identifying high-risk patients. Elevated or deteriorating Clinical Frailty Scores should prompt clinical reviews and ACPs when necessary. Addressing ACP discussion barriers through workshops, multilingual resources, and improved awareness is essential for optimal implementation.

53 A REVIEW OF A NEW MULTIDISCIPLINARY TEAM MEETING (MDT) FOR ADVANCE CARE PLANNING (ACP) FOR PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) AND IMPLEMENTING ELECTRONIC PALLIATIVE CARE COORDINATION SYSTEM (EPACCS) AS A CROSS-SYSTEM RECORD

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Background The incidence of, admission rates and mortality from COPD in the northwest are amongst the highest in the UK.[1] The Gold Standard Framework (GSF) helps to identify dying patients to facilitate early referral to palliative care, advance care planning (ACP) and an MDT approach. Data shows this increases the number of patients achieving their preferred place of death (PPD).[2] This project is designed to increase identification of deteriorating COPD patients to enable ACP discussions and complete EPaCCS records viewable across healthcare providers.
Methods Inpatients with COPD approaching the last year of life were identified and referred to the weekly MDT between June 2022 and May 2023. GSF criteria were discussed, and if met, a plan was made for ACP. Cases were revisited weekly until EPaCCS record completed. Additional outcomes: PPD achieved, admissions rates pre/post ACP, ReSPECT form completion, hospital/community palliative care referral.
Results 21/25 referred patients who met GSF criteria had ACP documented on EPaCCS (4/25 incomplete due to unavoidable circumstances). 9 patients have died since starting the work. PPD was met for 5/9 (4/9 had good reason why PPD was not achieved).

Average admissions in the last 12 months of life were reduced in the review group (0.39/month) compared to usual practice (0.42/month). Following ACP conversations, admissions reduced from (0.42/month) to (0.31/month). Records were most accessed by the ambulance service. Of 8 records accessed 5 admissions were avoided. Assessments for referral to palliative care were higher (9/9) than previous practice (6/9). 7/7 patients discharged home were referred to specialist services. All reviewed patients had a ReSPECT form which is an improvement on previous practice.
Conclusion The MDT shows positive outcomes, meriting research. The data will help with workforce planning and funding requirements. This data signals reduced admissions following MDT and ACP/EPaCCS implementation.

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54 OPIOID E-PRESCRIBING: ADHERENCE TO SAFE AND BEST PRACTICE CRITERIA IN A TERTIARY AND AN ACUTE HOSPITAL

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Background Unsafe prescribing of opioids can lead to significant harm to patients. A previous report identified improvement in safe practice prescribing following implementation of several interventions using quality improvement methodology. Our aim was to re-audit opioid prescribing practice following the introduction of a new e-prescribing system across the Trust.
Methods Opioid prescriptions at a tertiary cancer centre and acute hospital were reviewed against 'safe prescribing criteria' and 'best practice criteria' over three days. This criteria was formulated for the previous studies and are not national standards.
Results Safe prescribing adherence fell from 84% to 69% and best practice adherence improved from 33% to 41%. The sole reason for poor adherence to safe prescribing criteria was that there was no facility to document neither the preparation (immediate-release or modified-release) or the strength. We also found that 33% of patients did not have a regular laxative prescribed and 44% did not have an anti-emetic prescribed.
Conclusions The introduction of e-prescribing has led to improvements in opioid prescribing: correct drug name, correct dose unit, correct frequency of prescription and automatic e-signatures and date. However, we also identified issues with e-prescribing in particular the inability to document the preparation and strength of liquid opioids. The clinical relevance of this is uncertain and further work is needed to look at whether this would contribute to drug error or patient harm. We also found ongoing issues with lack of anti-emetic and regular laxative co-prescribing. Although, e-prescribing has been largely helpful in ensuring opioids are prescribed safely, we have demonstrated that there is still a need for specific opioid prescribing teaching, pharmacists involvement in checking prescriptions and ongoing quality improvement.

55 HOSPITAL ADMISSIONS AT THE END OF LIFE AND IN SEVERE FRAILTY: A SYSTEMATIC REVIEW AND NARRATIVE SYNTHESIS OF CLINICIAN DECISION MAKING

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Background Reducing 'avoidable' hospital admissions towards the end of life and facilitating death at home have had considerable attention in the literature. The role of a Primary Care clinician is central to many of these decisions and should be closely examined if we are to consider how current processes may be improved. Decision making in significant frailty deserves specific attention as it is rarely acknowledged as an end of life state.
Aim To explore what is currently known about how Primary Care clinicians approach hospitalisation decisions for people who are frail and/or may be near the end of their lives.
Design Systematic literature review and narrative synthesis.

