prioritised from the advisory caseload as patients with predominantly palliative care needs, requiring regular consultant input.

Aims Prospective audit of SCU admissions during the initial nine-month period from opening in August 2019.

Results Over the initial nine-month period, a total of 85 patients were admitted to SCU with a mean length of stay of 10 days. Of these, 86% (n=72) had a primary cancer diagnosis, compared with 64% of patients under our advisory caseload. Age range was 37–98 years, with a mean age of 67 years. Mean waiting time once listed was 2 days (median 1 day, range 0–32 days). Mean time from referral to the advisory HSPCT to referral to SCU was 5 days (median 1 day, range 0–88 days). Length of stay reduced from a mean of 15 days in month one to 7 days in month six. Patients were most commonly admitted from medical wards (58%), followed by assessment areas (32%) and surgical wards (5%). Four patients were admitted electively; two for blood transfusion and two for paracentesis.

Conclusion Without any additional resource, we have successfully opened a small number of specialist palliative care beds. In September 2020, this increased to eight beds. Informal feedback is positive, and our next objective is to capture formal patient and family feedback. We will also develop processes to facilitate elective admissions for patients already known to palliative care services. It is interesting to note that the proportion of patients with a cancer diagnosis is higher on SCU compared with the advisory HSPCT. Prospective data collection is ongoing to see if this trend continues.

98

IMPROVING USE OF CO-ORDINATE MY CARE ELECTRONIC PATIENT RECORD AT ST CHRISTOPHER'S HOSPICE – COMPLETING THE AUDIT CYCLE

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Introduction Co-ordinate my care(CMC) is the pan-london electronic patient record system for palliative care patients. It facilitates sharing urgent care records across settings, linking services which patients may access(GP, ambulance, district nurses, palliative care). By creating records and working with local services to update records, we aim to improve 'joined up working' for our patients.

Aims/objectives To audit use of CMC for patients under the hospice including numbers of patient consented/records created, congruence of information recorded with hospice electronic records and access of records by emergency services.

Methods We conducted snapshot audits of records in december 2018, subsequent QI initiatives including staff training and integration of CMC reviews into MDM meetings, with re-audit December 2019. Each audit examined 200 patient records, 100 indicated as 'CMC record created' on our hospice system and 100 indicated to have no record. Patients were randomly selected; 40 from each service:Bromley community, bromley care co-ordination, croydon community, Lambeth/southwark/lewisham community and sydenham outpatients. Information was cross-checked against the live CMC record. Standards included: 90% of patients should have a CMC record, 95% should have documentation of consideration of CMC, 95% of CMC records should have resuscitation and ceilings of

care decisions recorded with congruence between systems. We also recorded whether CMC records were accessed by OOH services.

Results Comparing data from our initial audit to the re-audit; 61% vs 73% of patients under our care were consented to have records created. Of these >95% had a live CMC record. For those not consented by us 220–40% had a live record across each of the 5 services. Between audits, numbers of patients with CMC records increased from 48–60% to 58–68%. Discussion of CMC with patients increased from 48–53% to 70–93%. Recording of DNAR status averaged >95%. Congruence of DNAR decisions was 82% with ceilings of care 61% congruent. Inclusion of hospice contact details varied across teams (30 to 74%). Records were accessed by out of hours services for 13 of these patients.

Conclusion Use of CMC is increasing with access to records by OOH services. Further QI initiatives to drive numbers and quality of records will be discussed with impact of OOH records accessed on patient outcome.

99

'TO FEED OR NOT TO FEED': REVIEW OF PRACTICE IN AN ACUTE HOSPITAL TRUST AROUND INITIATION AND WITHDRAWAL OF PARENTERAL NUTRITION (PN) IN PALLIATIVE PATIENTS

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Background/Introduction National and European guidance around use of PN in palliative patients emphasises the need to consider risks, benefits, and impact on QOL with it unlikely to be appropriate in the last weeks of life. Starting PN can delay discharge from hospital to other settings and affect PPC/PPD.

Aims/Objectives To assess whether local processes around initiating and withdrawing PN for hospital inpatients with palliative care needs are in line with current guidance.

Methods Retrospective case review: All Patients prescribed PN feed over a 6-month period identified by pharmacy and known to the hospital supportive and palliative care team (SPCT) were recruited and their notes reviewed regarding indication for PN, evidence of discussions around initiation and withdrawal, date PN started and stopped, interventions planned/performed, details of SPCT involvement, and patient outcomes. Data analysed using descriptive statistics.

Results 183 patients received PN over 6-month period. 33 were known to SPCT. SPCT involvement began after PN initiation for 77% of patients. Wide range of indications for initiation, most common being oesophageal obstruction (16%). Most commonly withdrawn because patient approaching terminal phase (52%). Relevant documented discussions with patients/families recorded in 29% prior to initiating PN (none involved SPCT) and 26% prior to withdrawing PN (half involving SPCT). Nearly half (48%) of patients died within 2 weeks of starting PN (65% within 4 weeks). Importantly 26% died within 24 hrs of stopping PN. Over 2/3 died in hospital. 65% had no intervention planned to stop the need for ongoing PN at the time of initiation. Findings showed results were not in line with current national guidance

Conclusion/Discussion Decision for SPCT to be involved in all MDT discussions prior to PN initiation in palliative patients