communicated to community teams. The GREAT acronym and Power BI are useful tools to drive improvements in the quality of information and communication for patients identified as GSF and supports the development of an individual plan of care.

P-67 THE LAST CHANCE TO GET IT RIGHT: THE EXPERIENCE OF HEALTH PROFESSIONALS DELIVERING END-OF-LIFE CARE IN AN IN-PATIENT MENTAL HEALTH SETTING. A MODIFIED CRITICAL REVIEW OF LITERATURE

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The purpose of this modified critical review of literature is to draw upon the contemporary evidence base to explore the lived experiences of healthcare professionals delivering end-of-life care to patients cared for in mental healthcare settings. People of severe and persistent mental illness are a very vulnerable cohort of patients. They often live with higher-than-average co-morbidities, low than average life expectancy and high mortality rates. Little is known about the experience of mental health professionals delivering end-of-life care to those patients whose care needs can only be met in an in-patient facility. This review aims to provide a window into this experience and draw out the barriers and enablers to good care. For this review, 64 unique titles and abstracts were identified through the search of six databases. The appraisal of these papers resulted in six meeting the inclusion and quality criteria and subsequent syntheses of the findings were presented into three themes:

1) There was a recurrent lack of preparedness of both services and staff to assess and meet the needs of patients at the end-of-life in mental healthcare settings.

2) There was a clear need for collaborative work between mental and physical healthcare professionals; however, this was often difficult to achieve.

3) Patients at the end-of-life with Severe Mental Illness poses specifically challenges which professional caring for them need to be aware of.

The findings of the review were in keeping with other work in the area and provides four main recommendations for practice:

1) Services must have a clearly defined collaborative approach to working relationships between palliative care and mental healthcare professionals.

2) Specific training and education for mental healthcare professionals in end-of-life care and visa verse for physical healthcare professionals when caring for a patient with a comorbid serious mental illness.

3) Thought should be put into the environment of an in-patient mental healthcare ward. While it is recognised the need to maintain safety of patients in these environments, considerations such as the availability to the correct equipment, décor and access to meaningful activity is invaluable for both care giver and patient.

4) Services should consider that their policies and procedures reflect that end-of-life care could be a need of any patient in a services care. The ability to refer to policy and procedure was found to be a comfort and a supportive measure for staff caring for patients at the end-of-life.

P-68 DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) AUDIT: DNACPR COMPLETION AND ADVANCE CARE PLANNING AT A CANCER HOSPITAL IN SHEFFIELD TEACHING HOSPITALS (STH)

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Background 'Addressing decisions surrounding Cardiopulmonary Resuscitation (CPR) is important for any patient who is approaching end of life and/or is at risk of cardiorespiratory arrest' (Resuscitation Council, 2016). Our audit aimed to establish if current practice of DNACPR form completion and documentation was in keeping with local guidelines and if unwell patients had appropriate escalation plans documented.
Methods DNACPR forms for inpatients were reviewed retrospectively (n=35). Data was collected by doctors who were not directly involved in completion of the forms. In addition, medical notes for newly admitted patients who were identified as having a National Early Warning Score (NEWS) of >5 and >7 were reviewed to identify if an escalation plan had been put in place on the post take Consultant ward round (n = 20).
Results 100% of completed DNACPR forms had correct patient identifiers and the reason for DNACPR completion clearly documented. However only 80% were countersigned by the Consultant in the required time (by the end of the next normal working day). Documentation in patient notes was completed for 97% of DNACPR discussions and 86% of DNACPR decisions were documented on the ward handover sheet. Only 57% had time for review clearly stated (unlimited or specific date specified). For patients who were identified as having a NEWS of 5–6, 60% had an appropriate escalation plan documented in the notes, compared to only 40% for those with a NEWS of 7 or above.
Conclusion Our audit identified shortcomings in meeting some of our standards and in making escalation decisions for patients with high NEWS. Staff education in DNACPR completion and facilitating interdisciplinary communication regarding such decisions in a timely manner are essential to ensuring dignified end of life care.

P-69 REVIEW OF DEATHS OCCURRING WITHING 48 HOURS OF ED ATTENDANCE, FOLLOWING THE SECOND WAVE OF THE COVID-19 PANDEMIC

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Introduction This review of patients who died rapidly after Emergency Department (ED) presentation, explores whether attendances were avoidable, and if so, how the pathway to attendance could be interrupted.
Method 22 consecutive patients who died within 48 hours of ED presentation in early 2021 were included. Data was collected from Primary Care records, ED and hospital notes. The patients' attendances were categorised as 'Unavoidable', 'Borderline', or 'Avoidable'. Demographics were compared and the Borderline and Avoidable attendances examined in detail.
Results Most attendances (59%) were Unavoidable, 23% Borderline, and the minority Avoidable (18%). Median age and

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frailty scores were highest in the Avoidable and lowest in the Unavoidable categories.

