- Communication with relatives/professionals
- Advance Care Planning
- End-of-life care
- Overall assessment

Each domain was ranked from 1 (poor care) to 5 (excellent care), and key learning points discussed at a monthly meeting open to all clinical staff, and learning points later circulated. Questionnaires were given to staff at the final presentation.

Results Six reviews in total were possible (due to Covid-19 these were not possible every month). Questionnaire responses were overwhelming positive with 100% stating that it was useful to be able to review deaths in this format, written comments gained were positive (on poster). The monthly programme has now been taken on regularly at the hospice as a learning event.

Conclusions This has been a positive learning experience, for both individuals and at an organisational level. SJRs received overwhelmingly positive responses from staff and allow informal discussions which also help to ensure organisations effectively respond to and learn from deaths. This could be easily replicated at other hospices to support learning.

Posters 57 – 81 | end of life care

57 COMMUNITY END-OF-LIFE ANTICIPATORY MEDICATION PRESCRIBING PRACTICE: RETROSPECTIVE MIXED METHODS OBSERVATIONAL STUDY

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10.1136/spcare-2021-PCC.75

Background Anticipatory medications (AMs) are injectable drugs prescribed to a named patient, ahead of possible need, for administration if distressing symptoms arise in the final days of life. Little is known about how and when drugs are prescribed in primary care.

Aim To investigate the frequency, timing and recorded circumstances of injectable end-of-life AMs prescribing decisions for patients living at home.

Methods Retrospective mixed methods observational study using GP and community nursing records for 329 deceased adult patients registered with 11 GP practices in two UK counties (30 most recent deaths per practice). Patients died between 2017 and 2019. Multivariable logistic regression models were built to detect key factors associated with AMs prescribing.

Results AMs were prescribed for 167/329 (50.8%) of patients, between 0 and 1212 days before death. The median prescribing timing was 17 days before death across all GP practices, with a range of median 3 to 33 days in individual GP practices. The likelihood of AMs prescribing was significantly higher for patients with a recorded preferred place of death (odds ratio [OR] 34; 95% CI 15–77; $p < 0.001$) and specialist palliative care involvement (OR 7; 95% CI 3–19; $p < 0.001$). AMs were typically prescribed (114/167, 68.3% patients) as part of one main end of-life planning intervention when preferred place of death and/or Do Not attempt

Cardiopulmonary Resuscitation (DNACPR) discussions were also first recorded. Standardised prescribing of four drugs and doses was commonplace and prompted by primary care electronic end-of-life templates.

Conclusion Standardised AM prescribing patterns and variability in the timing of prescriptions highlight challenges in diagnosing dying, and the risks involved in prescribing far in advance of possible need. Our findings warn about the dangers of electronic end of life templates and the bureaucratisation and standardisation of end-of-life care planning interventions.

58 ANTICIPATORY PRESCRIBING FOR CONTINUOUS SUBCUTANEOUS INFUSION: FRIEND OR FOE?

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Background Anticipatory prescribing of 'prn' medication for symptom control is recommended for those approaching the last week-of-life however practices regarding anticipatory prescribing for continuous subcutaneous infusions (CSCI) varies widely. The Gosport Report highlighted risks associated with anticipatory prescribing for CSCI. The Association of Supportive & Palliative Care Pharmacy state the perceived benefit does not outweigh the risks.

Methods A network-wide cross-boundary audit was undertaken of the use of CSCIs in patients known to specialist palliative care services. A survey was completed by each service-lead and feedback collated following presentation of results.

Results 208 of 347 patients (174 hospital, 49 community, 124 hospice) prescribed medication via a CSCI were recognised as likely to be dying.

Drugs prescribed included strong opioids (286) anti-emetics (133), anxiolytics (89), anti-cholinergics (102), anticonvulsants (20) and steroids (6). Median doses of opioids and benzodiazepines were low (e.g, morphine 10 mg CSCI q24h)

The CSCI had been prescribed in anticipation in 1/5 of patients across all care settings (hospital 20, hospice 24, community 16). 58% of services/organisations responding to the survey allow prescribing for CSCI in anticipation.

Feedback following presentation of results and proposed guideline highlighted two conflicting sets of views and practices: anticipatory prescribing for CSCI as vital to ensure timely symptom control in the dying vs. the view it is unsafe practice, citing incidents/near-misses resulting from lack of clinical assessment of need at the time a CSCI is commenced. This audit reviewed current practice but is unlikely to capture such clinical incidents or 'near-misses' where drugs are administered without indication or at high doses.

Conclusion There is conflicting practice and opinion surrounding the risks and benefits of anticipatory prescribing for CSCI. This audit did not identify unsafe practice but will not reliably capture incidents or near-misses. Further evidence-based national guidance is required to guide safe practice.