66% of patients had a malignancy; 34% had non-malignant disease.

27% of patients were discharged home, 28% of patients died and 23% were transferred to a palliative care unit.

Median duration of episode of care was 1 day; the mean was 3 days (range 0–157 days).

Discussion The opening of NSECH has transformed the hospital palliative care liaison team. The provision of palliative care within an acute, emergency care hospital provides particular challenges, including acute care for patients who are dying, and the rapid discharge of patients with complex needs and high dependency. Partnership working with an acute trust has enabled this rapid development in service in an emerging area of palliative care provision.

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P-113 FACTORS INFLUENCING ACUTE CARE UTILISATION IN NURSING HOME RESIDENTS WITH ADVANCED DEMENTIA IN FINAL THREE MONTHS OF LIFE: A SYSTEMATIC REVIEW AND NARRATIVE SYNTHESIS

¹Val O'Reilly, ²Katherine Bristowe, ²Jonathan Koffman. ¹University of Limerick/Milford Hospice, Limerick, Ireland; ²Cicely Saunders Institute, Dept Of Palliative Care, Policy and Rehabilitation, Kings College London

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Burdensome transfers to acute hospital are common and potentially unnecessary amongst nursing home residents with advanced dementia approaching last days of life

Aim To identify and appraise influencing factors associated with acute care utilisation amongst nursing home residents with advanced dementia in final three months of life with view to inform adaptation of an existing conceptual model.

To evaluate effectiveness of identified interventions influencing acute care utilisation amongst this cohort.

Methods Six electronic databases (MEDLINE, EMBASE, CINAHL, PsycINFO, Web of Science, Cochrane Library) were searched from inception through March 2015 for studies pertaining to the above research question supplemented by hand-searching selected journals, reference and citation tracking, contact with experts and grey literature search. Following a systematic process, key studies were identified, data extracted and results collated. Strength of evidence was determined according to quality, quality of studies and consistency of findings for individual factors and assigned as low, moderate and high to inform a conceptual model. Results were thereafter harmonised using the process of narrative synthesis.

Results No intervention studies meeting criteria for inclusion in the review were identified. Eight studies were identified

reporting four demographic, three clinical and five environmental factors across three countries and 5 02 323 individuals. High strength evidence was assigned for effect of four factors upon risk of acute care utilisation in final months of life; two increased risk (black ethnicity, co-morbidity {previous stroke}); two reduced risk (insurance status, presence of advance decision). The remaining were assigned moderate (two factors) and low (seven factors) strengths of evidence respectively impacting upon all domains of the model.

Conclusion A myriad of inter-related factors influence acute care utilisation in nursing home residents with advanced

dementia approaching end of life. Further interrogation of views of health-care proxies, professionals and other

stakeholders may elucidate additional influences upon decision making process, enhancing understanding.

Findings may assist in informing clinical, organisational and policy initiatives to attenuate unnecessary and burdensome transitions in this population.

P-114 END-STAGE CHRONIC LIVER DISEASE: A LOOK AT THE LAST YEAR OF LIFE

Ruth Yates, Eliana Saffouri, Alix Morieux, Fiona Finlay. Queen Elizabeth University Hospital, Glasgow, UK

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Introduction Liver disease is the fifth most common cause of death in the UK.¹ Patients with chronic liver disease (CLD) and its complications present frequently to hospital; when their disease reaches end-stage, their supportive and palliative care needs can be high.² In this study we describe the last year of patients' lives with CLD to identify opportunities for concurrent palliative care involvement in the future.

Methods We performed a comprehensive retrospective case-note analysis of patients who died of CLD (or complications) in a teaching hospital over a period of 12 months. Caldicott approval was obtained.

Results Reasons for admission in the cases were varied, but could all be attributed to decompensation of CLD. Alcohol was the causative factor in the majority of cases. Almost every patient had DNACPR in place when they died. Patients died both on the ward and in level 2/3 settings. A minority met the specialist palliative care team. Many patients had active interventions and investigations within 24 hours of death.

Conclusions We were able to perform a detailed examination of the hospital admissions of this cohort of patients during the last year of life. We identified alcohol as a contributing factor in the majority of cases, however this did not appear to prejudice clinicians from admitting patients to level 2/3 care. It appears that DNACPR is considered appropriately, however patients are still having investigations and non-symptomatic medications even after death is recognised as imminent. More work is needed to identify whether early palliative care involvement could be helpful to these patients.

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P-115 IMPLEMENTING AN ELECTRONIC WHITEBOARD SYSTEM ON THE IN PATIENT UNIT

Simon Brooks, Rebecca Bhatia, Karen Tudge, Ian Wilson. Dorothy House Hospice Care, Winsley, UK

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Background A web application (PSAG, Patient Status At a Glance) was developed to replace the existing wall mounted whiteboard and marker pen system for displaying the status of in-patient beds, patients and requests for admission. It was developed in order to provide a more efficient way to manage

and prioritise admissions to our hospice In Patient Unit (IPU), as well as enabling the capture of data for audit purposes. Planning for the process began in May 2015 with a pilot taking place in December 2015. It was formally rolled out in January 2016.

