**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.

**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 Cardiac-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.

**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% of...
patients), inpatient PD specialist nurse (7%) and neurologists (4%).

Conclusion Prescribing practice in patients dying with PD needs improvement. Prescribing guidelines were disseminated locally and educational content developed to improve practice.

**ANALYSING THE IMPACT OF THE COVID-19 PANDEMIC ON CLINICIANS’ PERCEPTIONS OF THE RESPECT PROCESS: A CROSS-SECTIONAL SURVEY OF HOSPITAL CLINICIANS IN THE UK**

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**Introduction** The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process encourages collaboration between clinicians, patients, and relatives on emergency wishes and resuscitation decisions. While the COVID-19 pandemic disrupted aspects of the ReSPECT process, the impact on clinicians’ views of ReSPECT was unknown.

**Objectives** The aim of this project was to examine whether there were changes in clinicians’ knowledge, skills, and attitudes regarding the ReSPECT process during the pandemic.

**Methods** We conducted a cross sectional survey of senior clinicians at one acute hospital in the UK. We developed a questionnaire with a defined 5-point Likert scale and asked clinicians to recall their views on ReSPECT before the COVID-19 pandemic as well as report their current views at the time of survey distribution (last two weeks of May 2020, end of the first COVID-19 wave in the UK). We compared their retrospective self-rating of their pre-pandemic views and current views during the pandemic.

**Results** We analysed 171 questionnaire responses. During the pandemic clinicians’ self-reported knowledge in conducting ReSPECT discussions increased (pre-pandemic median 4, IQR 2; during pandemic median 4, IQR 1; p < 0.001). Their skills (pre-pandemic median 3, IQR 1; during pandemic median 3, IQR 1; p < 0.001) and confidence (pre-pandemic median 3, IQR 1; during pandemic median 3, IQR 1; p < 0.001) in conducting ReSPECT discussions with relatives over the phone increased. Negative emotions whilst conducting these discussions with relatives increased during the pandemic (pre-pandemic median 3, IQR 1.5; during pandemic median 3, IQR 2; p < 0.001).

**Conclusions** There were differences in clinicians’ knowledge, skills, and attitudes scores on ReSPECT before and during the pandemic. Our findings highlighted that clinicians could benefit from training in remote ReSPECT conversations with relatives.

**THINK LIVER: A QUALITY IMPROVEMENT PROJECT ON ANTIPSYCHOMATIC PRESCRIBING FOR PATIENTS WITH ADVANCED LIVER DISEASE**

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**Introduction** Advanced Liver Disease (ALD) is the second leading cause of premature death in 35–49-year-olds. Symptom burdens are high, and place of death is often hospital. Specialist advice in the form of guidelines is invaluable for junior doctors to provide timely, effective symptom management. At Royal Albert Edward Infirmary an ALD symptom management guideline was published in March 2022. A QIP was undertaken to increase junior doctor guideline awareness and confidence, and improve prescribing practice.

**Methods** Junior doctors were surveyed for awareness of guidelines and confidence in prescribing, with scores of 1–5. Concordance for anticipatory medication prescriptions was audited, including medication choice and dose (July 2021–November 2022). Interventions undertaken included: peer-teaching for rotating junior doctors, prescribing-aid posters, and reminder emails (June-October 2022). Awareness, and confidence levels were re-surveyed post-intervention and compared by T-test. Concordance was re-audited and trend and special cause variance assessed by run charts.

**Results** On a score of 1–5, awareness of guidelines increased from an average score of 1.29, to 4.78 (p<0.001) post-intervention. Prescribing confidence increased from an average score of 2.75 to 4.67 (p<0.001). Concordance with guidelines for all anticipatory medication choices significantly increased from 84.7% pre-intervention to 96.2% post-intervention (p=0.019). Run-chart data showed a significant positive shift in percentage of medication choices concordant with guidelines from July to October 2022. Concordance for opiate choices increased from 55.6% to 83.3%(p=0.030) but run-chart data showed no special cause variation. For anticipatory medication dosing, there was no significant change in prescribing performance, with concordance rising from 60.3% pre-intervention to 64.1% post-intervention (p=0.293) and run-chart data showed no special cause variation.

**Conclusions** Interventions resulted in greater junior doctor awareness, confidence, and improvement in anticipatory medication choices. Further work is required to highlight lower doses of anticipatory medications advised in ALD and to maintain awareness given junior doctor rotations.

**VIEWS OF CARE AT END OF LIFE: A SECONDARY ANALYSIS OF ONLINE FEEDBACK USING CARE OPINION**

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**Introduction** In Scotland, there is an increasing focus on patient experience as an aspect of patient safety and quality improvement. However, there are limited studies specifically investigating the content of online public feedback about palliative and end-of-life care services. This study sought to understand experiences of end-of-life care provided in hospitals in the West of Scotland by exploring the main themes within the content of stories posted on a nationally endorsed nonprofit feedback online platform, Care Opinion, within a 2-year period.

**Methods** An ‘Appreciative Inquiry’ lens was chosen to guide this study to determine what works well in end-of-life care, while also identifying areas for further improvement. We gathered and thematically analysed public feedback stories, and their associated staff responses, posted on Care Opinion Scotland over a 24-month period (March 2019 to 2021) relevant to end-of-life care provided in acute hospitals the Greater Glasgow and Clyde area.