

advocated across all healthcare settings and the results can highlight deficits in service provision, knowledge, and skills (Care Quality Commission. Learning from deaths – A review of the first year of NHS trusts implementing the national guidance. 2019). This learning can then be used to inform service delivery and educational needs.

Aims To review the deaths of patients dying within their own home, hospice, hospital, and care home setting. Highlighting exemplary or poor experiences and exploring factors which contributed towards patients dying contrary to a patient's preferred place of death (PPD).

Method Each month a multidisciplinary team met to review patients chosen at random by a non-clinical team member. Patients' records were reviewed using an audit tool devised by the team evaluating areas including recognising dying, communication, symptom control, advance care planning (ACP), and PPD.

Results

- Between April 2022 and March 2023 a total of 40 patients were reviewed.
- 90% of patients discussed had ACP discussions documented.
- 72.5% of patients had achieved their PPD.
- For the majority of patients, there was excellent documentation regarding recognising dying and communication with families.
- Timely symptom control was being achieved by collaborative working.
- Patients in residential settings often had limited input from specialist palliative care.

Conclusion The data highlighted some excellent examples of care, and also identified some areas of improvement to action which included:

- Advocating earlier referrals into the hospice, ACP discussions and use of the electronic palliative care register.
- Recommending ACP is reviewed and updated regularly particularly RAG status when patients are deteriorating.
- Promoting clear documentation specifically regarding communication with family members.
- Encouraging early referral to the hospital palliative care team for patients admitted to an acute hospital to enable timely assessment.
- Promoting specialist palliative care services within local residential homes with support from the hospice education team.

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A CASE NOTE REVIEW: TESTING A PROCESS AND GATHERING DATA ACROSS THE INDEPENDENT HOSPICE SECTOR TO UNDERSTAND THE QUALITY AND OUTCOMES OF END OF LIFE CARE

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Background The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of end of life care in acute, community hospitals and mental health settings in England, Wales and Northern Ireland which comprises four separate elements, one of which is a case note review using a pre-designed template. Hospice UK amended the tool (with permission) to align with hospice care, and with the encouragement of the Executive Clinical

Leads in Hospice and Palliative Care (ECLiHP) Executive, member hospices were invited to take part.

Aims (1) To test the suitability of the NACEL case note review tool for the independent hospice sector, and (2) To understand the level of care being experienced by those dying during their hospice admission, and of those important to them.

Methods Several iterations of the template were tested using Plan Do Study Act (PDSA) methodology, 81 hospices registered interest and 69 hospices undertook a review of deaths that occurred from 1 – 21 February 2023 and submitted their data.

Findings 54% (n=37) of hospices returned feedback; 95% stated they had all the information they needed, 100% stated they could access the online form.

“It was a very useful exercise which highlighted to us that we don't write down everything in enough detail...” and “there were too many questions so it took a long time to review each set of notes”.

Of the 650 case notes reviewed, 56 graphs of aggregated data were created in a report so that hospices are now able to use the data for their own improvement plans.

Conclusion This collaborative exercise was the first across independent hospices, and highlighted several areas of practice hospices can include in their improvement plans. In terms of the process, while overall successful, iterative changes could be made if further rounds of audit are considered.

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END OF LIFE INPATIENT UNIT ADMISSION... OR NOT? A REVIEW OF HOSPICE ADMISSIONS

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Background It is widely recognised that accurately diagnosing end of life can be challenging (Taylor, Dowding, Johnson. *BMC Palliat Care*. 2017;16:1–1; National Institute for Health and Care Excellence. Care of dying adults in the last days of life. [NG31], 2015) and deciding when to refer for end of life care at a hospice inpatient unit (IPU) is often difficult. However, it is important to optimise end of life care, ensure patients' preferred place of death (PPD) is met, families' expectations can be managed and that patients can be transferred safely (National Institute for Health and Care Excellence. End of life care for adults: service delivery. [NG142], 2019).

Aims Analysis of IPU admissions, including days until death, to calculate the appropriateness of admissions for end of life care. Analysis of symptom control admissions to determine whether these became end of life and implications regarding end of life diagnosis.

Methods Data extracted from electronic records of patients admitted July to December 2022. Split into end of life care and symptom control arms, and then calculated the length of stay also split between those dying in IPU and those discharged and produced frequency charts.

Results Total of 81 admissions July-Dec. 2022:

- End of life. 36 (44%), of these 34 (94%) died in hospice, 2 discharged.
- Symptom control. 45 (56%), of these 30 (67%) died in hospice, 15 (33%) discharged.