

Methods The group was recruited to following an article in the local press entitled: ‘Poole Hospital wants to improve its end of life care. Can you help make it even better?’ The public were invited to respond to the article by email. Respondents were screened and if thought suitable for inclusion in the group, were invited along for the inaugural meeting in January 2017.

The group collectively decided to name themselves The Living Well Group and have continued to meet on a six weekly basis for a two hour meeting facilitated by a Palliative Care Consultant and Transformation Manager in End of Life Care.

Results The Living Well Group has evolved into a dynamic source of opinions and ideas to represent the local population. They have contributed to the following initiatives:

- Raising awareness and promoting dignity and compassion in dying
- Design of a new Advance Care Planning document
- Ideas for a befriending service at end of life in the hospital
- Involving families in the care of dying patients – touch, mouth care and hearing
- Feasibility of creating a standard of time to administration of analgesia
- A patient experience of care questionnaire at end of life

Conclusions The public are willing to contribute directly to the development of end of life care initiatives and it is possible to create an effective working group following advertisement in the local press.

82 TREATMENT ESCALATION PLANS – SUPPORTING INDIVIDUALISED CARE

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Background Failure to plan and document an appropriate ceiling of care can lead to treatment decisions being made urgently, out of hours, by a team unfamiliar with the patient; unwanted hospital admissions; investigations and treatments which do not contribute positively to the individual’s experience of care. To address this, we developed an electronic Treatment Escalation Plan (TEP) as part of the Electronic Patient Record. TEPs were implemented trust-wide in July 2015.

This is part of a wider project to improve end of life care: Poole Hospital is part of ‘Building on the best’ in partnership with NCPC, Macmillan, and locally funded by Forest Holme Hospice Charity.

Methods

- Electronic notes review of 40 consecutive adult inpatients who died within 100 days of hospital admission (index admission October 2015), using a standardised proforma (documentation of TEP or DNACPR, involvement of patients and families in discussions during the index admission).
- Run chart of TEP documentation showing how many electronic TEPs are created in EPR each month.
- Comparison with in-hospital mortality review in which notes of people who have died are reviewed by senior clinicians.

Results

- Of 40 patients, 17 died during the index admission, with documented discussion of prognosis for 88%, electronic TEP for 29%, DNACPR for 100%. Of 23 who died subsequently, discussion of prognosis had been documented in the index admission for 17%, electronic TEP for 4%, DNACPR for 30%.
- There has been a significant increase in the median number of TEPs created: 44 per month (2015/16) to 140 per month (2016/17).
- In 2017, 90% of adults dying in hospital have a documented ceiling of care.

Conclusion Treatment escalation plans are one way to improve decision making and documentation. TEPs are now widely used throughout the hospital, contributing to effective individualised care for people approaching the end of their life.

83 EVIDENCING CARE OF THE DYING ADULT IN A DISTRICT GENERAL HOSPITAL

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Background The Five Priorities of Care highlight the importance of individualised care planning for the dying adult. Ashford and St Peter’s NHS Trust is a district general hospital with over 1000 deaths per year. Over the last year, an individualised care plan based on the 5 priorities of care has been implemented across all wards. The initial baseline audit of care of the dying adult, lessons learnt from implementation and the re-audit of care are presented.

Methods A ward based training program was developed alongside a Priorities- individualised care plan document and communication sheet for family and loved ones.. An audit tool based on the 5 priorities of care was used to assess care of the dying before and after implementation across the acute hospital medical wards. Two weekly projects meetings were held during the implementation phase and data collected on the use of the ‘Priorities-individualised care plan’. The care of 50 patients before and after implementation was audited for comparison.

Results The initial audit showed recognition of dying on the wards ranged from 50%–100% however most patients were not recognised as dying until the last 48 hours, thus almost 80% of patients were unable to participate in decision making about their care. 5% of patients had adequate individualised care planning in the last days of life. Three months after implementation 31% of all medical deaths were supported with a Priorities care plan, however uptake varied across wards with the care of the elderly wards using it for over 60% of deaths compared to 15% on the acute medical unit.

Conclusion This quality improvement project highlights that implementing high quality end of life care through individualised care planning requires extensive training, resource and a culture shift for professionals. The post implementation audit findings will also be presented.