Improving Compliance with Statutory Death Certification, at a City Centre Tertiary Teaching Hospital: A Quality Improvement Project

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Introduction Medical certificate cause of death form (MCCD) completion is seen as a daunting process, especially for junior medical staff. Death certification is an expectation of all doctors, as set by the general medical council. Quick completion of medical examiner referral forms (MERFs) and MCCDs positively impacts on patients’ families. This requires confidence and knowledge in certifying death, which is why our quality improvement project aims to assess and improve.

Method

We brainstormed our stakeholders, created a driver diagram and SMART aims: 1) For 100% and 75% of MCCD’s to be completed within five and three days from death, respectively and 2) To improve junior doctor confidence in the death certification process at Manchester Foundation Trust (MFT). We collected qualitative data through an anonymized survey and quantitative data including time from death to MERF and MCCD completion from December 2020 – March 2021. Our interventions included teaching incoming junior doctors and creating visual aids to display in key clinical areas. The above data was re-audited from September – October 2021.

Results

Almost all of MCCDs were completed within five days, 95% (129/136), versus pre-intervention findings of 98% (128/133). The number of MCCDs completed within three days improved from 51% (68/133) pre-intervention to 66% (90/136) post-intervention. Confidence in completing MCCDs improved from 0% to 33%. MCCD completion times varied widely and there were a significant number of patients in whom it was not within the legal requirement of five days. Despite education and visual aids, junior doctors at MFT feel that there should be more senior support when completing MCCDs. There needs to be ongoing education around death certification including annual face-to-face teaching sessions for incoming junior doctors.

Conclusion

Junior doctors lack confidence and insight into the responsibility surrounding MCCD completion at MFT. This needs to be addressed through ongoing focus and education.

Let’s Stick Together: What Are the Relationship Needs of Caregivers of People with Dementia at the End of Life?

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Background

Globally, the incidence and prevalence of dementia are increasing exponentially. Caregiving is a clinically and socially relevant issue to dementia care. Informal care provision is a strong determinant of social and health inequalities throughout the life course (European Centre for Social Welfare Policy and Research 2021). Therefore, understanding the needs of caregivers is essential in terms of improving future dementia care worldwide.

Methods

A systematic review was conducted using the PRISMA framework and a narrative synthesis was performed. The electronic databases searched were APA PsycINFO, Ovid AMED, CINAHL by EBSCO, Cochrane Database, Ovid EMBASE, Ovid EMcare and Ovid MEDLINE. Inclusion criteria: English-language studies. Population: adults aged >18 years identified as informal caregivers of a formally-diagnosed person with dementia (PWD). Phenomenon of interest: psychological needs. Context: end of life (EOL) period of PWD.

CAREGIVER VIEWS AND EXPECTATIONS ABOUT THE USE OF ARTIFICIAL HYDRATION IN THE MANAGEMENT OF DYING PEOPLE WITH ADVANCED CANCER: A QUESTIONNAIRE STUDY

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Background

Evidence for the use of artificial hydration (AH) in people dying with cancer is inconclusive, which creates challenges for healthcare professionals. These situations can be distressing for family caregivers, who may have unmet information needs. Better understanding of caregiver perspectives about AH in the dying, can potentially help healthcare professionals to identify information needs to improve support for caregivers.

Aim

To examine caregivers’ beliefs, experiences and information needs about AH use in people dying with advanced cancer.

Methods

Questionnaire study of the caregivers of people with advanced cancer, who were participants on a research study (evaluating the association between hydration status with clinical cancer outcomes). Caregivers were recruited from 3 UK study sites, consisting of 2 hospices and 1 hospital palliative care inpatient unit.

Results

Fifty-two caregivers participated. Most participants were female (N=38, 73.1%) and aged between 50–59 (N=12, 23.1%) and 60–69 (N=13, 25%). Most participants (N=33, 63.5%) said they were not aware of the term ‘artificial hydration’. Most (N=35, 67.3%) believed that AH represented good care for the patient, with the majority stating that AH improved thirst (N=33, 63.5%) and dry mouth (N=30, 57.7%). Most participants did not believe AH affected prognosis, with 11 (21.2%) stating that AH prolonged life and 8 (15.4%) indicated that prognosis would be shorter without AH. Most expected AH to be available for patients in hospitals (N=42, 80.8%), hospice (N=43, 82.7%), nursing home (N=37, 71.2%) and home (N=31, 59.6%) settings. Most participants believed patients had the right to demand (N=39, 75%) or refuse (N=48, 92.3%) AH in the dying phase.

Conclusion

Our study provides information about caregivers’ views and expectations of the use of AH in dying cancer patients. Researchers should explore how healthcare professionals can better identify and address unmet information needs of caregivers, concerning the use of AH in the dying.
Results Caregivers identified three key relationship needs whilst caregiving for a PWD at EOL: i) the need for connection and intimacy at the EOL (including opportunities for forgiveness and rebuilding relationships); ii) the need to find joy and positivity and iii) the need to say goodbye.

