**A baseline review of end of life discussions and decisions with haemodialysis patients**

**Introduction**

Patients undergoing long term haemodialysis are often elderly and frail. These patients with failing health tend to have multiple hospital admissions during their last year of life. Nephrologists can find it difficult having discussions surrounding end of life care, often these do not happen until patients are in the final stages of life

The aim was to assess the end of life care received by haemodialysis patients at the Hospital. We looked for evidence of discussions with patients that their diagnosis was life limiting, we looked to see if the patients had opportunities for discussions expressing wishes around their future care. We looked to see if there was evidence of holistic needs assessment, any discussion around resuscitation status and finally if there had been input from a specialist palliative care services in the region.

**Methods**

We reviewed haemodialysis patients who died from the period of October 2016 to September 2017. Reviewing case notes and patient notes we looked at a period of 12 months prior to death. We looked at the following: whether or not a documented discussion that dialysis is life limiting, discussion of about resuscitation (and whether a do not resuscitate [DNA-CPR] form was filled), discussion surrounding advanced care planning, patient’s preferred place of death, referral to palliative care services and the number of hospital admissions in the 12 months prior to death.

**Results**

22 haemodialysis patients were identified (16 male and 8 female). The mean age of the patients was 71 years old. Documentation of dialysis being life limiting was only noted in 3 of the patients. A DNA CPR form was completed for 14 patients, advanced care planning was only discussed in one patient. Patient’s preferred place of death was discussed for 9 patients. Nearly all patients died in hospital (20), one patient died in a hospice and one at home. Most patients had multiple hospital admissions and the mean number of admissions was 2.7. It was noted that most discussions surrounding resuscitation was initiated by them rather than nephrologists. Palliative care referrals were often made when the patients were in the last stages of life for symptom relief.

**Conclusions**

To improve patient care when starting patients on dialysis renal physicians should discuss that dialysis is life limiting. Closer integration between the nephrology team and specialist palliative care would be recommended to try to identify patients whose health is deteriorating to try and prevent multiple hospital admissions. Taking these measures into account at the Hospital a collaboration between specialist palliative care services and nephrology has been set up to try and improve patient care and outcomes. We are hoping that these measures will help improve our patient’s experiences and encourage open and honest discussions regarding end of life care.

**References**

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