cycle was conducted after introducing the Cirrhosis care bundle.

Results

Astracts PTH-110 Table 1 Compliance with quality standards before and after introduction of Cirrhosis Care Bundle

No.	Quality Care Standards (Based on BSG guidelines)	Before (first audit cycle Nov – Dec 2016)	After (second audit cycle Mar – April 2017)
2.	Baseline investigations	100%	100%
3.	Blood culture if sepsis or SBP* suspected	100%	0%
4.	Ascitic tap	25%	50%
5.	Ultrasound abdomen ordered within 24 hour	55%	50%
6.	Alcohol history recorded	83%	77%
7.	CIWA completed	75%	88%
8.	Pabrinex given	75%	81%
9.	Broad spectrum antibiotics given in SBP	100%	100%
10.	IV Albumin given in SBP	0%	50%
11.	Fluid resuscitation in AKI	40%	0%
12.	Diuretics ad nephrotoxic drugs stopped in AKI	100%	100%
13.	Transfused if Hb<7 g/dL in a suspected or actual GI bleed	100%	100%
14.	Coagulopathy corrected in a suspected/actual GI bleed	100%	100%
15.	Referred for early endoscopy in a suspected/actual GI bleed	75%	100%
16.	Given Terlipressin in a suspected/actual GI bleed	0%	71%
17.	Given antibiotics prophylaxis in a suspected/actual GI bleed	0%	30%
18.	Lactulose or enema given in hepatic encephalopathy	71%	100%
19.	Dalteparin given in no contraindications	42%	50%

*SBP=spontaneous bacterial peritonitis

Conclusions After formally adopting the Cirrhosis care bundle, we have seen an improvement in the frequency of ascitic taps performed, treatment of spontaneous bacterial peritonitis, prescription of VTE prophylaxis and hepatic encephalopathy. Our targets have certainly approved but not enough to meet quality standards. It was decided to conduct third cycle to improve our targets. We decided to educate doctors in A and E because patients spend more time there before being transferred to MAU due to pressures on NHS. The teaching involved identifying patients presenting with signs and symptoms of decompensated liver disease and education about the cirrhosis care bundle, its importance. Third cycle is in progress and showing promising Results.

PTH-111 IMPROVING END OF LIFE CARE FOR PATIENTS WITH LIVER DISEASE

¹Sam Thomson*, ²Kim Batchelor, ¹Stephen Kriese, ²Suzanne Ford-Dunn. ¹Western Sussex Hospitals NHS Foundation Trust, Worthing, UK; ²St Barnabas House Hospice, Worthing, UK

10.1136/gutjnl-2018-BSGAbstracts.267

Introduction Liver disease is the 5th commonest cause of death in the UK and the only major cause of death still increasing. National data show that 73% of deaths occur in hospital and few patients are referred to palliative care services (PC) despite complex symptoms and psychosocial needs. Although preferred place of death for patients with end stage liver disease (ESLD) is unknown, studies of other diagnoses show the majority of patients prefer to die at home, rather than hospital. We aimed to increase access to PC for patients with ESLD and to ascertain preferred place of death.

Methods We commenced a monthly ESLD MDT, comprising Hepatology and PC Consultants, community ESLD Clinical Nurse Specialist (CNS), Alcohol CNS, Social Worker and hospital PC CNS. Patients were identified as outpatients and inpatients and referred to the MDT for discussion. The MDT reviewed patient needs, coordinated care and initiated referrals to additional community services and ESLD CNS. Patients referred to the ESLD CNS received holistic assessment with advanced care planning and contingency plans for future acute decompensation events.

Results In the first 12 months of the new MDT there were 43 deaths with ESLD in our locality, 60% in hospital, 37% in community (home/hospice); contrasting to 73% and 26% nationally. 79% of all patients were known to PC at the time of death. Of 22 patients that expressed a preference for place of death, 11 chose home and 11 hospice; none preferred to die in hospital. Of 22 patients under the ESLD CNS in the community, 73% died out of hospital (7 home, 9 hospice). 68% of patients under the ESLD CNS died in their preferred place of care. Of 26 who died in hospital 30% died on the acute medical unit, HDU or ITU, 30% on the Gastroenterology ward and the remainder (40%) on outlying wards.

Conclusions Most patients with ESLD prefer to die out of hospital, consistent with other terminal illnesses. Although ESLD patients present a challenging symptom burden it appears that an MDT approach including a dedicated CNS can help increase referrals to PC, and help more patients die in their preferred place. However, a third of those dying in hospital did so in an acute environment or while receiving intensive care and therefore were unlikely to have received adequate PC. A notable number also died on non-specialist outlying wards which may imply they too did not receive wholly integrated specialist or PC during their terminal phase.

Although the preliminary Results of our local intervention are promising, we recognise that more can still be done and encourage a continued focus on improving end of life support and care planning for patients with ESLD.

PTH-112 INVESTIGATION UPDATE: A CLUSTER OF GENOTYPE A2 'PRISONER VARIANT' ACUTE HEPATITIS B INFECTION

^{1,2}Sebastian Wallace*, ²Nicholas Young, ²Samreen Ijaz, ²Sema Mandal. ¹Royal Cornwall Hospital, Truro, UK; ²Public Health England, London, UK

10.1136/gutjnl-2018-BSGAbstracts.268

Introduction Between April 2012 and May 2015, a cluster of acute Hepatitis B virus (HBV) infection was investigated by Public Health England (PHE) in Southwest England. Compared nationally, it was observed that cases were above the average age, all male and did not belong to typical 'high-risk' groups; with a majority reporting no risk-factors for HBV exposure. It was hypothesised that these cases were