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END OF LIFE CARE FOR EXPECTED DEATHS IN PRISON CUSTODY: A SERVICE EVALUATION OF CURRENT PRACTICE IN FIVE PRISONS IN THE NORTH OF ENGLAND MAPPED TO THE DYING WELL IN CUSTODY CHARTER

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Background Deaths from natural causes are increasing in prison populations. The 2018 Dying Well in Custody Charter (DWCC)¹ aims to support delivery of holistic and individualised care for those dying in prison custody. We recognised the need to review expected prison deaths to better understand current practice and guide improvement.

Method A retrospective electronic notes review was performed for all expected prisoner deaths, within five prisons in northern England, across the calendar year of 2020. The DWCC Self-Assessment tool² was used to create ten assessment standards for use in this project. These were directly mapped to the DWCC ambitions. Data collected included evidence of multi-disciplinary team (MDT) working and advance care planning (ACP), documented DNACPR discussions, identification of dying and anticipatory medication prescribing.

Results Fourteen patients met inclusion criteria. 79% of deaths were due to cancer. 21% died in hospital and 79% died in prison. All had a DNACPR form in place. ACP occurred in 92.8%. Early release on compassionate grounds was considered in 79%. 86% had evidence of holistic needs assessment. Recognition of dying was documented in 57% and occurred between 7 hours to 1 month before death. 85.7% had some form of anticipatory medications prescribed. Palliative Care services provided support in 93%.

Conclusions Areas of good practice include engagement in ACP, DNACPR decision making and utilisation of palliative care services. Security and legal considerations were thoroughly and carefully considered. There were numerous examples of individualised care and collaborative MDT working in complex circumstances. Supporting skill development in recognition of dying and anticipatory prescribing were identified as areas for improvement. Despite the small sample size we believe this service evaluation provides an important snapshot of how patients are dying in prison custody. By sharing these experiences we hope to better support the delivery of holistic care in this setting.

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PILOT STUDY OF SYRINGE DRIVER PRESCRIBING PRACTICE HIGHLIGHTS CHALLENGES FACED BY NON-PALLIATIVE CARE TEAMS

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Background Data about continuous subcutaneous infusion (CSCI) prescribing is limited.¹ This survey reviewed practice

in the Surgical Emergency Unit (SEU) 01.08.22 – 03.12.22, using the Pallaborative Northwest guideline.² It aimed to determine the frequency and indication for CSCIs and to document the initial CSCI prescription.

Methods Data was collected prospectively, 07.10.22 – 03.12.22 with retrospective data added to increase sample size, 01.08.22 – 06.10.22. Electronic patient records were reviewed, data anonymised, and stored on NHS drives. Data was analysed by all authors. Ethics permission was not sought as the survey examined routine practice.

Results In 4 months, with greater than 1000 admissions, 26 CSCIs were initiated on SEU; 1 every 5 days. The indication, documented in (31%) or determined from the notes (69%) were; dying patient 61.3%, symptom control 31%, inappropriate prescription 7.7%.

All CSCIs contained opioids (73% morphine, 27% oxycodone). The median dose of morphine was 10mg/24 hours (IQR 10mg/24 hours), the median dose of oxycodone was 7.5 mg/24 hours (IQR 10mg/24 hours).

65% of CSCI contained an antiemetic (35% metoclopramide, 23.5% haloperidol, 41% cyclizine), 8% an antisecretory/antispasmodic agent (100% hyoscine butylbromide) and 50% an anxiolytic/antipsychotic (69% midazolam and 31% haloperidol).

77% of CSCIs were advised by the hospital palliative care team (HPCT). Of the other 23%, half were altered or discontinued because of concerns; CSCI not indicated, patient sedated, or concern about dose.

Commencing a CSCI was discussed with 23% of patients and 42% of families.

Conclusion CSCI prescribing on SEU is an infrequent event. Staff need support from HPCTs to guide initiation and medication doses. Initiation of a CSCI provides an opportunity to explore patient and family understanding and involve them in conversations about care. Learning will be fed back to SEU and hospital staff. Further larger scale data collection is planned in deanery to interrogate practice.²

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AN EXPLORATION OF FACTORS THAT PREPARE STUDENT NURSES TO CARE FOR DYING PATIENTS

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Background With an aging population, and an increasing incidence of long-term conditions, of which some cancers fit into this category as well as dementia, there will be a growing emphasis on end-of-life care provision (National Palliative & End of Life care partnership, 2015). Most patients receiving palliative care takes place within patients own homes, care homes and acute hospital wards (Department of Health, 2008; Virdun et al, 2015). Regardless of the environment, student nurses are on the front line of delivering this care.

