Adherence to local trust guidance was evident with regards choice of antimicrobial in 59%. The indication was recorded on the drug chart in 100%, with a review date in 35% and a stop date in 86%.

Advance discussions relating to antimicrobial treatment were documented in 48%. Seventeen patients died during the admission; the average time between stopping antimicrobials and death was 8 days.

Conclusions This audit highlights the importance of accessing updated guidelines which ensure appropriate prescribing whilst considering local resistance patterns. Alongside a drive to raise awareness, an advance care planning template was implemented for all patients, to record discussions and guide decision making when indications of infection arise. The continuing challenge lies in identifying patients who will benefit from the right antimicrobial and those for whom there will be minimal benefit, but could contribute to increasing antimicrobial resistance.

130 MEASURING SERUM-ASCITES ALBUMIN GRADIENT TO OPTIMIZE MANAGEMENT OF ASCITES IN A HOSPICE SETTING
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Background Paracentesis for management of ascites is frequently performed in hospices. Serum-ascites albumin gradient (SAAG) should be measured to guide management. Patients with ascites caused by portal hypertension have a SAAG 11 g/L. Usual management is to:

- give human albumin solution (HAS) for renal-protective effects
- prescribe spironolactone to reduce re-accumulation of ascites

This practice is established in the management of portal hypertension due to cirrhosis. However, the incidence of portal hypertension in patients requiring paracentesis for malignant ascites is unknown.

Methods In 2019 guidelines were written to ensure SAAG was checked for patients admitted to the hospice for paracentesis. These guidelines were audited in 2020. The audit covered an 11-month period, looking at whether SAAG was available pre-procedure, and whether HAS and spironolactone were given.

Results 25 drains were inserted in 12 different patients. 100% of these patients had SAAG calculated. 67% (n=8) received HAS. 50% of this group (n=4) had a diagnosis of cirrhosis, and 50% (n=4) had metastatic malignancy. 3 of the patients given HAS were already on spironolactone, 3 were started on it post procedure (these were patients with malignant ascites), and 1 had their dose increased.

4 patients with malignant ascites received HAS and 3 were started on spironolactone.

Conclusions Measuring SAAG demonstrated cases of malignant ascites associated with portal hypertension. This led to a change in management with increased use of HAS and spironolactone in patients with malignant ascites. All patients undergoing abdominal paracentesis should have SAAG recorded and used to determine appropriate use of HAS and spironolactone.