

25 patients received VTE prophylaxis within the last 72 hours of life. Of these, 12 had VTE prophylaxis stopped in the coming days. 6 patients who were recognised as dying received VTE prophylaxis in their last 24 hours of life.

Conclusions The results suggest that guidance regarding pharmacological thromboprophylaxis in the last days of life is not consistently followed even when the dying process has been recognised. They also highlight that improvement is needed in recognising the dying patient in the acute setting and that locally there is inadequate uptake of our 'last days of life' care plan.

43 COMPARING THE ASSESSMENT OF END OF LIFE CARE IN THE STRUCTURED JUDGEMENT REVIEW WITH AN END OF LIFE AUDIT

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Background The Structured Judgement Review (SJR) is a validated and standardised method for reviewing case notes of patients who died in hospital. One section assesses end of life care (EOLC); this can be rated from very poor to excellent. This audit aims to evaluate whether the SJR is providing us with an accurate assessment of the quality of EOLC in an Oncology inpatient department.

Methods This is a retrospective audit of adult patients that died on Oncology wards in 2017 and had an SJR completed. The end of life audit assessed whether the Hospital Trust's Key Performance Indicators (KPIs) were achieved. National standards were used to audit specific aspects of the individualised care plan. The care ratings and comments from each SJR were then compared with the end of life audit.

Results The notes of six patients were reviewed. The SJR ratings for EOLC were 'very good' in five cases and 'excellent' in one. However, the EOLC audit using Trust KPI's showed more variation in the quality of care. In three cases where the SJR rated 'very good' or 'excellent', this compared well with the EOLC audit where they achieved 80%–90% of Trust KPI's. In two cases where the SJR rated 'very good', they only achieved 30% of Trust KPI's. The final case was again rated 'very good', but only achieved 50% of Trust KPI's. The comments in the SJR did not discuss the same issues that the EOLC audit raised. For example, some focused on treatment escalation plans being completed rather than the quality of care.

Conclusion The recorded quality of EOLC according to SJR's did not consistently reflect the quality of care being given. In order to improve the accuracy of the SJR, we attached key KPI's on EOLC to the SJR form as a prompt for reviewers.

44 SERVICE EVALUATION OF THE USE OF FLUIDS AT END OF LIFE ACROSS TWO INPATIENT PALLIATIVE CARE UNITS

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Background 'Five Priorities of Care' requires an individualised plan for hydration at end of life and discussion with patients/those important to them. However there is little research surrounding this topic and the use of fluids is often dependent upon the individual prescriber.

Methods A service evaluation of the current practice in Sheffield's inpatient palliative care units.

A retrospective case-note review of deceased patients over a two-month period at St Luke's Hospice (SLH) and Macmillan Palliative Care Unit (MPCU), 37 and 20 cases respectively.

A qualitative staff survey of individual thoughts and practices with fluids.

Results Consistently good documentation of discussions about hydration risks and benefits, but less for symptoms of dry mouth and mouth care. These discussions were documented more often at SLH than MPCU (97/81% vs 60/35%). MPCU offered and prescribed fluids 2.5 times more often. Most commonly prescribed 1 litre of normal saline over 24 hours. Most common reason for stopping fluids was skin pooling (75% SLH) and secretions (89% MPCU). Documentation of discussions surrounding this seen for all cases SLH, 50% cases MPCU.

An inability to quench thirst ranked first on survey regarding reasons for fluid delivery, opposed to dry mouth in clinical practice. Opinion was that the likely benefit from fluids was almost equal to the risk of harm. Subcutaneous delivery was the preferred route for being less invasive.

Conclusions Hydration at end of life needs to be individualised and regularly reviewed. Documentation was higher at SLH than MPCU regarding fluids, due to the ADD CARING mnemonic. Steps have been made at MPCU to prompt consideration of fluids at end of life. Improved documentation needed for dry mouth symptoms/mouth care. Staff responses did not always correspond to documented reasons for initiating and stopping fluids, suggesting these need to be decisions made across the MDT.

45 ARCHEOLOGICAL DIG: A HISTORICAL REVIEW OF LOCAL EVIDENCE, GUIDELINES AND CLINICAL PRACTICE IN RESPONSE TO THE GOSPORT ENQUIRY

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Background The Gosport Report suggests over 450 patients died due to 'dangerous doses' of medication combinations without clinical indication. A cross-boundary integrated specialist palliative care service reviewed factors influencing prescribing culture for patients approaching end-of-life.

Methods A historical review of pain management and syringe driver use was considered alongside locality guidelines. Training programmes were reviewed and meetings held with stakeholders. Audits were undertaken to seek assurance of safe local prescribing practices.

Results

- During the Gosport period, there was clear guidance available for safe opioid starting doses, dose equivalences & syringe driver use.
- Medical Devices Alerts regarding the risks of multiple syringe driver devices in use, led to use of a single device across locality. Local guidelines have always stated no indication for 'anticipatory prescribing for medication via a syringe driver'.

