Results 12 months after initiation of the new integrated service, the proportion of patients with GC and RCC reviewed by PC at diagnosis of incurable disease had increased from 26% and 16% to 80% and 93% respectively. 79% (RCC) and 72% (GC) had severe or overwhelming psychosocial needs. 18% (RCC) and 25% (GC) had severe or overwhelming physical needs.

47 patients had died at time of analysis (16 RCC and 31 GC). Median time from review to death was 134 days (range 20–318 days). This compares to a median time between PC referral and death in the baseline cohort of 98 days (GC) and 83.5 days (RCC).

Conclusions The Integrated service proactively identifies patients with PC needs earlier and has highlighted the high burden of psychosocial needs. This study will underpin service development and improvement to include proactive intervention.

132 IMPROVING THE PRESCRIBING IN A GENERAL HOSPITAL OF 'AS REQUIRED' ANTICIPATORY MEDICATIONS FOR END OF LIFE SYMPTOMS, FOLLOWING THE INTRODUCTION OF AN ELECTRONIC PRESCRIBING 'ORDER-SET'

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10.1136/bmjspcare-2018-ASPabstracts.159

Background Availability of anticipatory medications for common end of life (EOL) symptoms is a quality indicator measured in recent hospital care of the dying audits. Local results from the 2013 audit demonstrated poor uptake of anticipatory prescribing. In 2014, the Trust moved to electronic patient records and prescribing across the acute trust. Working in partnership with the informatics leads for pharmacy and medicine,the palliative care team utilised the capabilities of 'Cerner's' electronic patient prescribing system to develop an 'order-set' of 5 medications, commonly needed at the end of life. The system went live in May 2015 and an early induction session to the new junior doctors was delivered in August 2015.

Aims To evaluate prescribing of anticipatory 'as required' EOL medications, following the introduction of the palliative care 'order-set'.

Methods A retrospective review of anticipatory, 'as required', prescribing for a 1 month period was undertaken 12 months after introducing the prescribing 'order-set'. Criteria applied as for the 2013 National Hospital audit.

Results were compared with local results from 2013. Baseline information from 2013 showed that the Trust under-performed for prescribing for all symptoms: (Agitation- 23%, Breathlessness- 20%, Nausea- 14%, Pain- 27%, and Secretions- 7%).

Twelve months after implementation of the 'order- set' the results were: (Agitation- 68%, Breathlessness- 74%, Nausea- 68%, Pain- 74%, and Secretions- 65%). These results are all above the national average from the 2016 RCP: National End of life care audit.

Conclusions Introduction of an electronic palliative care prescribing 'order-set' for anticipatory EOL medications, has demonstrated considerable improvement in the uptake of anticipatory prescribing for dying patients. This in conjunction with an early palliative care induction education session for junior doctors has demonstrated significant improvements in the quality of prescribing in the end of life phase of life for patients in an acute hospital.

133 ASSESSING THE MANAGEMENT OF HEART FAILURE PATIENTS IN THE INPATIENT HOSPICE SETTING: A RETROSPECTIVE AUDIT

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10.1136/bmjspcare-2018-ASPabstracts.160

Approximately 900,000 people in the UK have heart failure (HF) with 30–40% dying within a year. The incidence of HF is increasing. Patients have a high symptom burden; patients with HF will have similar numbers of symptoms to cancer patients. As UK life expectancy increases palliative services will need to provide more support to this patient group.

This retrospective audit assessed care from Severn Hospice to HF patients admitted to the hospice since November 2015. NICE guideline 'Chronic Heart Failure in Adults: Management' was used as the gold standard.

Of 962 patients admitted to the hospice, 13 had a diagnosis of HF. 9 had a primary diagnosis and 4 had HF as a co-morbidity. The majority of patients were referred for symptom control. At admission patients had a mean of 4.38 (range 1–7) symptoms. 9 patients had symptoms not in the NICE guideline including constipation, diarrhoea, anxiety, agitation and hallucinations. The majority had more symptoms at admission than at initial referral (mean 4.84). 9 patients had syringe drivers during their admission; 3 were furosemide infusions.

All patients had some advance care planning (ACP). All had a 'do not resuscitate order'. Preferred place of death was documented in 12 patients (1 had no capacity). 9 had a preferred place of care. No patients had an advance directive to refuse treatment. Most ACP was done on admission.

Surprisingly few patients with HF are admitted to the hospice. These patients have a significant symptom burden including some symptoms not always associated with HF. This suggests that the needs of HF patients are not being met. As a result efforts are being made to set up a joint HF and palliative care MDT. With this and increasing numbers of patients the hospice will continue to gain expertise in managing these patients.

134 STAFF VIEWS ON CHANGES TO THE MULTI-PROFESSIONAL ELECTRONIC-HANDOVER IN A SPECIALIST PALLIATIVE CARE UNIT: SERVICE DEVELOPMENT PROJECT

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10.1136/bmjspcare-2018-ASPabstracts.161

Background Introducing change to service can be challenging. Following an audit of electronic handover (e-handover), a multi-professional group of palliative care doctors, nurses and allied health professionals, developed a Standard Operational Procedure (SOP) to guide staff and ensure e-handover consistently addressed patients' specific palliative care needs. As part