0-14 ARE WE STILL PERFORMING INAPPROPRIATE CARDIOPULMONARY-RESUSCITATION ATTEMPTS AT THE END OF LIFE?

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Background Cardiopulmonary resuscitation (CPR) is likely to be inappropriate for patients who are approaching the end of life. Since 2006, General Practitioners (GPs) have been incentivised to maintain an end of life care (EoLC) register of patients considered to be in the final 12 months of life. Supportive Advance Care Planning (ACP) can then be provided, which may incorporate a 'do-not-attempt-cardiopulmonary-resuscitation' (DNACPR) decision. Anecdotally, paramedics felt a significant proportion of patients eligible for EoLC remain unidentified by their GP, often resulting in emergency interventions at the end of life, which may not be in the patient's best interests.

Aim To identify the number of patients transferred to the local Emergency Department (ED) with CPR ongoing who were eligible for inclusion on an EoLC register.

Methods Medical records of out-of-hospital cardiac arrest (OHCA) patients transferred with CPR ongoing to the ED of a district general hospital in the North West of England were reviewed over a 12 month period. Records were compared against Gold Standards Framework Proactive Indicator Guidance (GSF PIG), an evidence based tool for facilitating earlier identification of patients who may be approaching the end of life.

Results Of 86 cases identified, 39.5% (n. 34) met GSF PIG indicators, all died in the ED. Of these, 94.1% (n. 32) had general signs of decline and 91.2% (n. 31) presented with advanced disease. Frailty was the most prevalent presentation at 76.5% (n.26). Among the frail, 57.7% (n. 15) had significant comorbidities. 8.8% (n. 3) had formally recorded a choice for no further active treatment, yet no DNACPR had been recorded.

Conclusions Results indicate that inappropriate CPR was carried out on approximately four out of 10 OHCA patients. We are currently evaluating how paramedics can assist GPs in reducing this figure by facilitating timely uptake of ACP conversations and DNACPR decisions in the community.

Parallel session 5: Switching focus: finding new ways to support palliative care patients

0-15 SUPPORTIVE CARE IN CIRRHOSIS: HOW AN MDT CAN IMPROVE CARE FOR PATIENTS WITH ADVANCED LIVER DISEASE

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Introduction Liver disease is the fifth commonest cause of death in the UK: the only major cause of death still increasing (Public Health England, 2015). National data show 73% of deaths occur in hospital (National End of Life Care Intelligence Network, 2012) and few patients are referred to

palliative care services (PC) despite complex symptoms and psychosocial needs. Although preferred place of death (PPD) for patients with end stage liver disease (ESLD) is unknown, studies of other diagnoses show the majority of patients prefer to die at home, rather than hospital (Office for National Statistics, 2015). We aimed to increase access to PC for patients with ESLD and ascertain PPD.

Methods We commenced a monthly ESLD MDT, comprising Hepatology and PC Consultants, hospice ESLD Clinical Nurse Specialist (CNS), Alcohol CNS, Social Worker and hospital PC CNS. The MDT reviewed patient needs, coordinated care and initiated referrals to community services. Patients referred to the ESLD CNS received holistic assessment, advance care planning and contingency plans for future acute decompensation events.

Results In the first 12 months of the new MDT there were 43 deaths with ESLD in our locality, 60% in hospital, 37% in community (home/hospice); contrasting to 73% and 26% nationally. 79% of all patients were known to PC at the time of death. Of 22 patients that expressed a PPD, 11 chose home and 11 hospice; none preferred to die in hospital. Of 22 patients under the hospice ESLD CNS, 73% died out of hospital (seven home, nine hospice). 68% of patients under the ESLD CNS died in their preferred place of care.

Conclusions Most patients with ESLD prefer to die out of hospital, consistent with other terminal illnesses. Although ESLD patients present a challenging symptom burden it appears an MDT approach including a dedicated hospice CNS can help increase referrals to PC, and help more patients die in their preferred place.

0-16 A RETROSPECTIVE AUDIT LOOKING AT THE MANAGEMENT OF DIABETIC PATIENTS IN THEIR LAST DAYS OF LIFE

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Aim To review the current management of patients with diabetes in their last days of life.

Background An estimated 25% of patients in palliative care settings have diabetes (or steroid induced diabetes) (Diabetes UK, 2018). The focus of care for these patients should be comfort; avoiding unnecessary blood sugar testing, preventing symptomatic high and low blood sugar levels, while keeping medication burden to a minimum.

Method Audit of notes (16–23 January 2018) of patients who died with diabetes and were on the end of life care pathway. We reviewed if there had been discussion with the patient surrounding diabetic management, whether there was a review of diabetic medication and a review of blood sugar testing. We audited how often patients had their blood sugars checked in their last seventy-two and twenty-four hours of life and if there were any high (>20) or low (<4) blood sugar recordings. We also looked at when diabetic medications were stopped.

Results A total of 21 patients were included. There was one (5%) documented discussion with the patient surrounding diabetic management at the end of life. There was one (5%) review of diabetic medication and four (19%) reviews of blood sugar testing. On average patients had their blood sugar checked five times in their last seventy-two hours of life