these interventions has been demonstrated. These audits will continue on a regular basis to ensure maintenance of these standards, and improvement where necessary. A further audit of response to PCOC assessments will be conducted.

146 AUDIT OF PATIENT BLOOD MANAGEMENT AT A SPECIALIST PALLIATIVE CARE UNIT

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10.1136/spcare-2020-PCC.166

Background Blood transfusion is a common practice in palliative care despite a dearth of evidence supporting its routine use in this setting.

Objectives

1. To review patient blood management at Milford Hospice.
2. To explore potential for prospective research in this area.

Methods Data pertaining to a purposive sample of transfusion events at Milford Care Centre that occurred in 2016 and 2017 was collected retrospectively from patient records and laboratory results. Data included demographic information, primary diagnosis, cause of anaemia, indication for transfusion, performance status, investigations such as haemoglobin and iron studies, and outcomes including 30-day outcomes and length of stay.

Results Of these 52 transfusion episodes included, 29 were regarding female patients and 34 were over the age of 65. All patients had a diagnosis of malignancy, with bone metastases reported in 13 (25%). Average Haemoglobin pre-transfusion was 7.21 g/dl. Iron studies were checked in ten cases.

2 or more units were transfused in all but 1 instance.

A beneficial response to transfusion was documented in 15 cases.

3 patients had haemoglobin checks after individual units of blood. 18 patients had haemoglobin checks within a week of the transfusion episode.

30-Day Outcome Post Transfusion: 46% of patients had returned home; 33% of patients had died; 13% of patients remained in hospice; 8% other (long term care, missing data).

Conclusions The lack of full investigation prior to transfusion demonstrates non-compliance with NICE standards and allows for potential overuse of blood products. Routine prescription of two units of blood without interval symptom reassessment or haemoglobin measurement may also contribute. These results were disseminated among clinical staff and an action plan was developed. An algorithm was developed for use in the inpatient palliative care setting and this is being implemented currently. Accompanying guideline development is also underway.

147 PEACE PLAN: THE FUTURE OF ADVANCE CARE PLANNING IN THE ELDERLY

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10.1136/spcare-2020-PCC.167

Background The PEACE (Proactive Elderly Advance Care) plan supports proactive planning of community care escalation

through documenting patient wishes and communicating these with care stakeholders in primary and secondary care. It has been shown to reduce inappropriate re-admissions to hospitals at the end of life. Since September 2018, Broomfield Hospital has been promoting the use of the PEACE plan for elderly patients at the end of life being transferred to care homes. During rollout, it became apparent that there was a need to improve understanding amongst doctors about the indications for the document and their competence in its completion as well as related communication with patients and carers.

Aims To assess local impact of using the PEACE plan and competency in completion, derive relevant training needs, and coordinate the provision of multimodal education interventions.

Method A 1-year pilot study of PEACE plan completion and patient outcomes was implemented across two elderly care wards with Gold Standards Framework accreditation. An online confidence and knowledge questionnaire was completed by junior medical doctors and the results were used to model a training programme.

Results The majority of patients died within the year. Only 8% were readmitted, most were turned around within hours. The questionnaire indicates that, although most junior doctors were aware of the plan, only half had completed the form at the trust. Overall confidence in completing the plan was below expected and discussing artificial nutrition and hydration was a particular area of concern.

Conclusions The PEACE plan reduced inappropriate re-admissions to Broomfield hospital at the end of life. Specific training is required to improve knowledge and confidence of junior doctors before its introduction to all medical wards. This will be delivered as presentations, simulation workshops with a focus on communication skills, and multimedia instructional aids.

148 HOSPICE AT HOME

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10.1136/spcare-2020-PCC.168

Introduction Initially the 'Severn Hospice at Home Day Care Service' was created to provide specialist support and care to patients who were experiencing a crisis in their illness where additional nursing care could prevent hospital/hospice admission. The service needed a review to see if what it provided was what was needed by our local community.

Method Band 3 Healthcare Assistants were deployed to supplement other community teams supporting the assessment of that patient for a defined period of 72 hours. Evaluation of the service identified that most of these patients were in the last few weeks of life, requiring continual nursing care support. Subsequently the Hospice approached Complex Care (Continuing Health Care funding service) to become the palliative care provider of choice for Fast Track clients in the last 6 weeks of life.