Benefits

- It has improved the way in which we manage our admissions waiting list by allowing us to easily assign/update priority
- It will be a useful audit tool for looking at unmet need (those patients who would have been admitted if there had been a bed) as well as length of wait for a bed and reasons for admission
- Provides data on average urgency of request and whether we manage to meet the urgency stated
- It can be accessed by all clinical teams who work on IPU from any connected PC in the hospice
- Improved confidentiality (previous whiteboard could have been viewed through a window or open door)

Issues

- Time taken to train all staff and to adapt to the new system
- System relies on accurate and timely entering or updating of information
- Initial problems with maintenance and troubleshooting as there was no on-site IT support
- PSAG is not linked to our electronic records system (SystmOne) so risk of duplication of information or relevant clinical information not being entered into SystmOne
- It cannot collect some data that we have previously been collecting manually

The Future Use of the PSAG continues to evolve as new issues arise

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'SHOCKING' COMMUNICATION SKILLS – COMMUNICATION SKILLS TRAINING FOR CARDIAC PHYSIOLOGISTS DEACTIVATING ICDSS

¹Matthew Curtis, ¹Sioned Evans, ²Benjamin Clayton. ¹Plymouth Hospitals NHS Trust, UK; ²Torbay and South Devon NHS Foundation Trust, UK

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Background Studies have highlighted a strikingly low rate of preparatory conversations regarding the deactivation of patients' implantable cardiac defibrillators (ICDs) at the end of life. Rates of implantation of ICDs have increased, indicating that managing ICDs at the end of life will become a more common occurrence. Cardiac Physiologists carry out the deactivation of ICDs, yet locally in Devon, Cardiac Physiologists have highlighted that they have no training of how to communicate with patients when deactivating their ICDs.

Aims To improve end of life communication skills for Cardiac Physiologists.

Methods A joint educational programme was developed to improve end of life communication skills for Cardiac Physiologists and increase the ICD-related knowledge base of Palliative Care teams.

Interactive role-play sessions were developed based on examples of challenging or common communication scenarios provided by the Cardiac Physiologists prior to the session. Feedback was collected immediately after the session and then 4 months later to assess the impact on their actual practice.

Results Immediate feedback stated the training had been very useful. Further results regarding how well the Physiologists have put the learning into practice will be available in the near future.

The majority of Palliative Care attendees admitted to little understanding of cardiac devices before the study day compared to a good understanding afterwards.

Conclusions Cardiac Physiologists are a group of the non-cancer workforce who are potentially neglected with regards to end of life communication skills training. We would encourage other services around the country to provide this training to improve the end of life care for patients with ICDs.

Interactive role play appears to have been a successful method to provide this training.

The joint educational programme between Cardiology and Palliative Care facilitated learning from shared differing experiences and helped develop relationships between the teams.

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BY THE CLOCK: AUDIT INVESTIGATING THE ADMINISTRATION OF REGULARLY PRESCRIBED OPIOID ANALGESIA IN PALLIATIVE PATIENTS ON GENERAL HOSPITAL WARDS

¹Max Knipe, ^{2,3,4}Karen Groves. ¹School of Medicine, University of Liverpool, Liverpool, UK; ²West Lancs, Southport and Formby Palliative Care Services, UK; ³Southport and Ormskirk Hospitals NHS Trust, UK; ⁴Queenscourt Hospice, Town Lane, Southport, UK

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Background and aims Slow release opioids provide the mainstay of chronic pain control for many palliative patients. To ensure effective pain relief therapeutic levels must be maintained. Opioid pharmacokinetics require regular dosing intervals to achieve this and ensure no unnecessary breakthrough pain. The aim of the audit was to assess whether palliative patients on general hospital wards were receiving opioid doses at the appropriate times.

Method The audit was carried out across the general wards of the local District General Hospital. Palliative inpatients were identified via the hospital palliative team register. On two occasions two weeks apart all palliative inpatients on regular opioid analgesia were selected. Prescription charts and controlled drug books were used to gather data. Controlled drug book sign out times were used as a proxy for administration times. Outcomes recorded included prescriptions made, time and date doses given, and any doses omitted and reasons documented. Appropriate timing was considered administration within ± 30 min prescribed time.

Results 12 patients met the inclusion criteria with 290 opioid doses administered between them. Of these only 19 (6.6%) were given within 30 min of the prescribed time. The majority of these were given late (256 doses, 88.3%). The average time for doses given was 2 hours 10 after the prescribed time. 8 prescribed doses were not given and of these, 2 (25%) had documentation why. 4 out of a total of 28 prescriptions (14.3%) gave an incorrect prescribed time interval.

Recommendations Staff re-education to ensure timely administration of opioid doses and reiterate the need for documentation of omitted doses, is a priority. Prescribers need reminding of the correct opioid dosing intervals. Prescribers might also consider discussing prescribing times that could make timely nurse administration easier.