

Following these changes, we looked at the deaths in June 2019. 55 patients died. 33 (60%) patients had a discharge summary completed. 100% of patients who died on the ward with the 'Bereavement Box' had a discharge summary.

With these interventions, there was a 100% increase in discharge summaries being completed. However, there are still further improvements to be made. We plan to roll the 'Bereavement boxes' out to all wards, make an automatically generated notification sent to the GP upon a patient's death and roll out Medical Examiners within the Trust. We hope that these further interventions will ensure that all patients will have discharge summaries completed and there will be improved continuity of care.

## REFERENCES

1. Murphy SF, Lenihan L, Orefuwa F, Colohan G, Hynes I, Collins CG. Electronic discharge summary and prescription: improving communication between hospital and primary care. *Ir J Med Sci* 2017 May; **186**(2):455–459. doi: 10.1007/s11845-016-1397-7. Epub 2016 Jan 25.

## 11 CHART REVIEWS OF PALLIATIVE CARE DAY SERVICES: SIGNALLING THE START OF SOMETHING NEW

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The number of people requiring palliative care is increasing sharply (Etkind et al., 2017). Forty per cent more people will need palliative care by 2040. Recommendations are that palliative care should be initiated at diagnosis, even concurrently with curative treatment (Guo et al., 2012). In response, Palliative Care Day Services are designed to support people during assessment and treatment through the provision of regular outpatient attendance at specialist centres to deliver out-patient services so that patients can remain at home. Such interventions have been found to be effective (Stevens, Martin & White, 2011), however the evidence is limited. To inform further development, we undertook retrospective chart reviews at three Marie Curie centres: reviewing the records of people attending for the first time in 2015.

We found that services were accessed mainly by older people with a primary diagnosis of cancer; referrals came mostly from: hospitals, other palliative care services or a GP; and people typically attended weekly for 6 or 12 weeks. In 82 cases, we found people had their physical (331), psychological (55), social (46) and spiritual (14) needs addressed. Day Services were provided by nurses, doctors and therapists. Patients had their medication regime reviewed and equipment was 'prescribed' as necessary. In a third of cases, support was also offered to a family member. About half of patients were helped to develop an advance care plan and almost 300 referrals were made to other health and social care services.

Day Services can provide specialist palliative care outside the inpatient unit to help address specific, pre-identified health and social care needs. The effectiveness of such services requires further investigation and chart reviews can be useful in contributing to such evaluations.

## 12 OPIOIDS IN PALLIATIVE CARE: INITIATING DRUG TREATMENT

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**Background** A large proportion of the UK population have been diagnosed with progressive, chronic diseases resulting in pain. Potentially requiring strong opioids which are often prescribed in primary care (National Collaborating Centre for Cancer, 2012). Concerns about adverse effects, confusion about which opioid to prescribe and the wide array of available options may result in undertreated pain or increased risk of adverse effects (National Collaborating Centre for Cancer, 2012). The National Collaborating Centre for Cancer has developed guidelines for NICE to clarify the pathway for initiation of strong opioids in palliative care patients.

**Aims** To identify all patients in the practice population with progressive disease, specifically: Cancer, CKD 3/4, Heart Failure, Liver Failure, COPD who were initiated on a strong opioid and to investigate if prescribing practice and management was compliant with NICE guidance.

**Method** Standards based audit undertaken in a London General Practice. Data collection by foundation year 2 doctor. EMIS searches by practice IT manager with retrospective identification of patients coded as chronic kidney disease, COPD, heart failure, liver failure, cancer and initiated on a strong opioid before or on 31.12.2017, review of consultation notes to identify prescribing practice and referral if appropriate. Comparison against standards outlined in NICE 'Clinical audit tool : initiating drug treatment' and data collection sheet, data input into Microsoft Excel.

**Results** 33 patients identified for inclusion. 48% patients initiated appropriate initial strong opioid. Only 13% of patients with renal or hepatic failure were discussed with a specialist, 10% of patients were prescribed immediate release oral morphine for breakthrough pain and 21% of patients were prescribed laxatives.

**Conclusions** This audit has identified discrepancies between prescribing and referral practice and the guidelines, which could result in poor patient management and risk of adverse effects. The findings of this audit were presented in a practice meeting accompanied by teaching and distribution of the guidelines. A re-audit is due to be undertaken in 2020.

## 13 'WE CAN DO SO MUCH MORE': RECOGNISING THE NEEDS OF PEOPLE WITH DEMENTIA IN PALLIATIVE CARE

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With dementia on the rise, palliative care services are increasingly supporting people with dementia, as a primary or secondary diagnosis. Care provision can be challenging for palliative care staff who may have limited experience and knowledge of supporting people with dementia.

A survey assessed the confidence and competence in supporting people with dementia for healthcare staff in inpatient and community palliative care services. Only 10% of hospice staff had received any formal dementia training. Based on