to identify areas of commonality. Emerging themes included communication and information sharing, education and training, care planning, DNACPR, support and supervision for staff, and environment of care. From these themes, five key workstreams were developed (review of Trust guidance for care in last days of life, development of a staff EOLC intranet site, development of an EOLC planning toolkit, review compatibility of information platforms, education and training) and are currently being addressed by the EOLC working group.

Conclusion The comments collated from the consultation events provided a valuable source of rich qualitative data on the views of staff and have informed areas for development. The interest and engagement for this process confirmed the enthusiasm of staff, who valued the opportunity to shape future developments; many have since become involved in aspects of this work.

56 ARE THERE INAPPROPRIATE PALLIATIVE PATIENT DEATHS IN EMERGENCY DEPARTMENTS (ED)? A RETROSPECTIVE STUDY LOOKING AT THE DEATHS IN A DISTRICT GENERAL HOSPITAL ED

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Introduction Palliative patients sometimes present to emergency departments when dying and current policy aims to reduce such unnecessary admissions. This study provides a description of palliative care related deaths in an ED and an assessment of how many of these were preventable.

Methodology 32 consecutive deaths were reviewed in a district general ED department in Shropshire during 2016/2017. Death certification details, palliative status and DNACPR status were identified. We retrospectively judged whether their admission was potentially avoidable.

Results

Epidemiology

- Median age 83 years (range 40–95)
- 15 female patients (47%).

Mode of death

- 12 patients died from respiratory pathology (37%), 6 from cardiac (18%), 6 from gastrointestinal (18%), 3 from infection (9%), 3 from stroke (9%), 1 from cancer (3%) and 2 were uncategorised.
- Frailty and palliative status
- Frailty and old age was documented on 10 death certificates (29%), dementia on 3 (9%).
- 4 patients (12%) had oncological disease.
- 2 patients (6%) were known to be palliative, 16 patients (50%) were not. There is uncertainty regarding the palliative status of the remaining patients and clarification using the gold standard framework is ongoing.
- 25 patients were DNACPR (81%).

We believe 3 admissions were preventable (9%), 17 were unavoidable (53%) and the remaining 12 are unclear (38%).

Conclusion This study suggests that some palliative patients do present to ED and die, and that some of these admissions were avoidable. With ever increasing ED pressures we suggest

it's imperative to understand the reasons, assess the scale, and find solutions to inappropriate palliative ED admissions.

57 UNIFIED DO NOT ATTEMPT RESUSCITATION (UDNACPR) ORDERS – AN AUDIT OF COMMUNICATION BETWEEN DIFFERENT HEALTHCARE SETTINGS

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Background The use of unified Do Not Attempt Resuscitation ('uDNACPR') orders aims to facilitate effective communication of DNA-CPR decisions between primary and secondary care. The document remains valid in primary and secondary care facilities and ensures continuity of care. The Salford uDNACPR policy reinforces the importance of communication of such decisions with all healthcare professionals involved in the patients care.

Aims/objectives To review the quality of communication of uDNACPR decisions with General Practitioners (GPs), out of hours services and the North West Ambulance Service (NWAS) on discharge from hospital.

Method A retrospective audit included 26 patients who had a uDNACPR order introduced whilst an inpatient at Salford Royal Hospital. Data was collected from the electronic patient record, uDNACPR paper forms, GP practices, out of Hours services and the NWAS Electronic Referral Information Sharing System: 'ERISS'.

Results In 33% of cases, GPs had no record of uDNACPR decisions. The NWAS had no record of uDNACPR orders in 81% of cases, and Out of Hours services had records of only 1/26 orders.

Conclusion Current communication of uDNA-CPR decisions to community providers is inconsistent and there is clearly room for improvement. This may result in patients receiving futile and undesired interventions. One key factor identified for poor communication of uDNACPR orders was poor knowledge amongst healthcare professionals on communication channels for such decisions. Work is currently being done to facilitate and support communication to different providers on discharge from secondary care. This includes education sessions on electronic systems such as EPaCCS, discussions with the individuals responsible for 'electronic note templates' within the hospital electronic patient record and involvement in work aiming to introduce a 'Medical intraoperatively gateway' (MIG) allowing GP/hospital/other systems to communicate and share information.

58 ANTICIPATORY PRESCRIBING PRACTICE AT A DISTRICT GENERAL HOSPITAL: A SERVICE EVALUATION

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Background NICE guidelines (NG31, 2015) advise that suitable anticipatory medicines (AMs) are prescribed as early as possible for people likely to need symptom control in the last days of life. To date, there has been limited evaluation of this practice. This study aimed to characterise anticipatory prescribing (AP) at a district general hospital in relation to three main

areas: patient population, outcomes, and prescribing and administration patterns.

