

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.

Length of stay for end of life admissions tended to be a few days, 61% dying by three days, suggesting when diagnosed as end of life, this is likely to be accurate, but 39% dying within one day could indicate late diagnosis or delayed admission. 67% of symptom control admissions died in hospice, 30% within three days, suggesting possible under-diagnosis of dying.

Conclusion Evaluation indicates that end of life referrals are appropriate, but short duration of admission suggests either late diagnosis or delays in admission. High percentage of symptom control admissions becoming end of life may indicate under-diagnosis of symptom control patients. Better recognition of dying and ongoing review of admissions process will help optimise end of life care and IPU bed prioritisation.

P-126 **LIVED EXPERIENCES OF END OF LIFE CANCER CARE DURING COVID-19 – SECONDARY QUALITATIVE ANALYSIS**

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Background COVID-19 impacted end-of-life experiences for all people bereaved during the pandemic, whilst also affecting the services that support them (Harrop, Goss, Farnell, et al. *Palliat Med.* 2021;35(10):1985–97). Evidence suggests that the grief experiences of those bereaved during the height of the pandemic may be even more devastating than in usual circumstances (Torrens-Burton, Goss, Sutton, et al. *Palliat Care Soc Pract.* 2022;16:26323524221092456; Smith, Wild, Ehlers. *Clin Psychol Sci.* 2020;8(3):464–76; Selman, Farnell, Longo, et al. *Palliat Med.* 2022;36(4):717–29). Restrictions on services, such as hospices, care homes and third sector organisations, led to inadequate cancer care from specialties usually well equipped to provide sensitive end-of-life care (Smith, Wild, Ehlers. 2020).

Aims To explore the end-of-life care experiences of people whose friends/relatives died of cancer during the COVID-19 pandemic, including: (a) impacts on coping and wellbeing; (b) impacts of restrictions in different care settings; (c) features of good and sub-optimal care, communication and support, and (d) implications for improving patient care and family support in cancer and palliative care settings.

Methods Secondary, inductive thematic analysis of qualitative survey and interview data (survey N=156; interview N=10), collected as part of a national COVID bereavement study (Harrop, Goss, Farnell, et al. *Palliat Med.* 2021;35(10):1985–97). Baseline surveys and first telephone interview data were used.

Results Four key themes were identified: The impact of COVID-19 on contact with end-of-life patients; Mixed experiences of support; Poor communication from health and social care professionals (HSCP); Prioritisation of COVID-19 and the impact on patient care. Hospital care was perceived more negatively than community care in almost all areas, with support from cancer charities and district nurses appreciated the most. Almost all participants felt that COVID-19

was detrimentally prioritised over care for their relative/friend.

Conclusions These experiences reflect those described in all cause COVID bereavement literature, (Harrop, Goss, Farnell, et al. *Palliat Med.* 2021;35(10):1985–97) however, with greater emphasis on the injustice of de-prioritising cancer care, disregarding regulations in favour of time together and appreciation for compassionate community services. As services re-build post-pandemic, improvements in communication around hospital palliative care, significant investment into community care, and improved service integration is recommended.

P-127 **SOCIAL SUPPORT IN PALLIATIVE CARE – PATIENT PERSPECTIVES ON HOSPICE DAY SERVICES SINCE THE COVID-19 PANDEMIC**

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Background Unmet social needs in palliative care can be a component of suffering towards the end of life. Social isolation or loneliness in patients is associated with low mood, pain, and increased caregiver burden. Hospices in the UK provide a range of day and outpatient services that facilitate social support for patients and caregivers. These interventions are thought to improve wellbeing and quality of life, however, there is limited work interrogating the contexts and mechanisms through which these groups can lead to positive outcomes.

Aims This research aims to develop evidence-based explanations of how social support interventions can improve outcomes in palliative care, for whom, and in what circumstances.

Methods Previous work has developed initial programme theories, initially through interviews with hospice staff (n=19) and researcher observations of day services (n=12), followed by focus groups with hospice staff (n=30). These theories have now been 'tested' through interviews with palliative care patients from five hospices in England (n=18).

Results The physical and social restrictions of life-limiting illness can give rise to social isolation and loneliness. The hospice group environment provides opportunities to engage in reciprocal support – patients share useful information, empathy, and humour – which can contribute to feelings of belonging, or peace of mind about the future. Engaging in new or adapted activities can help to restore meaning and boost mood. These experiences help attendees to cope with the challenges of life-limiting illness and reach a point of acceptance with their mortality.

Conclusion The findings of this research detail how and why social support with others 'in the same boat' enables people with life-limiting illness to adapt to change and prepare for the future. Social settings within hospice day services may be impactful in reducing or preventing distress for patients, and in alleviating perceived burden on caregivers or family members.

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