

Background 15–20% of critical care patients die during their hospital admission. This service evaluation assesses the quality of palliative care on ICUs compared to national (NICE) standards, and which triggers identify palliative care needs.

Methods Retrospective service evaluation, using records review for all patients who died in four ICUs, between 1 June and July 31 2019. Descriptive statistics were reported for patient characteristics, length of stay, admission route, identification triggers, and palliative care delivery.

Results N=43. Death was recognised in 88% (38). Among those in which dying was recognized (N=35), 97%(34) had a documented family discussion before death, 9%(3) were offered religious/spiritual support, 11%(4) had review of hydration/nutrition, 6%(2) had documented preferred place of death. Prescription of anticipatory medications was complete in 71%(25) opioids, 34%(12) haloperidol, 54%(19) midazolam, 43%(15) hyoscine. Combining five triggers - length of stay >10 days prior to ICU admission 7%(3), multi-organ failure ≥ 3 systems 33%(14), stage IV malignancy 5%(2), post-cardiac arrest 23%(10), and intracerebral haemorrhage requiring mechanical ventilation 12%(5) - identified 60%(26) of patients. 14%(5) were referred to the palliative care team, and 8%(3) had specialist palliative care team review.

Conclusions Recognition of dying was high, but occurred close to death. Standard of end of life care was good in terms of family discussion, but religious/spiritual needs, review of hydration/nutrition, and prescription of anticipatory medications were less often considered. The ICUs delivered palliative care using a mainly 'integrative' model. Combining five triggers may increase identification of palliative care needs, but a larger study is needed.

117 A RETROSPECTIVE AUDIT TO ASSESS IF ADVANCE CARE PLANNING (ACP) DISCUSSIONS WERE INITIATED PRIOR TO IN-PATIENT DEATH AT A SPECIALIST CANCER CENTRE

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Background There are no national standards about the timing of initiating ACP discussions. It is suggested that ACP may be initiated following the diagnosis of a life-limiting condition, with a change in treatment focus, or following multiple hospital admissions. It was unknown how many patients dying at a specialist cancer centre had been involved in ACP prior to death, and at what stage in their illness this was commenced.

Methods This was a baseline retrospective audit. The population sampled was all inpatient adult deaths over a two-month period in 2019 in a specialist cancer centre. Medical records and Co-ordinate My Care records (Electronic urgent care plan) were reviewed from six months prior to patient death for evidence and timing of ACP discussions. We anticipated that 70% of patients sampled would have ACP prior to death.

Results There were 36 inpatient adult deaths. 89% of these patients had non-curative disease. 63% patients were involved in a DNAR discussion. Of these patients, 22% had a DNAR discussion prior to their final admission versus 78% who had a DNAR discussion during their final admission. 44% patients had a discussion about preferred place of care (PPC) and/or death (PPD). Of these patients, only 31% had these

discussions prior to final admission compared to 69% who had these discussions during their final admission.

Conclusions The most common form of ACP was a DNAR discussion, followed by PPC/PPD. The vast majority of ACP discussions occurred in the final inpatient admission as opposed to during outpatient clinics or previous hospital admissions. There is concern that by the time these conversations were being initiated, patients' options about future care and wishes were already restricted and had less chance of being achieved. This baseline audit will inform an education programme to encourage earlier and broader ACP discussions.

118 PLANNING AND IMPLEMENTATION OF A CANCER CONTROL PROGRAM WITH INTEGRATION OF PRIMARY HEALTH CARE AND PALLIATIVE CARE SERVICES IN A LOW MIDDLE INCOME COUNTRY

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Background Cancer, the second leading cause of death globally, accounted for an estimated 9.6 million deaths in 2018. More than 70% of all cancer deaths occur in low and middle income countries, where resources available for prevention, diagnosis and treatment of cancer are inadequate with limited health care infrastructure and competing health care priorities. Kerala, a state in South India, has higher than Indian average of social and health indicators like education, life expectancy, maternal and infant mortality, with well-integrated primary health care and palliative care services. Palliative care in the state has grown to be a sustainable model recognized in global palliative care and public health scene. We describe an approach that integrates cancer prevention, early detection and supportive care by utilizing the services of existing primary health and palliative care.

Methods We planned and executed the program funded by local-self-government over a period from July -December 2019, which targeted three common cancers, breast, cervix and oral cavity. The strategies implemented include; improving cancer literacy among the public to encourage self-referral, and awareness of early warning signs of cancers among primary care physicians, also to empower specialists in diagnostic procedures, prompt referral and timely initiation of treatment and integrate cancer surveillance with palliative care network.

Results The program was able to train about 700 healthcare workers and 70,000 members of public. There were 575 biopsies performed over 6 months out of which 53 were malignant, 8 premalignant. Median age of diagnosis was 60, 55% were female. 48% of the total cancer diagnosis was oral cancer. The median time of availability of biopsy report was 6 days. 86% of patients with a cancer diagnosis was contacted by community palliative care nurse at diagnosis.

Conclusion Palliative care and primary care services can be successfully integrated into Oncology practice. Further research is planned to evaluate the long term goals of down-staging cancer, reducing the time period from diagnosis to treatment and improvement of cancer care outcome.