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 diabetics adhered closer to guidelines, suggesting availability of services being beneficial. Hospices were more likely to communicate plans effectively. 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.

76 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.

77 MOUTH CARE AND HYDRATION AT THE END OF LIFE: A SURVEY FOR MEDICAL STAFF

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Introduction The regular assessment of hydration status and provision of mouth care are vital parts of care in the last days of life. We present the results of a survey assessing the knowledge and attitudes of medical staff towards mouth care and hydration at the end of life, based on recommendations from the National Audit of Care at the End of Life (NACEL, 2018) and from NICE Quality Standard 144.

Methods A survey for medical staff was devised based on the above recommendations. This was sent in May 2020 to all junior doctors in Leeds Teaching Hospitals NHS Trust.

Results Fifty three questionnaires were completed and the respondents varied from Foundation Year 1 doctor to Registrar, across a range of specialties. Only 8% of respondents indicated that they usually ask patients about their mouth problems, and 32% indicated that they rarely examine the mouth. A variety of barriers to oral assessment were highlighted: the most common being a lack of time, followed closely by a lack of priority, and a lack of training. Sixty percent felt confident assessing the hydration status of adults in the last days of life. The most common listed indication for CAH was to relieve distressing symptoms, or to provide comfort (53%). Sixty three percent reported feeling uncomfortable prescribing CAH, either due to a lack of knowledge or confidence, or because they felt it would be inappropriate (18%). Half reported a lack of confidence discussing CAH with patients and relatives.

Conclusions This survey provided an insight into the knowledge and practice of junior doctors regarding mouth care and hydration needs at the end of life and has provided a focus for education. A fact sheet has been developed in response to this survey, in order to improve compliance with recommendations from NACEL and NICE.

78 ADVANCE CARE PLANNING IN HOSPITAL IN THE LAST YEAR OF LIFE: WHERE ARE WE NOW?

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Background Advance care planning allows individuals with a life-limiting illness to plan ahead with their preferred wishes for treatment and care towards the end of life. Many patients in the last year of life are likely to experience an unplanned hospital admission. It is recommended hospital healthcare professionals should feel equipped in their roles to implement advance care planning. However, significantly low numbers of patients have a documented advance care plan.

Aim The aim was to explore the experiences of hospital healthcare professionals when delivering advance care planning with patients in the last year of life.

Methods Systematic synthesis of qualitative literature. Four databases were searched for primary research studies written in English language between 2013 to present. The search yielded 671 articles for screening. Studies were excluded if they included specialist palliative care practitioners and if

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.

79 DOES THE ANTICIPATION OF DEATH INCREASE THE LIKELIHOOD OF HOSPITAL INPATIENTS RECEIVING SPIRITUAL OR RELIGIOUS CARE DURING THEIR FINAL ADMISSION? RESULTS OF AN AUDIT OF PATIENT RECORDS FROM A TERTIARY CARE CENTRE IN CENTRAL ENGLAND

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Background The National Institute for Health and Care Excellence (2015) states that end of life patients should receive a holistic, tailored care plan, encompassing physical and psychological treatment, alongside social, emotional, spiritual and religious support. Spiritual and religious support has proven to be an important facet of palliative care.

Objectives To investigate whether the anticipation and recognition of death during hospital inpatients' final admission increases the likelihood of these patients receiving spiritual or religious care at the end of life.

Methods Anticipation of death was measured using three markers: (1) initiation of comfort observations (CO), (2) completion of a DNA CPR form, (3) visit from the palliative care team. Records of patients' final admission were scrutinised for evidence of anticipation of death and spiritual or religious care. Documented chaplaincy visits were utilised as surrogate markers of spiritual or religious care.

Results The sample population comprised patients who died in hospital in August 2019; 116 patients were included. Only 18.1% of the total population received a chaplaincy visit. This percentage increased when death was anticipated using the three markers. If seen by the palliative team, the percentage visited by a chaplain increased to 38.3%, if CO were initiated, 21.8%, and with a DNA CPR in place, 20.2%

Conclusions Current efforts in providing spiritual and religious care are poor; under a quarter of end of life hospital

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.

80 A DEATH BY ANY OTHER NAME: THE USE OF EUPHEMISMS 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. Data were tabulated and analysed using Microsoft Excel.

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.

81 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