It is recommended that doctors fully document the CPR discussions when completing these templates even if the uDNACPR is in place, especially with relatives of patients without capacity.

73 INTRODUCTION OF A COMMUNITY PALLIATIVE CARE DRUG CHART TO FACILITATE INDIVIDUALISED AND APPROPRIATE ANTICIPATORY PRESCRIBING

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Background NICE guidelines stress the importance of individualised anticipatory prescribing for people who are likely to need symptom control in the last days of life. A Community Palliative Care Drug Chart for the authorisation of individualised subcutaneous palliative care medication via injection or syringe pump was developed and introduced by a regional anticipatory prescribing working party. The chart does not use a proforma approach, which has been linked to over medication, but does incorporate guidance and is designed to cross settings.

Aim

- To evaluate whether the chart and guidance facilitates safe, appropriate and consistent anticipatory prescribing for patients 1 year after introduction.
- To identify any required chart adaptations and areas for education.

Methods The notes of 49 expected deaths from District Nurse caseloads were examined for the presence of a chart. 32 charts were reviewed to establish whether anticipatory prescribing complied with local guidelines and to record any themes from non-compliance. A survey of 20 local GPs was conducted.

Results 47 of the 49 expected deaths had a chart in place. For as required medication the percentage meeting the standards for choice of drug, dose and route were as follows: opioid (84%), antiemetic (97%), antisecretory (94%) and anxiolytic (94%). In 7 cases the range for opioid or midazolam in a syringe pump was greater than advised in guidelines. All GPs surveyed agreed that the chart facilitates safe and appropriate anticipatory prescribing.

Conclusion The chart and guidance facilitate safe, appropriate and consistent anticipatory prescribing for patients, resulting in improved compliance with standards when compared to a local audit from 2010. Changes to the chart and further education is needed in relation to syringe pump ranges and timing of authorisation. We have subsequently developed a new 'intelligent' protocol within the EMIS GP record to further enhance individualised anticipatory prescribing.

74 ANTICIPATORY PRESCRIBING IN PALLIATIVE CARE: EVALUATION OF CURRENT PRACTICE

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Background National guidelines endorse prescription of medications in anticipation of symptoms in the last days of life.

Little is known about current practice in anticipatory prescribing (AP). A service evaluation was undertaken to evaluate AP across one county in the UK.

Method Electronic records were searched of patients known to the Bedfordshire PEPS (Partnership for Excellence in Palliative Support) Co-ordination Centre, who had died during a one-year period and had been prescribed injectable medications for symptom control.

Results Out of 392 eligible patients, the records of 132 were selected at random. 486 injectable medications were prescribed: 77% were in anticipation of symptoms and 23% in response to existing symptoms. Diamorphine and midazolam were most commonly prescribed in anticipation, with 43/88 (49%) and 41/93 (44%) prescriptions leading to drug administration respectively. The corresponding data for glycopyrronium, cyclizine, haloperidol and metoclopramide were 25/78 (32%), 15/67 (22%), 3/11 (27%) and 3/14 (21%). Overall, only 37% of all medications prescribed in anticipation were administered. Recognition of the need for AP came from palliative care nurses (50%), GPs (32%) and District Nurses (14%).

Most patients had malignant disease (87%). The median time between prescription and first drug administration was 9 days in patients with cancer (range 0–368), and 61 days in those with non-malignant disease (range 3–298).

Conclusion Most prescribing of injectable medications was in anticipation, rather than in response to, symptoms. About a third of anticipatory prescribing led to drug administration. Although diamorphine and midazolam were both commonly prescribed and administered, antiemetics were less so. Further work is needed to evaluate the cost-effectiveness of AP, particularly in relation to antiemetics, and to investigate the unexpectedly long interval between drug prescription and administration in patients with non-malignant disease.

75 SYMPTOM MANAGEMENT AT THE END OF LIFE: AN EVALUATION OF DOCUMENTED RESPONSE POST-ADMINISTRATION OF ANTICIPATORY MEDICATIONS IN A DISTRICT GENERAL HOSPITAL

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Background The standard of practice for end of life care in the UK is to use anticipatory medications for symptom control. Given this it is important for the benefits or side effects of the medication to be identified so they can be adjusted to meet the patient's needs.

Aim To assess how frequently the response to anticipatory medications was documented by nursing staff, in both general wards and specialist palliative care beds at a district general hospital.

Methods A retrospective audit was conducted at a district general hospital in the UK. All palliative care referrals during October 2016 were audited for evidence of anticipatory medication use and whether there was any nursing documentation of its effectiveness. This was also done for all patients admitted to the newly-established specialist palliative care beds at the same hospital over a three month period in 2017.