Aim To explore factors which prepare student to care for dying patients.

Research Objectives

- Identify how current Care of the Dying education prepares student nurses to care for dying patients
- Explore what socio-cultural factors prepare student nurses to care for dying patients
- Gain an understanding of individual experiences of exposure to death and dying prior to commencing their nurse training

- Explore their individual experiences of caring for dying patients within clinical practice
- Develop an emerging theory to understand student nurses' perceptions and the impact that this has on the care delivered to dying patients

Methods (Design, Data collection and Analysis)

A constructivist grounded theory approach was utilised, influenced by the theoretical perspectives of symbolic interactionism and social constructionism. Students enrolled on an undergraduate degree programme were approached to participate in the study. Using theoretical sampling, data was collected from 18 interviews. Data analysis utilised initial, focused, and advanced coding techniques, supported by constant comparative analysis.

Findings Preliminary findings that emerged from the data are : Morality of Caring, Belonging, Socialisation of Dying and Antecedence. The theoretical insight gained from this study has provided a more detailed understanding of factors that prepare students to care for dying patients, an insight which will help to shape education delivery and practice support, as well as opportunities for future research.

58 WHAT SUPPORT DO CARE HOME RESIDENTS NEED FROM COMMUNITY SPECIALIST PALLIATIVE CARE?

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Objectives City Hospice is a community specialist palliative care (SPC) team caring for the population of Cardiff (372,000). A service evaluation was undertaken to review the scope of SPC input required for residents referred from care homes (residential and nursing homes).

Methods A mixed method evaluation was undertaken for all patients from care homes referred between 1st January 2019 and 31st December 2020. Key themes of the required input from the SPC team at first assessment were analysed by 2 Palliative Medicine Consultants. Data including demographics was entered into a Microsoft Excel spreadsheet, and statistical analysis performed.

Results 272 referrals (12% of total referrals) were from care homes during the specified time period, the majority with a non-malignant diagnosis (67%). 42 residents (15% of those referred) were not reviewed, dying from an acute deterioration before initial assessment. 81% of residents reviewed were deemed to have SPC needs, with only 5% of residents being discharged at first assessment. The main SPC needs identified at first assessment fell into the following categories: recognition of deteriorating condition; symptom control including ordering subcutaneous anticipatory medications in 69% of residents; Advance Care Planning (ACP) including DNACPR decisions in 89% of residents, establishing preferred place of death (PPD) in 94% of residents and completion of an ACP document in 58% of residents; facilitation of communication; supporting care home staff.

Conclusions Community SPC teams have an important role in supporting residents, care home staff and primary care in delivering high quality palliative care to care home residents approaching the end of life. This service evaluation has highlighted that the majority of care home residents have SPC needs and highlights the key themes of need. Meeting these

needs resulting in achieving PPD in 96% of nursing home and 88% of residential home residents.

59 THE IMPACT OF ETHNIC BACKGROUND ON ACCESS TO COMMUNITY PALLIATIVE CARE SERVICES IN CARDIFF

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A recent study describes inequitable end of life care was received by those from minority ethnic groups during the pandemic.¹ This supports existing literature describing disparities in care received by these groups including lower access to care and higher unmet needs.²

In Wales, Cardiff and the Vale has the highest proportion of Black, Asian and Minority Ethnic people. This service evaluation describes the current situation in the community palliative care service for people living in Cardiff. Quantitative data was collected in a cross-sectional, retrospective review of records for all patients who were known to the service and died in 2021.

Data included 818 patient records, of which 591 had documented self-reported ethnicity. 95% of patients were from White Ethnic background, compared to 84% of the Cardiff population. Data was compared between the White Ethnic group and combined Minority Ethnic groups. A number of data points were similar; average age (77.3 vs 74.2 years), time between referral and death (88.5 vs 82.4 days) and proportion who died at home (72% vs 75%). There were some differences, including diagnosis at death with 68% of those from the White Ethnic group dying from cancer compared to 44% of Minority Ethnic groups. Additionally, those from minority groups were less likely to have documented preferred place of death (81% vs 87%) but where discussions had taken place, were more likely to achieve this (92% vs 86%). Finally, religion was documented more often in Minority Ethnic groups (81% vs 59%).

This paper shows a difference in the expected proportion of people from different ethnic groups referred to the community palliative care team. Discussion examines the data more closely exploring reasons behind this. It concludes further in-depth qualitative data is needed on a local level to explore individual experiences of care and potential existing barriers to referrals.

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60 ENABLING EXCELLENT END OF LIFE CARE IN THE ICU

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Background Prior to the COVID-19 pandemic, an estimated 10–20% of the UK population died in the intensive care unit