Additionally, many caregivers reported the benefits of sharing experiences with other caregivers; it fostered a sense of solidarity, normalised the experience and offered validation from peers. Caregivers found emotional security in setting boundaries, building relationships with staff and having confidence in staff expertise. The need for caregivers to feel a sense of control during the EOL period was also identified. Role recognition in the form of both acknowledgement of caregiving duties and defining an identity outside the caregiving role were fundamental relationship needs.

Conclusion Caregivers wanted to feel listened to, primarily as advocates for PWD but also to validate their caregiving role and recognise the intimate knowledge that they have acquired whilst caregiving for a PWD at EOL.

LIVED EXPERIENCES OF END-OF-LIFE CARE AT HOME IN THE UK: A SCOPING LITERATURE REVIEW

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10.1136/spcare-2023-PCC.27

Background Home is the preferred place of care and death for most people with advanced illness and the proportion of people dying at home has risen sharply during the COVID-19 pandemic. However, little is known about the reality of end-of-life care in this setting for patients, their families and unpaid carers. We aimed to examine the published literature on these lived experiences.

Methods A scoping review was undertaken in accordance with the PRISMA-ScR checklist. All primary qualitative research papers published in the English language between 2010 and 2022 and exploring the lived experience of patients, families and/or unpaid carers in the United Kingdom were eligible for inclusion. The online databases CINAHL and MEDLINE were searched with relevant MeSH terms and keywords.

Results In total, 462 papers were screened, 58 underwent full text review and 13 studies were retained in the final set. All studies explored the experience of bereaved family and/or carers and only one study interviewed a dying patient. Where specified, the majority of experiences related to deaths from cancer, many with specialist palliative team involvement. No studies considered end-of-life care at home during the COVID-19 pandemic. The included papers yielded a breadth of diverse findings but the most common subject themes related to the availability and quality of care and support for families and carers.

Conclusion Currently, there is limited published evidence exploring the lived experience of those receiving and supporting end-of-life care at home. More research is needed to examine the first-hand experience of patients and to understand better the reality of deaths at home due to non-cancer conditions and where specialist palliative care services are not involved.

Poster Nos 8–10: Covid-19

8 THE EFFECT OF THE COVID-19 PANDEMIC ON IMMINENCE OF DEATH AMONGST NHS AYRSHIRE AND ARRAN HOSPITAL INPATIENTS

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10.1136/spcare-2023-PCC.28

Background A 2014 paper by Clark et al found that 28.8% of hospital inpatients in Scotland died within 12 months. In the years pre, during and post Covid-19 we wished to repeat this at a local level to see if there had been any impact of the pandemic on death rates within our inpatient population. Knowing this information may have an impact on hospital policies, realistic medicine implementation and palliative care service development.

Aim To establish the incidence of death during index admission and within the following 12 months of a cohort of NHS Ayrshire and Arran acute hospital inpatients on a given census date over a three year period 2019–2022.

Method A retrospective cohort study of all inpatients at University Hospital Crosshouse (UHC) and University Hospital Ayr (UHA), excluding paediatrics and obstetrics, on the date 31st March 2019, 2020 and 2021 was performed. Data was collected by Business Intelligence and analysed by researchers.

Results 720, 331 and 685 inpatients were identified on the given census date on all three years. End points were death at 7 days, 30 days, 3 months, 6 months, 9 months and 1 year. Rates of death at all end points were lower in 2019 and highest in 2020. The incidence of death at one year was 28.6% in 2019, 38% in 2020 and 31.2% in 2021. The incidence of death during index admission was 7.5% (2019), 14% (2020) and 9.2% (2021).

Conclusion Our results show that during the Covid-19 pandemic death rates during index admission and at all follow up points rose. They have now reduced but still remain higher than pre-pandemic levels. This data should assist in realistic medicine strategies as well as palliative care service development.

9 CARDIO PULMONARY RESUSCITATION (CPR) IN THE FRAIL AND MULTIMORBID; OUTCOMES BEFORE AND DURING THE COVID PANDEMIC

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10.1136/spcare-2023-PCC.29

Introduction SARS-COV2 placed greater emphasis on identifying frail or comorbid patients early and limiting treatment where appropriate. Resuscitation guidelines changed as cardiopulmonary resuscitation (CPR) was classified an aerosol generating procedure (AGP). We assessed the impact of these changes in our tertiary centre focusing on frail and/or comorbid patients.

Methods Retrospective analysis of prospectively collected data from contemporaneous clinical and electronic records for all patients with a recorded cardiac arrest between June 2020 and June 2021. Data collected on features of the cardiac arrest, clinical frailty scale (CFS), Charlson comorbidity index (CCI), survival at discharge, 30 days and 12 months. The