

67 END OF LIFE CARE REGISTERS IN UK RENAL UNITS

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Background The End of Life Care in Advanced Kidney Disease Framework suggests identifying patients approaching the end of life using a register to facilitate care planning, improve communication, co-ordinate service delivery and provide bereavement support. We aimed to survey the use of these registers in UK Renal units.

Methods Anonymous structured questionnaires were distributed electronically to UK Renal units.

Results 59% of respondents formally identified patients using a register. The commonest methods used to identify these patients included worsening symptoms despite optimal management (100%), deteriorating performance status, increasing care needs (95%) and unplanned hospital admissions (80%). Registers triggered interventions including discussions about resuscitation status (100% of units using registers compared with 50% not using registers), advance care planning (95% of units using registers compared with 43% not using registers), communication with GP (90% of units using registers compared with 50% not using registers) and referral to palliative care services (80% of units using registers compared with 21% not using registers). 88% of respondents discussed these patients with palliative care teams and 15% invite palliative care professionals to their MDT meetings. 21% use a structured pathway to withdraw dialysis. Nearly half of units surveyed did not use a formal bereavement pathway for the deceased's next of kin.

Conclusions This survey suggests that many UK Renal units use a register to formally identify dialysis patients approaching the end of life and use similar methods to identify these patients. Our results also suggest that these registers are effective in facilitating advance care planning, improving communication and coordinating care. However, the results suggest significant variation between units in follow up and provision of bereavement support.

68 THE IMPACT OF ADVANCE CARE PLANNING ON DYING IN HOSPITAL

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Background Fewer than half of patients opt to die in hospital, yet this remains the most common place of death in England. Coordinate My Care (CMC) is London's Electronic Palliative Care Coordination Service. Previous analysis has shown that individuals with a 'do not resuscitate' order shared through CMC are 76% more likely to die in a place of their choosing, however the relationship between a recorded preferred place of death (PPD) and death outside of hospital is unknown. Enabling individuals to die outside of hospital is an indicator of quality in end of life care, and a cost-saving strategy.

Aims To analyse the relationship between documentation of a preferred place of death and resuscitation status on the likelihood of death in hospital.

Methods Retrospective cohort study of all adults with a CMC plan made between 31 st March 2011 and 31 st September 2016 with a recorded place of death. We explored the cohort with standard descriptive statistics before using multiple imputation by chained equations and multivariable logistic regression.

Results Of all 11 839 persons, 1% with a recorded PPD wished to die in hospital. Those missing a PPD were 80% more likely to die in hospital (OR, 95% CI: 1.80, 1.61 to 2.01, $p < 0.001$; 31% vs 14%), whilst those who were 'for resuscitation' were 89% more likely to die in hospital (OR, 95% CI: 1.89, 1.69 to 2.13, $p < 0.001$; 30% vs 13%). Those missing one aspect of advance care planning were more likely to be either for resuscitation or to have no recorded preferred place of death, respectively.

Conclusions Advance care planning in the form of shared PPD and resuscitation status is significantly associated with dying outside of hospital. These discussions should be offered to those at the end of life, and shared with relevant healthcare professions involved in an individual's care.

69 AMBULANCE PRACTITIONERS AND END-OF-LIFE HOSPITAL ADMISSIONS: AN INTERVIEW STUDY

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Background Hospital admissions for end-of-life patients, particularly those who die shortly after being admitted, are recognised to be an international policy problem. How patients come to be transferred to hospital for care, and the central role of decisions made by ambulance practitioners in facilitating transfer, are under-explored.

Aim To understand the role of ambulance practitioners in the admission to hospital of patients close to the end of life.

Design Case study interviews, analysed thematically.

Participants/setting Ambulance practitioners (n=6) and other healthcare staff (n=33), involved in the transfer of patients (case-patients) aged over 65 years to a large English hospital who died within three days of admission with either cancer, chronic obstructive pulmonary disease, or dementia.

Results Ambulance practitioners were broadly positive about enabling people to die at home, provided they could be sure that they would not benefit from treatment available in hospital. Barriers for non-conveyance included difficulties arranging care for case-patients, particularly out-of-hours, limited available patient information, and service emphasis on emergency care.

Conclusion Ambulance practitioners fulfilled an important role in the admission of end-of-life patients to hospital, having to decide whether to leave a patient at home or instigate transfer to hospital. Their difficulty in facilitating non-hospital care at the end of life challenges the negative view of near end-of-life hospital admissions as failures. Hospital provision was sought