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 perios, 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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10.1136/bmjspcare-2018-ASPabstracts.103

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 RECOGNTION AND END OF LIFE CARE COORDINATION ACROSS 3 CCGS. EVALUATION OF OUR SERVICE

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10.1136/bmjspcare-2018-ASPabstracts.104

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 we 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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10.1136/bmjspcare-2018-ASPabstracts.105

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 paeds and maternity)

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Mean age 66.5 years
Percent of female 50.47%
Unplanned admissions 82.28%
Over the following 365 days, of the 858:
Number of patients that died 223 (25.99%)
Number that died in CUH 51 (5.94%)
Median number if A and E attendance 2
The median bed days in the census year 40
The median number of admissions in the census year 3

Higher rates in geriatrics and oncology as expected. Data is being used to engage clinicians in End of LIfe Care and point out that hospitals are in a good position to provide advance care and EOLC planning

79 AN AUDIT OF DOCUMENTATION OF CARDIOPULMONARY RESUSCITATION (CPR) DECISION MAKING AND COMMUNICATION ON ADMISSION TO A HOSPICE INPATIENT UNIT

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10.1136/bmjspcare-2018-ASPabstracts.106

Background CPR decisions are a significant part of advanced care planning. Clear communication with patients and those important to them, and documentation of decision making, is essential for good care and, following court cases, is now also a legal requirement.

Purpose The audit aim was to assess documentation of CPR decisions and communication on admission to Marie Curie Hospice Bradford and review CPR documentation on the patient's electronic palliative care co-ordination system (EPaCCS).

Methods Standards were set using Resuscitation Council (UK) and GMC guidance and the hospice's CPR policy. All admissions between 1 st-31st January 2017 were audited and results compared to an initial audit in 2016. The 2017 audit was extended to assess CPR decision making documentation on EPaCCS.

Results 38 admissions were audited. All had a CPR decision documented of which 32 were DNACPR. 22 were discussed with patients, 9 with relatives and 8 were not discussed. In 2016 of 37 admissions audited, all had a CPR decision. Only 13 DNACPR decisions were discussed with patients.

On EPaCCS, of the 10 DNACPR decisions not discussed at admission, 6 were discussed previously with patients and 2 were not discussed.

Conclusions and recommendations In both audits 2 audit standards were met:

- All patients should have a decision about CPR at the time of admission.
- CPR decisions and rationale should be clearly documented.

2 standards were not met:

- CPR should be discussed with all patients.
- CPR should be discussed with relatives/those important to the patient.

As the hospice moves to electronic patient records documentation will be modified. In addition to general advanced care plans, 3 specific sections are to be completed for CPR decision, discussion with patient and discussion with relatives. The aim is to improve documentation of discussions and continuity with EPaCCS. A re-audit will be completed.

80 WHAT PREVENTS ADVANCE CARE PLANNING IN HAEMATOLOGY?

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10.1136/bmjspcare-2018-ASPabstracts.107

Background Despite a clear emphasis in policy on the importance of advance care planning (ACP) for achieving quality end of life care, rates of ACP completion remain low. This is particularly apparent for patients with haematological malignancies and is associated with high rates of hospital death and patients receiving aggressive treatments at the end of life. This impacts on quality of life and family bereavement. Although patients tend to be receptive to ACP discussions they expect healthcare professionals to instigate them. Current evidence exploring barriers and facilitators to ACP from the healthcare professionals' perspective is limited.

Aim To explore what doctors and nurses identify as the barriers and facilitators to ACP for patients with haematological malignancies.

Method One-to-one semi-structured interviews were conducted with a purposively recruited sample of 5 doctors and 5 nurses working in a haematological malignancy setting. Thematic data analysis was conducted using a multi-perspectival Interpretative Phenomenological Analysis (IPA) approach. Demographic questionnaires were also used to capture key participant characteristics and provide a rich contextual description of participants.

Findings Six super-ordinate themes were identified: the problem with haematology; haematology team culture; approaching the patient; balancing hope and reality; managing patient psychology; opportunities for ACP; and staff awareness and training; each with associated subthemes.

Conclusion Though general claims are cautious, the findings of the study provide indications for future research exploring this phenomenon from the patient's perspective, as well as introducing prompts to trigger early ACP discussions despite prognostic uncertainty. It also poses potential clinical implications to improve holistic patient-centred shared decision-making by: addressing the hierarchical structure of haematology; inter-professional education and ACP awareness promotion; and empowering nurses to initiate ACP.

81 THE LIVING WELL GROUP: A PUBLIC PARTNERSHIP INITIATIVE TO IMPROVE END OF LIFE CARE IN AN ACUTE HOSPITAL

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10.1136/bmjspcare-2018-ASPabstracts.108

Background Poole Hospital NHS Foundation Trust is participating in Building on the best (Botb) – a national initiative to improve end of life care in acute hospitals. The Ambitions Framework recognises the important role of partnerships between communities and professional services.

A Public Partnership Group was created to support delivery of the projects comprising Botb.

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