(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 patent 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.

116 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.

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

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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.

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