Methods A retrospective review of electronic prescriptions and clinical records was undertaken in April 2017. All patients who were prescribed AMs using the hospital electronic AP protocol from 1 st July to 31 st Sept 2016 were identified. Demographic, clinical and outcome data were collected for all identified patients (n=118). Prescribing and administration patterns were reviewed for a representative subsample (n=50).

Results 118 patients were prescribed AMs (mean age: 81.2 ±10.3 years, 63 men). 38 (32.3%) had malignant disease and 49 (41.5%) had inpatient palliative team involvement. 66% (n=78) died in hospital, representing 49.7% of all inpatient deaths in that 3 month period. Median time from AM prescription to inpatient death was 1 day (IQR: 0–3). 34% (n=40) of those prescribed AMs as an inpatient were discharged. Of these, 33 (82.5%) had died within 6 months, a median of 8 days (IQR: 4–26) after discharge; AMs were omitted from the discharge prescription in 30%. For the 50-patient subsample, AMs were administered in 54% of cases, usually within a few hours of death.

Conclusions There appeared to be an appropriate rate of AP but prescribing patterns suggest a reactive rather than anticipatory approach, with some lack of continuity between inpatient and discharge prescriptions. More education and research are needed to support earlier identification of those in need of AP and smoother transitions between the inpatient and community setting.

59 ADDRESSING PATIENTS' HYDRATION NEEDS AT THE END OF LIFE: A CROSS-SITE AUDIT

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10.1136/bmjspcare-2018-ASPabstracts.86

Background Assessment of hydration needs including, if appropriate, a trial of clinically assisted hydration (CAH) is a key recommendation of national guidelines for dying patients.^{1,2} There is insufficient evidence regarding the benefits and burdens of CAH at the end of life^{3,4,5} including inconclusive findings from a systematic review.⁶ Research is ongoing⁷ including a cluster RCT.⁸ The audit aim was to assess compliance with national guidelines in three settings: the hospice inpatient unit (IPU), a district general hospital and patients known to the community palliative care team.

Methods Ten audit standards were derived from NICE and GMC guidelines.^{1,2} A target of 100% compliance with each standard was set. The audit comprised retrospective case note review of 60 patients (20 in each setting), identified as consecutive deaths of patients on an individualised end of life care plan from 1 st October 2016.

Results The frequency of documented mouth care and hydration assessment did not meet the audit standards in any setting. Most hospital inpatients had CAH in the last week of life (90%), compared with 10% of IPU patients and none of the community cohort. Discussion regarding risks and benefits of CAH was not widely documented, with the lowest figures for community (5%) and IPU patients (15%). In all cases in

which CAH was started, the documented frequency of reassessment was less than the twice daily recommendation in national guidelines.¹

Discussion In part, some of the findings may reflect incomplete documentation. Since the audit, the following steps have been taken:

- Review of hydration needs assessment including changes to care plan documentation
- Meetings with district nursing teams
- Review of access to required equipment for administering CAH
- Education sessions for staff
- Review of hospital mouth care guidelines

We plan to re-audit to assess compliance with the guidelines following implementation of these changes.

60 MULTI ORGANISATIONAL AUDIT OF THE RECORD AND PROMPT FOR ADULT CARE IN THE LAST DAYS OF LIFE IN WIRRAL

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Background The Wirral Multidisciplinary Record and Prompt for Adult Care in the Last Days of Life was developed in 2016 to support the delivery of excellent individualised care in last days of life in keeping with the Priorities for Care of the Dying Person and NICE guidance for Care of Dying Adults in the Last Days of Life. Following its introduction across Wirral University Teaching Hospitals NHS Foundation Trust and Wirral Hospice St John's, audits were undertaken across both settings assessing whether care in the last days of life was delivered and documented in line with national guidance.

Method A retrospective case note review was conducted using a standardised data collection tool. In the hospital setting, the audit sample from January-March 2017 included 30 cases where care was supported with the record of care, and 29 cases where it was not. In the hospice setting the audit sample from June-September 2016 included 34 patients whose care had been supported using this tool with comparison to a previous audit in 2015 assessing care in the last days of life.

Results The results across both organisations showed a considerable improvement in care delivered to patients in the last days of life, when the record of care was used, as evidenced by key findings in table 1 and 2.

Conclusion The use of the record of care has led to meaningful improvements in the care documented for dying patients and those close to them across all domains. The tool has been embedded across both organisations, with the focus now on ongoing education, awareness-raising of the improvement seen when the tool is used, and developments of electronic templates to support its use. Roll-out across the community setting is planned during 2018, with the aim of assuring the same high quality care in any setting.