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.

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.

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.

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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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

Lucy Ison, Treena Saini. Meadow House Hospice

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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