

ACP documented. Most patients had hospital admissions during this time (23/27), more than one third of patients were referred to the Palliative Care Team. During the last 7 days of life 19/27 patients were recognised as dying, and had their wishes documented, all patients had DNA-CPR in place and 18/27 were referred to the Palliative Care Team.

Conclusions From this audit there were significant opportunities for healthcare workers to identify patients in the last 12 months of life, if this can be recognised sooner advanced care planning could be offered earlier to patients. These results suggest a need to make use of tools such as the Gold Standard Framework to better recognise patients who may be approaching end of life in order to help plan their preferred care.

P-105 END OF LIFE CARE AT THE WEEKEND IN A UK DISTRICT GENERAL HOSPITAL

Katharine Perry, Holly Randall, Katherine Webb. *Royal Surrey County Hospital, Guildford, UK*

10.1136/bmjspcare-2017-00133.104

Background In 2014 an independent review (Neuberger report) recommended discontinuation of the Liverpool Care Pathway. A subsequent report advised replacing the LCP with individualised end of life care plans, the contents of which were to be determined at local level.

The Supportive and Palliative Care Team (SPCT) at a UK District General Hospital and Cancer Centre developed a Personalised End of Life Care Plan (PELiCan) encompassing the five key priorities of care (One chance to get it right). Each patient on the PELiCan is assessed daily by a member of the SPCT. This study aimed to assess the use of the PELiCan and the utilisation of a seven day SPCT service.

Methods A database was created and every patient commenced on a PELiCan was entered. This database was retrospectively analysed over a 2 year period (1stSept 2014 and 31stAugust 2016). Descriptive statistics were used to assess demographic details and diagnosis. The day each PELiCan started was noted as well as the date of death or discontinuation.

Results Nine-hundred and ten patients had an end of life care plan. The most common diagnosis was cancer (27%), followed by diseases of respiratory system (25%) and disease of circulatory system (16%).

Twenty four percent (n=222) of patients with a PELiCan died on a Saturday or Sunday. Five hundred and thirty-two patients (58%) with a PELiCan were reviewed daily over the weekend. One-hundred and forty patients (15%) were started with a PELiCan during the weekend (Saturday n=56, Sunday n=84). Of these patients 34% had died before 9am on Monday morning.

Conclusions A significant proportion of end of life assessment and support occurs at a weekend. There is a requirement for seven-day palliative care services to implement effective specialist end of life symptom assessment.

P-106 CHECKPOINT CHARLIE: AUDIT OF REGULAR SYRINGE DRIVER CHECKS ACROSS HEALTHCARE SETTINGS

^{1,2}Joseph Rassam, ^{1,2}Akash Chowdhury, ^{1,3,4}Karen Groves. ¹West Lancs, Southport and Formby Palliative Care Services, Southport, UK; ²Liverpool University, Southport and Ormskirk Hospitals NHS Trust; ⁴Queenscourt Hospice, Southport

10.1136/bmjspcare-2017-00133.105

Background Syringe drivers are integral part to palliative care practice. The most widely used model, McKinley T34, is used to administer controlled drugs including opioids. As a result the documentation and monitoring of the use of syringe drivers is vital for ensuring safe treatment and in prevention or detection of potential adverse events.

Aim The aim of this audit was to review how effectively syringe driver checks and the subsequent documentation of such checks were carried out for patients in hospital, community and hospice settings.

Method Standards were set using current guidance and safety information. Patients were systematically identified through the help of the transform team (a palliative care liaison team), contacting the medical equipment library responsible for issuing the syringe drivers and by systematically going round the wards in the hospital setting. The checklists were analysed using a predetermined spreadsheet. A second improved checklist was introduced and the process repeated.

Results Data from the first cycle indicated the frequency of syringe driver checks was half that of the required 6 per day. A number of important safety parameters were under recorded and reasons identified included misleading questions and poor formatting of the syringe driver checklist (eg, questions on the reverse side of the page). After implementing the new sheet some modest improvements were made, most notably the documentation of syringe volume and syringe brand improved. Hospice and community data checklists were completed more accurately in accordance with clinical guidelines, compared to the hospital setting.

Conclusion The implementation of a checklist with clearer questions and an improved format resulted in some improvement. However the discrepancy between the hospital and community/hospice setting, where staff are more experienced with the use of syringe drivers, indicates the potential need for more training amongst hospital staff.

P-107 IDENTIFICATION AND EVALUATION OF OBSERVATIONAL MEASURES FOR MONITORING SEDATION IN ADULT PALLIATIVE CARE PATIENTS: FINDINGS FROM A SYSTEMATIC REVIEW FOR I-CAN-CARE

¹Anna-Maria Krooupa, ¹Bella Vivat, ¹Bridget Candy, ²Stephen McKeever, ¹Elena Marcus, ¹Nuriye Kupeli, ¹Paddy Stone. ¹University College London, London, UK; ²Department of Children's Nursing, London South Bank University, London, UK

10.1136/bmjspcare-2017-00133.106

Introduction Palliative sedation is sometimes used to manage refractory symptoms in adult palliative care patients in the UK. However, there is limited knowledge regarding which observational tools are most appropriate for monitoring the effects of sedative drugs. This review is a part of the I-CAN-CARE, a Marie Curie funded research programme.

