with type 1 diabetes 50% were prescribed a once daily insulin regime with 100% having initial appropriate dose adjustments. Only 62.5% had a daily CBG (80% hospital, 33% hospice).

Discussion In hospitals there was increased diabetes specialist involvement and management of type 1 diabetes adhered closer to guidelines, suggesting availability of services being beneficial. Insulin use and monitoring of CBG varied, possibly demonstrating lack of knowledge or familiarity with guidelines. Recommendations include improvements in education (especially insulin use) and establishing formal links between palliative care and diabetic services.

RESPECT: FIND OUT WHAT IT MEANS TO ME – A PATIENT’S PERSPECTIVE

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Note to assessors This data has been produced by further investigation of the introduction of ReSPECT forms in our Trust. It looks at the perspective of patients’ and links with the already accepted poster entitled ‘ReSPECT, find out what it means to me- an audit of advanced care planning’ (ID: 34336) which investigated staff’s perspective.

Introduction ReSPECT is a national initiative to embrace shared decision-making around treatment and advanced care planning. Patients are encouraged to discuss their wishes regarding treatment escalation with their care providers and families. All adults admitted to the hospital are now expected to have a ReSPECT form filled on admission. The aim of this project was to evaluate patients’ familiarity with the process and their response to discussions regarding DNAR status and treatment escalation.

Methods A questionnaire was devised that could be filled-out by patients or by their next-of-kin (NoK) if the patient was unable to respond. It evaluated the respondent’s awareness of the ReSPECT process and if they had been involved in discussion regarding treatment escalation. They were also asked if they felt the patient discussed on the form had had their wishes respected. This questionnaire was distributed to patients across 10 acute medical and surgical adult wards from 2019–20.

Results There were 68 respondents in total, including 57 patients and 11 next-of-kin. The mean age of respondents was 87. 19% of respondents were aware of the ReSPECT process by name. 25% recalled a discussion regarding DNAR status and treatment escalation. 88% of those that had this conversation felt their wishes had been respected. 55% of those that had not had the conversation stated they would have preferred to have a discussion regarding treatment escalation and DNAR wishes.

Conclusions Based on the evidence presented, it would seem that patients aware of the ReSPECT process are a minority. It would also appear that clinicians are not succeeding in having discussions regarding advanced care planning with all patients on admission as is our target. However, it seems as though when these discussions are had, they are appreciated by a majority of the recipients. It also shows that there are patients who would have liked to express their views had they been given the opportunity.
advance care planning was experienced early in a disease trajectory.

**Results** Six articles were identified, critically appraised and used for data extraction and synthesis. These studies were synthesised using meta-aggregation and the following themes were established:

1) There are important communication considerations when effectively delivering advance care planning in hospital. The process of information sharing plays a fundamental role in communication.

2) Both professional and organisational barriers exist in hospital-based advance care planning which are compounded by the medicalised approach of hospital admissions and perceived differences between the professions involved.

3) Hospital healthcare professionals express feelings of uncertainty but are less likely to discuss or utilise other emotional responses.

**Conclusion** This literature review reveals there continues to be barriers that hinder how hospital healthcare professionals, not working in palliative care, experience involvement in advance care planning with patients at the end of life. It is suggested further research focuses on validated and effective models of education and that implementation of advance care planning is approached inter-professionally.

**A DEATH BY ANY OTHER NAME: THE USE OF EUHEMISMS IN THE MEDICAL NOTES OF PATIENTS DYING IN A LARGE TERTIARY CARE CENTRE IN CENTRAL ENGLAND**

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**Introduction** Care of the dying person begins with the recognition that they are approaching the last days of life (LDOL), but there is no universal definition for ‘dying’. Variations in terminology can be misinterpreted by patients, relatives, and healthcare professionals (HCPs) alike. The main aims of the present study were to: 1) describe the different ways clinicians document in the medical notes when someone is thought to be in the LDOL, and 2) determine the prevalence of explicit phrasing about the LDOL, viz., the use of the term ‘dying’ or some alteration thereof.

**Method** A list of all inpatients who died at the Queen Elizabeth Hospital Birmingham in August 2019 was obtained from Bereavement Services (N=142). Patients on A&E and ITU, patients admitted for less than 24-hours, or those who died unexpectedly were excluded. Individual patient case notes spanning 7 days prior to death were retrospectively scrutinised for the terminology used in the documentation of LDOL.

**Results** The records of 66 decedents were analysed. Explicit documentation (i.e. ‘this patient is dying’ or variants) occurred for 15 patients (22.7%). Of the remaining 51 patients, whilst there was no explicit documentation, an estimate of life expectancy was stated for 11 patients (16.7%). For the remaining 40 patients (60.6%), for whom there was no explicit documentation or an estimate of life expectancy provided, the most common terms used to describe LDOL were: ‘prognosis poor’, ‘end of life’, ‘deterioration’ and ‘very unwell’.

**Conclusion** This project has highlighted a clear disparity amongst clinicians regarding their documentation of dying; explicit documentation occurred infrequently. It is not known what the impact of this is on HCP-patient/relative or HCP-HCP communication. Poor written communication could well reflect poor quality of LDOL care. Further studies are needed.

**A QUALITATIVE STUDY OF FAMILY CARER EXPERIENCE OF ANTICIPATORY PRESCRIBING OF INJECTABLE MEDICATIONS FOR END OF LIFE CARE AT HOME**

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**Background** Healthcare professionals believe that anticipatory prescribing of injectable medications provides reassurance, improves symptom control and prevents hospital admissions. Carers’ roles are intertwined with use of these medications in inpatients received spiritual or religious care in the form of chaplaincy. Anticipation of death increased the likelihood of end of life patients receiving spiritual or religious care, particularly palliative care involvement, and this represents an important opportunity to improve provision of this care.