

(ICU).¹ Approximately 70% of these deaths occur after decisions to withhold or withdraw life-sustaining treatments.² During the pandemic (April 2020-March 2021), one acute London hospital trust reported delivering increased end-of-life care (EOLC) on ICU (with 39.9% of deaths occurring in ICU).

An individualised EOLC plan was in use across the trust to support people in their last days of life, however this was used infrequently in ICU.

Methods A staff survey revealed the need for ICU specific EOLC plans, training on difficult discussions and empowerment of nursing staff to collaborate in decision making. These findings align with the literature on EOLC in ICU.³ A multi-disciplinary working group devised a template for an ICU-specific individualised EOLC plan. The template was presented at grand round, an educational program on EOLC was delivered to ICU nursing staff, and a series of workshops on difficult conversations commenced with ICU junior doctors.

Results In the four months following the rollout of the care plan 29.9% (20/67) of people who died in ICU had an individualised care plan. This represents a 69.8% increase from baseline. Workshops on difficult conversations were evaluated positively by attendees.

Conclusions The described interventions led to increased awareness of EOLC among ICU staff and an improvement in number of patients having an individualised care plan at EOL.

Next steps ongoing review of the EOLC plan using quality improvement methodology; development of a checklist for withdrawal of invasive organ support at the end of life; continuation of the education programme.

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INCREASING COMPLIANCE WITH END-OF-LIFE CARE GUIDELINES IN GENERAL INTENSIVE CARE UNIT: QUALITY IMPROVEMENT PROJECT

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10.1136/spcare-2023-PCC.81

Introduction End-of-life (EOL) care following a withdrawal of life-sustaining treatment occurs commonly in an intensive care unit (ICU) (1,2). Following the discontinuation of the Liverpool Care Pathway in 2014, local guidelines have been developed and tailored to the University Hospitals Bristol and Weston NHS Foundation Trust ICU, United Kingdom. This quality improvement project (QIP) aims to assess awareness and improve compliance with the guideline.

Method A clinical audit and staff survey were undertaken to establish current compliance with local guidelines. Findings were presented to stakeholders for evaluation, followed by two Plan, Do, Study, Act cycles. A set of educational, barrier-reducing and sustainability-ensuring interventions were implemented following Kotter's model for change management (3).

Results The baseline data analysis revealed that The EOL Care Tool, a Trust-wide available checklist outlining the appropriate approach to EOL care delivery, was used in 14% of cases over five months. The initial clinical staff survey demonstrated that this was due to the lack of awareness and uncertainty about the applicability of a Trust-wide tool in the ICU. Following the implementation of educational and barrier-reducing interventions, compliance with the EOL Care Tool slightly increased to 29%. However, a change in the daily safety brief resulted in 73% compliance with the EOL Care Tool while significantly improving the delivery of EOL care, such as EOL prescribing, stopping interventions and switching from vital sign monitoring to symptom observations. Furthermore, qualitative feedback from clinical staff following the second PDSA cycle revealed increased occupational satisfaction with the departmental provision of EOL care and improved interprofessional cooperation within the unit.

Conclusion This QIP optimised patient-centred EOL care with adequate symptom control in the local ICU by raising awareness of available resources and encouraging compliance with relevant guidelines. Subsequently, the interprofessional collaboration resulted in a positive culture change in the local unit.

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GROUPS OFTEN UNDER-SERVED BY RESEARCH ARE KEEN TO PARTICIPATE, REGARDLESS OF PROGNOSIS, PERFORMANCE STATUS AND SOCIO-ECONOMIC POSITION. A MULTI-CENTRE COHORT STUDY OF 100 SPECIALIST PALLIATIVE CARE INPATIENTS

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10.1136/spcare-2023-PCC.82

Objectives Palliative care services need to embrace research to guide service development and effective symptom management. Healthcare professionals often feel research is too burdensome for patients who have poor performance status or are near the end-of-life. In addition to gatekeeping from clinicians, many studies explicitly exclude these groups from participating. We aimed to identify whether specialist palliative care inpatients would wish to take part in research and whether preference varies according to study design, demographics, diagnosis, performance status and prognosis.

Methods 100 inpatients in two NHS Specialist Palliative Care Units and one independent Hospice in the Northeast of England completed a short questionnaire about preferences for involvement in research.

Results 92% of participants stated they were interested in being involved in research. This was mostly unaffected by age, diagnosis, prognosis, performance status and socioeconomic status. Three quarters of the patients surveyed were within the last three months of life. Simple questions or interviews