RE-AUDIT OF THE ASSESSMENT OF THE USE OF INTRAVENOUS/SUBCUTANEOUS FLUIDS IN PATIENTS IN THE LAST DAYS OF LIFE

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Background Maintaining hydration at the end of life can be emotive and controversial. Practice varies widely regarding use of clinically assisted hydration (CAH) and there is lack of evidence-based guidance. Communication and documentation surrounding CAH and mouth care is essential. Practice on a Palliative Care Unit was assessed, comparing to results from 2017 and 2018.

Methods Retrospective review of medical notes for deaths between 1st October-31st December 2019. A data collection tool utilised during previous audit cycles was used to ensure comparable results. Patients not identified in the dying phase and sudden deaths were excluded.

Results A reduction in documented discussions about hydration, the risks/benefits of this (44% vs 60% 2017, 73% 2018) and mouth care (32% vs 35% 2017, 61% 2018) with patients and/or those important to them were identified. Where prescribed fluids were not completely delivered, reasons for this in previous years were documented in 100% of cases, reducing to just 80% in 2019. There was a decrease in documented reasons for stopping fluids prior to death (90% vs 80% 2017, 100% 2018) and discussion of this with the patient and/or those important to them (20% vs 50% 2017, 20% 2018). Fluids were most commonly prescribed for thirst and dry mouth, and stopped due to chest secretions and pooling.

Conclusion Introduction of a consultant ward round sticker prompting individualised hydration and mouth care plans following cycle 1 (2017) initially resulted in an improvement of discussions about hydration and mouth care, and documented reasons for any changes. Whilst the stickers provide evidence that hydration and mouth care are always considered, there is a decrease in documented discussions surrounding this. This is possibly due to lack of documentation, rather than a failure to discuss and may have been contributed to by a change in personnel, highlighting a need for education.

WITHDRAWAL OF NON-INVASIVE VENTILATION IN PATIENTS WITH TYPE 2 RESPIRATORY FAILURE AT KETTERING GENERAL HOSPITAL

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Background There is little specific guidance for the process of withdrawing Non-Invasive Ventilation (NIV) for patients with Type 2 Respiratory Failure (T2RF), despite the potential for development of distressing symptoms. We evaluated current practice to assess the need for such guidance.

Method The Palliative Care Team at Northamptonshire Healthcare Foundation Trust and the Respiratory Team at Kettering General Hospital (KGH) worked collaboratively to review the medical notes of patients admitted to KGH between August 2018 and August 2019, who were coded for T2RF and NIV and had died on that admission. Exclusion

criteria were use of invasive ventilation, patients who had not received NIV and those weaned off NIV after clinical improvement. 48 patients were identified; 26 were included, 8 were excluded due to the above criteria and 14 were excluded due to unavailability of medical notes.

Results Clear plans were documented regarding ceiling of treatment at initiation of NIV in 73%. Discussions concerning NIV withdrawal occurred with patients and/or relatives in 100% of cases, but patients were only involved in 15% due to confusion or reduced consciousness. The plan for withdrawal was documented in 58% of cases. 46% of patients were referred to the Palliative Care team, but 58% of Palliative Care referrals were made after NIV was withdrawn. There was significant variation in prescribing, with only six patients being given medication prior to NIV withdrawal. 69% had anticipatory end of life medications prescribed but there was variation in which opioid, antiemetic and antisecretory was used.

Conclusion The differences observed in practice regarding communication, medical management and the process of withdrawal show a lack of standardised approach. Maintaining individualised patient care is important, but there may be a place for structured guidance to ensure that conversations are had, the need for symptomatic relief prior to withdrawal is considered, and medications are prescribed in anticipation of potential distress.

IS HIGH FIDELITY SIMULATION AN EFFECTIVE WAY TO TEACH PALLIATIVE AND END OF LIFE CARE SKILLS TO REGISTERED NURSES?

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Background There is little published work regarding simulation training in end of life care for registered nurses. Simulation training offers the opportunity to learn in a safe environment, without compromising patient safety.

Methods Each simulation day covered five scenarios, written by Specialist Palliative Care Clinical Nurse Specialists (SPC CNS), based on real cases that ward nurses had reported difficulty in managing. Scenarios included seizures, pain, breathlessness, care planning in last days of life, breaking bad news on the telephone, and dealing with distressed relatives.

In each scenario there was an HCA in the room and a doctor available for telephone advice. The patient and relative were either played by the actor or the 'SimMan'. The candidates participated in pairs and the remaining candidates observed via video-link.

The subsequent debrief utilising 'The Diamond' model was led by a Palliative Medicine Consultant and SPC CNS. This model encourages description, analysis and application of learning in a non-judgemental way.

Results Pre and post-simulation day feedback was collected via a 1 - 5 scale and revealed:

- confidence to manage physical symptoms increased (3.15 vs 4.25)
- confidence in communication increased (3.3 vs 4.24)
- candidates learnt something new from the day (free text)
- scenarios were rated as useful/very useful
- confidence with simulation training was unchanged (3 vs 3)