

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.

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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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10.1136/spcare-2021-PCC.97

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.

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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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10.1136/spcare-2021-PCC.98

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.

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

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10.1136/spcare-2021-PCC.99

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