Results 102 patients were referred to palliative care in October 2016, of which 50 had anticipatory medications given. Of

103 anticipatory medications administered 18.4% (19 out of 103 medications) had documentation of the effect on symptoms. There were 24 patients admitted to the specialist palliative care beds for end of life care over a 6 week period, of which 21 had anticipatory medications administered. Of these patients 31.6% (18 out of 57 medications) had documentation of the effect on the patient's symptoms.

Conclusions This study demonstrates that the effect of anticipatory medications is poorly recorded in the nursing notes on wards in a district general hospital. However, there is improvement when the patient is managed in a specialist palliative care bed on a general hospital ward. Further training is required to improve this documentation and allow accurate monitoring of symptoms. The designated specialist palliative care bed model may provide an opportunity for training of nurses across the hospital.

76 END OF LIFE CARE MEDICATION PRESCRIPTIONS: IMPROVING ACCURACY FOR A TIMELY DISCHARGE

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Introduction Prescribing medications for patients 'to take out' (TTO) on discharge is a routine task for junior doctors. Prescribing end of life care medications as a TTO, such that a rapid discharge can be arranged for a patient wishing to die at home, is not so common.

Inspiration and aim Born out of a highly emotive incident in which a patient did not receive his medications, a project to test, and subsequently improve, the accuracy of TTO prescriptions of these medications was initiated.

Method A cohort of foundation year one doctors undertook an end of life care prescribing quiz (Quiz 1), asking them to give an example prescription for both controlled and non-controlled drugs, and to state any additional documentation required to validate the prescription in the community. A guideline was then created in collaboration with the palliative care team, junior doctors and pharmacists to improve the accuracy of TTO end of life care medications. The new guideline was delivered alongside a palliative care teaching session, with cross-reference to the Trust's palliative care guidelines. The same cohort of doctors then re-took the prescribing quiz (Quiz 2).

Results The results of Quiz 1 highlighted worrying prescription inaccuracies: only 5% (1/20) of doctors correctly prescribed the medications and only 10% (2/20) identified the need for a community prescription chart. After guidance and training there was a considerable improvement in prescription accuracy (Quiz 2), with 75% (15/20) of doctors correctly prescribing the medications, and 88% (17/20) identifying the additional chart needed for administration.

Future Going forward, the guideline is to be distributed to all junior doctors within the trust, through inclusion on the intranet and the introductory handbook, such that future situations of delayed dispensing of end of life care medications can be avoided.

77 IMPROVING RECOGNITION AND END OF LIFE CARE COORDINATION ACROSS 3 CCGS. EVALUATION OF OUR SERVICE

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Introduction In Airedale, Bradford and Craven we have been developing end of life care services at a population level, aiming to identify, offer sensitive conversations and care coordination via a 24/7 hub based at an acute hospital (Gold Line) to as many patients as possible who are in the months/year of life.

Method Multiple interventions to support identification, communication and care planning for all patients thought to be in the last year of life across primary and secondary care. Includes communication skill training via Sage and Thyme, bespoke sessions for senior clinicians and one of two of NHS England Serious Illnesses care pilot sites. Use of EPACCS end of life template. Provision of 24 hour support hub. Support for primary care EOL MDT meetings via EOL facilitation in 1 CCG.

Results Please refer to attached documents.

1 CCG now has 68% of all deaths (90% 'predictable' deaths) identified, registered on EPACCS and receiving care. This CCG also has the lowest% hospital deaths in England. One CCG is less well engaged.

Discussion Multiple interventions to identify, communicate and provide coordinated care have been successful in increasing the number of patients and their carers receiving support in the last year of life. Use of a 24 hour hub provided by non-specialist staff appears to be well received and successful. Quality of care provided to individuals now needs to be measured.

78 WHO SURVIVES 1 YEAR AFTER HOSPITAL ADMISSION?

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As part of a NCPC and ECIP project a day one census was carried out on the 21 st October 2015 and the patients survival followed up for a year. The census included all patients who were inpatients on the day of the census, excluding those in paediatric and maternity services with the main objective to calculate rates of death.

Available data items included demographics, date of death, division and specialty of those involved in care; admission type (planned and unplanned), and frailty scores for the over 75. For patients who died in the year the census identified; resource utilisation data; bed days; admissions and A and E attendances.

Results of the census

858 patients identified in CUHFT on 21 st 2015 (excluding those under the care of paediatrics and maternity)