Data Sources We searched the following databases: CINAHL, Cochrane Library, Embase, MedLine, PsychInfo and Web of Science followed by reference and forward citation reviews of included records.
Results 18 research studies were identified and included: 14 qualitative, 3 quantitative and one mixed methods study. Five key themes were identified: navigating the views of other stakeholders; clinician experiences and attributes; clinicians' interpretation of events; the perceived adequacy of the current setting and the alternatives; system factors; continuity of care and a perceived lack of choice.
Conclusion This review illustrates the number and complexity of factors influencing how Primary Care clinicians make hospitalisation decisions. The views of other stakeholders take great importance, and may be a source of conflict, and it is unclear how this should be navigated. Clinician factors, such as experience with palliative care and clinical judgement, are also important. There is significant geographical and system variation in approaches to decisions. Future research should focus on how the different aspects of the decision are balanced and to consider if, and how, this could be improved to ensure hospital admissions at the end of life are appropriate.

56 EXPLORING THE IMPACT OF PROACTIVE IN-REACH BY THE SUPPORTIVE AND PALLIATIVE CARE TEAM (SPCT) IN THE EMERGENCY DEPARTMENT (ED) OF MANCHESTER ROYAL INFIRMARY (MRI), A CITY CENTRE TEACHING HOSPITAL

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Introduction ED attendance during the final year of life is a significant challenge (Marie Curie, 2018). Models providing palliative care in the ED have shown numerous benefits (Wang et al, 2015). We embarked on a 6 month test of change providing specialist palliative care support to the MRI ED.
Methods The SPCT ACP proactively in-reached into ED two afternoons a week for 6 months. Quantitative and qualitative data was collected to demonstrate our outcomes and compared with retrospective data collected prior to this intervention.
Results Identifying patients presenting to ED who would benefit from SPCT input improved during the test of change with more than three times as many being identified by the SPCT ACP. Retrospective data showed 23.1% of patients had been identified in the last year of life by ED staff in comparison to 68% of patients by the ACP using prognostication tools. Patients presenting to ED often had a poor performance status (AKPS) of 50% or less, an initial median iPOS score of 24.5 and had an average of 3.13 admissions in the previous 12 months. Whilst many patients presented to ED appropriately with acute illness, SPCT input earlier on in their journey demonstrated reduction in symptom burden and improved quality of life reflected by a reduction of median iPOS score from 24.5 to 15.5 and patient experience stories. We were able to influence goals of care and subsequent hospital stay at an earlier point, demonstrated by a median reduction in length of stay of 17 days. The change also had positive impacts for ED staff, demonstrated by findings of the staff survey.
Conclusion Proactive SPCT input into our ED positively impacts on patient experience and outcomes, supports an often stretched department and can reduce length of stay. Further exploration is needed to provide a sustainable model.

57 ATTITUDES OF STAFF TO CONDUCTING RESEARCH IN A HOSPICE INPATIENT UNIT

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10.1136/spcare-2024-PCC.75

Introduction Hospices are encouraged to be research active and contribute to the evidence base. Participating in research studies requires engagement by staff to assist with recruitment and implementation. During participation in a research study requiring recruitment of inpatients on our hospice inpatient unit (IPU), we sought to understand the views of IPU staff members about research being conducted on the ward.
Methods An anonymous online survey hosted on Survey Monkey was sent to nurses and doctors working on the IPU. Responses were collected between April and July 2023. Questions focussed on their own experiences of contributing to research and their views about research taking place on a hospice IPU.
Results We received 24 responses (8 doctors, 16 nurses) with a range of years of experience working in a hospice. 12.5% (3 nurses, all with less than 5 years' experience) had not yet contributed to research in their careers. 79% (19) had undertaken an audit including all 8 doctors. The majority (85.7%, 21 respondents) were supportive of research and most (75%, 18 respondents) felt it was extremely or very important that research is undertaken in hospice IPU settings. 18 (75%) respondents stated that patients and families were usually happy to be approached about participating in research. Barriers to engaging in research included lack of time, concerns about burdening patients and families, lack of staff confidence in undertaking research, paternalism, causing potential harm to patients if implementing an intervention, 'lack of understanding about how research could actually benefit the patients and their care' and resistance to change.
Conclusions Nurses and doctors working on our hospice IPU are supportive of research taking place on the ward but note a number of barriers to research engagement. Having a better understanding of these challenges will help the research team to support colleagues in future studies.

58 FRONT DOOR PALLIATIVE CARE: DEVELOPMENT OF A MACMILLAN SPECIALIST PALLIATIVE CARE PRACTITIONER ROLE IN THE EMERGENCY DEPARTMENT OF A TERTIARY HOSPITAL IN THE UK

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In recent years attendances to the emergency department (ED), and consequently patient waiting times have skyrocketed. This combined with increasingly stretched community services has led to growing numbers of patients presenting at