

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

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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

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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

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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