guidelines for staff, teaching sessions and the development of a standardised protocol for timely report to GP.

P-121 SERVICE EVALUATION: WHAT HAPPENED TO HOSPICE IN-PATIENTS TRANSFERRED TO AN ACUTE HOSPITAL AND LESSONS LEARNED

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The 2 hospice in-patient units combined have 27 in-patient beds. For every admission we document decisions about cardio-pulmonary resuscitation and transfer to acute hospital. Both units offer intra-venous treatments (blood products, bisphosphonates and antibiotics). Previously published audits[1] were done in units were intravenous antibiotics were not available. This retrospective service evaluation was done in order to evaluate what happened to transferred patients and whether we can improve our practice in the future.

The authors looked at the clinical notes of all transfers to acute hospital between January 2014 and July 2015. Case finding relied on memory and documentation in admission books.

There were 16 transfer (involving 13 patients) 8 for diagnosis (fracture, MSCC, PE) 7 for treatment (electrolyte abnormality, neutropaenic sepsis and NIV initiation) and 1 for a post-surgical complication. Ten transfers happened during normal working hours and six out of usual working hours. Decisions tended to be well documented and consultants were involved in eleven cases.

In 11 instances the patient returned to the unit, 2 died in hospital, 2 were discharged home, 1 patient died 3 weeks later (location unclear) and in 12 cases the aim of the transfer was met.

Further analysis revealed that most transfer decisions were well documented. However what information was sent with the patient and criteria for return to the unit were not clear and patients lingered longer than intended in the acute hospital. We did not evaluate decisions not to transfer to hospital.

In future we aim

- Not only to document suitability for transfer on admission but also review this regularly.
- To document changes in clinical condition which may lead to transfer to acute hospital whether or not patient is transferred.
- On transfer to communicate doctor-to-doctor with clear goals and return criteria
- To liaise with hospital palliative care team.

REFERENCES

1. Castanheira T, Wright BA. Survey about patients transferred from a Specialist Palliative Care unit to an acute hospital setting . *European Journal of Palliative Care* 2014;**21**:219–221
2. Doidge M, Perkins P. Letter to the editor. *European Journal of Palliative Care* 2015;**22**(1)

P-122 LIDOCAINE 5% PATCH INITIATION AND ASSESSMENT

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Background The Scottish Palliative Care Guidelines (SPCG) provide guidance for initiating lidocaine 5% patches and assessing their efficacy. As most patients will respond within 1–2 weeks, patches should be reviewed around this time, by way of a patch-free trial, and discontinued if not beneficial.

In Roxburghe House hospice, Dundee, lidocaine patches are not routinely reviewed. My aim was to educate prescribers regarding national guidance, and to encourage them to review lidocaine patches 1–2 weeks after initiation.

Methods A record was kept of all inpatients who commenced lidocaine patches in Roxburghe between 1st December 2015 and 29th February 2016. Indication for starting patch, pain assessments and outcome of patch-free trial were all recorded.

Following cycle 1 I provided education sessions about the SPCG guidance for prescribers in Roxburghe. I introduced an assessment sheet based on the SPCG recommendations. I then repeated the data collection with patients who commenced lidocaine patches in Roxburghe House between 1st July and 30th September 2016.

Results Cycle 1 confirmed that the SPCG guidance was not being followed in Roxburghe House. Only one patient had a patch-free trial and the majority of patients had no pain assessment at 48 hours or 1–2 weeks.

In cycle 2 100% of patients had pain scores documented, although only 50% had the new assessment form completed. Of the patients who survived past 1–2 weeks, 100% had clear instructions to their GP requesting review of the patch in the community.

Conclusions The introduction of a lidocaine patch assessment form has had some success so far in Roxburghe House, however further education is required to reinforce the importance of following the SPCG guidance. Other interventions which may be interesting would be providing education updates on the SPCG guidance for GPs and formulating an information leaflet for patients which provides instructions for how and when to initiate a patch-free trial.

P-123 USING THE MODEL OF IMPROVEMENT TO INCREASE THE EFFICIENCY OF DISCHARGE MEDICATION PRESCRIBING IN PALLIATIVE CARE

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Aim To reduce the time taken and the quality of To Take Away (TTA) prescribing in a hospice setting

Background Using and learning from the model for improvement can help guide us through change. A hospice discharge process can be lengthy and complicated by the prescription of medications. It was hypothesised that too much time was being spent by clinicians on handwriting discharge prescriptions (FP10s). We proposed that typing, printing and electronically storing FP10 prescriptions would reduce the time taken and improve legibility.

Method An electronic TTA template was created in MS Word and stored on a secured network. We measured the time taken to produce and process handwritten and electronic TTAs after a period of change. The whole process was timed from creation to electronic submission to the pharmacy. Any enquiries or extra work sought by the pharmacy team was measured as an additional added time to this process.

