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



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