

66 IDENTIFICATION OF DYING PATIENTS BY TEAMS PROVIDING GENERALIST PALLIATIVE CARE WITHIN NHS AYRSHIRE AND ARRAN

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Background The national SEECare audit aimed to evaluate the provision of generalist-led end-of-life care in hospital adult in-patients. The audit was replicated within NHS Ayrshire and Arran in June 2022. Results of the SEECare audit are predicated on hospital teams recognising when patients not known to specialist palliative care are dying. Local audit identified that hospital teams are not recognising that patients are dying timeously and further investigated this.

Methods As a supplement to the SEECare audit, the number of hospital in-patients who died in the 7 days following the snapshot audit were identified, and their age and cause of death investigated.

Results 7 acute hospital in-patients were identified by their parent team as imminently dying. A further 17 patients who would have been eligible for inclusion in the audit died in the subsequent 7 days.

Median number of days from the audit to death was 4 days. 71% of these patients had an infection listed as their primary cause of death and mean age of these patients was 77 years (versus 85 years for those identified as dying).

Conclusion The SEECare audit format assesses quality of end-of-life care for patients identified as dying. There is a risk that those not identified as dying receive poorer quality end-of-life care. The majority of the patients not identified as dying, but who subsequently did, had an infection listed as their primary cause of death. This may signify uncertainty of response to antimicrobial treatment. This prognostic uncertainty should be shared with patients and carers to allow full assessment of their holistic needs. The difference in mean age between those identified as dying and those not may reflect doctors erring on the side of erroneously continuing treatment in younger patients.

67 FACTORS ASSOCIATED WITH RECORDING A PREFERENCE FOR PLACE OF DEATH OR NOT. ANALYSIS OF ROUTINELY COLLECTED DATA FROM AN ELECTRONIC PALLIATIVE CARE COORDINATION SYSTEM BEFORE AND DURING THE COVID-19 PANDEMIC

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Background The consideration, recording and sharing of where individual patients would prefer to die are core elements of advance care planning and help ensure care is in keeping with patients' wishes.

Aim To explore the factors associated with recording a preferred place of death in Coordinate My Care, a large Electronic Palliative Care Coordination System in London.

Methods Adults who created a Coordinate My Care record between 01/01/2018 and 05/03/2021 were included. Multivariate logistic regression modelling was used to identify demographic and clinical factors associated with documenting a preference for place of death, as well as timing (before and

during the COVID-19 pandemic) and setting of record creation

Results 72,591 records were included (52,006 (71.6%) with a recorded preferred place of death and 20,585 (28.4%) without). Individuals with a recorded preferred place of death were more likely to be aged over 80 (compared to <80) OR: 1.19, CI 1.14 – 1.24), require assistance for their functional needs (WHO performance status 4 compared to 1, OR: 1.28, CI 1.19 – 1.37), have a 'Do Not Attempt Cardio-Pulmonary Resuscitation' status (OR: 1.70, CI 1.60 – 1.80), be from the least deprived areas (compared to most deprived, OR: 1.08, CI 1.01 – 1.16), live in a care home (OR:1.42, CI 1.35 – 1.50), created their record during the first wave of the pandemic (compared to pre-pandemic OR: 1.56, CI 1.49 – 1.63), and create their record in the General Practice setting (compared to at an hospital setting OR: 1.42, CI 1.34 – 1.53).

Conclusions People's health and socio-economic status, and the COVID-19 pandemic, were associated with recording a preference for place of death. When exploring what matters most to people approaching the end of their lives and providing patient centred end-of-life care, these factors have important implications for patient empowerment and professional training.

68 DYING WITH PARKINSON'S DISEASE: A SURVEY OF CLINICAL PRACTICE

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Background Patients with Parkinson's disease (PD) may have an unsafe swallow and unreliable absorption of oral dopamine therapy when dying. First line symptom management medication have anti-dopaminergic activity. Transdermal dopamine replacement, rotigotine, may cause delirium.

Aims To understand prescribing practice for patients with PD at end of life in an acute hospital.

- dopamine replacement therapy
- adjustments to treatment where signs of rigidity or symptoms and signs of delirium
- medication use in symptom management.

Methods Deaths where PD/atypical PD entered on medical certificate of cause of death (MCCD) were collated in a 12-month period 2021.22. A data collection form was tested and refined. A convenience sample of deaths (60%) was selected. Electronic patient records were reviewed, anonymised data collected and stored on secure NHS drives. Data was analysed by all authors. Ethics permission was not sought as the survey examined routine clinical practice.

Results 55 patients had PD/atypical PD on their MCCD over a 12-month period, 2% of all adult inpatient deaths. 31 patients had idiopathic PD, 1 Multisystems atrophy and 1 Progressive Supranuclear Palsy in the sample. The severity of PD was mixed. 79% were recognised to be approaching the end of life. Where death was expected, 7 were prescribed orodispersible dopamine replacement therapy, 20 transdermal therapy, all had dopamine replacement therapy. No prescription was adjusted, though agitation and/or delirium noted in 50% of patients. Anticipatory medications with anti-dopaminergic activity were prescribed in 58% of expected deaths and in 50% where death was not expected. Where death was expected, advice was sought from palliative care (79%