

P-61 REINVENTING NURSE ADMINISTRATION OF CONTROLLED DRUGS

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Background Double-checking the administration of controlled drugs has been standard practice worldwide for decades. This process may appear to be a logical safety precaution. However, research has indicated that there is insufficient evidence to support the argument that the process reduces the rate of medication incidents compared to single-checking. The gold standard is independent double-checking meaning both the nurses separately perform a check without sharing information. In practice, this rarely happens: instead, primed double-checking often occurs whereby one nurse shares some information with the other nurse e.g. drug name. Our hospice sought to challenge this longstanding practice by introducing single nurse administration of controlled drugs with the aim to improve promptness in administration and release time to care, whilst maintaining patient safety.

Method We adopted a change management process, starting with an educational session for nurses to explain the rationale for this proposed change. Staff were then assessed in single nurse administration to ensure that they were competent. In order to establish if our aims were met, the administering nurse recorded the time taken to administer controlled drugs (from identification of need to completion of administration) both before and after single nurse administration was introduced. The balancing measure of patient safety was assessed by reviewing the frequency of controlled drug incidents before and after single nurse administration was introduced.

Results We found a 46% reduction in the mean time taken to administer controlled drugs through single nurse administration compared to double-checking. Furthermore, there was a 25% reduction in controlled drug administration incidents in the first six months of the introduction of single nurse administration compared to double-checking.

Conclusion Through this project we demonstrated that single nurse administration is more time-efficient than, and at least as safe as, double-checking. This project demonstrates successful change management in reinventing long-established nursing administration practice.

P-62 THE EXPERIENCES OF COMMUNITY NURSES PROVIDING END-OF-LIFE CARE FOR PATIENTS FROM BLACK AND ASIAN MINORITY ETHNIC BACKGROUNDS

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Background Providing end-of-life care in the patient's own environment is challenging, especially if the nurse is from a different ethnic and cultural background from the patient. Evidence shows that people from the Black and Asian Minority Ethnic (BAME) background communities experience poorer end-of-life care in the UK due to the care providers and commissioners not understanding their care needs.

Methods A qualitative approach, using semi-structured interviews, was used to explore the experiences of 16 community nursing staff caring for end-of-life patients from the BAME community in Leicester, Leicestershire, and Rutland. Virtual

interviews were audio-recorded, transcribed verbatim and thematically analysed.

Results Family hierarchy meant that the nurses had to deal with large tight-knit families, paternalism and controlling behaviours, and had to establish advocacy processes. There was a strong mistrust and suspicion of Western medicine and a belief that Western medicine speeds up death. There was a desire to hold onto life, continue to have nutrition, and these feelings were influenced by Spiritual beliefs. Consequently, there was low uptake of end-of-life care services for this group. There were also language barriers and challenges faced by the nurses, resulting in difficult conversations with the families. Despite the challenges, nurses tried to build relationships with the families in order to meet the patients' end of life care needs. Different levels of the nurses' cultural and religious competencies in caring for BAME patients were also identified. As the research was conducted during pandemic, COVID-19 effects contributed to the above challenges.

Conclusion This research has shed light on the challenges of individualising end-of-life care patients in a culturally diverse community. The nurses' cultural and religious competencies were challenged as they attempted to ensure their expert healthcare professional philosophy of care met the needs and preferences of the dying patient and their family.

P-63 INCREASING THE USE OF, AND EXPLORING JUNIOR DOCTORS UNDERSTANDING OF, INDIVIDUALISED CARE PLANS FOR DYING PATIENTS AT AN EAST LONDON DISTRICT GENERAL HOSPITAL IN 2021

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Background We observed at our Trust, a reduction in the number of dying patients being supported with our individualised care plan for the dying (Compassionate Care Plan; CCP) during 2021 and sought to both improve this and explore junior doctors' understanding of the plan.

Methods An audit was designed to review the use of CCP documentation as well as other allied measures for one month pre interventions and for one month following. The interventions included paper copies of the CCP document being placed in accessible locations and posters explaining the role and rationale of the CCP placed in communal rest and work areas. Alongside this an online survey about the CCP was sent to junior doctors.

Results CCP usage was largely unchanged (87% compared to 84%) across the two months and palliative care referrals and anticipatory medications prescriptions had declined by 16% and 9% respectively. There had also been a decline in communication with next of kin. The initial interventions had not improved CCP usage but it highlighted the correlation between anticipatory medication prescribing, NOK communication and palliative care team reviews. The second part of our project was to investigate junior doctors understanding of the CCP. Our results showed that 100% knew what the CCP was, 90% had previously completed one and 81% felt comfortable suggesting it to a senior. However only 59% knew where to find it and only 72% felt it was a useful tool in end of life care.

