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.

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