

Method Databases including conference abstracts and grey literature were searched using pre-defined terms. Screening of title and abstract, followed by full text review against inclusion criteria. Two reviewers extracted data from included studies and assessed Hayden risk of bias. Findings were subjected to narrative synthesis as meta-analysis was not possible.

Results 29306 records were screened resulting in 37 included studies. There was a plethora of prognostic variables studied, including demographic, laboratory, electrocardiography, echocardiogram and clinical variables as well as studies that developed models from multiple variables. The primary variables were often only studied once, but even for the few that were investigated more than once, were adjusted for by different covariates and so could not be combined.

Conclusions This systematic review failed to find clinically useful prognostic variables to identify patients in the last year of life. Although we identified a variety of proposed prognostic variables, these were explored in a single or in only a few studies, often in restricted populations meaning they cannot be generalised. Identifying good predictors of this phase of life is useful to facilitate advance care planning. Future prognostication research should concentrate on variables measured over time and studying real life populations more representative of patients with advanced heart failure and comorbidity.

64 IMPROVING COMPLETION RATES OF DISCHARGE SUMMARIES FOR PATIENTS THAT DIE DURING THEIR ADMISSION TO HOSPITAL

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Introduction All patients admitted to hospital should have a discharge summary completed, including those that die during their admission. This ensures good continuity of care between secondary and primary care and allows for Bereavement support to be offered. We looked at the current level of discharge summaries being completed for these patients, and the quality of information provided.

Methods We initially identified patients who died between November and December 2018. 114 patients died. Only 35 (31%) patients had a discharge summary completed. A survey of doctors highlighted confusion about what documentation was required, they felt that they are often too busy to do summaries and see deceased patients as a 'lesser priority'.

A project was conducted to highlight the importance of these summaries and to improve the quantity and quality of them. This included presenting our initial data at Grand Round, the Junior Doctor Forum and piloting a 'Bereavement Box' on one of the elderly care wards. This was used in morning board rounds to highlight summaries that needed to be done, but also as an opportunity to debrief and learn from deaths.

Results 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.

Conclusions 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 out 'Bereavement boxes' to all wards, make an automatic notification sent to the GP upon a patient's death and introduce Medical Examiners within the Trust. We hope that these interventions will ensure that all patients will have discharge summaries completed and there will be improved continuity of end of life care.

65 THE CHALLENGE OF DE-ESCALATING CARE; TRANSFER FROM ICU TO A WARD SETTING FOR END OF LIFE CARE

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Background The Palliative Care Team (PCT) in an acute hospital are referred patients from the regional Intensive Care Unit (ICU) who have had withdrawal of active treatment and are being discharged to a ward for end of life care (EOLC). Transfer between teams and wards is a challenging time. ICU patients are often on intravenous (IV) infusions of drugs which require conversion to the subcutaneous (SC) route.

Aim The aim of this review is to assess the care pathway and symptom control of patients in ICU who are recognized to be dying, who are being transferred from ICU to a ward for EOLC.

Methods Retrospective audit. PCT database was searched over a 12 month period to identify patients. Literature search and data collection completed.

Results 9 patients were eligible for inclusion. 3 patients were referred to PCT but not seen as they died on day of referral. All patients with PCT input in ICU had a continuous subcutaneous infusion (CSCI) commenced prior to discharge, and were well symptom controlled for remainder of admission. One patient was identified as having uncontrolled symptoms; they had been discharged from ICU on a weekend and had no PCT input. 3 patients had IV infusions of opioid and/or midazolam converted to CSCI with a 40–50% dose reduction which maintained symptom control.

Conclusions This review highlights that early PCT input into ICU discharges for EOLC facilitates better symptom control. Out of hours transfers are highlighted as a time of risk. The IV to SC conversions used here were tolerated well, however a 50% dose reduction is not seen as standard as the management of this conversion will vary depending on the prescriber's assessment of the patient. Further review of this care pathway and prescribing practice is merited to allow development of guidance.

66 DIGNIFIED DEATH: THE IMPACT OF PALLIATIVE CARE ON POLYPHARMACY AND ANTICIPATORY PRESCRIBING

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Background and Aims At the end of life, a person's needs and goals change. It is, therefore, important to review medications to ensure optimum symptom control and to deprescribe

unnecessary treatment. The aim of the study was to assess the impact of Specialist Palliative Care (SPC) review on reducing polypharmacy and prescribing anticipatory symptom control medication in inpatients at the end of life.

