Results Questionnaire response rate: 69/487=14%. Sudden, unexpected deaths: 33/69=48%.

Sudden deaths communicated in face-to-face meetings: 28/33=85%. By telephone: 5/33=15%.

Location of disclosure: at bedside 22/28=79%, private room 6/28=21%. Communication by: consultant 18/33=55%; nurses 8/33=24%; trainee doctor 1/33=3%; others 6/33=18%.

Communication empathetic and caring 33/33=100%. Time of disclosure: immediately on arrival 17/33=52%; within 30 minutes 7/33=21%; within 1 hour 2/33=6%; within 1–2 hours 2/33=6%; > 2 hours after arrival 2/33=6% and present at death 3/33=9%. Full explanation of the cause of death offered 32/33=97%. Sufficient time for questions 32/33=97%. Allowed to view deceased: 32/33=97%.

Explanation for referral to Coroner: 14/21=67%. Religious and cultural observances facilitated: 16/33=48%. Organ and tissue donation discussed 7/33=21%.

Conclusion In general, the process of disclosing unexpected hospital deaths to relatives is done well. Improvements could be made by expediting family meetings, prioritising privacy, discussing tissue donation and facilitating religious and cultural observances. A national guideline would be useful.

49 UNDERSTANDING CURRENT PRACTICE IN PRESCRIBING AND USING ANTICIPATORY MEDICINES AT THE END OF LIFE

Ben Bowers, Kristian Pollock, Stephen Barclay. *University of Cambridge, University of Nottingham*

10.1136/spcare-2020-PCC.70

Background Anticipatory medications (AMs) are injectable drugs prescribed to a named patient, ahead of likely clinical need, for administration by visiting General Practitioners (GPs) and Community Nurses if symptoms arise in the final days of life. While the prescribing of AMs is recommended best practice in the UK, little is known about how they are used in primary care.

Aim To investigate primary care practice in issuing and using AMs for patients approaching the end of life.

Methods Retrospective review of the GP and Community Nursing records of 240 sequential patient deaths in eight GP practices in two UK counties (30 deaths per practice). Analysis used descriptive statistics and constant comparison between patient cases.

Results 132/240 (55%) of deceased patients were issued AMs, between 695 and 0 days before death (median 17 days across all eight practices, range of median 38 days to 6 days in individual GP practices). AMs were often issued alongside completion of a DNACPR form: documented discussions centred on patients expressing preferences to stay at home and avoid hospital admission.

79/132 (60%) of the patients issued AMs went on to have them administered, almost exclusively by Community Nurses. Drugs were first used between 586 and 0 days before death (median 3 days). AMs were typically used when patients were identified as dying and unable to swallow oral medications. However, for 10/79 (13%) of patient where AMs were used, they were started more than 2 months before death for reversible conditions and/or not at the end of life.

Conclusions The issuing and use of AMs were commonplace in all the GP practices, with considerable variation in timing between GP practices and community nursing teams. The findings highlight the challenges in diagnosing dying and the risks involved in prescribing AMs far in advance of likely need.

50 SYSTEMATIC REVIEW LOOKING AT HOW EFFECTIVE CLINICIANS ARE AT PROGNOSTICATION AT THE END OF LIFE – TEMPORAL AND PROBABILISTIC

C Campion, J Grant, N Shah, J Riley, J Droney. *Royal Marsden NHS Trust – Coordinate my Care*

10.1136/spcare-2020-PCC.71

Background Clinician's estimation of patient survival can influence decisions regarding treatment, enable patients to make plans, improve quality of life and increase meeting preferred place of care and death. The two survival predictors frequently used are temporal and probabilistic. Temporal-the patient is predicted to live a certain amount of time, probabilistic-the chance of a person surviving to a certain time.

Aims Describe the published evidence, relating to the effectiveness and accuracy of clinicians at predicting clinical survival in patients with cancer and non-cancer.

Methodology The databases Embase, Cinahl, Medline and Emcare were searched using the terms 'prognosis', 'prognostication', 'surprise question' and 'advanced care planning'. Duplicates were removed. 127 papers were identified, 40 papers were selected as relevant to clinical effectiveness of prognostication at end of life. Literature was reviewed using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses principles.

Results Clinicians are overly optimistic in their estimated survival predictions (studies found by at least 50%). Recent systematic reviews of clinician's survival predictions suggest that they were correct in only 25% of cancer patients by within a week. This accuracy of predictions increased to 70% when patients were in the last days to weeks of life. Predictions utilizing probabilistic measures over the temporal approach have been found to be significantly more accurate. A large meta-analysis looking at the accuracy of the 'surprise question' and outcomes in 22 studies showed that 75% of clinicians accurately predicted if a patient would die within 12 months.

Conclusion Clinician's prognostication predictions are complex and evidence shows that clinicians are often over optimistic in their estimated survival predictions. Clinicians are significantly more accurate in prognosticating survival with use of probabilistic measures than temporal approach.

51 REHABILITATIVE PALLIATIVE CARE AS A HEALTH PROMOTING APPROACH: A PARTICIPATORY ACTION RESEARCH STUDY

Karen L Clarke. *St Michael's Hospice*

10.1136/spcare-2020-PCC.72

Background Health promoting palliative care (HPPC) considers dying and death as a social phenomenon where communities play an integral role. The dominant interpretation of HPPC in the UK has been through community engagement activities

but there is a disconnect between this and the support provided in the hospice in-patient setting.

