

Conclusions The checklist is in its pilot phase. Evaluation is planned for February 2021. Adaptations, if required, shall be made when this data is available. Discharge home from critical care for patients who are dying is possible. To ensure fair and equitable care for all, PPOD should be discussed and explored for patients in ITU, and although a complex process, it is achievable and highly rewarding for all involved.

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A REVIEW OF END OF LIFE CARE OF PATIENTS ON HIGH FLOW NASAL CANNULA AT THE ROYAL VICTORIA INFIRMARY, NEWCASTLE UPON TYNE

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Background High flow nasal cannula (HFNC) has a role in managing chronic and acute respiratory failure. Many published reports suggest that HFNC decreases breathing frequency and work of breathing and reduces needs of escalation of respiratory support in patients with diverse underlying diseases. These properties may provide beneficial symptom control where reversibility of the condition is not possible.

Method Our aim was to evaluate end of life care delivered in patients who received HFNC in their terminal admission. These patients were identified via database kept by Critical Care Outreach Nurses from December 2019 - February 2020. Data was collected retrospectively from electronic notes.

Results 33 patient notes were reviewed (mean age= 77.2 years (15 female, 18 Male)). A majority (24) were admitted from home, with the remainder from nursing or residential care. Initiation of HFNC happened throughout the hospital (Emergency Department and admission unit= 14, Respiratory unit= 8, other medical wards= 6, Non-medical wards= 5). The primary indication for commencing HFNC was pneumonias (15), with an average duration of 7.24 days. 15 patients weaned off HFNC, 11 died with HFNC in situ, 4 did not tolerate treatment, 2 were discharged to community for end of life care and 1 was intubated. Regarding the recognition and management of the dying patient: 31 were recognised to be dying by medical teams and of these, 29 had documented discussions regarding end of life care with patient or relatives. 27 patients were referred to Palliative Care for specialist advice and 27 were prescribed anticipatory medications for symptom management.

Conclusion There was clear evidence of good symptom management and onward referral to Specialist Palliative Care for patients who were treated with HFNC during their final admission. However, we are limited by reviewing retrospective documentation and the likely change in practice given the Covid-19 pandemic.

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HOW AND WHEN TO ASK CANCER PATIENTS WITH A PALLIATIVE DIAGNOSIS ABOUT CORNEAL DONATION. A QUESTIONNAIRE BASED STUDY

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Background Fewer than half of families agree to donation if unaware of their loved one's decision to be a donor. This rises to over 9 in 10 when the decision is known (organdonation.nhs.uk). All previous research on this topic bar one recent qualitative study has focused on views of health professionals, or relatives.

Aims The aim of this study was to determine the best way to ask about corneal donation; by asking patients directly. Secondary aims were to establish whether patients knew they could donate corneas despite having cancer, if they would donate and if they had registered their wishes.

Methods Twenty patients with a palliative cancer diagnosis, were given a questionnaire to complete anonymously. Questions asked about current understanding and views on organ donation, whether any wishes were registered, and how they felt we should ask about donation.

Results 18 completed questionnaires were returned. Only 2 patients were aware that cancer patients can donate corneas. Despite 11 patients stating they had previously considered donation, and 17 stating they would wish to donate, only 4 had registered their wishes online. The same 4 also carried a donor card. The majority felt it didn't matter who asked (10), or where (16). 11 felt face to face was best although 6 felt it would be acceptable to ask via questionnaire. Patients were divided on when the best timing would be. 15 patients felt we should discuss donation routinely at the time of hospice admission, and the same 15 felt we should routinely ask all patients under hospice care.

Conclusion The majority of patients would consider donating but don't realise they are eligible to do so. Most patients feel we should routinely ask about donation; even if they did not wish to donate themselves. Education is required to empower health professionals to start conversations.

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THE BUTTERFLY PROJECT – IMPROVING TREATMENT ESCALATION PLANNING IN THE EMERGENCY DEPARTMENT

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Background The 2017 End of Life Care Hospital Improvement Programme (ELCHIP) audit of deaths at the Leicester Royal Infirmary (LRI) an Emergency Department (ED) attendance may be an opportunity to proactively identify and plan for deterioration. The clinical frailty scale (CFS) can identify older people at increased risk of deterioration or dying and local data suggests a 1 year mortality rate of 50% in the cohort of patients with CFS 7–9.

Methods The Butterfly Project is a multidisciplinary quality improvement project aiming to increase the percentage of older people CFS 7–9 dying in their preferred place of care, with additional outcomes based on early identification of uncertain recovery and treatment escalation planning.

