The overall mean number of comorbidities was 3 (range of 0–7) with a mean of 3.5 for those with an incorrect code. Most common co-morbidities were hypertension (30%), type two diabetes (22%), ischaemic heart disease/heart failure (17%), atrial fibrillation (17%), and other malignancy (15%).

Conclusions Recommendations to improve clinical coding included: identifying clinical and administrative points during patient journey to review ICD 10 diagnostic code; use of multiple diagnostic codes; and staff education around data collection. The difficulties identified reflect the challenge of accurate clinical coding within the context of an increasingly complex caseload and multiple co-morbidities. It highlights the importance of developing more nuanced approaches to clinical coding within the palliative care setting.

113 OUR JOURNEY TO IMPLEMENTING THE CASTLE REGISTER: THE LOCAL ELECTRONIC PALLIATIVE CARE COORDINATION SYSTEM (EPACCS) FOR COVENTRY AND WARWICKSHIRE

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Background EPACCS enable the recording and sharing of key details and care preferences for patients approaching the end of life, supporting co-ordination of care and delivery of the right care, in the right place, by the right person, at the right time. Core content was identified in an NHS England national information standard for end of life care co-ordination (ISB 1580).

Methods In 2011 a local EPACCS implementation group was formed with clinical and IT representation from 3 CCGs, 3 acute NHS Trusts, 2 community NHS Trusts, 4 independent hospices, GPs, out-of-hours providers and the ambulance service. From 2012–2014 existing EPACCS across the country were viewed, an appropriate IT platform was identified, clinical staff were involved to agree content, and bespoke clinical templates were built. From 2014–2016 development took place through a test-launch-review cycle. Information governance issues were addressed with an executive governance policy, standard operating procedure and data sharing agreements. Extensive communication supported a launch across providers.

Results The system went live in November 2016. Over 600 patients have a CASTLE Register record and over 900 staff have been trained and licensed to use the system. It can be viewed in acute, community and hospice settings with automated notifications sent to ambulance and out-of-hours services. Key challenges have included the need for continuous collaboration between all providers; clinical/IT leads learning to speak a common language; interoperability between 10 clinical IT systems; need for culture change across the entire health economy.

Conclusions The journey through engagement, scoping, development and communication has been challenging with many obstacles to overcome along the way. Throughout, the patient has been kept at the centre with passionate clinical leadership and perseverance over years. Ongoing sustainability is being

supported through engagement of local clinical champions, CCG funding incentives for GPs, shared resources, training and video learning.

114 WHERE CHILDREN DIE; A RETROSPECTIVE COHORT STUDY OF CHILD DEATH OVERVIEW PANEL (CDOP) DATA

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Aims There is a statutory requirement to review all child deaths as part of the safeguarding children guidance. The aim of this cohort study is to collate and evaluate child death data from all Child Death Overview Panels within the Yorkshire and Humber region to inform strategic planning, justify funding, and ultimately improve the care provided to children.

Methods Retrospective cohort study. Data audited from all 14 CDOPs in the region. Descriptive analysis performed using SPSS. The dataset included: 3 full years of CDOP data (2013/2014 – 2015/16), all child deaths (expected and unexpected), age (0–17 inclusive), gender, ethnicity, partial postcode, place of death and category of death following review. Ethical approval not required as audit and no patient identifiable data collected. Missing data excluded from analysis on a pairwise basis.

Results Over the study period there were 1221 deaths, with an average mortality rate of 407 deaths pa (total child population=1.1 million, 3.5 deaths/10000 children). The major causes of death were perinatal/neonatal events, and chromosomal, genetic and congenital anomalies; Combined these account for 60% (n=712/1183) of the dataset. 'Expected' deaths accounted for 64% (n=730/1149) of all child deaths. Place of death for expected deaths=Hospital deaths: 77% (n=564) Home: 9% (n=67), Hospice: 13% (n=91). When ethnicity data analysed for place of death (excluding neonatal and unexpected deaths), a greater proportion of white British children (n=201) died at home (16%, n=33) or within a hospice (23%, n=47) when compared to Asian children (Home: 12%, n=14; Hospice: 9%, n=10); Chi-squared 15.07, p=0.002.

Conclusions

- Place of Death (POD) key quality indicator for EOL care. Limited evidence preferred POD in paediatrics.
- Ethnicity appears to affects POD.
- Oncology patients are more likely than children dying from other causes to die at home. This is likely due to the provision of POON services.

115 EXPERIENCE OF USING INTRAVENOUS ANTIBIOTICS IN AN INPATIENT HOSPICE UNIT

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Background The rationale for initiating intravenous antibiotics is variable (symptom control vs life prolongation). There is limited data to show efficacy. Not all hospice inpatient units

(IPUs) offer intravenous therapy, and this may influence decisions to admit, particularly in the non-malignant patient group. Following staff training, intravenous antibiotics have been available in our IPU since February 2018. This audit aimed to review their use.

