

and CPOT. Observational pain assessments are advantageous when the patient is unable to express verbally. Facial expressions, vocalisations and body movements can be used to interpret pain behaviours, and associated pain assessments are quick and simple to use. In addition to better pain management, this can lead to less stress for the carer, the patient and their families.

**Conclusion** There are observational pain assessment tools trialled in specific patient groups, but limited recognised evidence-based pain assessment tools for dying patients that cannot self-report.

Although there are some disadvantages to observational pain assessments, there is potential to increase evidence-based practice and improve patient outcomes, by implementing an observational pain assessment tool for dying patients.

**P-53 REVIEW, REFRESH, RELAUNCH: SCOPING OF ANTICIPATORY CLINICAL MANAGEMENT PLANNING AND DECISIONS ABOUT CARDIO PULMONARY RESUSCITATION**

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10.1136/spcare-2022-SCPSC.74

**Background** The need for a consistent approach to Advance Care Planning (ACP) was highlighted in the CQC Report: Protect, Respect, Connect. Regional guidelines outline a consistent approach to Anticipatory Clinical Management Planning (ACMP), including decisions about cardiopulmonary resuscitation (CPR), but it was not known how widely these guidelines were implemented.

**Methods** A scoping survey was undertaken across 5 Integrated Care Partnerships (ICPs) within an Integrated Care System (ICS) to provide a high level overview of principles of practice regarding decision-making, documentation, education and governance of ACMPs.

**Key findings** The ACMP guidelines are followed across the ICS, with their use predominantly driven by palliative and end-of-life networks. A consistent approach to resuscitation decisions is in place across the ICS. Approaches to other elements of anticipatory clinical management planning varies but each ICP has some processes in place (e.g. Anticipatory Clinical Management Plans, AMBER care bundle). The ability to share information between organisations manner remains a challenge. A regional education program supports education and training on future care planning, but this does not address the clinician-led elements of advance care planning. Individual provider organisations have some systems for oversight and assurance.

**Conclusions** Regional ACMP guidelines inform a consistent approach to Advance Care Planning and have supported the implementation of a common approach to resuscitation decisions. It is recognised that a 'consistent approach' does not mean 'all organisations and specialties using the same form' and there is a need for ongoing collaboration across primary, secondary and social care in order to develop system-wide processes which support shared decision making and patient centered care. An action plan includes refreshing current guidance and agreeing insight metrics and an education and training framework to promote and support effective advance care planning.

**P-54 MAPPING FUTURE CARE: PROCESS MAPPING OF ANTICIPATORY CLINICAL MANAGEMENT PLANNING (ACMP) IN THE HOSPITAL SETTING**

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10.1136/spcare-2022-SCPSC.75

**Background** An Anticipatory Clinical Management Plan (ACMP) is a proactive clinical plan, made in advance for a predicted clinical situation. ACMPs are the clinically-led elements of Advance Care Planning and include treatment escalation plans and decisions about cardio-pulmonary resuscitation. They require sensitive conversations about the individuals wishes and preferences, and provide guidance for treatment at a future date. A consistent approach is out-lined in regional guidelines.

**Methods** Process-mapping was undertaken by hospital and community colleagues to identify the blocks to effective anticipatory clinical management planning within the hospital and an action plan agreed.

**Results** Process-mapping highlighted the complexities of a process which spans different care-settings and organisations. Blocks identified included identification of individuals who may benefit; staff knowledge, skills and confidence; lack of patient alerts on clinical records; information sharing between organisations.

**Conclusions** Bringing together professionals from primary, secondary and social care highlighted both the complex nature of ACMPs but also the shared desire for collaboration to improve patient care.

A multi-professional, interactive, ACMP workshop has been developed and delivered to 77 members of staff (41 hospital, 36 community; 44 doctors, 34 other). This is well-evaluated. On-going work-placed base support is available for those who have completed training from the course facilitators. In response to feedback during training, both a clinical template and a prompt list are being piloted to support clinicians. A trust-wide treatment escalation plan is currently being implemented. Work is ongoing to establish electronics alerts on patient records and effective processes for information sharing between organisations. Education is supporting staff to gain the skills and confidence required to follow a shared-decision making model when planning for future anticipated clinical events. Digital solutions to information-sharing are required to ensure plans are shared effectively to support patient-centered care.

**P-55 CLINICAL AUDIT EVALUATING THE IMPACT OF SPECIALIST PALLIATIVE CARE TEAM ON TIME BETWEEN RECOGNITION OF DYING AND DEATH OF HOSPITAL INPATIENTS**

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10.1136/spcare-2022-SCPSC.76

**Background** Recognition of dying is important to give people time to communicate and achieve wishes, organise finances and begin the bereavement process. This audit aims to evaluate the time between recognition of dying (ROD) and death among inpatients at a District General Hospital and the impact of involvement of the Specialist Palliative Care Team (SPCT).