ED notes were reviewed for all CFS 7–9 patients dying within 30 days of an ED attendance between February 2019 and May 2020. Interventions were broadly within two streams. The first focused on improving treatment escalation planning including verbal and visual prompts and the introduction of the ReSPECT process. The second was based on improving the skillset of ED staff via educational interventions.

Results Between May 2019 and May 2020, although there was no change in the percentage of patients dying in their preferred place of care, statistical process control charts showed sustained upward shift in:

- Identification and communication of uncertain recovery
- Documented CPR decision
- Clear, individualised treatment escalation plan

ReSPECT introduction had the most significant impact on treatment escalation planning, although incremental improvements were seen with verbal nudges to action at staff handover.

Conclusions Sustained verbal and visual prompts, in conjunction with introduction of the ReSPECT process and educational support, can increase early identification and communication of uncertain recovery and prompt treatment escalation. Ensuring that these improvements translate into patients dying in their preferred place of care is complex and requires organisational collaboration.

73 HOSPITAL ADMISSIONS AND HOSPITAL DEATHS IN MEADOW HOUSE HOSPICE (MHH) COMMUNITY PATIENTS

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Background Death in hospital is viewed as undesirable, with more patients reporting that their preferred place of death (PPD) is home. Government policy focuses on reducing hospital admissions at end of life. This study examines hospital admissions and hospital deaths in patients known to the community team at MHH.

Methods An After Death Analysis (ADA) was completed after death of patients under the community team and was triangulated with patient's hospice and hospital notes.

Results An ADA was completed for 188 patients. 66% died at home, while 19% died in hospital. PPD was documented for 97% of patients, and achieved in 82%. 64% had a CMC record.

53% had an unplanned hospital admission in the last year of life. 3 patients had 5 or more admissions. The most common reasons for admission were infection and shortness of breath. Specialist palliative care (SPC) was involved in the decision to admit in 2% of cases. Average length of hospital stay was 17 days, with 22% in hospital for over a month.

Conclusion This shows that the majority of patients died at home in their PPD. However half of patients had an unplanned admission at the end of life. Some patients benefited from these admissions, however in some cases family distress or lack of community resources were cited as a reason for admission. SPC was only involved in 2% of decisions to admit and over 30% did not have CMC filled in. We hypothesise that more palliative care input at the time of admission and clear documentation of wishes may reduce unnecessary admissions at the end of life.

REFERENCES

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74 HELPING NON-SPECIALISTS IMPROVE ASSESSMENT OF 'END OF LIFE CARE' PHASE IN STRUCTURED JUDGEMENT REVIEWS

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Introduction The Royal College of Physicians introduced National Mortality Case Records Review (NMCRR) programme and the Structured Judgement Review (SJR). Assessment of the 'end of life care phase' in SJRs are often undertaken by a clinician without expertise in palliative medicine.

Methods Criteria were developed in 2019 to guide non specialists in assessing the quality of the 'end of life' phase. 75% of SJRs carried out in OUHFT were reviewed in 2020 - assessing the phase of care score and the text relating to care at the end of life

Results Prior to the introduction of the quality indicators 96% of EOLC was judged good or excellent. Afterward 68% of EoLC was judged good or excellent in keeping with other phases of care.

Conclusion Supporting clinicians by providing quality indicators enabled better assessment of the 'end of life care' phase of SJR. In 2019/20 the distribution of scores is more in line with other domains across the SJR. The scores align with the written information on the SJR forms.

Resources Quality indicators available to all delegates for their use.

75 AN AUDIT TO EVALUATE THE MANAGEMENT OF DIABETES IN THE LAST DAYS OF LIFE ACROSS THE NORTH WEST OF ENGLAND

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Introduction Diabetes is an increasingly common co-morbidity and Diabetes UK has provided guidelines to help decision-making during patients' last days of life to maximise symptom control.

Method Standards were created based upon Diabetes UK guidelines and were approved by the North West Audit Group. An online data collection tool was created and distributed regionally.

Results There were 135 responses from 6 hospitals and 7 hospices with 88% of patients aged over 60, 56% female and 94% had type 2 diabetes. On recognition of dying, 41% patients had a plan communicated with them, however, compliance increased if insulin was prescribed or having type 1 diabetes. For those on insulin, only 47% involved a management discussion with diabetes specialists (54% hospital, 33% hospice). In type 2 diabetes controlled by diet or metformin alone, 85% had medication and monitoring stopped. In patients with type 2 diabetes who continued insulin in last days of life, 57% were prescribed once daily insulin (46% hospital, 75% hospice) and 57% had an appropriate initial dose adjustment (50% hospital, 67% hospice). Daily capillary blood glucose (CBG) occurred in 96% patients and when not within satisfactory ranges 75% patients had an appropriate insulin dose adjustment. In the last days of life for patients