Methodology Adult inpatient deaths between July 2018 and February 2019 in an acute London Hospital were identified. Deaths in Intensive Care Unit and within 24 hours of admission were excluded. Demographic data, medication name and number on admission, at death and which were discontinued, were collected. Evidence of a SPC review and prescription for anticipatory medication were recorded. Using SPSS software, Chi Squared and Mann Whitney U tests were performed to identify statistical differences in prescribing for patients who had been reviewed by SPC.

Results 201 patients were identified. 159 patients (79%) were reviewed by SPC, a median of 5 days prior to death (interquartile range 2–11 days). Significantly more medications were discontinued in those who were reviewed by SPC (6.4 medications per patient) than those who were not reviewed (4.2 medications per patient, <0.001). 179 patients (89%) were prescribed anticipatory medications. Of those reviewed by SPC, 158 (99%) were prescribed these medications, therefore a SPC review made anticipatory medication prescription significantly more likely (<0.001).

Conclusion SPC review reduced polypharmacy at the end of life and also increased the likelihood of anticipatory medication prescription. However, this mostly occurred only a few days prior to death. There needs to be continued focus on early identification of patients nearing end of life and medication review to enable appropriate deprescribing. Further research needs to determine whether deprescribing improves quality of life.

67 WHAT ARE THE ATTITUDES OF PATIENTS RECEIVING PALLIATIVE CARE TOWARDS ASSISTED DYING?

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Research was undertaken for an MSc with the aim of gaining an idea of the attitudes of Hospice inpatients towards Assisted Dying (AD) and related subjects, in order to inform the current debate on legalising it in the UK. The study also aimed to identify whether there were associations between these attitudes and symptom and performance scores and whether or not these attitudes changed following inpatient Hospice care. This was a small pilot study using quantitative methods with a face to face questionnaire administered to Hospice inpatients soon after admission and two weeks later.

Small sample size limited statistical analysis, however it appears that a large majority of Hospice inpatients would agree with a change in the law to allow AD and many had considered measures to end their own lives in the past. Under half would have considered AD in the previous week, with lowest rates seen amongst patients nearest to death, suggesting that the 'worst case scenario' feared by many who wish to see AD legalised may not come to pass, and many find quality of life in circumstances which might not seem likely to those who are well. Links between attitudes and some symptoms and the possibility of changing views in response to symptom severity are discussed, with the suggestion that many would see AD as a reassuring future possibility rather than an option

for their current situation. Participants seemed to welcome the opportunity to discuss this topic.

68 MISSED OPPORTUNITIES TO DIE AT HOME: AN ANALYSIS OF LIVER DISEASE DEATHS IN THE VOICES SURVEY

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Background Liver disease was the 2nd most common cause of death in working age adults in 2018 with deaths increasing four-fold in the last 4 decades. Patients with advanced disease are often unaware of their prognosis and report significant unaddressed symptoms. Over 70% of deaths occur in hospital but it is unclear how avoidable admissions are and whether this reflects patients' preferences. We aimed to compare bereaved carers' perceptions of the quality of end of life care for patients with non-malignant liver disease (NMLD), malignant liver disease (MLD) and other non-malignant diseases (ONMD).

Methods We conducted an analysis of individual-level data from the VOICES National Bereavement Survey. This dataset included 110,311 completed surveys from bereaved carers, related to a stratified random sample of 246,763 deaths registered in England 2011–2015. We compared demographics, access to specialist palliative care (SPC), place of death and overall quality of care.

Results NMLD and MLD patients had greater levels of deprivation than ONMD patients. More patients with NMLD received home and hospice SPC compared with ONMD, but less than for MLD (11% vs. 7% vs. 55% respectively). A higher proportion of NMLD patients die in hospital than ONMD and MLD patients (74% vs. 53% vs. 38% respectively), despite their carers reporting 89% had expressed a preference to die at home. Comparing with ONMD and MLD, carers of NMLD patients were less likely to rate the overall quality of care in the last 3 months of life as outstanding or excellent.

Conclusions It is concerning that carers report the quality of end of life care for patients with non-malignant liver disease to be worse than with other diseases. Further research should focus on achieving integration of hepatology and community services, including SPC, to prevent unwanted hospital admissions and better facilitate care and death at home.

69 OPIATES AND SEDATIVES PRESCRIPTION IN CCC – A COMPARISON WITH BEST PRACTICE AND THE GOSPORT MEMORIAL ENQUIRY

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Background The Gosport Independent Panel was set up to address concerns raised by families about the initial care of their relatives in Gosport War Memorial Hospital, where discrepancies were discovered over prescription of opiates and syringe drivers. This audit was created to review opiate/sedative medications prescription in EOL patients in CCC