

and prioritise admissions to our hospice In Patient Unit (IPU), as well as enabling the capture of data for audit purposes. Planning for the process began in May 2015 with a pilot taking place in December 2015. It was formally rolled out in January 2016.

Benefits

- It has improved the way in which we manage our admissions waiting list by allowing us to easily assign/update priority
- It will be a useful audit tool for looking at unmet need (those patients who would have been admitted if there had been a bed) as well as length of wait for a bed and reasons for admission
- Provides data on average urgency of request and whether we manage to meet the urgency stated
- It can be accessed by all clinical teams who work on IPU from any connected PC in the hospice
- Improved confidentiality (previous whiteboard could have been viewed through a window or open door)

Issues

- Time taken to train all staff and to adapt to the new system
- System relies on accurate and timely entering or updating of information
- Initial problems with maintenance and troubleshooting as there was no on-site IT support
- PSAG is not linked to our electronic records system (SystmOne) so risk of duplication of information or relevant clinical information not being entered into SystmOne
- It cannot collect some data that we have previously been collecting manually

The Future Use of the PSAG continues to evolve as new issues arise

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'SHOCKING' COMMUNICATION SKILLS – COMMUNICATION SKILLS TRAINING FOR CARDIAC PHYSIOLOGISTS DEACTIVATING ICDSS

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Background Studies have highlighted a strikingly low rate of preparatory conversations regarding the deactivation of patients' implantable cardiac defibrillators (ICDs) at the end of life. Rates of implantation of ICDs have increased, indicating that managing ICDs at the end of life will become a more common occurrence. Cardiac Physiologists carry out the deactivation of ICDs, yet locally in Devon, Cardiac Physiologists have highlighted that they have no training of how to communicate with patients when deactivating their ICDs.

Aims To improve end of life communication skills for Cardiac Physiologists.

Methods A joint educational programme was developed to improve end of life communication skills for Cardiac Physiologists and increase the ICD-related knowledge base of Palliative Care teams.

Interactive role-play sessions were developed based on examples of challenging or common communication scenarios provided by the Cardiac Physiologists prior to the session. Feedback was collected immediately after the session and then 4 months later to assess the impact on their actual practice.

Results Immediate feedback stated the training had been very useful. Further results regarding how well the Physiologists have put the learning into practice will be available in the near future.

The majority of Palliative Care attendees admitted to little understanding of cardiac devices before the study day compared to a good understanding afterwards.

Conclusions Cardiac Physiologists are a group of the non-cancer workforce who are potentially neglected with regards to end of life communication skills training. We would encourage other services around the country to provide this training to improve the end of life care for patients with ICDs.

Interactive role play appears to have been a successful method to provide this training.

The joint educational programme between Cardiology and Palliative Care facilitated learning from shared differing experiences and helped develop relationships between the teams.

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BY THE CLOCK: AUDIT INVESTIGATING THE ADMINISTRATION OF REGULARLY PRESCRIBED OPIOID ANALGESIA IN PALLIATIVE PATIENTS ON GENERAL HOSPITAL WARDS

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Background and aims Slow release opioids provide the mainstay of chronic pain control for many palliative patients. To ensure effective pain relief therapeutic levels must be maintained. Opioid pharmacokinetics require regular dosing intervals to achieve this and ensure no unnecessary breakthrough pain. The aim of the audit was to assess whether palliative patients on general hospital wards were receiving opioid doses at the appropriate times.

Method The audit was carried out across the general wards of the local District General Hospital. Palliative inpatients were identified via the hospital palliative team register. On two occasions two weeks apart all palliative inpatients on regular opioid analgesia were selected. Prescription charts and controlled drug books were used to gather data. Controlled drug book sign out times were used as a proxy for administration times. Outcomes recorded included prescriptions made, time and date doses given, and any doses omitted and reasons documented. Appropriate timing was considered administration within ± 30 min prescribed time.

Results 12 patients met the inclusion criteria with 290 opioid doses administered between them. Of these only 19 (6.6%) were given within 30 min of the prescribed time. The majority of these were given late (256 doses, 88.3%). The average time for doses given was 2 hours 10 after the prescribed time. 8 prescribed doses were not given and of these, 2 (25%) had documentation why. 4 out of a total of 28 prescriptions (14.3%) gave an incorrect prescribed time interval.

Recommendations Staff re-education to ensure timely administration of opioid doses and reiterate the need for documentation of omitted doses, is a priority. Prescribers need reminding of the correct opioid dosing intervals. Prescribers might also consider discussing prescribing times that could make timely nurse administration easier.