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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10.1136/spcare-2021-PCC.91

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.

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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