

59

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.

60

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.

61

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)

Conclusion High fidelity simulation training for registered nurses in an acute hospital is an effective way to teach palliative/end of life care skills. Registered nurses are keen for simulation training to be integrated into end of life care education.

62 CHANGING PREFERENCE FOR, AND ACTUAL PLACE OF DEATH, AMONG PALLIATIVE CARE PATIENTS: A SECONDARY DATA ANALYSIS

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Background Place of death has been used as a quality indicator. However, evidence on changes in preferences for place of death remains limited. This study describes preferred and actual place of death, plus changes, among patients who died while receiving inpatient and community palliative care.

Methods Secondary analysis of routinely-collected clinical and outcomes data between June–November 2019. Inpatient hospice and community settings were included; for each setting, we compared first-documented preferred place of death with the latest-documented preference across the episode of care. We also compared the latest-documented preferred place with actual place of death. Caldicott Guardian approval was received for analysis of this anonymized data.

Results 269 patients received 277 complete episodes of care in the inpatient unit, and 510 patients received 527 complete episodes of community-based palliative care. Median age for inpatients was 75 years (IQR 63 “ 83) compared with 81 years (IQR 71 “ 89) for community. 82% inpatients had cancer compared with 63% in the community. 98% inpatients had no documented change in preferred place of death (69% and 27% preferred hospice or home, respectively). 92% community patients had no documented change in preferred place of death (74% preferred home). We compared the latest-documented preferred place with actual place of death. Two thirds of inpatients (66%) preferred and died at the hospice, while 27% preferred home, but died in hospice. In the community, 57% of patients preferred and died at home, while 19% preferred home, but died elsewhere (in hospital or nursing/residential home).

Conclusion There is high concordance between preferred and actual place of death among both inpatients and community palliative care patients in this cohort; with the exception of some hospice inpatients who prefer home but die elsewhere. Change in preference for place of death are very infrequently reported.

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63 TO EXPLORE FACTORS INVOLVED IN 'SHORT' END OF LIFE CARE ADMISSIONS WITHIN A HOSPICE SETTING

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Background Transfer of patient care to inpatient hospice settings is often associated with improved symptom control,

psychological well-being and reduction of carer stress. Patients and their carers may not receive the full range of benefits of hospice care when admissions are short, less than 48 hours. Despite the brevity of the admission stay, families report very positively on the care experience of their loved one. We aimed to explore patient characteristics and factors that could contribute to short inpatient hospice stays.

Methods Prospective case note review of deaths at St Michael's Hospice with a short (less than 48 hrs) length of stay. Data was collected over a 1-year period, comprising referral source, reason for admission and patient preferences.

Results 225 inpatient deaths occurred over the 1-year period.; 51 patients (23%) died within 48 hours of admission. The majority of patients had metastatic cancer diagnosis (88%), coupled with poor performance status (ECOG 4(90%)) and the vast majority already known to our Community Palliative Care Team (86%). Given the challenges with prognostication, 98% of individuals were identified as being in the last days of life. Common themes were acute and sudden clinical deterioration, uncontrolled symptoms, preference to delay admission for as long as possible and finally, a strong patient or family preference for admission. Patients were admitted within 24 hours of referral (88%).

Conclusion This piece of work highlights certain characteristics; metastatic cancer, poor performance status and individuals already under the community service, linked to 'short' inpatient stays. Patient and family documented preferred place of care, clearly plays an important role. This work underpins the need for advance care planning from both patient and their family. Therefore, rather than length of stay determining patient and carer experience, the tangible sharing of patient and carer preferences across a health system is key.

64 EVALUATION OF RESPECT FORM DOCUMENTATION IN A HOSPICE INPATIENT UNIT

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Background Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms were introduced to St Michael's Hospice (SMH) in July 2019 and have been adopted throughout the UK to assist in Advance Care Planning. The form is a key enabler facilitating cross organisational efforts to support individuals to die in their preferred place of care.

Method Retrospective case note review of hospice inpatient admissions over a 3-month period. ReSPECT forms were evaluated using a proforma, assessing the completeness of the form as well as the quality using the commissioned initiative, Frail and Vulnerable Patients Scheme (FVPS) with a global scoring 1–5, based on content.

Results 65 ReSPECT forms were identified for analysis. Forms were completed in hospital (44%) and hospice (45%) settings, with a smaller number from GP settings (11%). High completion of clinical recommendations (85%), resuscitation decision (98%) with low completion rate of patient preferences; priorities of care (54%) and what is important to the patient (42%). 55% of forms were assessed as higher quality, scoring 4 or 5 on FVPS. A proportion were assessed as low quality (18% (1) 9% (2). Of the forms scoring 4 or 5, most were