

- 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.