tools, they are inappropriate for PICUs. We devised an Agreed Limitation of Treatment Form (ALT) for professionals caring for children for whom a decision has been made to withdraw or withhold life-sustaining treatment. We have been using it for 5 years. Recent changes to national guidance have prompted us to review our practice.

**Aims**
To evaluate our Limitation of Treatment process by reviewing our current practice, comparing it to professional guidance and to practice in other PICUs.

**Method**
We compared children for whom an ALT had been completed to children who died without an ALT.

We reviewed each ALT form and the entries in the medical notes.

We obtained the opinions of staff on our PICU.

We reviewed practice in our PICU against the recent changes to professional guidance from the Royal College of Paediatrics and Child Health and the General Medical Council.

We surveyed practice in other units.

**Results**
There were pre-existing severe or life-limiting conditions in 85% of patients with an ALT compared with 46% of those who died without an ALT.

13 out of 16 ALT forms were either not fully completed or not consistent with entries in patient notes.

Nursing and medical staff found the form to be useful as a communication tool but requested some changes to the wording and layout of the form.

Our practice is in line with National Guidance.

There is no uniformity among the different PICUs and only a few use forms.

**Conclusion**
We found the Limitation of Treatment forms very useful and consistent with the professional guidance but the quality of documentation needed to be improved. We have made changes to our practice and would suggest that a similar document would be beneficial for all PICUs.

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**END OF LIFE CARE IN HOSPITAL. SCOPE FOR PAEDIATRIC PALLIATIVE CARE INVOLVEMENT?**

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**Background**
End of life care in the setting of choice is important in palliative care. The majority of children die in hospital intensive care where end of life frequently involves withholding/withdrawing life sustaining treatment: many have conditions that may benefit from palliative care. We hypothesised children were dying without specific palliative care support despite a well established paediatric palliative care team and that a proportion of children would be suitable for rapid discharge to the setting of choice for end of life care.

**Method**
Casenotes for inpatient deaths from January to December 2013 were reviewed to identify: children with a life limiting condition, whether the end of life occurred following planned withholding/withdrawing of life sustaining treatment and if so whether the child was stable enough to be transferred to an alternative care setting for end of life care.

**Result**
62 children (31 male) died. Median age at death was 10 ½ months (Q1 6 weeks, Q3 2 years 8 months). Primary diagnoses were cardiac 40%, general paediatrics/neonates 19%, oncology 14%, neurology 11%, congenital malformations 11%. 85% children had life threatening conditions. 58% children died following planned withholding/withdrawing of whom 39% (N = 14) were stable enough to transfer to an alternative setting for end of life care. Median interval between withholding/withdrawing and death was 30 min but 27 h (Q1 = 4 h, Q3 = 132 h) for those stable enough to move. All 15% (N = 8) children with life limiting conditions known to the palliative care team, but no other children had documented discussion of preferred place of care. Preferred place of care was hospital for 6 and home for 2 of whom both were stable enough to move but not notified to palliative care team until after death.

**Conclusion**
Approximately 22% children dying in our institution would have been suitable for rapid discharge, living median of 27 h following transfer to their setting of choice.