Objectives
1. To investigate the documentation of code status discussion on admission to hospital.
2. To investigate patient outcomes in those referred to Palliative care services.

Methods
The electronic health records (EHR) of 50 patients referred to the Palliative Care consult service were retrospectively reviewed, following Institutional Review Board (IRB) approval. The patients code status orders, clinical notes, and outcomes were documented.

Results
The average age of the patients was 67.86 years. 48% had an active cancer diagnosis, 10% were left ventricular device (LVAD) patients and 42% had an acute cardiac, pulmonary or neurological presentation. 34% of patients were admitted directly to an intensive care setting. The majority (80%) of patients were ‘Full Code’ on admission, 12% were ‘Do Not Resuscitate’ (DNR) and 8% were ‘Partial Code’. For those who were documented as ‘DNR’, only 1 patient had a documented ‘Do Not Intubate’ (DNI) order. While code status was documented in all admission notes, the discussion of code status clarification was only documented in 14% of notes. Only one emergency department note referenced a discussion of code status. Code status was changed within 24 hours in 6% of patients, and 20% of patients changed code status during admission, with Palliative Care involvement in the majority (80%) of these cases. Regarding outcomes, 56% returned home, 14% were discharged for rehabilitation, 22% were discharged with hospice care, and 6% died in hospital on comfort care.

Conclusion
Code status discussion should be an integral part of an acute hospital admission to ensure patient’s wishes are being followed and respected.

COMPLIANCE WITH HOSPITAL GUIDELINES ON PRESCRIPTION OF ANTICIPATORY MEDICATIONS – SCOPE FOR IMPROVEMENT?

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Background
NICE guidelines for the Care of the Dying Adult recommend the prescription of anticipatory medication as early as possible to minimise symptomatic distress during last days of life. Literature on prescribing of anticipatory medications in secondary care is limited. Incorrect prescribing and inadequate understanding among hospital staff regarding symptom management for a dying patient prompted the need to establish compliance of prescribing and administration of anticipatory medications (AMs) against Trust guidelines on symptom control in the last days of life.

Method
A retrospective audit cycle comprising of 3 audits was conducted examining hospital records of patients recognized as in the dying phase, between December 2015 and October 2017. Documentation within drug charts, doctors’ and nursing notes were scrutinised to establish whether AMs were prescribed and used for specific indications as per guidelines.

Results
There was improvement in compliance with prescribing of AMs for patients at point of recognition of being in the dying phase (88% to 96%) and the administration of AMs according to correct indications (23% to 91%). Nursing documentation of indication for AM use improved (23% to 40%). Despite an improvement in selection of appropriate AM per symptom, compliance around doctors’ prescription of accurate doses dropped (21% to 12%).

Conclusions
Whilst compliance in the initiation of anticipatory medications for the main symptoms associated with last days of life improved, accuracy of doses needs to improve. The role of hospital pharmacists in enabling compliance was identified as an additional resource alongside periodic trust-wide communication of guidelines, to support better symptom control at end of life. The prevalence of hospital staff turnover (doctors changing rotations and bank nurses) necessitates the need for regular educational events to facilitate safe, evidence based symptom control at end of life. Embedding clinical guidelines for end of life care requires an ongoing proactive approach.