Method A retrospective review of notes and drug charts was conducted for patients admitted between February and May 2018. Data was collected on compliance with local guidelines, overall outcome and counselling prior to initiating therapy.

Results Over four months, 11 courses of intravenous antibiotics were administered to 9 patients. 7 of 9 patients subsequently died in the IPU, with an average interval of 7 days between completion of the intravenous antibiotic course and death. One patient died of sepsis shortly after discharge and the other died at home several months later. The justification for intravenous antibiotics was clearly documented in 8 of 9 patients (89%). The switch to oral antibiotics appeared to be appropriate and justified in all cases (100%). The average course length was 3 days. Prior to starting intravenous antibiotics, discussion with the patient and/or families occurred in every case except one.

Conclusions The review demonstrated intravenous antibiotics frequently being administered to patients in their last week of life, leading the team to review the appropriateness of their use. However, treatment frequently supported patients' preferences regarding place of death; avoidance of hospital transfer; wish to receive active treatment; and likely prolongation of survival in one case. Decisions to prescribe were justified and balanced, in conjunction with patients and their families wishes. We should continue to consider effectiveness alongside potential for harm, together with managing the challenges associated with intravenous therapy.

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BUILDING STANDARDS BASED ON THE AMBITIONS FRAMEWORK INTO WARD ACCREDITATIONS TO HELP ASSESS THE DELIVERY OF PALLIATIVE AND END OF LIFE CARE

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Background The ward accreditation process measures standards underpinned by the trusts Values and Behavioural Framework, Improving Quality Programme and the Nursing and Midwifery Strategy. The Supportive and Palliative Care Team have developed standards based on the national Ambitions Framework to be included in this process to assess and promote the delivery of high quality palliative and end of life care (PEOLC).

Methods The standards were used across 5 divisions, including critical care. Nursing staff were interviewed using these standards and a 'RAG' rating system applied to analyse responses. The standards incorporated defined action plans for each division to complete.

Results Common themes emerged from all clinical areas

Identified Gaps in Practice:

- Staff members not involved in audit and monitoring of PEOLC on their ward.
- Clinical support staff not writing in the individualised plan of care for a dying adult.

- Senior staff unable to provide evidence of the number of staff who have undergone an annual reassessment in their competence to use a T34 syringe driver as per the strategy.

Good practice identified:

- Staff can describe efforts required to improve the care environment for patients and carers.
- Wards have EOLC champions named on the EOLC board.
- Staff can describe how to access religious and spiritual support 24/7.

Conclusions Acute trusts are important providers of PEOLC and it is vital that generalist ward staff are equipped with the right skills to be able to deliver excellent care. These standards provide a systematic structure within the accreditation process to assess this care and then further develop structured training and education programmes tailored to meet specific needs of ward staff. Further work is required in developing a more robust system of measurable outcomes using the standards which will strengthen our audit data and commitment to improving PEOLC practice across our generic nursing workforce.

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PALLIATIVE CARE IN THE EMERGENCY DEPARTMENT: CAN MORE BE DONE TO PREVENT ACUTE HOSPITAL ADMISSIONS?

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10.1136/bmjspcare-2019-ASP.140

Background It is becoming increasingly recognised among healthcare professionals that for patients approaching the end of life, a busy Emergency Department (ED) or acute hospital ward is an unsuitable environment to meet their needs.

Methods A retrospective data analysis of patients (n=131) with a known palliative diagnosis who were admitted to hospital via the ED in January 2018. Data was gathered through use of online patient records and hospital notes.

Results In January 2018, 3% of all admissions via the ED were patients with known palliative diagnoses. On arrival in the ED, less than 1 in 4 were known to the community palliative care team, and 35% had a DNACPR form. 67% attended outside normal working hours. For 83% it was felt that ED attendance could have been avoided if more community support had been in place or if an appropriate service had been contacted.

More than half (60%) of patients died in hospital this admission. Of the 53 patients who survived this admission and were discharged; 83% had a DNACPR form in place, 40% had an Emergency Healthcare Plan, and 38% of those not known to the community palliative care team were referred on discharge.

The majority (84%) of patients with an existing palliative diagnosis who were admitted via the ED did so in the last 100 days of life.

Conclusions This study highlights the importance of implementing advance care planning both in and out of hospital, and prioritising time with patients to discuss values, anxieties, anticipated emergencies, resuscitation and death. This would not only reduce futile treatments and deaths in hospital for palliative patients, but ensure that their preferences are respected and their needs are appropriately met when they are at their most vulnerable.