**END OF LIFE CARE FOR EXPECTED DEATHS IN PRISON CUSTODY: A SERVICE EVALUATION OF CURRENT PRACTICE IN FIVE PRISONS IN THE NORTH OF ENGLAND MAPPED TO THE DYING WELL IN CUSTODY CHARTER**

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**Background** Deaths from natural causes are increasing in prison populations. The 2018 Dying Well in Custody Charter (DWCC) aims to support delivery of holistic and individualised care for those dying in prison custody. We recognised the need to review expected prison deaths to better understand current practice and guide improvement.

**Method** A retrospective electronic notes review was performed for all expected prisoner deaths, within five prisons in northern England, across the calendar year of 2020. The DWCC Self-Assessment tool was used to create ten assessment standards for use in this project. These were directly mapped to the DWCC ambitions. Data collected included evidence of multi-disciplinary team (MDT) working and advance care planning (ACP), documented DNACPR discussions, identification of dying and anticipatory medication prescribing.

**Results** Fourteen patients met inclusion criteria. 79% of deaths were due to cancer. 21% died in hospital and 79% died in prison. All had a DNACPR form in place. ACP occurred in 92.8%. Early release on compassionate grounds was considered in 79%. 86% had evidence of holistic needs assessment. Recognition of dying was documented in 57% and occurred between 7 hours to 1 month before death. 85.7% had some form of anticipatory medications prescribed. Palliative care services provided support in 93%.

**Conclusions** Areas of good practice include engagement in ACP, DNACPR decision making and utilisation of palliative care services. Security and legal considerations were thoroughly and carefully considered. There were numerous examples of individualised care and collaborative MDT working in complex circumstances. Supporting skill development in recognition of dying and anticipatory prescribing were identified as areas for improvement. Despite the small sample size we believe this service evaluation provides an important snapshot of how patients are dying in prison custody. By sharing these experiences we hope to better support the delivery of holistic care in this setting.

**REFERENCES**


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**PILOT STUDY OF SYRINGE DRIVER PRESCRIBING PRACTICE HIGHLIGHTS CHALLENGES FACED BY NON-PALLIATIVE CARE TEAMS**

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**Background** Data about continuous subcutaneous infusion (CSCI) prescribing is limited. This survey reviewed practice in the Surgical Emergency Unit (SEU) 01.08.22 – 03.12.22, using the Pallaborative Northwest guideline. It aimed to determine the frequency and indication for CSCIs and to document the initial CSCI prescription.

**Methods** Data was collected prospectively, 07.10.22 – 03.12.22 with retrospective data added to increase sample size, 01.08.22 – 06.10.22. Electronic patient records were reviewed, data anonymised, and stored on NHS drives. Data was analysed by all authors. Ethics permission was not sought as the survey examined routine practice.

**Results** In 4 months, with greater than 1000 admissions, 26 CSCIs were initiated on SEU; 1 every 5 days. The indication, documented in (31%) or determined from the notes (69%) were: dying patient 61.3%, symptom control 31%, inappropriate prescription 7.7%.

All CSCIs contained opioids (73% morphine, 27% oxycodone). The median dose of morphine was 10mg/24 hours (IQR 10mg/24 hours), the median dose of oxycodone was 7.5 mg/24 hours (IQR 10mg/24 hours). 65% of CSCI contained an antiemetic (35% metoclopramide, 23.5% haloperidol, 41% cyclizine), 8% an antianxiety/antipsychotic (100% hyoscine butylbromide) and 50% an anxiolytic/antipsychotic (69% midazolam and 31% haloperidol).

77% of CSCIs were advised by the hospital palliative care team (HPCT). Of the other 23%, half were altered or discontinued because of concerns; CSCI not indicated, patient sedated, or concern about dose.

Commsing a CSCI was discussed with 23% of patients and 42% of families.

**Conclusion** CSCI prescribing on SEU is an infrequent event. Staff need support from HPCTs to guide initiation and medication doses. Initiation of a CSCI provides an opportunity to explore patient and family understanding and involve them in conversations about care. Learning will be fed back to SEU and hospital staff. Further larger scale data collection is planned in deannery to interrogate practice.

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**AN EXPLORATION OF FACTORS THAT PREPARE STUDENT NURSES TO CARE FOR DYING PATIENTS**

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**Background** With an aging population, and an increasing incidence of long-term conditions, of which some cancers fit into this category as well as dementia, there will be a growing emphasis on end-of-life care provision (National Palliative & End of Life care partnership, 2015). Most patients receiving palliative care takes place within patients own homes, care homes and acute hospital wards (Department of Health, 2008; Virdun et al, 2015). Regardless of the environment, student nurses are on the front line of delivering this care.

**Aim** To explore factors which prepare student to care for dying patients.

**Research Objectives**

- Identify how current Care of the Dying education prepares student nurses to care for dying patients
- Explore what socio-cultural factors prepare student nurses to care for dying patients
- Gain an understanding of individual experiences of exposure to death and dying prior to commencing their nurse training