IS AN END OF LIFE CARE SURVEY AT THE BEREAVEMENT APPOINTMENT ACCEPTABLE TO CARERS?

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Methods We surveyed deceased patients’ next of kin (NOK) on the care they felt their relative received in their last admission to hospital. The survey was conducted from July 2016 to June 2017 within a large teaching hospital. A 28 question survey focused on communication with the patient and those important to them, management of their symptoms, care and dignity shown to the patient, fluids and nutrition at end of life, and care of those persons important to the patient. This mirrored the local and national end of life care guidance. The survey was initially posted to the deceased patients registered NOK 2–6 weeks after death. However it became apparent that the details for the NOK were not fully completed in the hospital records and this only allowed contact with 39% of NOK. From September 2016 it was decided to trial distributing the survey at the bereavement appointment, this is the time when the NOK receives the death certificate. The survey was paired with a covering letter detailing bereavement support information and self-addressed envelope for return. Maternal and neonatal deaths, suicide, cases accepted by the coroner and deaths in A and E were excluded. The team also used their discretion when handing out surveys and if they felt it would complicate a person’s grief they excluded them.

Results 297 completed surveys were returned over the 12 month period. There was only one complaint regarding the survey itself. This complaint related to a survey sent at 6 weeks.

There were no verbal complaints to any staff members involved in the survey process and the process was acceptable to staff.

Conclusion This study suggests that it is acceptable to carers and staff to sensitively distribute a bereavement survey at the bereavement appointment.

QUALITY OF DEATH OF RENAL PATIENTS DYING IN ACUTE HOSPITAL – DOES RENAL SUPPORTIVE CARE (RSC) LEAD TO BETTER DEATHS?

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Methods Retrospective chart review of all deaths in the acute hospital under a Nephrology service in the years 2004 (establishment of RSC), 2009 and 2014 at St George Hospital (SGH) and in 2009 (establishment of RSC) and 2014 at Concord Repatriation General Hospital (CRGH).

Results 66 patients died with PELiCan pathways in place. 63 of 68 (92.65%) were reviewed daily by the Supportive and Palliative Care Team (SPCT) between starting a PELiCan and their death. Contact details were recorded in only 44 of 68 documents (64.71%), and PPD, in 46 of 68 documents (67.65%). However, the carer was documented as aware of the prognosis in 63 of 68 documents (92.65%).

Conclusion The trust met its internal target (90%) for SPCT reviews and carer notification of prognosis, but fell short in documenting PPD. Reviewing the notes, it is feasible that important discussions with families were taking place, but remained insufficiently documented. The authors intend this audit to be developed into a quality improvement project which will familiarise ward teams with PELiCan documentation and the most important areas for completion. The audit will then be repeated.