

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