Conclusion Expedited hospital discharges utilising NHS Continuing Care Fast Tracking provide an opportunity to undertake and record ACP. Undertaking ACP discussions at this point in the patient's care appears to be acceptable to both patients and healthcare professionals.

75 SYMPTOM CONTROL MEDICATION FOR PATIENTS DYING IN CRITICAL CARE: SYSTEMATIC REVIEW OF THE LITERATURE AND CURRENT PRACTICE IN CHESHIRE AND MERSEYSIDE

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Background Symptom control at the end of life within Critical Care settings varies. Within the literature there is no consensus for titration of infusion rates, the use of PRN medications or subcutaneous infusions.

Methods A literature review was performed, the databases MedLINE, EMBASE and CINAHL searched using relevant terms and results independently reviewed. A case note review was undertaken via an electronic proforma sent to Acute and Specialist Trusts with Critical Care units in Cheshire and Merseyside.

Results 633 articles were identified from the literature search, 66 having full text review, 14 accepted. These highlighted a wide range of doses prescribed, including 0–217 mg/hr of Morphine being reported. 95 case notes reviewed. Mean age was 69, 60% were male. 63% had Specialist Palliative Care input and 80% remained in Critical Care until death. There were discussions relating to dying in 96% of cases, 80% had a documented assessment of symptoms at the time dying was recognised. There was a wide range of time from recognising dying to death, 5 minutes to 9 days. When dying was recognised, 52% of patients were receiving intravenous infusions for sedation, symptom control or inotropes. After dying was recognised, 64% received medications via continuous infusion, 30% intravenous, 28% subcutaneous, 6% both. 65% of patients had anticipatory medication prescribed which increased to 83% when SPCT were involved. The mean dose of Morphine administered when dying recognised was 4.5 mg/hour, vs 5.9 mg/hour at the time of death, for Midazolam 1.5 mg/hour vs 3 mg/hour.

Conclusions Within Critical Care we found a wide range in time from withdrawal of life sustaining interventions to death. Routes and doses changed over this period and patients were more likely to have PRN medications prescribed when SPCT were involved. Doses of medication given by intravenous infusion were lower than the average doses reported in the literature.

76 AN ANALYSIS OF THE QUALITY OF ADVANCED CARE PLAN AND DNACPR DOCUMENTATION FOLLOWING THE INTRODUCTION OF THE RESPECT PROCESS

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An Advanced Care Plan (ACP) allows discussion and documentation of patient preferences for future medical care, not only limited to resuscitation. Despite national guidance, communication remains poor and there is inconsistent documentation of ACP and DNACPR decisions, potentially resulting in inappropriate treatment and unnecessary hospital admissions. ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) is a newly introduced emergency care plan which aims to help support discussions and record recommendations. We assessed the quality of ACP and DNACPR documentation at a UK District General Hospital before and after introducing ReSPECT.

Retrospective data was collected on all patients from elderly care wards (one male and one female) in March 2018 and March 2019 through case-note review following ReSPECT going live in October 2018. Section headings on the form were used as basis for collection. Data also included ACP/DNAR decision communication on discharge paperwork.

The March 2018 cohort included 87 patients (35 female and 52 male) with 113 patients (67 female and 46 male) in March 2019. In patients who had an ACP discussion, there was an increase from 68.2% to 100% of the specific nature around this documented, and it was communicated better in discharge documentation (81.8% to 100%). Furthermore, in patients whom DNACPR was agreed, there were improved levels of recorded documentation from 79.4% to 87.1%.

ACP and DNACPR decisions are individual to each patient and pre-ReSPECT form data shows documentation was poor. However, following introduction of the ReSPECT form there were significant improvements noted in two key areas - in clinical notes for DNACPR decisions and subsequent discharge paperwork, and following ACP discussions there was an improved level of documentation regarding the specific nature of the ACP. We have demonstrated that the ReSPECT form can empower clinicians to ensure patients have an appropriate care plan documented to guide future care.

77 IMPROVING END OF LIFE CARE IN AN ACUTE SURGICAL UNIT AND TRAUMA TEAM – A QUALITY IMPROVEMENT PROJECT

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Objectives To audit end of life care (EOLC) delivered by the Acute Surgical Unit (ASU) and Trauma team at Kings College Hospital against local guidelines, and to identify methods to improve quality of care.

Methods Retrospective analysis of electronic notes of all patients who died under the care of ASU/Trauma between August and November 2018. Patients who had isolated neuro-surgical injuries, were transferred to another team more than 24 hours before death, or who died unexpectedly were excluded. Data concerning the five priorities of care for the dying person were extracted using a standardised tool. Interventions carried out after cycle one included junior doctor refreshers, EOLC lanyard prompts and posters in the doctors' office, with repeat data sampling from April to July 2019 inclusive.

