Conclusion Expedited hospital discharges utilising NHS Continuing Care Fast Tracking provide an opportunity to undertake and record ACP. Undertaking ACP discussions at this point in the patient's care appears to be acceptable to both patients and healthcare professionals.

75 SYMPTOM CONTROL MEDICATION FOR PATIENTS DYING IN CRITICAL CARE: SYSTEMATIC REVIEW OF THE LITERATURE AND CURRENT PRACTICE IN CHESHIRE AND MERSEYSIDE

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Background Symptom control at the end of life within Critical Care settings varies. Within the literature there is no consensus for titration of infusion rates, the use of PRN medications or subcutaneous infusions.

Methods A literature review was performed, the databases MedLINE, EMBASE and CiNAHL searched using relevant terms and results independently reviewed. A case note review was undertaken via an electronic proforma sent to Acute and Specialist Trusts with Critical Care units in Cheshire and Merseyside.

Results 633 articles were identified from the literature search, 66 having full text review, 14 accepted. These highlighted a wide range of doses prescribed, including 0–217 mg/hr of Morphine being reported. 95 case notes reviewed. Mean age was 69, 60% were male. 63% had Specialist Palliative Care input and 80% remained in Critical Care until death. There were discussions relating to dying in 96% of cases, 80% had a documented assessment of symptoms at the time dying was recognised. There was a wide range of time from recognising dying to death, 5 minutes to 9 days. When dying was recognised, 52% of patients were receiving intravenous infusions for sedation, symptom control or inotropes. After dying was recognised, 64% received medications via continuous infusion, 30% intravenous, 28% subcutaneous, 6% both. 65% of patients had anticipatory medication prescribed which increased to 83% when SPCT were involved. The mean dose of Morphine administered when dying recognised was 4.5 mg/hour, vs 5.9 mg/hour at the time of death, for Midazolam 1.5 mg/hour vs 3 mg/hour.

Conclusions Within Critical Care we found a wide range in time from withdrawal of life sustaining interventions to death. Routes and doses changed over this period and patients were more likely to have PRN medications prescribed when SPCT were involved. Doses of medication given by intravenous infusion were lower than the average doses reported in the literature.

76 AN ANALYSIS OF THE QUALITY OF ADVANCED CARE PLAN AND DNACPR DOCUMENTATION FOLLOWING THE INTRODUCTION OF THE RESPECT PROCESS

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An Advanced Care Plan (ACP) allows discussion and documentation of patient preferences for future medical care, not only limited to resuscitation. Despite national guidance, communication remains poor and there is inconsistent documentation of ACP and DNACPR decisions, potentially resulting in inappropriate treatment and unnecessary hospital admissions. ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) is a newly introduced emergency care plan which aims to help support discussions and record recommendations. We assessed the quality of ACP and DNACPR documentation at a UK District General Hospital before and after introducing ReSPECT.

Retrospective data was collected on all patients from elderly care wards (one male and one female) in March 2018 and March 2019 through case-note review following ReSPECT going live in October 2018. Section headings on the form were used as basis for collection. Data also included ACP/DNAR decision communication on discharge paperwork.

The March 2018 cohort included 87 patients (35 female and 52 male) with 113 patients (67 female and 46 male) in March 2019. In patients who had an ACP discussion, there was an increase from 68.2% to 100% of the specific nature around this documented, and it was communicated better in discharge documentation (81.8% to 100%). Furthermore, in patients whom DNACPR was agreed, there were improved levels of recorded documentation from 79.4% to 87.1%.

ACP and DNACPR decisions are individual to each patient and pre-ReSPECT form data shows documentation was poor. However, following introduction of the ReSPECT form there were significant improvements noted in two key areas - in clinical notes for DNACPR decisions and subsequent discharge paperwork, and following ACP discussions there was an improved level of documentation regarding the specific nature of the ACP. We have demonstrated that the ReSPECT form can empower clinicians to ensure patients have an appropriate care plan documented to guide future care.

77 IMPROVING END OF LIFE CARE IN AN ACUTE SURGICAL UNIT AND TRAUMA TEAM – A QUALITY IMPROVEMENT PROJECT

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Objectives To audit end of life care (EOLC) delivered by the Acute Surgical Unit (ASU) and Trauma team at Kings College Hospital against local guidelines, and to identify methods to improve quality of care.

Methods Retrospective analysis of electronic notes of all patients who died under the care of ASU/Trauma between August and November 2018. Patients who had isolated neurosurgical injuries, were transferred to another team more than 24 hours before death, or who died unexpectedly were excluded. Data concerning the five priorities of care for the dying person were extracted using a standardised tool. Interventions carried out after cycle one included junior doctor refreshers, EOLC lanyard prompts and posters in the doctors' office, with repeat data sampling from April to July 2019 inclusive.