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.

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

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10.1136/spcare-2021-PCC.81

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.

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EVALUATION OF RESPECT FORM DOCUMENTATION IN A HOSPICE INPATIENT UNIT

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10.1136/spcare-2021-PCC.82

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

completed in the hospice (19) followed by those completed in hospital (13) and then GP settings (4).

Conclusions The piece of work identified the majority of ReSPECT forms completed were of high quality and had high completion rate for clinical recommendations and resuscitation decisions. Interestingly, forms completed within a hospice setting were assessed to be of higher quality. This quality improvement process used standard reporting and benchmarking quality standards to compare across the health economy. This emphasises the need for services to use co-created tools both in terms of assessment and governance.

65 THE USE OF OPTIFLOW THERAPY IN A SPECIALIST CANCER HOSPITAL AND ITS IMPLICATION FOR PATIENTS RECEIVING PALLIATIVE CARE

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10.1136/spcare-2021-PCC.83

Background Optiflow therapy (OF) is nasal high flow Oxygen that is hospital based. Its aims are to reduce work of breathing and symptomatic breathlessness. Its use is generally initiated by critical care outreach in order to prevent admissions to critical care for ventilatory support. The concern was that OF was mainly commenced acutely without considering ramifications on achieving Preferred place of care or death (PPC/PPD). Local and National guidance is lacking for patients who are receiving palliative care. We aimed to develop a guideline for initiating OF within the hospital.

Methods A baseline retrospective notes review was conducted. 60 adult medical in-patients who started OF on the wards between October 2018 and October 2019 were included.

Results The most common reason for commencing OF was infection (61%), Pulmonary oedema (13.4%), Pneumonitis (4.9%) and Pleural effusions (4.9%). Most patients remained on OF for less than 4 days (43 patients, 71.7%). OF was initiated in 65% patients out of hours. Most often an MDT was used to make the decision. In 43% patients a 'ceiling of treatment' decision was documented prior to starting OF: of these 35% were for full escalation, 35% for inotropes but not intubation and 30% for ward-based treatment only. Prior to starting OF 3% had a PPD documented. The majority of patients 65% improved on OF and were weaned off. However, 82% patients died within 8 (most of those within the first 4) months of initiation of OF; either whilst on OF, later in the admission when stopped OF, or following discharge.

Conclusions The results suggest that although the vast majority of patients are weaned off OF, it does signal a deteriorating patient and referral to palliative care should be initiated. A guideline is being developed to support clinical decision making around the use of OF.

66 ASSESSING THE QUALITY OF END OF LIFE CARE IN PATIENTS DYING IN AN ACUTE HOSPITAL IN LONDON AND THE IMPACT OF THE COVID-19 PANDEMIC

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10.1136/spcare-2021-PCC.84

Background This audit measures the extent to which in hospital end of life care is meeting the Five Priorities of Care for the Dying Person. 1) Recognise 2) Communicate 3) Involve 4) Support 5) Plan & Do.

Aims

1. To assess the impact of the Covid-19 pandemic on end of life care.
2. To provide trust wide feedback in preparation for increasing rates of Covid-19.

Methods Cases were audited retrospectively using quality measures based on the 2016 National End of Life Care Audit. Thirty deaths from November/December 2019 were compared with forty deaths from April 2020 (first peak of Covid-19)

Results Median age was similar pre and during pandemic (81.5 vs 80.3). During the pandemic 70% of patients audited tested positive for covid 19. Pre pandemic 13% of patients died without a Treatment Escalation Plan (TEP) compared to 2% during the pandemic. Pre pandemic 27% of patients received active treatment in the last days of life compared 48% during the pandemic. Involvement of the patient and next of (NOK) in decisions remained >90% pre and during pandemic. During the pandemic spiritual/cultural needs assessments fell by 25% and discussions around place of death fell by 36%.

Conclusions The increased likelihood of active treatment in the last days of life during the pandemic may reflect the rapid disease trajectory of covid-19. The consistent high level of communication with patients and NOKs reflects efforts to communicate via telephone due to visiting restrictions. TEP completion improved during the pandemic in keeping with national drives to establish ceilings of care and the transfer to electronic TEPs in the Trust during the pandemic. Prioritisation of communication and medical intervention during the pandemic may have adversely impacted holistic needs assessment. Learning points from this audit have been publicised in the Trust in preparation for the second wave of the pandemic.

67 GOLD STANDARDS FRAMEWORK IMPLEMENTATION DUDLEY GROUP NHS FOUNDATION TRUST

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10.1136/spcare-2021-PCC.85

Gold Standards Framework (GSF) is a systematic, evidence based approach to optimise care for all patients approaching the end of life, delivered by generalist frontline care providers. There is evidence that 30% of adult hospital inpatients are in the last year of life (Clarke et al. 2014). The specialist palliative care team have completed a yearly audit to establish the percentage of adult inpatients on a particular date in June, who died during the following 12 months. The overall percentage is 33 percent of adult inpatients on the 3rd June 2018 had died within 1 year. Therefore, this data supported the published evidence and also supported the wards with the GSF implementation programme.

Over the last 2 years the wards have engaged with six workshops and developed care plans based on national documentation for Gold Standards Framework Green, Amber and Red.