

Poster Nos 44–73: End-of-Life-Care

44 LET'S TALK ABOUT DEATH: COMMUNICATION BETWEEN HEALTHCARE PROFESSIONALS AND NEXT-OF-KIN

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Background or Introduction The rise of COVID-19 and subsequent decline in hospital visitation placed increased importance on the quality of communication between healthcare professionals and the next-of-kin at the end of life. Despite this, the general public perceived that sometimes information about their relative was not adequately communicated, and that there was a significant delay in important conversations about changes in management and prognosis. The National Institute for Health and Care Excellence (NICE) describes how prognosis should be discussed 'as soon as it is recognised that [the patient] may be entering the last days of life' and that prognosis should be clearly documented in the patients' care record to facilitate shared decision making.

Method(s) A retrospective case note review and audit was undertaken using data from patients who died in August 2020 in a large tertiary hospital in the West Midlands. Data collected included age, gender, diagnosis, details of admission, any changes in management and prognosis, any communication with relatives documented in the care record, and the presence of relatives in the last days of life.

Results Of the 67 cases audited, 42% had a clear documentation of prognosis in the case record prior to death. The average time delay between the identification of a significant patient deterioration and when this was communicated to the Next-of-Kin was 3.78 hours, and 3 cases had a delay of over 24 hours. A potential correlation was also identified between those who had the longest delay, and those who were least likely to have Next-of-Kin present in their last days of life.

Conclusion(s) Most conversations to notify Next-of-Kin of a significant deterioration were had within 4 hours of the deterioration. However, prognosis is not always clearly documented in the case record which raised potential for standardisation and creation of protocol to aid this process.

45 DYING FROM ACUTE STROKE: ORCHESTRATING AN AUTOETHNOGRAPHIC SONATA OF CARE

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Background It remains difficult to accurately predict when palliative and end of life care should be offered in non-malignant disease with stroke patients often experiencing a high prevalence of palliative care needs, including symptoms, when nearing the end of their life.

Methods This study took a predominantly evocative autoethnographic approach and draws together the experiences of both researcher and bereaved family members of patients cared for within an acute stroke ward. A Sonata Framework created for this study comprised four parts with an additional beginning (prelude) and ending (coda). Its structure mirrors the narrative and duration of the onset of the researcher's experiences following his mother's stroke, hospital care and discharge home to die. In addition, six adult primary relatives

of patients who died in hospital following an acute stroke were interviewed using a 16 question semi-structured interview schedule.

Results Data from six participants was analysed using Attride-Stirling's Thematic Model (2011) and presented utilising two themes: The Family Experience and Dying & Death. Findings suggested shortfalls in the provision of palliative and end of life care following acute stroke, although areas of good practice were identified. Overall, participants were complimentary of the care provided to their family member although the transition from acute to palliative was variable. The quality of communication between patients, relatives and staff was variable, with no evidence of engagement with the hospital palliative care team, nor any discussions instigated by staff relating to preferred place of death.

Conclusions This study provided evidence of some improvement in local palliative and end of life care provision when compared with previous research, although gaps in such provision still exist. Staff should receive palliative and end of life care training, including communication skills training to identify individuals who may be nearing the end of life and to instigate timely conversations with their family members. Further research relating to the provision of palliative and end of life care for individuals following an acute stroke is recommended.

46 UNDERSTANDING PATIENT AND FAMILY UTILISATION OF COMMUNITY-BASED PALLIATIVE CARE SERVICES OUT-OF-HOURS: SECONDARY ANALYSIS OF A SYSTEMATIC REVIEW

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Background Community-based out-of-hours services are an integral component of end-of-life care. The provision of out-of-hours services, however, is highly variable, and there is little understanding of how patients and families utilise these services. This review aims to understand and identify patterns of out-of-hours service utilisation and produce recommendations for future service design.

Method Data on service use was extracted and secondary analysis undertaken, from a systematic review of models of community out-of-hours services. In the original review, 61 papers relating to 54 studies were included. Narrative synthesis was completed, addressing four research questions on service use: 1. When do patients/families/healthcare professionals need out-of-hours services? 2. Who is contacting the out-of-hours services? 3. Is a telephone call, centre visit or home visit provided? 4. Who is providing the out-of-hours care?

Results Community-based out-of-hours palliative care services were most accessed in the evenings between 5pm and midnight, especially on weekdays (with reports of 69% of calls being made out-of-hours). Family members and carers were the most frequent contacts to the services, with studies reporting between 60% and 80% of all calls being from this group. The type of contact (telephone, centre visit or home visit) varied based on what was offered and on patient need. Over half of services were led by a single discipline (nurse).