- Multi-professional education has evolved & adapted over time to reflect key national guidelines & staff training needs.
- Review of all hospital deaths during April 2018 showed less than 30% received a continuous subcutaneous infusion of medication prior to death. Clinical indication was clearly documented & mean starting doses were small (Diamorphine 6 mg, midazolam 7.5 mg). There was no evidence of anticipatory prescribing of syringe drivers, or the prescribing of dose ranges in hospital.

Conclusion A review of end-of-life prescribing prompted by the Gosport Report gives assurance that prescribing practices described, are not seen locally. A culture promoting safe end-of-life prescribing has been fostered through readily available, evidence-based guidelines, safe procedures for syringe driver use, wide-reaching multi-professional education co-ordinated by the hospice education centre and an active end-of-life audit group. Strong clinical leadership gives a co-ordinated approach to promoting excellent end-of-life care.

46 IMPROVING THE PRESCRIPTION OF ANTICIPATORY MEDICATIONS FOR ADULTS RECOGNISED AS DYING IN A DISTRICT GENERAL HOSPITAL

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Introduction The NICE quality standards for care of adults in the last hours/days of life state that all patients should have appropriate as required medication (PRN) prescribed for the symptoms (pain/breathlessness, agitation, nausea/vomiting and respiratory secretions) that can occur at the end of life (EoL). This quality improvement project tested the adherence to this in one UK district general hospital.

Aims To investigate whether PRN anticipatory medications were prescribed in accordance to trust guidelines to inform future quality improvement work.

Method This was a prospective audit of 20 consecutive patients across adult wards in June 2018. Drug charts were audited using a tool based on the trust guideline, and the auditor met with junior doctors to discuss concerns around prescribing.

Results 25% (n=5) of prescriptions were accurately compliant with guidelines. In medications for pain relief and agitation drug dose was correct in 75% (14) and 60% (12) respectively, however dose frequency was incorrect in 45% (9) and 70% (14), with too long a dose interval in 40% (8) and 50% (10) respectively. The PRN medication with the most errors were medication for nausea/vomiting and respiratory secretions with the dose missing or incorrect (no maximum 24 hour dose recommendation) in 95% (19) and 80% (16) respectively. Discussion with junior doctors highlighted a lack of awareness of the guidelines.

Conclusions Despite the existence of trust guidelines prescription errors for anticipatory medication at EoL were common. The main concern being patients may have symptoms under treated due missing drugs or too long dose frequency. In collaboration with the specialist palliative care team, pharmacy and junior doctors a poster was created and displayed across all wards. This was supported by teaching sessions delivered by a junior doctor to junior doctors to promote the content of the poster. The adherence to guidelines will be re-audited in 2019 and included in the presentation.

47 DEMONSTRATING SAFE PRESCRIBING AT THE END OF LIFE AFTER THE GOSPORT WAR MEMORIAL HOSPITAL REPORT: A REGIONAL SURVEY OF INPATIENT HOSPICE PRACTICE

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Background The Gosport War Memorial Hospital (GWMH) report highlighted significant concerns relating to opioid and sedative prescribing at the end of life. It concluded that the lives of over 450 people were shortened and probably at least another 200 patients were similarly affected. In light of the concern this might raise for the public, the seven hospices in Kent and Medway undertook to compare practice in end of life prescribing and communication.

Methods A medication and record review of patients dying in the in patient units who were admitted for >24 hours. To identify patterns of opioid and sedative prescribing and outlying cases for peer review.

Results Continuous subcutaneous infusions (syringe drivers) were used in 70%–95% of patients. Specific explanation to patient or families for their use varied greatly from 20%–100%. This may in part be due to different interpretation of the standard. Discussion with family that the patient was dying was recorded in 63%–100% of cases. Mean parenteral morphine dose/24 hours varied from 44–141 mg with corresponding medians: 30–60 mg. The highest dose used was 930 mg.

Mean midazolam doses ranged from 15–34 mg. Median 10–17 mg with the highest dose in 24 hours being 130 mg

Levomopromazine was used in less than a third of cases and haloperidol in approximately 10%.

Phenobarbitone was used once at the final 24 hour dose was 1200 mg

Conclusion Whilst our doses are generally comparable with previously published studies, comparing opioid and sedative doses across units enables peer review of the exceptional cases.

Improved communication with patients and relatives about CSCI use and approaching death are needed in some of the units. This survey tool and process offer patients, families and hospice governance structures reassurance that the shocking findings from GWMH are not a risk in these units.

48 USING ELECTRONIC COMFORT OBSERVATIONS TO SUPPORT THE CARE OF THE DYING ADULT PATIENT – WHAT DO STAFF USERS THINK?

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Background The comfort observations is an electronic assessment method that mandates a minimum of 4 hourly checks using parameters that measure comfort (such as pain assessment, mouth care and respiratory effort) rather than physiological measurements, and trigger alerts for escalation of care. It was implemented by the Supportive and Palliative Care Team (SPCT) from October 2017 in the care of dying adult patients trust wide.