Conclusion Although our interventions did not improve end of life care through CCP utilisation, it has informed us which

strategies to focus on instead; namely accessibility of the document, the importance of referring to the hospital specialist palliative care service and the need to improve junior doctors understanding of the value of individualised care planning for dying patients.

P-64 CARE OF THE DYING ON INTENSIVE CARE

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Introduction We completed an audit to review end of life care for adult patients who died on intensive care (ICU) at the Royal Victoria Infirmary, Newcastle upon Tyne. The audit aimed to benchmark against NICE guidelines: Care of dying adults in the last days of life (NG 31).

Methods Case notes from all expected deaths on adult ICU during April and May 2021 were reviewed retrospectively by four reviewers. The reviewers included a collaboration of palliative and critical care doctors. Data was collected on recognition of dying, communication with the patient and their family and individualised care.

Results There were 16 expected deaths. 100% of patients were recognised to be dying. The median time from recognition to death was 46 hours. In all cases there was discussion, with family, about the patient being unwell enough to die. 94% included discussion about patient wishes at the end of life. These discussions were had with the patient in only 25% of cases – in the majority, the patient was too unwell for these discussions. Reviewers agreed that daily symptom and hydration assessment was applicable for 9/16 patients, with 100% achieving these indicators. 7/16 were felt not applicable for this aspect of the review, due to brain stem death (3/16) or short time to death (hours) after withdrawal of life sustaining treatment (4/16). 92% of patients had anticipatory medications prescribed, with indications. Only 31% of cases had documented assessment of whether there was a pre-existing advance care plan (including advance statement, lasting power of attorney or emergency healthcare plan).

Conclusion The audit demonstrated good individualised care of dying patients, with examples of excellent communication and individualised care. An area for improvement is to include assessment of pre-existing advance care planning within ICU admission documentation.

P-65 THE PHYSICIAN RESPONSE UNIT, SUPPORTING PALLIATIVE AND END OF LIFE PATIENTS IN THE COMMUNITY

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Background The Physician Response Unit (PRU) is a Community Emergency Medicine model, bringing highly skilled medical care to the patient. This is in the form of a senior Emergency Physician and an ambulance service clinician equipped with point-of-care diagnostics, medications and they can access health records including Coordinate My Care.

Aim To show the activity and interventions carried out by the PRU in patients who have been identified as having palliative care needs or being at the end of life.

Method A retrospective descriptive analysis of patients identified by the PRU as having palliative care needs or being at the end of life at the point of review between January 2021 to April 2021. Information recorded included origin of the call, outcome of the visit and whether they were known to palliative care services prior to the review.

Results A total of 58 palliative care patients were seen by the PRU in their own home between January and April 2021. 56 patients following review by the PRU stayed at home. 32 of the calls requesting a PRU visit originated from an ambulance crew that was already at the place of residence. Of the patients in the study, 22 were known to palliative care services prior to the review, and 34 were not known with their services previously. The most common reasons for review included possible end of life care for 19, followed by difficulty in breathing in 10.

Conclusion In this study the majority of patients reviewed by the PRU managed to stay at home despite an ambulance being called. Over half the patients who were identified with palliative or end of life care needs were not known to palliative care services prior to this emergency review.

P-66 DEVELOPMENT OF POWER BI TO REVIEW GREAT DISCHARGE TO IMPROVE CO-ORDINATION OF CARE FOR PATIENTS AS PART OF GOLD STANDARDS FRAMEWORK IMPLEMENTATION AT DUDLEY GROUP NHS FOUNDATION TRUST

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Background A third of hospital patients are in their last year of life and almost 50% of people die in hospital. At Dudley Group NHS Foundation Trust (DGFT) we have implemented the Gold Standards Framework (GSF). To support co-ordination of care across settings a template was developed using the 'GREAT' acronym (G – GSF register, R – resuscitation status, E – end of life care medications, A – advance care planning and T – treatment escalation plan) to support discharge summaries for GSF identified patients.

Method On the electronic summary of admission completed for each patient on discharge there is a section to complete if the patient has been identified as GSF which includes the GREAT template. A random sample of GSF identified patients was identified and summary of admission reviewed to see if the GREAT template sections had been completed.

Results From audits approximately 60% had GSF recorded on the summary of admission and less than a third had any of the other sections completed. Therefore, working with data analyst a Power BI was developed that provides a break down by ward and for each patient identified as GSF the GREAT template sections completed within the summary of admission. This is then used by the ward to drive improvements in the quality of information communicated to community teams and primary care.

Conclusion Co-ordination of care across settings is important to ensure continuity of care and therefore, it is important to ensure discussions regarding end of life care are