warning score (EWS) was implemented to aid identification of deterioration in those appropriate for medical intervention. Similar hospice protocols were reviewed and adapted. Admission baseline EWS and planned observation frequency is recorded, with emphasis on deviation from baseline triggering medical assessment.

**Methods** Retrospective analysis of patient notes admitted to SGH during August 2018 (n=39). Parameters recorded included: escalation status, planned observation frequency and adherence, baseline admission EWS documentation, EWS deviations prompting medical assessment and any resulting changes to patient management. The audit will continue incorporating September and October.

**Results** 23 patients (59%) were for best supportive care only. Of the remainder (n=16), 89% had baseline admission EWS documented. Observations were recorded as required in 63% cases (n=10) and once daily in 37% (n=6). All were compliant to planned frequency. EWS deviation prompted medical assessment on seven occasions. Of these, six EWS recordings were triggered by concern from nursing staff or patient. Management was changed on three occasions, with initiation of intravenous antibiotics, fluids or supplemental oxygen. Minor deviation from baseline EWS of up to two points did not automatically trigger medical assessment; this was at the discretion of nursing staff.

**Conclusions** Modified EWS may benefit the subset of palliative care patients suitable for life prolonging measures by allowing earlier identification of acute deterioration. Recording observations on an as required basis seems sufficient to detect clinical deterioration. Management was changed in the minority of cases, although these interventions were significant. Clear documentation of escalation status to avoid inappropriate observation monitoring is essential.

**106** **AUDIT OF EFFECTIVENESS OF IN-PATIENT CLINICAL MANAGEMENT ESCALATION PLAN**

Cathrine Vincent, Peter Day, Alpna Chauhan. John Eastwood Hospice

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**Background** In 2017, a formal escalation planning process for the management of patients at a hospice inpatient unit was initiated in response to the inappropriate transfer of a patient to the acute setting out-of-hours. This initiative involves formation of an escalation plan (EP) in advance consisting of one of three categories: supportive hospice care, hospice escalation or hospital escalation.

**Aims and objectives** This study aims to answer the question ‘Does advanced escalation planning and documentation improve patient care?’

**Methods** Data was collected retrospectively of 50 cases from the in-patient unit 1 year after the EP plan process was commenced. A staff questionnaire was also included. The notes were reviewed for details of any treatment escalations that occurred or were considered and this was compared to their escalation plan at the time.

**Results** The process is being used effectively with 94% of patient’s having an EP documented. There were 45 escalation events, mostly for symptom control, and nearly half the patients had at least 1 event during their admission which reflects the current level of intervention in palliative care. In 36% the acute hospital was involved for symptom control and diagnostic investigations. 4% were appropriately transferred from the hospice to the hospital for in-patient care. Escalation events matched the EP in 88% and where they didn’t this involved patient choice or a rapid change in the patient’s condition. The staff who engaged with the staff questionnaire reported finding the EP helpful.

**Conclusion** This audit shows overall positive results of engagement and clinical outcomes of this new initiative. It shows plans are formed in advance, they are documented, and clinical judgment is being used in individual situations to ensure appropriate clinical treatments are offered and outcomes are of benefit to the patient.