**Method** A two-cycle audit was completed. Cycle 1 reviewed 49 decedents from April-May 2020; Cycle 2 reviewed 21 decedents from October 2020. Data included length of admission, involvement of SPCT, date treating team ROD and date SPCT ROD. Standards were based on National Audit for Care at the End of Life data. Interventions included education and attendance at board rounds.

**Results** National standards were met in many areas. Data was significantly above standards with SPCT involvement. 88% (43/49) of decedents were recognised as dying. Median time between recognition and death: 48 hours with 81% (35/43) of people dying more than 24 hours after ROD. This is an improvement on the national standard of 88%, 41 hours and 64% respectively. Cycle two showed 33% (7/21) seen by SPCT with 71% (5/7) of these recognised as dying. Median time before death: 52 hours, with 80% (4/5) dying more than 24 hours after ROD.

**Conclusion** Results indicate SPCT involvement extends time between ROD and death. Perhaps due to experience in caring for dying people, having more in-depth discussions potentially revealing information to guide prognosis and the characteristics of persons referred to them. This has supported increased referrals to the SPCT and led to further work considering earlier opportunities to involve the SPCT in a person's care.

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#### AUDIT OF TREATMENT ESCALATION PLANNING IN PATIENTS REFERRED TO A HOSPITAL SPECIALIST PALLIATIVE CARE TEAM

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10.1136/spcare-2022-SCPSC.77

**Introduction** Whilst treatment escalation planning is widely acknowledged as an important aspect of care its clinical application is variable. We set out to audit what proportion of patients referred to a hospital specialist palliative care team (SPCT) had treatment escalation plans in place and of those who did the circumstances of this decision making.

**Methods** A retrospective audit of 140 patients referred to the SPCT over July 2020. Electronic records examined to establish whether patients had a DNACPR and/or treatment escalation plan (ie written record of whether consideration of escalation to level 2/3 care would be appropriate) in place at time of referral. If a treatment escalation plan was in place records were further examined to evaluate what prompted this decision, who lead the decision making and when it was made.

**Results** Of the 140 patients audited 65% had a DNACPR in place at time of referral and 46% had a treatment escalation plan in place. Of those who had a treatment escalation plan 35% had this plan made with their treating consultant with others having this plan made with specialty registrars (33%), SHO grade doctors (22%), or other consultants including critical care (7%). Hospital admission prompted planning in the majority of cases (66%). A significant proportion of decisions were made out of hours (47%).

**Conclusion** Despite all the patients in this cohort having identified, inpatient specialist palliative care needs 64% did not have a treatment escalation plan in place. Of those who did only 35% had made this with their treating consultant and many decisions were made out of hours. This audit shows that we have significant opportunity to improve treatment

escalation planning in patients referred to SPCTs. We aim to introduce improved treatment escalation planning in the Trust through education and clearer documentation.

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#### THE OPPORTUNITY OF BENCHMARKING AS A PEER-REVIEW STRATEGY TO SUPPORT TRANSPARENCY OF PRESCRIBING IN LIGHT OF THE GOSPORT REPORT RECOMMENDATIONS

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10.1136/spcare-2022-SCPSC.78

**Background** The Gosport Report has highlighted the importance of maintaining appropriate opioid and sedative use in palliative care, ensuring transparency, and demonstrating safe and effective prescribing. Comparing prescribing practices of organisations providing services to similar cohorts of patients is one way of achieving this. A local collaborative project by geographically neighbouring hospices used a common data collection sheet to compare across organisations and commissioning boundaries, to assess regional consistency in opioid and sedative prescribing at EoL.

**Method** This review of practice involved using an existing data collection sheet (from a different commissioning area) within two hospices (SWH, SMH) to facilitate a retrospective, case-note review of randomly selected inpatients unit deaths over 12 months. Data from those hospices, and 7 others in the wider region, was collated and shared by one coordinating organisation.

**Results** Both SWH and SMH had clear documentation that the patient was dying, 87%(SMH) and 94%(SWH), with the indication and use of syringe pumps being clearly documented, 88%(SMH) and 94%(SWH.) The IQR of median doses for morphine were 30.5 – 51.25, SMH median value [35] is within IQR and SWH median value [15] is below IQR. The IQR of median doses for midazolam were IQR of median doses is 10.75 – 15, SMH median value [8] is below IQR and median value [13] is within IQR.

**Conclusion** Comparison of data from hospices within the region has allowed each organisation to critically look at their opioid prescribing compared to practice in similar organisations across Kent, Surrey, and Sussex. This project demonstrates an example of how the Gosport Report recommendation to annually review opioid and sedative medication prescribing in EoL can be facilitated. Including comparison of outcome measures to assess prescribing effectiveness is a proposed future development.

#### REFERENCE

<https://www.rpharms.com/about-us/who-we-are/expert-advisors/hospital-expert-advisory-group/gosport-report>

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#### DYING FROM LIVER CIRRHOSIS. ARE WE COMMUNICATING WITH PATIENTS AND THEIR RELATIVES

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10.1136/spcare-2022-SCPSC.79

**Introduction** The prospect of dying is a difficult subject to broach with patients and their relatives. This is exacerbated