In Borderline and Avoidable groups:

Advance Care Plans (ACP) were completed pre-admission with wishes to die at home in 1/5 Borderline, and 4/4 Avoidable, cases. RESPECT forms completed in 77%. Dying was only identified pre-attendance in 2 patients – both categorised as Avoidable. One patient was conveyed because care could not be sourced quickly enough and one because despite care the family felt unable to cope. The remainder were admitted due to possible reversibility of and/or unexpected nature of deterioration.

ACP was not completed in 3/5 Borderline cases, despite opportunities, but may have prevented admission in just one. 55% of patients had only virtual assessments from GP/Community Palliative Care prior to conveyance to hospital.

Discussion Most attendances were Unavoidable. For patients dying in the community, timely availability of adequate support is important to enable people to remain at home. ACP and RESPECT forms were often available but did not prevent admissions when it was not apparent the patient's deterioration represented a terminal event, highlighting the importance of senior clinician availability in the community. Further understanding of the impact of virtual working on clinical decision making, particularly for patients wishing to die at home.

P-70 ANTICIPATORY CSCI PRESCRIBING AND ADMINISTRATION IN THE COMMUNITY – IS IT SAFE?

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Background The anticipatory prescribing of PRN medications and continuous subcutaneous infusion (CSCI) medication is essential for the timely management of symptomatic patients at the end of life. There is no evidence to support the safety or appropriateness of anticipatory CSCIs. In 2013, in response to safety concerns about end of life prescribing in the community, we designed an educational intervention to improve prescribing practices among non-specialist prescribers in this area.

Methods We performed a safety-focused retrospective cohort analysis of end of life community prescriptions of anticipatory continuous subcutaneous infusions over a 12 month period, 5 years after creating clinical guidelines and embedding a multiprofessional rolling education programme. Medications prescribed and administered for symptom control at the end of life are compared between specialist and non-specialist prescribers in terms of their adherence to best practice guidance.

Results Medications prescribed were not universally administered and more commonly not administered without specialist input. Prescriptions of higher doses of opioids and benzodiazepines beyond those recommended by guidance were significantly greater within the cohort of patients receiving specialist oversight. The prescription of a dose range did not result in excessive dose escalation. For patients not receiving specialist palliative care, median morphine and midazolam doses did not escalate at all once a CSCI was commenced. All midazolam administrations were safe.

Conclusions The practice of anticipatory continuous subcutaneous infusion prescribing and administration can be safe in the community non-specialist setting when supported by clinical guidelines, specialist advice and ongoing multi-professional education.

P-71 ACCEPTANCE AND COMMITMENT THERAPY (ACT) FOR PEOPLE WITH PALLIATIVE CARE NEEDS, THEIR CAREGIVERS AND STAFF INVOLVED IN THEIR CARE: A SYSTEMATIC SCOPING REVIEW

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Background/Introduction People with advanced progressive illness are likely to develop psychological co-morbidities, such as fear of dying, being a burden to others, and existential distress. Acceptance and Commitment Therapy is a mindfulness-based behavioural therapy aimed at improving wellbeing and promoting values-based living and acceptance. There is evidence for its effectiveness for people with a range of psychiatric disorders and health problems. Evidence in palliative care settings is emerging.

Objectives To explore evidence for Acceptance and Commitment Therapy for people with palliative care needs, their informal caregivers, and staff involved in their care.

Methods A systematic scoping review was undertaken using four databases (Medline, PsychInfo, Embase and Amed), with relevant MeSH terms and key words from January 1999 to June 2021. Three research registries were also searched.

Results 1622 records were identified, 85 articles underwent full text review and 20 were included in the final set. Thirteen studies examined ACT for patients and showed a reduction in anxiety and depressive symptoms, fatigue interference, pain interference and improvements in physical status post ACT intervention. Four studies examined ACT for informal caregivers and showed a reduction in anxiety and depressive symptoms, and improvements in valued living and grief. One study focused on formal caregivers of people with dementia, reported reductions in anxiety, depressive symptoms and burnout following an ACT intervention. Two studies involving bereaved people found that increased acceptance led to valued living and reductions in anticipatory grief.

Conclusion Preliminary evidence suggests that Acceptance and Commitment Therapy can improve anxiety, depression, sleep, physical symptoms and quality of life for people with advanced progressive illness; and is beneficial for informal caregivers and professionals. Future research is needed to strengthen the evidence base using larger samples, involving a control group and including outcomes that assess effectiveness over time.

P-72 EVALUATION OF A MEDICAL EXAMINER SERVICE IN AN ACUTE TRUST WITHIN NHS ENGLAND

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Background Medical Examiner services have been introduced in England and Wales by the Department of Health and Social

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