advised. Previous studies have shown poor documentation of indication, monitoring and side-effects of corticosteroids in a palliative setting.

Aims

Primary Aim Within 3 months, 90% of patients treated with steroids in Roxburghe House (RH) will be screened for hyperglycaemia with twice weekly BM monitoring.

Secondary Aim Within 12 months, 90% of steroid prescriptions in RH will have documented weekly re-assessment.

Methods The Plan Do Study Act method of quality improvement was used. Baseline data was collected for all inpatients in December 2016 from medical notes and medication administration charts(Kardex). Documentation of indication, PPI prescription, twice weekly BM, evidence of re-assessment and response was reviewed. Baseline data was re-collected following interventions over 12 months.

Interventions: A new steroid form was created with input from all grades of medical staff. Form revised and re-printed on brightly coloured paper. Education given to nursing and medical staff about steroid-induced hyperglycaemia. Reminders displayed in doctors' room. Senior charge nurse implemented set days for BM monitoring. Progress discussed at quality meeting. Included in junior doctors' induction. Patients on corticosteroids highlighted in doctors' room board.

Results Between 45–76% of inpatients were prescribed corticosteroids. Documentation of BM monitoring improved from 0% at baseline to 43% at 3 months and 100% at 8 months. No trend identified in documentation of indication (33–86%), re-assessment (23–83%), response (0–43%) or PPI prescription (80–100%) over 12 months.

Conclusions Regular monitoring of BMs has become successfully imbedded. Documentation of response and re-assessment remains poor. The rotation of junior doctors is a likely influencing factor to achieving sustained improvement, highlighting the importance of induction and education.

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152 MALIGNANT URETERIC OBSTRUCTION DECOMPRESSION: HOW MUCH GAIN FOR HOW MUCH PAIN? A SYSTEMATIC REVIEW OF THE LITERATURE.

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Background Over the last thirty years, the management of Malignant Ureteric Obstruction (MUO) has evolved from a single disciplinary decision to a multi-disciplinary approach. Careful consideration must be given to the risks and benefits of decompression of hydronephrosis for an individual patient. Though there is some recommendations within cancer specific guidelines, both the European Association of Urology and the American Urological Association guidelines recommend drainage or de-obstructing the urinary systems, there is a lack of consensus of opinion as well as strong evidence to support the decision process.

Methodology The review was conducted using Cochrane and PRISMA guidelines. Outcomes that were identified amongst patients undergoing treatment for MUO included prognosis, quality of life (QOL), complications, morbidity and prognostication tools.

Results The initial review found 169 papers. A total of 56 papers were included. Median survival was 6.4 months in the 50 papers that stated this outcome. The average reported complication rate was 41% with one fifth of patients never leaving hospital post procedure. Significant predictors to poor outcomes included low serum albumin, hyponatremia, the number of malignancy related events, and performance status of 2 or worse on the European cooperative cancer group. For those patients with 2 or more risk factors, median survival ranged from 1.7–2.6 months and 12-month survival ranged from 0%–12%. QOL using several measures ranged from 41–88%.

Conclusion In this post Montgomery era with the concept of the 'reasonable patient', can we continue to justify discussing decompression without stating the evidence-based risks from the emergent body of literature? We propose a multi-centre review of outcomes to enable evidence-based consultations for patients and their families.

153 AUDIT OF THE USE OF TREATMENT ESCALATION PERSONALISED PLANS IN UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

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Background Treatment Escalation Personalised Plans (TEPPs) were introduced across the Trust in 2014 to record ceilings of care for patients who fulfil specified criteria. TEPPs aim to encourage clinical decision making by senior clinicians familiar with the patient, in discussion with the patient and/or their next of kin (NOK). An initial audit was completed in 2015.

Methods We performed a re-audit of case notes on 12 medical, surgical and oncology wards over 5 weeks in early 2017. The criteria for a TEPP were: patients with a DNACPR, those meeting poor prognostic criteria for long-term conditions, or those deteriorating despite active treatment. Documentation of TEPP discussions with patients and/or NOK was also examined.

Results Of 268 notes reviewed, 126 met criteria for a TEPP (47.0%). Of these, 59/126 (46.8%) had a TEPP, and a further 6 had ceilings of care documented in their medical notes. 75% of TEPPs were completed within 48 hours of admission. Appropriate completion of TEPPs varied between specialities, from 80% in Stroke to 0% in Surgery. Evidence of TEPP discussion was present for 93% of patients with capacity and 89% of those without (discussed with NOK).

Conclusions Completion of appropriately indicated TEPPs was stable across audit cycles. Documentation rates of TEPP discussions with relatives had improved, but the extent of documentation varied significantly. The variable rate of TEPP completion between specialties is worthy of further investigation. Further work is required to reinforce the indications for TEPPs, raise awareness of formal poor prognostic indicators and emphasise the importance of full documentation of

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