Objective To identify and critique primary studies describing the use of observational measures to assess the depth of sedation at the end of life.

Methods We searched six databases (CENTRAL, Cinahl, Embase, Medline, PsychINFO, Scopus, and Web of Science) until November 2016, using search terms combining subject headings and free-text terms. Primary studies reporting on the use of observational measures to assess the effect of palliative sedation were eligible for inclusion. Two investigators independently reviewed the titles, abstracts and full-text articles retrieved, and performed the data extraction. From the included papers, a list of observational tools, their characteristics and the degree to which they have been validated, using the COSMIN checklist (Mokkink *et al.*, 2010), will be generated.

Results to-date The searches yielded 10 208 articles after removing duplicates. The majority of studies meeting the inclusion criteria and discussing the monitoring of sedation reported using observational measures for assessing not only depth of sedation but also symptom severity. Of the identified scales assessing management of intractable symptoms, only one had been validated for palliative care settings. Five measures assessing level of consciousness had undergone partial validation for use in palliative care. Six of the observational measures identified had been evaluated for their psychometric properties in single study populations.

Conclusions Few measures for monitoring sedation have been evaluated for their psychometric properties in palliative care. Next steps will be a detailed evaluation of the overall quality of the studies identified, and of the validity and reliability of the scales used. Definitive results will become available in February 2017.

P-108 EVIDENCING CARE OF THE DYING ADULT IN A DISTRICT GENERAL HOSPITAL

Sinead Henderson, Susan Dargan, Ria Wright, Clare Smith. *Ashford and St Peters NHS Trust, Chertsey, UK*

10.1136/bmjspcare-2017-00133.107

Background Recent national documents, such as One Chance to Get it Right and Ambitions for Palliative and End of Life Care, have highlighted the importance of high quality end of life care. In particular they have promoted the use of individualised care planning for the dying adult. Ashford and St Peters NHS Trust is a busy district general hospital in Surrey and has over 1000 deaths per year. To ensure that high quality care was delivered to all by all healthcare professionals an individualised care plan was devised. A baseline audit was undertaken before this was rolled out across the trust.

Methods An audit tool was created based on the 5 priorities of care and NICE guidance for care of the dying adult. This was to assess the documentation of care given to the dying adult and their family. A retrospective notes review of the first 100 deaths in quarter 1 was undertaken.

Results Recognition of dying on the wards ranged from 50%–100% and was initially documented by the medical team in 60%. Most patients were recognised as dying in the last 48 hours. Almost 80% of patients were unable to participate in decision making about their care, although family was involved in over 95%. Over 55% were prescribed anticipatory medication and over 20% had evidence of a holistic assessment. Less than 5% of notes reviewed showed evidence of adequate individualised care planning in the last days of life.

Conclusion This audit has highlighted that health professionals were recognising dying. Late recognition leads to patients not being involved in their care planning and achieving their priorities of care. Documentation and care is reliant on individual health care professionals approach rather than an informed, standardised practice. Individualised care planning can support healthcare professionals in delivering and evidencing this care.

P-109 TRANSFORMING AN ACUTE PALLIATIVE CARE SERVICE IN A SPECIALIST EMERGENCY CARE HOSPITAL

¹Katherine Frew, ¹Leonie Armstrong, ¹Louise Whitfield, ²Jennifer Samuelson, ²Anna Office, ¹Carole Duff, ¹Hannah Hall, ²Patricia Robson. *¹Northumbria Healthcare NHS FT, North Shields, UK; ²Marie Curie*

10.1136/bmjspcare-2017-00133.108

Background Northumbria Healthcare NHS FT has developed a novel approach to providing emergency care with a new Northumbria Specialist Emergency Care Hospital (NSECH), which opened in 2015. This innovative model of care has been highlighted by NHS England as an example of good practice and, in line with the five year forward view¹, may be replicated in other areas of the country. Northumbria has developed a partnership with Marie Curie which has enabled successful team expansion. It is imperative to assess the impact of such a development on existing and developing palliative care services.

Design This service evaluation compared the number of patients, number of face to face contacts, duration of episode of care, and the time from referral to first contact, before and after the opening of NSECH. Data were extracted from an existing palliative care database.

Results In 2014, 439 patients were seen, with a total of 830 face to face patient contacts.

In 2016, 873 patients were seen, with a total of 2610 face to face patient contacts.

In 2014 the mean duration of the episode of care was 18 days: in 2016 this was 10 days. In NSECH the median was 1 day; the mean was 3 days (range 0–157 days).

In 2014 69% of patients were seen within 24 hours of referral; in 2016 this had risen to 96%.

Discussion The opening of a NSECH has transformed the model of the hospital palliative care liaison team, with a 99% increase in patients seen, 199% increase in face to face contacts with patients and a significant reduction in the duration of an episode of care. The service now incorporates a hyper-acute palliative care service which has an implication for service development for all trusts considering a similar approach to care.

REFERENCES

1. <http://www.england.nhs.uk/ourwork/futurenhs/> accessed on 11/11/2016.