

medications. Gastric protection drugs (72.5%), antihypertensives (37.5%) and calcium supplements (30%) were the most common PIMs amongst inpatients.

**Conclusion** Although small-scale, these results indicate that there may be potential for deprescribing PIMs in the hospice inpatient unit.

**87 DISCHARGE DISCUSSIONS IN HOSPICE: PATIENT AND FAMILIES' EXPERIENCES**

Stephen Rose, Sarah Mollart. *St. Nicholas Hospice Care*

10.1136/bmjspcare-2018-ASpabstracts.114

**Background** St Nicholas Hospice Care covers a population of 2 85 000 across West Suffolk/South Norfolk, with a 10-bed ward and community services. This project was prompted by feedback that discharge planning was a source of distress for some patients/families, particularly if the patient died during admission. We aimed to investigate the scale of the problem and identify areas for improvement.

**Method** Admissions April-July 2017 inclusive were identified. Demographics and details of admission and discharge were retrieved for each patient, collated and analysed.

**Results** 77 admissions were identified from 73 patients (4 readmissions). 40 (52%) patients died in hospice, 35 (45%) were discharged (3% were transferred to hospital). For those dying in hospice, only 15 (37.5%) had discharge discussed at any point, though for 11 (73%) of those, discussions continued, within a week of death. Discharge discussions were much more likely to be hospice-led for those who died here (13/15; 87%), whereas patients who were discharged initiated the planning discussions 60% of the time (21/35). Rearranging, in hospice-led discharge discussions, 48% (13/27) went on to die during admission, whereas in patient-led discussions, just 9% (2/23) died, a statistically significant difference ( $p=0.002$ ).

Of those discharged, 29 (83%) had a positive reaction to discussions; 6 (17%) had a neutral (accepting) reaction. For those who died in hospice having discharge discussions, reactions were 8 (53%) positive, 5 (33%) neutral and 2 (13%) negative. Families' reactions were very similar. Of those discharged, 20 (57%) lived for over four weeks after discharge. 10 (29%) died within 2 weeks of discharge: only one had a non-positive reaction to discharge planning.

**Conclusions** The majority of patients do not appear to have inappropriate discharge discussions very close to a death in the hospice. Hospice-led discharge discussions more often are followed by patients dying prior to discharge – a known source of distress – than patient-led discussions are. This study therefore suggests that hospice-led discharge discussions would be a time for caution.

**88 'THE MOST DIFFICULT CONVERSATIONS THAT WE HAVE'. THE DIFFICULTIES OF DISCHARGING HOSPICE PATIENTS TO CARE HOMES AT THE END OF LIFE: A QUALITATIVE FOCUS GROUP STUDY**

Tabitha Thomas, Gemma Clarke, Stephen Barclay. *Arthur Rank Hospice Cambridge, University of Cambridge*

10.1136/bmjspcare-2018-ASpabstracts.115

**Background** Discharge from in-patient palliative care units to long term care can be challenging. In the UK, hospice palliative care unit in-patients move to a care home if they no longer require specialist palliative care and cannot be discharged home. There is evidence from the UK and Australia to suggest that patients and families find the prospect of such a move distressing.

**Aim** To investigate the experiences of hospice in-patient multidisciplinary teams concerning discharging patients from hospice to a care home for end of life care.

**Design** A qualitative study, using thematic analysis to formulate themes from focus group discussions with hospice staff.

**Setting/participants** Five focus groups were conducted with staff at five UK hospices. Participants included multidisciplinary team members involved in discharge decisions. All groups had representation from a senior nurse and doctor at the hospice, with group size between three and eight participants. All but one group included physiotherapists, occupational therapists and family support workers.

**Results** Two main themes emerged: practical concerns and dilemmas around decision making. The latter are reported in this paper. Dilemmas included;

- Ethical concerns (dilemmas around the decision, lack of patient autonomy and allocation of resources);
- Communication challenges and;
- Discrepancies between the ideals and realities of hospice palliative care.

**Conclusions** Hospice palliative care unit staff find discharging patients to care homes necessary, but often unsatisfactory for themselves and distressing for patients and relatives. Further research is needed to understand patients' experiences concerning moving to care homes for end of life care, in order that interventions can be implemented to mitigate this distress.

**89 END OF LIFE CARE AND COGNITIVE IMPAIRMENT: A QUALITY IMPROVEMENT STUDY**

Amanda Powell, Sally Boa, Gillian Foster. *Strathcarron Hospice*

10.1136/bmjspcare-2018-ASpabstracts.116

**Background** A hospice retrospective in-patient case notes review explored care provision at the end of life, mapped against the four key principles in the Scottish Government guidance. Most patients had documentation of informative, sensitive and timely discussions about dying, and exploration of their fears, concerns, goals, wishes, and social, spiritual and psychological needs. However, this was less likely if patients had cognitive impairment.

**Aim** To understand from staff caring for patients with cognitive impairment in a hospice in-patient unit, what prevents them from exploring and documenting their wider holistic needs.

**Methodology** A qualitative study was undertaken, interviewing in-patient hospice medical and nursing staff, using the 5 Whys tool. Results were analysed using a framework analysis approach.

**Results** Fifteen staff members were interviewed – five doctors, five registered general nurses and five healthcare assistants. Themes that emerged included: confidence and skills when communicating with cognitively impaired patients and their informal carers; the importance of familiarity and developing