from socioeconomically deprived areas suffer from worse physical and mental health, inequitable service provision and worse service experience, and feel greater financial and social pressures due to caring. Halton and Knowsley – in North West England – are among the most socioeconomically deprived Local Authorities in England.

Method Eight semi-structured individual interviews were conducted with previous informal carers from Halton and Knowsley (caring ended between six months and 12 years prior to interview). Interview recordings were transcribed and analysed inductively, generating themes that arose during interview.

Results Informal carers face numerous challenges during caring and bereavement. Participants were unequivocal in their view that there is not only a pressure, but an expectation that family provide care for terminally ill relatives. Lack of communication from, and between formal care and healthcare professionals left carers feeling isolated and unsupported in providing home end of life care. Patient comorbidities and a system sometimes failing to take responsibility for patient care, impacted on the quality of care received and resulted in carers feeling a loss of control over their situation.

Conclusions This research suggests a more flexible, accountable and better-funded community end of life care system could improve the situation for terminally ill people and informal caregivers. It is also suggested that more research into the costs of providing informal end of life care would illuminate the pressures faced at this highly pressurised time.

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8 ARE PEOPLE WITH DEMENTIA GETTING THE MOST OUT OF OUR HOSPICE SERVICES?

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Background NICE guidance (NG97) recommends we offer early and ongoing opportunities for people living with dementia and their carers to discuss the benefits of planning ahead and preferences regarding their care. A previous hospice audit demonstrated small numbers of referrals for people with dementia. These referrals tended to come late, when disease was advanced. This re-audit aimed to describe how people with dementia are benefitting from our hospice services and identify areas for improvement.

Methods Retrospective review of electronic records for all patients with a dementia diagnosis referred between April 2017 and April 2018.

Results 5% (56/1154) of all referrals were for people with dementia.

66% (37/56) were referred for end of life care.

63% (35/56) were nursing home residents.

None were admitted to the inpatient unit.

None had capacity to discuss Advance Care Planning at time of referral.

41% (23/56) were discharged from services; after either telephone advice 65% (15/23) or a home visit 35% (8/23).

100% had a DNACPR status.

36% (20/56) lacked both documented Preferred Place of Care and Preferred Place of Death.

The median time between referral and death was 13 days.

Conclusions People with dementia make up a small percentage of referrals to our hospice. The referrals are coming late in the course of illness, at a time when patients are approaching death and lack capacity to make decisions about their care. Early involvement of specialist palliative care services could promote opportunities for advance care planning and improved patient care. With our ageing population, focus on integration between services and improving accessibility for non-malignant life limiting illnesses such as dementia is increasingly important. We have recently appointed an 'Admiral Nurse' with the aim of building closer relations with local dementia services.

9 USE OF DEPRIVATION OF LIBERTY SAFEGUARDS

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The Deprivation of Liberty Safeguards (DoLS) are an important safeguarding measure for all patients. It has particular relevance in Elderly Medicine and, increasingly, the Palliative care setting. When patients lack capacity, the use of restrictions and restraints may be authorised, if, in a patient's best interests. Their appropriateness and overlap with end of life care is a complex and ethically challenging area. This piece of legislation has led to an increased workload for healthcare professionals as the number of DoLS applications, and hence paperwork, has spiked in recent years. In an already resource stretched setting, this audit aims to:

1. Assess the current use of DoLS at UCLH including:
2. Clear documentation when patient lacks capacity to consent to staying in hospital.
3. Timely identification of potential deprivation of liberty and therefore DoLS applications.
4. Identify areas for quality improvement.

Method Patients' capacity status was discussed with their consultant. The acid test was applied to determine if a DoLS application was indicated. The medical notes were reviewed to see if this had been completed. Data was collected for 40 patients across two wards.

Results

- 45% of patients lacked capacity and met the acid test criteria meaning a DoLS application is indicated. Only 33% of these patients had evidence in the notes of a completed DoLS application.
- On review of the medical notes, capacity assessments were documented in 1/3 of cases.
- When a DoLS application was indicated, 50% of cases had a form sent on Ward 1 but 0% did on Ward 2.

Our findings show that more work is needed in this safeguarding domain. We recommend identifying ways to improve compliance with this piece of legislation to avoid potential unlawful practice. We will address three areas prior to re-auditing:

- Teaching.
- Increasing awareness of existing resources.
- Simplifying process of completing a DoLS application.