Results 12 patients satisfied inclusion criteria in cycle one and 6 in cycle two. Data demonstrated improvements in a number of areas. These included involvement of the palliative care team increasing from 50% to 83%, documentation of plans for hydration from 42% to 67% and nutrition from 50% to 67%, rationalisation of medication from 42% to 83% and of interventions from 33% to 83%. Improvement was seen in documentation of communication with patients and their family such as those relating to prognosis from 75% to 100%, CPR decisions from 50% to 83%, preferred place of death from 25% to 83%, assessment of Psychosocial or spiritual needs of the patient from 50% to 83% and for their families from 33% to 83%. However, the percentage of patients with CPR decisions remained 83% in both cycles.

Conclusions Use of simple educational interventions and prompts have demonstrated improved documentation of individualised end of life care plans in ASU/Trauma. Ongoing audit and continued education may lead to sustainable improvement in the quality of EOLC delivered by these teams.

78 ASSESSING THE END OF LIFE CARE NEEDS OF PATIENTS IN ACUTE HOSPITAL SETTING? FINDINGS FROM A SCOPING REVIEW

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10.1136/spcare-2020-PCC.98

Background High quality end-of-life care is required to ensure the care patients receive in acute settings meets their needs, but end-of-life care needs are not always adequately assessed on admission. The use of appropriate assessment tools that guide clinical decision-making and care planning could improve care and enable rapid transfer to the preferred place of care. This paper reports the findings of a literature review which investigates the use of end-of-life care assessment tools in acute hospitals.

Methods This scoping review adopted a three-step search strategy using five databases. 760 citations were generated and following the PRISMA process, 55 full texts were assessed for eligibility and sixteen of these were identified as suitable for data synthesis. Data were retrieved from each paper and analysed thematically using Braun and Clark (2006). The assessment tools were critiqued to assess validity and reliability to determine which were the most feasible for use in the acute hospital setting. A further search was carried out to identify any reports of the use of the tools in clinical practice.

Results Sixteen papers published since 2000, reported the development and application of fifteen different assessment tools in acute hospitals. Of these, only five reported the use of assessment tools in acute clinical practice. Analysis identified four key issues - potential improvement to patient well-being, training on the usability of assessment tools, burden to patient and staff, and validity and reliability of the assessment tools.

Conclusions Only a limited number of end of life assessment tools have been developed and fewer have been tested in routine practice. Some of the assessment tools reported for use in the acute hospitals made a positive impact on patients' end-of-life care. Further research is necessary to understand how assessment tools can help assess end-of-life care needs and ultimately improve supportive care in the acute setting.

79 IMPROVING DNAR DISCUSSIONS: A QUALITATIVE QUALITY IMPROVEMENT PROJECT

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Background Patients often do not recall all the key points in discussion with healthcare professionals, perhaps even more so when discussing topics like a Do Not Resuscitate (DNAR) decision. If communication in these potentially emotional situations can be enhanced using patient leaflets compared to discussion alone, perhaps it would be worth considering using them more often in future. The aim of this project was to ascertain whether at least 50% of participants felt that using the All Wales patient leaflets improved their understanding of CPR and DNAR decisions.

Method 10 patients and loved ones who were present for the initial DNAR discussion were surveyed. A questionnaire elicited whether they felt their understanding of CPR and DNAR decisions was good before reading the leaflet and if it improved after. This involved 8 participants on the Medical Assessment Unit at the Royal Gwent Hospital and 2 on a Care of the Elderly ward at Nevill Hall Hospital who had documented DNAR discussions.

Results 50% felt the leaflet improved their understanding and that it would have benefited them at the time of discussion. 70% felt it was a useful reference and 40% asked to keep the leaflet after the encounter. Anecdotally, cases where participants particularly found it useful were those where death was not imminent, large numbers of family members were involved and had different views and in complex advance care planning.

Conclusion The data gathered from this small, qualitative project suggest there may be a role for patient information leaflets on DNAR decisions when used in the right context.

80 CARE DOESN'T STOP WHEN LIFE DOES: IMPROVING DOCUMENTATION OF CARE AFTER DEATH IN A HOSPITAL SETTING

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Background Staff responsible for care after death should 'Record all aspects of care after death in locally relevant documentation and identify the professionals involved.'¹ A Trust-wide audit in 2017 showed that documentation of care after death at the trust was poor and only 30% of patients had any documentation of care after death recorded. The care after death checklist was developed and launched as a prompt for staff providing care after death to complete.

Aims To measure and evaluate the correct use of the care after death checklist and to ascertain whether the checklist has effected the documentation of the care provided after death.

Methods A retrospective audit involving review of the clinical notes and the care after death Checklist when completed was performed. Thirty sets of notes, across two hospitals within the trust were reviewed. Patients who died in the first two