Results There were 30 TTA prescriptions between August-December 2016. 11 were handwritten and 19 were electronic. The average time to complete the process of a TTA was 20 (19–21) minutes for handwritten and 14 (12–16) minutes for a typed electronic version. The average number of items prescribed was equivocal between the groups. There were 8 enquires raised by the pharmacy team, equating to an additional 4 min average of extra processing time per TTA. For the first two months there were 5 enquiries raised, 4 were related to legibility. A further 3 enquiries were raised up to December and these were related to prescribing practices.
Conclusion The time taken to process TTAs has been reduced with the introduction of an electronic printed version. By learning from this cycle, we hope to continue our improvement in the discharge process by preventing delays. By using the model for improvement, small changes can help improve patient care.

P-124 TO AVOID READMISSION, PATIENTS AGED 65 AND OVER ADMITTED TO HOSPITAL WITH A CARE QUALITY COMMISSION AVOIDABLE CONDITION SHOULD BE EXAMINED FOR LIFE LIMITING ILLNESSES AND CONSIDERATION GIVEN TO ADVANCE CARE PLANNING

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Background The Care Quality Commission (CQC) published the State of Care report in 2013. This highlighted the increasing number of persons aged 65 and over who had had potentially avoidable admissions to hospital with conditions such as! > pneumonia and urinary infections.
Aim To investigate whether the CQC's criteria can aid admission avoidance in those with life limiting illnesses or who have multiple co-morbidities where Advance Care Planning (ACP) is appropriate.
Method Two series took place between October 2014 and August 2016. The first at Tameside Hospital reviewing deaths of those aged 65 and over. The second included those transferred to Willow Wood Hospice for end of life care.
Results

Status	Series 1 (%) n=31	Series 2 (%) n=153
CQC avoidable admission condition	12.9	9.2
	n=4	n=14
ACP appropriate - pre-existing life limiting illness or	22.3	18.3
comorbidities	n=7	n=28
Both a CQC avoidable admission condition and ACP	16.1	15.7
appropriate	n=5	n=24
Unavoidable	48.4	56.9
	n=15	n=87

Discussion There was often a lack of agreement in cases, reflecting the complexity of admission avoidance.

Using the CQC criteria alone, between 9.2% and 12.9% of admissions could have been avoided, we disagreed and felt they were unavoidable. However, combined with those who are also appropriate for an ACP this could reduce admissions on average by 15.9%.

Our aim is for a practitioner to offer ACP to inpatients at Tameside Hospital to reduce readmissions.

P-125 IS AN EMERGENCY REALLY AN EMERGENCY? A FOLLOW UP STUDY OF AN EVALUATION OF URGENT ADMISSION REQUESTS TO A HOSPICE

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Introduction Delivering 24/7 specialist palliative care is a national priority. A previous study looking at the urgent requests to the hospice, over 3 months, showed that over ¾ of appropriate admissions were admitted within 24 hours.
Aim To describe the characteristics of patients who were admitted following a request for emergency admission over a 3 month period.
Methodology This was a retrospective case note review of data for the 12 months prior to emergency admission, describing the events leading up to and the outcome of the admission.
Results Twenty-nine patients were included in the analysis. Of the 29 patients included, 34% were from the most deprived quintile. Ninety percent of emergency referrals and 100% of admissions had a malignant diagnosis. Forty-one percent of emergency admissions were for end-of-life care (EOLC). Sixty-six percent had a DNACPR before admission and 90% had an electronic key information summary. Seventy-five percent had at least 1 hospital admission in the previous year but only 1 patient was admitted from hospital. Patients being admitted for EOLC or by their GP had a shorter length of admission. Seventy-two percent died during the admission and 28% were discharged home and later died at home or in the hospice. No patients died in hospital.
Conclusion The emergency admissions to the hospice over these 3 months were genuine emergencies. Most of the patients were living in deprivation, meaning they are more likely to have multiple co-morbidities and social complexities. These emergency admissions to the hospice prevented admission to hospital and furthermore any of these patients dying in hospital. Anticipatory care planning was evident but further work needs done to explore the impact of deprivation, the reasons behind the lack of emergency requests for patients with non-malignant conditions and pathways for direct hospice transfer of acute front door hospital admissions where appropriate.

P-126 EFFECTIVENESS OF GABAPENTIN AND PREGABALIN FOR CANCER-INDUCED BONE PAIN: A SYSTEMATIC REVIEW

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Background Managing cancer-induced bone pain (CIBP) is challenging as background pain combined with more severe incident pain on movement makes balancing analgesia and side effects difficult. Pregabalin and gabapentin are indicated for neuropathic pain and pre-clinical studies suggest these drugs could modulate CIBP.