Aim To assess whether rehabilitative palliative care (RPC) enables HPPC to be integrated in the in-patient setting.

Method Using participatory action research, a co-operative inquiry group planned how to integrate RPC in a UK Hospice in-patient unit paying attention to the facilitators and barriers.

The findings from this study and the literature were examined to identify the alignment and dissonance between HPPC and RPC.

Results A post intervention review indicated that RPC had been implemented, but there was conflict, also identified in the literature, between a model perceived to be focused on caring (palliative), and one based on enabling (rehabilitation).

Factors demonstrating the similarities between HPPC and RPC were presented:

- democracy, empowerment and participation were underpinning principles
- focused on enablement, control, choice and independence where self-esteem, self-determination and self-reliance co-existed with high levels of physical dependence
- participatory models with an emphasis on social interaction
- encouraged health care professionals to relinquish an expert-led approach to enable patients to become active participants in their care
- interdisciplinary – involving all health and social care professionals, patients, families, communities and volunteers.

Claims challenging whether RPC could be considered as HPPC, e.g. lack of community involvement, a failure to address death education, RPC was death denying and perpetuated a clinical model of death and dying were discussed and alternative perspectives presented.

Conclusion Despite its close associations with community initiatives, the principles of HPPC can be integrated in a hospice in-patient setting using RPC.

52 DOCUMENTATION OF RESUSCITATION DISCUSSIONS IN 2013 AND 2015: PRE AND POST TRACEY JUDGEMENT – A NATIONAL AUDIT OF PRACTICE

Hazel Coop, Charlotte Chamberlain, Nikhil Sanyal, Alistair Duncan, Felicity Dewhurst, on behalf of UK PRC. *UK Palliative Trainee Research Collaborative (UK_PRC)*

10.1136/spcare-2020-PCC.73

Background In 2014 the Tracey judgement resulted in amended Resuscitation Council guidance, recommending that patients and relatives should be involved in resuscitation discussions unless it would cause harm. This project aimed to examine whether improved hospice resuscitation discussion documentation between 2013 and 2015 found regionally by the West Midlands palliative trainee collaborative (WM CARES) was evident in hospice and hospital settings across the United Kingdom.

Methods National resuscitation standards in 2013 and 2015 from the UK Resuscitation Council were identified. Data collectors were recruited by the UK Palliative trainee Research Collaborative (UK PRC). Do not attempt resuscitation decision (DNACPR) documentation was sought for 30 deaths in 2013

and 30 deaths in 2015 from each participating hospice and hospital. An excel database was used for data collection and analysis.

Results Data for 805 patients across 17 sites (5 hospitals and 12 hospices) in England and Wales were collected. 2013 data were missing from one site and 130 patients were excluded as did not meet audit criteria. 40% (157) of patients had documented resuscitation discussions in 2013 compared to 60% (271) in 2015. More documented DNACPR discussions occurred with patients in hospices (57%, 330) compared with patients in hospital (42%, 98). However, relatives in hospital settings (73%, 168) were more likely to be documented as involved in discussions compared with relatives in hospice settings (58%, 334). The most common reasons cited for not discussing DNACPR with patients (2013 and 2015) were: lack of capacity or advanced illness. 20% (171) did not document a reason for no resuscitation discussion, but this was 75% less (120 to 30) in 2015 compared with 2013.

Conclusions DNACPR discussions appear to be happening more frequently in 2015, compared with 2013, but there is clearly room for improvement in hospices and hospitals.

53 A CLINICAL AUDIT TO EVALUATE HOW DNACPR DECISIONS ARE SHARED ON DISCHARGE FROM TY OLWEN – A SPECIALIST PALLIATIVE CARE UNIT IN WALES

Alice Crabtree, Jessica Gutjahr, Edward Presswood. *NHS*

10.1136/spcare-2020-PCC.74

Background The ‘Sharing and Involving’ Clinical Policy for Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) for Adults in Wales sets standards for how DNACPR decisions are documented and shared. The aim was to find out if Ty Olwen, a 14 bed Inpatient Palliative Care Unit in South Wales, meets the specified standards.

Method In October 2016, a new DNACPR discharge checklist was created to improve practice and enable collection of prospective data for this audit. Data collection took place in December 2018, of all discharged between October 2016 and November 2018. Following an education intervention, the audit data collection was repeated in August 2019 for discharges between January 2019 and July 2019. Compliance with each standard was calculated as a percentage.

Results Between October 2016 and November 2018, 64 patients were discharged from Ty Olwen. There were 58 completed checklists during this period. 93% of DNACPR forms were signed or countersigned by a senior responsible clinician. 90% of patients were given a copy of the DNACPR form prior to discharge. 86% of DNACPR forms were forwarded to the patient's GP. The audit data and our recommendations were presented at the Ty Olwen clinical governance meeting. Re-audit in August 2019 showed limited improvement to these figures.

Conclusion Ty Olwen is not fully compliant with the policy standards. Other hospices and inpatient units in Wales, and across the UK, may face similar challenges. This audit, and the resulting recommendations, should be considered by palliative care teams throughout Wales to measure and improve compliance with the national policy.