Following these changes, we looked at the deaths in June 2019. 55 patients died. 33 (60%) patients had a discharge summary completed. 100% of patients who died on the ward with the 'Bereavement Box' had a discharge summary.

With these interventions, there was a 100% increase in discharge summaries being completed. However, there are still further improvements to be made. We plan to roll the 'Bereavement boxes' out to all wards, make an automatically generated notification sent to the GP upon a patient's death and roll out Medical Examiners within the Trust. We hope that these further interventions will ensure that all patients will have discharge summaries completed and there will be improved continuity of care.

REFERENCES

1. Murphy SF, Lenihan L, Orefuwa F, Colohan G, Hynes I, Collins CG. Electronic discharge summary and prescription: improving communication between hospital and primary care. *Ir J Med Sci* 2017 May; **186**(2):455–459. doi: 10.1007/s11845-016-1397-7. Epub 2016 Jan 25.

11 CHART REVIEWS OF PALLIATIVE CARE DAY SERVICES: SIGNALLING THE START OF SOMETHING NEW

¹George Kernohan, ¹Sonja Mcllpatrick, ¹Felicity Hasson, ²Joanne Jordan, ³Kevin Brazil, ³Lisa Graham-Wisener, ³Noleen McCorry, ⁴Anne Finucane, ⁵Shazia Zafar, ⁵Alistair Hewison. ¹Ulster University, UK; ²Open University, UK; ³Queen's University of Belfast, UK; ⁴Marie Curie, UK; ⁵University of Birmingham, UK

10.1136/spcare-2019-mariecuriepalativecare.11

The number of people requiring palliative care is increasing sharply (Etkind et al., 2017). Forty per cent more people will need palliative care by 2040. Recommendations are that palliative care should be initiated at diagnosis, even concurrently with curative treatment (Guo et al., 2012). In response, Palliative Care Day Services are designed to support people during assessment and treatment through the provision of regular outpatient attendance at specialist centres to deliver out-patient services so that patients can remain at home. Such interventions have been found to be effective (Stevens, Martin & White, 2011), however the evidence is limited. To inform further development, we undertook retrospective chart reviews at three Marie Curie centres: reviewing the records of people attending for the first time in 2015.

We found that services were accessed mainly by older people with a primary diagnosis of cancer; referrals came mostly from: hospitals, other palliative care services or a GP; and people typically attended weekly for 6 or 12 weeks. In 82 cases, we found people had their physical (331), psychological (55), social (46) and spiritual (14) needs addressed. Day Services were provided by nurses, doctors and therapists. Patients had their medication regime reviewed and equipment was 'prescribed' as necessary. In a third of cases, support was also offered to a family member. About half of patients were helped to develop an advance care plan and almost 300 referrals were made to other health and social care services.

Day Services can provide specialist palliative care outside the inpatient unit to help address specific, pre-identified health and social care needs. The effectiveness of such services requires further investigation and chart reviews can be useful in contributing to such evaluations.

12 OPIOIDS IN PALLIATIVE CARE: INITIATING DRUG TREATMENT

Charlotte Mann. *Lewisham and Greenwich NHS Trust, UK*

10.1136/spcare-2019-mariecuriepalativecare.12

Background A large proportion of the UK population have been diagnosed with progressive, chronic diseases resulting in pain. Potentially requiring strong opioids which are often prescribed in primary care (National Collaborating Centre for Cancer, 2012). Concerns about adverse effects, confusion about which opioid to prescribe and the wide array of available options may result in undertreated pain or increased risk of adverse effects (National Collaborating Centre for Cancer, 2012). The National Collaborating Centre for Cancer has developed guidelines for NICE to clarify the pathway for initiation of strong opioids in palliative care patients.

Aims To identify all patients in the practice population with progressive disease, specifically: Cancer, CKD 3/4, Heart Failure, Liver Failure, COPD who were initiated on a strong opioid and to investigate if prescribing practice and management was compliant with NICE guidance.

Method Standards based audit undertaken in a London General Practice. Data collection by foundation year 2 doctor. EMIS searches by practice IT manager with retrospective identification of patients coded as chronic kidney disease, COPD, heart failure, liver failure, cancer and initiated on a strong opioid before or on 31.12.2017, review of consultation notes to identify prescribing practice and referral if appropriate. Comparison against standards outlined in NICE 'Clinical audit tool : initiating drug treatment' and data collection sheet, data input into Microsoft Excel.

Results 33 patients identified for inclusion. 48% patients initiated appropriate initial strong opioid. Only 13% of patients with renal or hepatic failure were discussed with a specialist, 10% of patients were prescribed immediate release oral morphine for breakthrough pain and 21% of patients were prescribed laxatives.

Conclusions This audit has identified discrepancies between prescribing and referral practice and the guidelines, which could result in poor patient management and risk of adverse effects. The findings of this audit were presented in a practice meeting accompanied by teaching and distribution of the guidelines. A re-audit is due to be undertaken in 2020.

13 'WE CAN DO SO MUCH MORE': RECOGNISING THE NEEDS OF PEOPLE WITH DEMENTIA IN PALLIATIVE CARE

Monica Reardon. *Marie Curie, UK*

10.1136/spcare-2019-mariecuriepalativecare.13

With dementia on the rise, palliative care services are increasingly supporting people with dementia, as a primary or secondary diagnosis. Care provision can be challenging for palliative care staff who may have limited experience and knowledge of supporting people with dementia.

