

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.

47

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

Catriona Seed, James Davies, Terri Gazi, Fiona Rawlinson, Mirella Longo. *City Hospice; Cardiff University*

10.1136/spcare-2023-PCC.67

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.

48

END-OF-LIFE CARE IN THE INTENSIVE CARE UNIT

Chooi Shawn Loh, Millie Watkins, Sundar Raj Ashok. *Croydon University Hospital*

10.1136/spcare-2023-PCC.68

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.

49

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

Ebun Abarshi, Michael Hadjihari, Elina Daitey, Bairavi Manoharan, Chinenye Ilozue. *The Margaret Centre, Whipps Cross University Hospital, London*

10.1136/spcare-2023-PCC.69

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).

Indications (n) chest sepsis (3), perforated viscus (2), colitis (1), bacteraemia (1), alcoholic hepatitis (1), urinary tract infection (1), unclear source (2).

The median antibiotic course length was 5 days (1–14). Median WCC: 13.8×10^9 cells per litre (3.6 to 45); Median C-reactive protein: 119.1mg/L (7 to 204).

Continuation of an antibiotic course was more likely if an IV cannula was in situ, and less likely when there was an alternative diagnosis.

A decision to prescribe antibiotics was documented as pre-emptively discussed with the patient in only 1%.

Conclusions 1. A significant proportion of patients that are identified as being in their last weeks of life are prescribed antibiotics

2. Decisions about antibiotic prescribing and ceilings of care were made as part of routine clinical care. This was without patient involvement and was not as a part of an ACP.

3. ACP, specifically including antibiotic use should be standard practice for all patients admitted to a specialist inpatient palliative care unit.

4. More research is needed, including evaluating patient acceptability.

50 RECOGNISING DYING IN MOTOR NEURONE DISEASE: A SCOPING REVIEW

Elizabeth Abbey, Maimoona Ali, Matthew Cooper, Paul Taylor, Catriona R Mayland. *Department of Oncology and Metabolism, University of Sheffield, School of Health and Related Research, University of Sheffield, Sheffield Teaching Hospitals NHS Foundation Trust*

10.1136/spcare-2023-PCC.70

Background Recognising when an individual is dying helps to guide clinical decision making and facilitate communication. Recognising dying, however, remains challenging for healthcare professionals (HCPs). Palliative care research in motor neurone disease (MND) is limited relative to other conditions. Our scoping review aimed to explore the recognition of dying in MND to inform the provision of high-quality end-of-life care.

Methods A scoping review was conducted according to Arksey and O'Malley's framework and Joanna Briggs Institute guidance. Five databases (Ovid MEDLINE, PubMed, PsycInfo, CINAHL and Scopus) were searched. Citations and grey literature were also searched. Screening and full text review were conducted by two independent reviewers and results thematically organized.

Results From 1067 papers, twelve studies were included. Studies spanned seven countries and included quantitative (n=7), qualitative (n=3), and mixed methods (n=2). Three themes were identified; 1) 'Symptoms and medical treatment in the last week of life'; 2) 'Circumstances leading to death'; 3) 'Challenges of recognising end of life'. Patterns of symptoms and medical management in the last week of life were described. Although variable, a picture of often rapid and unpredictable decline emerged, often over short hours to days. Challenges when recognising dying included preserved functional level late in the illness, and repeated episodes of revival after deterioration. The unique nature of the dying phase of MND was noted, and withdrawal of NIV adds complexity.

Conclusions Overall, few studies examined recognition of dying in MND. Research describes a high symptom burden with an often sudden terminal decline. To meet the needs of these patients, pro-active advance care planning is paramount.

Further research should explore the perspectives of HCPs and carers, to explore patterns of the dying process in this condition, how this is recognised, and ensure care is consistent with the needs, priorities, and experiences of stakeholders.

51 THE IMPORTANCE OF PLANNING: A COMPARISON OF THE USE OF ADVANCE CARE PLANS IN THE CARE HOME AND HOSPITAL SETTING

Elizabeth Fleming, Helena Spriggs, Anne Pelham, Elizabeth Tarala, Jolene Brown. *The Newcastle upon Tyne Hospitals NHS Foundation Trust, Health Education England North East*

10.1136/spcare-2023-PCC.71

Background Average life expectancy in UK care homes is 24 months in residential care and 12 months in nursing care. The Department of Health defines 'End of Life' as the last 12 months of a person's life and encourages advance care planning (ACP) discussions. In the North East Emergency Health Care Plans (EHCP) and Care for the Dying Patient Document (CDP) are used to support ACP and end of life care. This review compared to what extent ACPs were present for people who died in a hospital setting as opposed to a care home setting.

Methods Two retrospective audits reviewed notes of care home residents who died between April and October 2021. Audit one (A1) reviewed the notes of patients who died within seven days of admission to hospital using hospital records and recorded whether an ACP was present (n=69). Audit two (A2) reviewed notes of residents who died in a care home for evidence of ACP (n=67).

Results A1 showed 54 residents had a Do Not Attempt Cardiopulmonary Resuscitation form (DNACPR) in place prior to admission and 16 had an EHCP. A2 demonstrated 59 residents had a DNACPR and 40 had an EHCP. 38 of the EHCPs in A2 advised that hospital admission should be avoided. No care home residents in A1 were supported by the CDP document prior to admission. 30 residents from A1 died within 48 hours of admission into hospital. In A2 34 had an admission to hospital in the last three months of life. 37 residents in A2 were supported by the CDP.

Conclusions Residents who died in care homes had more evidence of ACP than those who died in hospital. This may suggest that ACP has a role in prevention of hospital admission for care home residents.

52 NEEDS ASSESSMENT OF END-OF-LIFE CARE IN THE EMERGENCY DEPARTMENT

Faith Jacob, Adam Hurlow, Stephanie Deddick-Dyson, Grace Fowler-Roughton, Aimee Ferguson, Suzie Gillon, Suzanne Kite, Elizabeth Rees. *Leeds Teaching Hospital Trust*

10.1136/spcare-2023-PCC.72

Background Improving end-of-life care (EOLC) in Emergency Departments (ED) is a top research priority for the Royal College of Emergency Medicine¹ Our hospital palliative care team created a Senior Clinical Nurse Specialist (CNS) role to facilitate quality improvement and address this priority. This project scoped the current workflow to identify needs and barriers to excellent EOLC in the ED.

Methods Retrospective review over ten months of patients' notes who received palliative care input, in ED. Baseline data