Results End of life care is provided to all patients over the age of 18 regardless of diagnosis. The service provides one point of contact for all referrers seven days a week. Service quality standards already identified:

- Links to access to specialist advice – Outreach team, GP
- Prescribing and monitoring of medications
- Decrease in complaints received by complex care

- Fast track status reviewed early if not appropriate
- Coordination of care – having oversight of care at the end of life
- Having links to the hospice – work more effectively together
- Flexibility – challenge the standard ‘x2 carers/x4 a day request’ – refocus on patient-centred care

Typical 4-month stats (April - July 2019): Referrals – 296 and Care Hours - 6,331.75

Conclusion The primary objective of the service is to provide Individualised packages of care, increased/reduced according to need for patients in the last 6 weeks of life and those closest to them. Through this provision of home care, we are demonstrating that we can improve the assessment and management of symptoms.

149 HOSPICE OUTREACH TEAM

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10.1136/spcare-2020-PCC.169

Introduction The community nursing service was restructured to ensure that all adult people, regardless of their diagnosis, have choices and access to specialist palliative and end of life care; to strengthen the integration with our community colleagues; to improve anticipatory and advanced care planning; to reduce unplanned hospital admissions; and to ensure a timely response during episodes of palliative care crises.

Method To evidence a proposal for change an activity audit was completed, a triage system was tested, and views sought from GPs and community nursing leads. The team was changed and became comprised of two tiers of specialist nurse - Outreach Nurses and Outreach Practitioners who have extended skills of physical assessment and prescribing as well as overall responsibility for the wider caseload and the team. The service aimed to support GP's and District Nursing teams within cluster locations. The telephone triage facility was used to determine the appropriateness of referrals and the location for the first assessment, allowing care to be prioritised and the team to offer a responsive service to complex and urgent cases.

Results By managing complex, individual and changing information and supporting patients in choices around treatment and care we have demonstrating improvement in quality and experience along with an increase in referrals. Using and applying clinical knowledge to oversee and coordinate services, we can personalise the palliative pathway for individual patients and support the needs of their families. Additionally, we can act as the key accessible professional for the multidisciplinary team, undertaking proactive case management and using clinical acumen to reduce risk.

Typical 4-month stats (April – July 2019):

Referrals - 695

Home visits - 748

Triage calls – 1307

150 OFF-LABEL PRESCRIBING RECOMMENDATIONS BY A HOSPITAL PALLIATIVE CARE TEAM (HPCT)

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10.1136/spcare-2020-PCC.170

Background It is well recognised that the off-label prescribing of medications is an essential part of practice in palliative care. ‘Off-label’ generally refers to a medicinal product that is used beyond the specification of its Marketing Authority. There are many reasons for the high incidence of such prescribing in palliative care including that the costly and time-intensive process of obtaining or expanding a licence can only be performed by a pharmaceutical company. Additionally, there is common use of subcutaneous medications, the majority of which are used off-label. While it is widely accepted as normal practice, there is a lack of standardisation regarding gaining informed consent from patients and its documentation.

Aim To gain information regarding the prevalence of off-label prescribing and address some of the issues that this presents.

Methods A retrospective study was conducted of the notes of patients referred to a HPCT over a 1 month period. All medications that were off-label (as determined by the Palliative Care Formulary, sixth edition and expert consensus) and recommended by the team were recorded including the drug, indication and route and whether by a HPCT consultant, doctor or Clinical Nurse Specialist (CNS).

Results 175 patients were referred. 541 drug recommendations were made, of which 266 (49%) were for off-label medications. The most commonly recommended off-label medications included opioids for breathlessness and levomepromazine for nausea and vomiting. All members of the HPCT made recommendations at a similar frequency.

Discussion By determining the prevalence of off-label prescribing, we have an understanding of the volume, patterns of drugs, doses and routes and doctor versus CNS variability. This will guide education of the HPCT, improve teaching throughout our Trust and inform the development of Patient Information documentation.

151 EVERY BREATH YOU TAKE : TRACHEOSTOMY VENTILATION IN CHILDREN'S PALLIATIVE CARE

Elli Rushton, Christine Greenfield. *Wessex Childrens Hospice Trust*

10.1136/spcare-2020-PCC.171

Background Children's palliative care is changing. Medical and technological advances enable an increasing number of children with life limiting conditions to survive on long term ventilation (LTV) via tracheostomy. A specialist hospital identified that children spend months in hospital awaiting adaptations to accommodation, and establishment of a care package.

Aims

- Set up a unit for tracheostomy ventilated children within a Children's Hospice in partnership with the hospital. This unit would provide accommodation and nursing support for 3 children and families in preparation for discharge home.
- Facilitate care of child outside the hospital environment.

Methods October 2016-March 2017:

- Literature review
- Partnership working with respiratory team
- Agreed practice framework

March 2017–October 2017:

- Collaboration with specialist paediatric respiratory, and hospice palliative care teams