

about grief and bereavement. Due to COVID-19, the festival was held online over 3 days in October 2020.

**Aim** To evaluate the festival's reach and impact.

**Methods** A pre/post evaluation was conducted via online surveys. Pre-festival surveys assessed reasons for attending and attitudes to bereavement across 4 items (being scared of saying the wrong thing, avoiding talking to someone bereaved, knowing what to do if someone bereaved was having trouble, knowing what kind of help/support to offer). Post-festival surveys evaluated audience experiences and the 4 attitude items.

**Results** 8500+ people attended, with most attending 2–5 events. Pre-festival survey participants (n=3785) were majority women (91%) and White (91%). 9% were from Black or minoritized ethnic communities. 14% were age  $\geq 65$  years, 16% age  $\leq 34$  years. 44% were members of the public. A third had been bereaved in the last year; 6% had never been bereaved. People attended to learn about grief/bereavement (77%), be inspired (52%) and feel part of a community (49%). Post-festival participants (n=685) reported feeling part of a community (68%), learning about grief/bereavement (68%) and being inspired (66%). 89% rated the festival as excellent/very good, with a higher rating associated with attending a greater number of events. 75% agreed that through attending they felt more confident talking about grief. Post-festival attitudes were significantly higher across all 4 items ( $P < 0.001$ ). Free-text data showed appreciation e.g. for the online format, connection in the context of lockdown and ethnic diversity in speakers. Suggestions included improving registration, more interactive/arts-based events and reducing the volume of content.

**Conclusion** Good Grief Festival was successful at reaching a large public audience, with data indicating benefit in terms of engagement and confidence. The evaluation was critical in shaping future events.

## Posters 4–10 | caregivers and the family

### P-4 FAMILY EXPERIENCES RELATING TO END OF LIFE CARE FOR PATIENTS WITH COVID-19 RELATED RESPIRATORY FAILURE

Rodanthe Nixon, Bonnie Benoiton, George Noorland, William Parry-Jones, Ruari McGowan, Sindhu Naidu, Eburn Abarshi. *Bartshealth NHS Trust*

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**Introduction** Issues of resource allocation, visitation restrictions and infection control inevitably impacted the experience for relatives of patients who died due to COVID-19.

**Methods** We conducted telephone consultations with the next-of-kin (NOK) of patients admitted to the respiratory HDU ward at Whipps Cross Hospital who did not survive their admission. This focused on a 19-week period between 17/09/2020–30/01/2021. Patients transferred to ITU were excluded.

**Results** Out of 84 patients who did not survive their admission we were able to conduct a telephone interview with 53 NOK relatives. 34 (64%) relatives reported an overall positive experience relating to end-of-life care on the ward and 19 (36%) had a negative experience. 23 (43%) reported they were concerned about visiting due to the risk of acquiring infection and in fact 12 (23%) opted not to

visit for this reason. 36 (68%) felt they were kept well informed by the medical team. 14 relatives (34% of those who visited) felt that PPE negatively impacted on their experience. 22 (53% of those who visited) felt the restriction on visitor numbers negatively impacted their experience and a similar number felt the ward environment negatively impacted on their experience. Out of the 24 relatives who had experienced a death before, 19 reported that visiting limitations were the main difference and this had had a negative impact. Relatives were invited to make general comments about what negatively impacted their experience and the most commonly recurring answer was the hospital-acquired nature of the infection (6 cases) and poor communication (5 cases). In the case of relatives with a positive experience, good nursing care was most commonly self-reported as having an impact (8 cases).

**Discussion** This data highlights the challenging nature of end-of-life care in the COVID pandemic era and reveals some of the difficulties families faced under the circumstances.

### P-5 BREAKING BAD NEWS VIA TELEPHONE; HOW CAN WE IMPROVE?

Conal Corr. *Belfast Health and Social Care Trust*

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**Introduction** The Covid 19 pandemic changed how we break bad news. Restrictions meant that families were no longer able to be taken to a quiet room and healthcare professionals could no longer use body language and non verbal cues to guide conversations. This small project sought feedback from bereaved relatives to create guidance on how to conduct important conversations via telephone.

**Method** Recruitment was via the hospital bereavement team conducting routine follow up calls to families of those who died in ICU from Covid 19. Relatives were asked if they would be willing to participate in feedback. 15 respondents were interviewed and asked the extent to which they agreed with statements regarding how bad news was broken to them. This was applied to a sliding scale, 1 being strongly disagree and 5 being strongly agree. Participants were also encouraged to give comment.

**Results** Almost all participants strongly agreed that bad news should be broken early in the conversation. A theme emerged that there was a strong preference for a direct approach. Largely, being asked if relatives were ready to have the conversation was not thought to be important but most did strongly agree that a warning shot was beneficial. A significant proportion of respondents agreed that time to react during the conversation was important. Interestingly, a number of relatives remarked on the impact of these conversations on medical staff. Respondents appreciated a kind and emotive response but this appeared less important than being direct.

**Conclusion** This study brought about lots of personal learning, changing my approach when teaching on the subject. Being direct and to the point was a key theme. Bad news should not be shielded away from. There was an understanding that these conversations are difficult so perhaps breaking bad news could be thought of as a less daunting prospect.