A survey assessed the confidence and competence in supporting people with dementia for healthcare staff in inpatient and community palliative care services. Only 10% of hospice staff had received any formal dementia training. Based on

areas of need identified, we worked with a training provider to develop a bespoke training course on supporting people with dementia in palliative care. The course was delivered to 41 staff within a hospice, and the impact assessed. Prior to training, 30% of staff reported they were 'not at all confident' in caring for people with dementia. Post-training all staff reported feeling 'fairly' or 'very' confident. Staff reported that the training:

- Helped them recognise dementia as a terminal condition and how palliative care can support people with dementia
- Improved understanding of 'challenging' behaviours and managing these
- Taught them enabling approaches to care provision which they felt would improve their practice.

Staff trainers across both settings are integrating this into core curriculum. The positive response represents a culture change. Staff better understand the value of palliative care for people with dementia and are motivated to explore how care practices can be improved for people with dementia. The organisation recognises this work as best practice and are exploring its potential as a national training standard.

14 STARTING A COLLABORATIVE RESEARCH IMPACT ASSESSMENT: A TALE OF TWO RESEARCH FUNDERS

¹Kay Lakin, ²Sanjay Thakrar, ¹Claire Vaughan, ²Sabine Best, ²Laura Chatland, ¹Adam Lockwood, ¹Howard Simons, ¹Sarah Thomas, ¹Sam Watson, ³Sam Ahmedzai, ³Shamaila Anwar. ¹National Institute for Health Research, UK; ²Marie Curie, UK; ³National Institute for Health Research Clinical Research Network

10.1136/spcare-2019-mariecuriepalliativecare.14

The National Institute for Health Research (NIHR) and Marie Curie are the two largest funders of end of life care research in the UK. NIHR and Marie Curie enable and support research at different times of the translational pathway, or by co-funding research. Undertaking a research impact assessment (RIA) on our combined investment is important to make the case for continued investment research and to be accountable to our stakeholders (Morgan Jones and Grant, 2013). RIA is a developing field (Adam et al., 2018). To ensure our approach is relevant, we have involved people with experience of end of life care. We hope that by undertaking this process together, we will gain a better understanding of the research funding landscape and its interdependencies in this area, identify gaps and opportunities, and learn from and support each other. We believe that our project marks the first time that a collaborative RIA of this kind has been undertaken by research funders. We hope that by exchanging, reflecting and sharing our experiences, lessons learned and approach, it will aid discussion, promote shared learning and transparency around funders' impact assessment processes and may help future collaborative projects. Our learning so far:

- Appropriate oversight, governance and data sharing is a must
- Identify organisational risks up front
- Review organisational factors including resource which may impact on capacity to deliver
- Use of similar tools for data collection enables joint analysis and efficient of data
- collection

- A clear and shared understanding of the project scope is important

15 A 'GOOD' DEATH IN THE EMERGENCY DEPARTMENT? IDENTIFYING PATIENTS NEARING THE END OF LIFE IN THE ED

Renate Fromson. *The Whittington Hospital, Whittington Health NHS, London, UK*

10.1136/spcare-2019-mariecuriepalliativecare.15

An important aspect of end of life (EOL) care is identifying patients entering this stage, thus enabling clinicians to make plans and referrals. Despite many patients wishing to die at home, a significant proportion will attend the ED. Hence it is important that ED doctors identify and support these individuals. Given the nature of work in ED, this is challenging. The Supportive and Palliative Care Indicators Tool (SPICTM) can help with patient identification.

A sample of 30 patients aged ≥ 60 attending the Whittington Hospital ED were assessed using the SPICTM criteria. For patients who met EOL criteria, it was documented what action was taken, including Advanced Care Planning, DNACPR, referral to Palliative Care or discussion about preferred place of care and of death.

10 met the criteria. Action was taken in 40% of these, most commonly Advanced Care Planning and DNACPR discussion. Use of the SPICTM, in poster or app format, could help ED doctors to identify EOL patients, thus prompting them to take action.

Further ways to improve the identification of EOL patients in the ED include use of tools such as the 3 triggers outlined by the GSF Prognostic Indicator Guide for GPs. Other ideas include an alert system to flag patients known to Palliative Care. Rapid discharge pathways for patients who wish to die at home is also an important initiative which relies on rapid identification and close working with community teams.

16 IMPROVING CARE FOR PEOPLE LIVING AND DYING WITH DEMENTIA THROUGH ADVANCE CARE PLANNING

Julie Skelton. *Marie Curie Cardiff and The Vale Hospice, Cardiff, UK*

10.1136/spcare-2019-mariecuriepalliativecare.16

The number of people living and dying with dementia is forecast to increase by 270% over the next 20 years. Current practices to encourage advance care planning do not meet the needs of people with a dementia diagnosis as they don't engage people early enough in the dementia journey.

We undertook a literature review of international evaluated models of ACP for people with dementia, focusing on its impact on care received, and mapped existing provision across a rural health board area. The work was facilitated by interviews with health and social care professionals (n=50), focus groups and interviews with people living with dementia and carers (n=17).

Our findings

- ACP is an intervention which can reduce unnecessary hospital admissions and healthcare costs, without negatively impacting