Sepsis is a significant cause of morbidity and mortality and patients in the palliative phase of their illness are particularly vulnerable. In 2016 health care organisations were asked to review their management of the deteriorating (often septic) patient through a Patient Safety Alert from NHS Improvement.

Patients being cared for in hospice in- patient units are increasingly complex and earlier in their disease trajectory. This means that robust protocols must be in place to support staff in recognising acute deterioration, making an appropriate assessment and putting a management plan in place that takes account of the particular clinical complexities of the patient and their wishes and preferences with regard to care and treatment, including transfer to an acute setting if appropriate.

Hospital scoring systems and management approaches are often inappropriate in hospice in-patient units and it was with this in mind that we decided to develop our own protocol for care of the septic patient

This poster describes the development of a 'Sepsis Care Bundle' for Willowbrook Hospice specialist palliative care in-patient unit and the education that underpinned this. The Care bundle was designed to be easily accessible to and followed by staff, including flow charts and aide memoires.

P-166 FEELING DRAINED = FEELING BETTER! AUDIT OF HOSPICE PLEURAL ASPIRATION

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10.1136/bmjspcare-2017-hospice.191

Background Hospice pleural aspiration has been undertaken for the last 25 years, following training by local chest physician. When the requirement for ultrasound (US) guided aspiration was introduced, a US machine was purchased and staff training undertaken. The British Thoracic Society issued guidance for pleural drainage in 2003 and standards were adapted for use in respect of pleural aspiration in hospice.
Method Retrospective review of all pleural aspirations undertaken over a three year period drawn from electronic clinical record. Documentation of the procedure was audited against 20 standards identified.
Results 36 procedures identified. 14 of 20 standards were 100% met; two met in 97% and two in 94%. Although pleural aspiration was always undertaken with a standard pleural aspiration kit with a small bore needle and 3 way tap, the documentation did not specifically say so. The consent form (one missing) did not contain the list of common complications, which were outlined on the leaflet about the procedure given to each patient. The procedure sometimes took place out of hours where symptom control demanded it. Post procedure – analgesia was not always prescribed, as it was often done as a day case and patients brought their own and observations were not recorded as per protocol in the two failed procedures.
Conclusions The template for procedure documentation has been adjusted to incorporate items which were not present; consent form and information leaflet rewritten to include same list of common complications; analgesia now routinely prescribed and offered, and use of patient's own is documented; procedure adjusted to ensure that post- procedure observations completed even when procedure failed; anticoagulant administration and blood results documentation improved; standard rewritten to ensure that out of hours procedures should continue to take place when required for symptom management, but undertaken by most experienced clinician.

P-167 RELIEVING THE PRESSURE! HOSPICE PARACENTESIS AUDIT ABSTRACT

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Background Paracentesis is commonly used for drainage of malignant ascites in the palliative setting with 90% of patients reporting improvement of symptoms following the procedure. Despite this, there is limited evidence surrounding best practice and there are currently no national paracentesis standards.
Aims To assess whether paracentesis standards are being met in practice, to compare with the results of 2010 audit and identify areas for improvement.
Method A retrospective analysis of all paracentesis procedures carried out in 2015 was done by searching for and analysing procedures documented on SystmOne (patient electronic record).
Results 41 procedures were performed on 10 patients, with average of 83% of standards met. All procedures had informed consent, INR documented and were done with appropriate anaesthetic and equipment. 98% were preceded by ultrasound, compared with 43% in 2010. Fewer procedures met the standards regarding documentation of observations and drain removal. PRN analgesia was prescribed in 85% of cases. The main complication was leakage post -drain removal.
Conclusions Results demonstrate more procedures are being done, with ultrasound now being used regularly to identify a safe drainage site. Recommendations were made to improve documentation of the insertion, observations and drain removal by altering the paracentesis template on SystmOne. Further action is to discuss the need for hourly observations and to research and review prevention and management of leaking from the drain site.

P-168 USE OF DIAGNOSTIC ULTRASOUND IN A HOSPICE AT HOME TEAM – A SERVICE EVALUATION

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10.1136/bmjspcare-2017-hospice.193

Background Ultrasound is a diagnostic tool that can supplement clinical examination. Members of the Princess Alice Hospice medical team have attended a course which teaches clinicians how to use ultrasound to assess for the presence of ascites and whether the urinary bladder contains fluid. The hospice has purchased a portable ultrasound machine.

Aims To review whether ultrasounds are being performed for Hospice at Home (H@H) patients and what impact this has.
Method A retrospective service evaluation of the use of the ultrasound in H@H patients over a one-year period.
Results 10 ultrasounds were performed in H@H patients over one year, seven were in the patient's home and three were in hospice outpatient appointments. Nine ultrasounds were performed to assess for ascites and one to assess for urinary retention.

