

## 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

for dying patients in need of care which was inaccessible in the community.

### 70 RENAL REPLACEMENT THERAPY IN PATIENTS APPROACHING THE END OF LIFE: A CASE SERIES OF 3 PATIENTS WHO MADE DIFFERENT CHOICES

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**Objective** To explore decisions regarding the use renal replacement therapy (RRT) as patients approach end of life.

**Background** End stage renal failure (ESRF) has many potential treatment options, including RRT, renal transplantation and conservative management. Complexities exist (including the impact on quality of life and length of life) regarding the instigation or withdrawal of RRT in patients who are nearing end of life. RRT is unique as no other organ function can be as readily and effectively replaced; this alone can make it difficult for people to choose not to have treatment.

**Method** We reviewed three cases of patients with ESRF approaching the end of life:

Patient 1 – On renal replacement therapy, wishing to withdraw from RRT

Patient 2 – A patient with a short life expectancy due to comorbidities but who wanted to commence RRT for acute-on-chronic renal failure who developed immediate cardiac complications requiring end of life care

Patient 3 – A patient who was being conservatively managed who then developed acute-on-chronic renal failure due to an acute illness who declined RRT

The role of the multi-disciplinary team in the decision-making process, in conjunction with discussions with patients and their relatives, was also considered.

**Results** The three patients made different choices for the management of their renal failure as they approached end of life. They made informed decisions about their care with the support their family and the renal multi-disciplinary team.

**Lessons learnt** The impact of RRT on quality and length of life should be considered in patients nearing the end of their lives. Renal MDT involvement in the decision-making process is imperative to ensure the patient makes an informed decision. The three patients considered made different choices as they approached end of life reminding us of the importance of patient's wishes in their end of life planning.

### 71 THE ROLE OF NURSES IN CARE OF THE DEAD PERSON

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**Background** The care of a person who has died is of importance to the person themselves and to their loved ones. Nurses have a unique role in providing this care. This work explored the literature concerning the formal practices of the care of a dead person, the teaching of such practices and the cultural and informal curriculum by which such practices are passed on in nursing.

**Methods** A pragmatic review of UK and US published literature since the establishment of nursing as a trained profession in 1860. Journal databases, textbooks of nursing as well as historical archives were searched for materials.

**Results** The care of the dead person is ritualistic and prescribed. There are strong cultural influences on practices and little evidence base upon which these practices are based. Geo-political, religious and local cultures all have strong influences in both the practices and the tone of the care. The informal or tacit curriculum, such as the placement of tokens of respect such as flowers or the opening of windows to 'let the spirit out' is absent from teaching materials but alluded to in memoirs and personal accounts.

The care of the dead person is secretive and professionally guarded. By some it is seen as a privileged activity and by others as an activity akin to punishment or of low value in the work of that shift, even one to avoid.

**Conclusions** The care of the dead person is an area of secrets and diversity of cultural values and approaches. There is a paucity of literature and evidence base.

### 72 TALKING RESUSCITATION – CAN WE GET IT RIGHT AT THE HOSPICE?

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**Background** There have been a number of high profile cases about resuscitation decisions in recent years.<sup>1,2</sup> This has prompted regular updates in the national guidance on decisions relating to cardiopulmonary resuscitation (CPR).<sup>3–5</sup> At the hospice a specific template is used to document CPR decisions on SystmOne, electronic patient record system. Current practice on the inpatient unit was audited against the hospice resuscitation policy following local and national guidance.<sup>3,6</sup> Fourteen standards were set specifically reviewing documentation on admission, at multidisciplinary team meetings and discharge. A 100% target was set for each standard due to the important implications of the do not attempt cardiopulmonary resuscitation (DNACPR) decision. The aim was to establish whether CPR decisions were documented and communicated appropriately to highlight any areas for improvement.

**Method** Retrospective review of 39 patient notes on SystmOne for patients admitted to the hospice from October to November 2016.

**Results** Of the fourteen standards set, only one standard met the 100% target. This was informing the GP of the unified DNACPR (uDNACPR) status at discharge.

Standards that achieved over 90% included: making a resuscitation decision on admission and discussing this with the patient, as well as reviewing resuscitation status at multidisciplinary team meetings.

Standards that achieved less than 80% included: discussing resuscitation decision with relatives when the patient lacks capacity and documenting decisions for uDNACPR at discharge.

**Conclusion** Using SystmOne templates has been helpful for documenting CPR status on admission, at multidisciplinary meeting review and on discharge letters to the GP. Recommended amendments to the CPR template include a prompt for a uDNACPR decision at discharge and an updated discharge checklist.