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

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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

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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

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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

relationships over time; that physical care tended to take priority over time spent exploring issues especially when time was limited. Reasons for not exploring and documenting were common for all staff groups.

Conclusions and recommendations The results were presented to the wider hospice team who made suggestions for change. These included: offering additional staff education and training in communicating with cognitively impaired people; proactively consulting informal carers to gain a deeper understanding of patients' needs; the use of a person-centred document for informal carers to complete with patients if able, that encouraged identification and exploration of psycho-social concerns; using routine handovers to highlight when these areas had not been addressed. A working group will be formed to implement and test changes to practice as part of the quality improvement in this area.

90 EMERGENCY ADMISSIONS FROM CARE HOME TO HOSPITAL AT THE END OF LIFE: AN ANALYSIS OF NATIONAL DATA 2006–2015 FOR ENGLAND

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Objective Hospital admissions of care home residents close to the end of life are a source of concern and frequently described as 'inappropriate' and avoidable. However, the magnitude of this 'problem' on a national scale has not been investigated to date. This recently completed study investigated trends and characteristics of emergency admissions from care home to hospital where death occurred within seven days.

Methods Longitudinal and cross-sectional analysis of linked Hospital Episode Statistics with ONS mortality data for England 2006 to 2015: 1 85 830 care home residents aged 25 + who experienced a last week of life emergency admission to hospital, with comparator group 9 03 175 care home residents who died in care homes.

Results Of those in the last week of life in a care home 16.1% had an emergency hospital admission; of whom 91.3% died in hospital. Last week of life admissions contributed 14.6% of emergency admissions from care home to hospital and 9.2% of hospital mortality following emergency admission. Residents who had an emergency admission in the last week of life were less likely to be female (OR 0.84, CI: 0.83 to 0.85), from older age groups (OR 0.35, CI: 0.34 to 0.37, for 95+ compared with 25–64) or to have dementia (OR 0.37, CI: 0.36 to 0.37). They were more likely to have an underlying cause of death of stroke (OR 2.74, CI: 2.67 to 2.80), heart disease (OR 3.29, CI: 3.21 to 3.36), chronic respiratory disease (OR 3.91, CI: 3.81 to 4.01) acute respiratory disease (OR 5.74, CI: 5.61 to 5.88) or external injury (OR 9.73, CI: 9.32 to 10.16) compared to cancer. Trend analysis revealed significant decreases in these admissions from 2008 onwards

Conclusions Last week of life hospital admissions are a small, and decreasing, risk for care home residents, the majority of whom remain in their care home in the final week of life. The implications for practice and policy are discussed

N.B. Data analysis recently completed: late-breaking abstract

91 HOW THE TRACEY JUDGEMENT HAS CHANGED DNACPR DISCUSSIONS IN PALLIATIVE CARE

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10.1136/bmjspcare-2018-ASPabstracts.118

Background The decision published from the Court of Appeal of England and Wales in 2014 in the case of Tracey vs Cambridge University Hospital ('the Tracey judgement') changed the requirements for discussing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions with patients.

Methods A retrospective case note review aiming to identify changes in practice when discussing DNACPR decisions following the Tracey judgement. 150 case notes from 2013 (before the Tracey judgement) were compared with 150 case notes from 2015 (following the Tracey judgement) at five hospices in the West Midlands. The notes were analysed to identify whether the judgement had resulted in a change in how frequently DNACPR decisions were discussed with patients or their families, as well as any changes in the rationale for not discussing such decisions.

Results Discussions with patients increased from 31% to 60% and with relatives from 29% to 59%. The most common reason that DNACPR decisions were not discussed with patients or relatives changed from a belief that these discussions would cause distress in 2013 (23%) to the patient lacking capacity to engage in such discussions in 2015 (40%). There was a lack of consistency and clarity in defining the concept of 'physical or psychological harm' following the Tracey judgement.

Conclusion Healthcare professionals specialising in palliative care in the region and time frame studied are discussing DNACPR decisions more frequently with patients and families following the Tracey judgement but clarity on what constitutes 'physical or psychological harm' caused by these discussions is still required.

92 AN AUDIT OF CURRENT GUIDELINES AND RECOMMENDATIONS FOR MOUTH CARE IN PALLIATIVE AND END OF LIFE CARE

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Background Oral complications in palliative care patients are very common. Guidelines for oral care of these patients are available from several different sources within the UK. However, these guidelines are often inconsistent and it is unclear whether the recommendations are implemented in practice. This project aims to determine if the guidelines for oral care translate into the care provided to patients, and identify any additional techniques that are not published but provide benefits to patients in end of life care.

Methods A literature review of the guidelines and published evidence was conducted to collate a list of recommendations. A pilot survey and qualitative research was conducted with Special Care Dentistry Consultants, Palliative Care consultants, geriatricians, and those providing day-to-day care for palliative care patients. This focused on what treatment was being provided to maintain oral care and comfort for palliative care patients.