaken by the hospice pharmacists. Prescribers received feedback verbally and via posters.

An annual administration of medicines audit was conducted by the practice development nurses. Nurses received feedback and an action plan was agreed.

During the period April 2015 to June 2016, the hospice introduced the Medicine Safety Thermometer (MST) to assess recording of allergy status, pharmacy medicines reconciliation, omitted medicines and safety of high risk medicines.

Results Audit results are displayed in the clinical areas to highlight the current issues. Findings were also used to inform changes in the medicine chart.

An anonymous questionnaire to doctors showed the prescribing audit was felt to be a useful educational tool.

An action from the MST included the development of a variance recording form, integrated in the medicine chart. This records details why a medication was omitted rather than just using a variance code. For example a patient may decline a medicine because they don't like the taste. The extra detail should trigger an action to resolve the issue.

Implications Prescribing and administration audits and the MST were used in the in-patient hospice environment to identify medicine-related safety incidents. Subsequent learning contributed to the safer use of medicines.

P-79 DISTRESS VERSUS HARM; HAVE WE IMPLEMENTED CHANGES TO DNACPR DOCUMENTATION FOLLOWING THE TRACEY JUDGMENT?

^{1,2}Stephanie Shaylor, ¹Mike Macfarlane, ¹Derek Willis. ¹Severn Hospice, Telford, Warwick, UK; ²St Marys Hospice, Birmingham, UK

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Background Following the Tracey judgment in 2014, DNACPR decisions *must* now be communicated to the patient or, when this is not possible, their relatives. The *only* exceptions are if the patient has expressed a clear wish not to be involved or there is significant risk of causing physical or psychological harm to the patient by communicating the information.

Currently there is no guidance on what constitutes 'physical or psychological harm', therefore it is subject to varying interpretation.

The aim of this pilot was to investigate the communication of DNACPR decisions following the Tracey case and the interpretation of 'physical or psychological harm' by healthcare professionals.

Methods A retrospective audit of clinical notes was performed. 30 notes were analysed from 2013 (before the Tracey ruling) to determine who DNACPR decisions were communicated to and, if this information was withheld, the reasons why. 30 patient notes from 2015 (following the Tracey ruling) were analysed to obtain the same information, then a comparison was made between both years.

Results 6/30 (20%) DNACPR decisions were discussed with patients in 2013 compared to 17/30 (57%) in 2015. 4/30 (13%) decisions were discussed with families in 2013 compared to 17/30 (57%) in 2015.

Reasons for not discussing DNACPR decisions in 2013: distress (79%); patient choice (13%); no reason documented (4%); anxiety (4%).

Reasons for not discussing DNACPR discussions in 2015: psychological harm (39%); no reason documented (23%); patient choice (15%); patient confused (15%) patient unable to communicate (8%)

Psychological harm in 2015 was described as 'extreme distress', 'anxiety', 'distress', 'extreme distress' and 'upset'.

Conclusions Communication of DNACPR decisions increased following the Tracey judgment.

There was no clear consensus on what constitutes 'harm' although the term 'distress' was most commonly included in its explanation. This indicates the need for further research and guidance in this area.

P-80 PATIENTS WITH METASTATIC CANCER: HOSPICE PATIENTS DIE; HOSPITAL PATIENTS SURVIVE – TRUE OR FALSE?

^{1,2}Sanjay Shah. ¹Northamptonshire Healthcare NHS Foundation Trust, Kettering, UK. ²Kettering General Hospital NHS Foundation Trust

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Background No evidence could be found to support the general perception that hospice patients die whereas hospital palliative care patients survive. Such a perception could make patients reluctant to accept hospice support; and lead clinicians to over treat hospital patients and deny beneficial interventions to hospice patients.