Of the nine ultrasounds performed to assess for ascites, three demonstrated large volume of ascites that was amenable to drainage. Of these three patients, one had a drain inserted on the hospice inpatient unit and two were referred to hospital for drainage. The other six patients were found to have small volume or no ascites. The patient who had an ultrasound to assess for urinary retention was found not to have a distended bladder.
Conclusion The use of ultrasound in H@H patients does influence patient care and supports clinical decision making. The value of hospices performing ultrasounds comes from the ability to avoid unnecessary visits to hospital for ultrasounds, as well as avoiding unnecessary admissions to the hospice inpatient unit or hospital for assessment or drainage of ascites. Rapidly establishing whether a patient has ascites and whether it is amenable to drainage in the community, reduces delays and distress for the patient, as well as reducing the burden on the wider health service.

P-169 WEIGHING PATIENTS IN A HOSPICE SETTING

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Background Standard practice at our hospice did not encourage routine weighing of patients on admission, which potentially limited ability to meet best practice standards for medicine management and nutritional assessment.
Aim This project measured if patients were weighed at or soon after admission. Many were prescribed medication where dose was dependent on weight. The opinions of staff and patients towards routine weighing was also investigated.
Methods An audit of 40 patients measured if patients were weighed on admission or a reason for not doing so recorded and whether weight dependent doses were in line with the British National Formulary or other specialist advice.

A staff questionnaire gained the opinions of 79 clinical staff towards weighing patients, their understanding of the reason for weighing, and rationale for their opinions. A patient questionnaire gained the opinions of 38 patients on being weighed and their understanding of the reason for being weighed.
Results 97% patients did not find being weighed distressing. However, 51% staff members were opposed to routine weighing.13% of patients had a weight recorded. 13% were prescribed low molecular weight heparin, 80% of these patients were weighed and only 60% were on the correct dose.
Conclusions Routine weighing has been introduced for all patients or a recorded reason for not doing so. Clinical staff now receive training that demonstrates the inaccuracy of estimating body weight. An alert sticker is now attached to the medicine chart, for patients prescribed weight dependant medication and a prompt on the shelves where the medication is stored acts as a reminder to check body weight.

There is a plan for regular audits of the weighing of patients to maintain the profile of the importance of weighing and these results will be fed back real time to the clinical teams.

P-170 DETECTING SUICIDAL THOUGHTS IN PALLIATIVE CARE: WHEN DO PATIENTS VOICE THESE THOUGHTS?

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Background Early identification of suicidal ideation would allow more opportunities for intervention and may ultimately reduce risk of suicide. Knowing when patients are likely to voice suicidal thoughts is important, as it may increase confidence of healthcare professionals to have earlier conversations with their patients regarding suicide risk.
Aim To establish the time period between first assessment and recorded suicidal ideation in a patient population.
Methods 385 patients under the care of inpatient and community palliative care teams at St Christopher's Hospice, Sydenham, were identified to have keyword 'suicide' in their electronic patient records (EPR) during the period of April 2015 to March 2016. In these individuals, EPR was reviewed against inclusion criteria and 124 patients were identified to have documented suicidal ideation. Time from first assessment to detection of suicidal thoughts was calculated.
Results 61% of patients with expressed suicidal thoughts (n=76) were male, and mean age of those who voiced suicidal thoughts was 67.4 ± 13.6 years (mean ± SD). 69% (n=86) had a diagnosis of malignancy, and 62% (n=77) had a previous psychiatric history. 15% (n=19) of all patients we identified with suicidal thoughts voiced their suicidal ideation at their first assessment. A further 10% (n=12) voiced these thoughts within the first week of contact, and in 45% (n=55) suicidal thoughts had been detected within the first month.
Conclusions A large proportion of patients expressed their suicidal ideation early in their contact with the hospice-centred palliative care team. As previously established, asking patients about thoughts of suicide does not increase risk of suicide or self-harm (Gould et al., 2005; Eynan et al., 2014). This data provides further encouragement to explore suicidal thoughts in palliative care patients from first contact.

P-171 COMFORT ROUNDS: TASK-ORIENTATED NURSING OR EFFECTIVE CARE?

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Background Active nursing rounds, also known as intentional, care or comfort rounds were first developed in the USA (Struder Group, 2007) and later introduced into UK hospitals in 2012 alongside other measures to improve the quality of nursing care (www.harmfreecare.org). They have been associated with reductions in pressure ulcers, falls and increased