Conclusions This secondary data analysis has illustrated out-of-hours services are highly used up to midnight, particularly by patients' family and carers. Recommendations to commissioners and service providers:

- Ensure telephone services are available between 5pm and midnight.
- Prioritise family and carers in the design of out-of-hours telephone services.
- Undertake further research with patients and families to understand when home visits or telephone calls are appropriate to meet patients' needs.

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CAN STAFF EDUCATION IMPROVE UTILISATION OF THE 'ALL WALES GUIDANCE: CARE DECISIONS FOR THE LAST DAYS OF LIFE' FOR PEOPLE APPROACHING THE END OF LIFE RESIDING IN NURSING HOMES? – A QUALITY IMPROVEMENT PROJECT

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Aims Recognition of when a person is approaching the last hours/days of life can be challenging for healthcare professionals with a search of the literature demonstrating that the dying phase is poorly recognised across different clinical and home settings. The provision of end-of-life-care for people approaching the last hours/days of life in Wales is supported by the All Wales Guidance: Care Decisions for the Last Days of Life (CDLDoL), however there is poor utilisation of this guidance in nursing homes (NH). A quality improvement project (QIP) was designed to evaluate if education on recognising the dying person and the CDLDoL would improve the utilisation of the guidance with the aim of improving the provision of end-of-life-care in NHs in the Cardiff area.

Methods Three NHs were recruited and ten teaching sessions across the three NHs were conducted. Data on all deaths was compared for a 6-month period pre- and post-intervention.

Results Before the teaching intervention, there were no residents (0%) that had their care guided by the CDLDoL. Following the teaching intervention, both qualified and non-qualified staff stated improved confidence in recognising when a person is approaching the end of life and providing end-of-life-care. 2 residents (6.5%) had their care guided by the CDLDoL and the percentage of residents with end-of-life medications prescribed at time of death increased from 56.5% – 76.2%.

Conclusion The QIP demonstrated that the teaching had a positive impact on the confidence levels of NH staff with improved provision of end-of-life-care. Further clinical research within the wider palliative care community on the dying phase should be conducted as well as further research into the perceived barriers and challenges of using the CDLDoL. The QIP will be extended across other NHs across Cardiff, as well as extending the teaching to GPs and community nurses.

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END-OF-LIFE CARE IN THE INTENSIVE CARE UNIT

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Background/Aims Many ICU patients continue to die despite advances in medicine. It is important to provide patients with dignified deaths. This includes symptoms assessment and management, spiritual, religious and psychological support for both patients and their families. The aim of the audit is to assess our current performance in providing end-of-life care in our ICU.

Methods A retrospective audit of patients who died between 1st July 2021 and 31st December 2021 at the ICU of Croydon University Hospital. Their electronic medical records were reviewed for assessment and management of end-of-life symptoms, provision of psychological and spiritual needs, patient and family involvement in end-of-life discussions and palliative care involvement.

Results 66 patients were studied. 37 of them were males and 29 females. 22 of the patients had a Covid positive status. The mean age of the patients was 60 years old. 77% of the patients were intubated. Of the intubated patients, 39% of patients had assessment for pain, 37% for agitation, 16% for secretions, 10% for nausea and vomiting and 12% for breathlessness. In contrast, 90% of the intubated patients had pharmacological management for pain, 88% for agitation, 92% respectively for secretions, nausea and vomiting as well as breathlessness. For the non-intubated patients, 85% of patients had pain and agitation assessments, 69% for secretions and breathlessness and 54% for nausea and vomiting. Spiritual support was offered in less than half (47%) of the patients. The local palliative care team were involved in a total of 12 cases.

Conclusions The most significant finding was the lack of documentation in our assessment of end-of-life symptoms in intubated patients. Many of the intubated patients had pharmacological management of their symptoms despite the lack of assessment as they were on sedatives. A dedicated end-of-life symptoms assessment section on the electronic system would be useful.

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ANTIBIOTIC USE IN THE LAST WEEKS OF LIFE ON AN ACUTE HOSPITAL'S SPECIALIST INPATIENT PALLIATIVE CARE UNIT

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Introduction End of life care prioritises early recognition of death and dying, and proportionate advance care planning (ACP). The National Audit of Care at the End of Life (NACEL) recommends timely communication regarding treatment options, including antibiotic use. Specialist palliative care teams often rationalise medications, but some patients who are approaching the end of life remain on antibiotics.

Aim & Methods To describe the practice of antibiotic prescribing for patients who have been admitted to a specialist inpatient palliative care unit within an acute hospital. The clinical records of all patients admitted in July 2022 were reviewed.

Results

Thirty-seven patients were admitted The median age was 84 years (range 52–101 years). Fifty-one percent were male.

Eleven (30%) patients were prescribed an antibiotic. Co-amoxiclav and Ciprofloxacin were most frequently used (45% and 27% respectively).