

Those not signed up to the Standards were asked about their end-of-life care activities, their experiences, and challenges they have faced. We will undertake semi-structured interviews with a sub-sample of survey respondents to identify processes and mechanisms of implementation. We are prepared for pragmatic contingency plans should we experience poor engagement due to the challenges NHS primary care is facing, including focus groups with participants signed up to the Standards. Data will be analysed using descriptive statistics (survey) and Framework Analysis (survey, interviews, and/or focus groups).

Results Ten respondents have completed the survey to date. Preliminary data will be available for presentation in February 2023.

Conclusions The data will be used to inform and refine the design of a set of case studies to capture learning and identify exemplars of best practice for later phases of the study.

Impact Greater understanding of key barriers and enablers from existing efforts to sustain and improve end-of-life care in general practice, and identify exemplars of high-quality practice, building up an evidence-base to encourage wider implementation of the Standards.

REFERENCE(S)

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'IT'S NOT OUR GRIEF TO HAVE...?' THE LIVED EXPERIENCES OF PROFESSIONAL GRIEF THAT PALLIATIVE CARE NURSES EXPERIENCE WHILST DELIVERING END OF LIFE CARE IN ACUTE HOSPITAL SETTINGS

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Introduction The world is experiencing an ageing population with the numbers requiring palliative and end of life care (PEOLC) increasing and many of those people will receive care and die in acute and generalist settings. The personal and lived experiences of the nurses delivering PEOLC in busy acute environments therefore need to be reflected upon, understood, and acknowledged.

Nurses experience grief for their patients but do so in a very different manner to that experienced by the patient's family. The nurse often finds them self in a conflicting role as they need to remain strong and offer support on one hand whilst managing their own emotions and acknowledge their loss on the other.

Aims This aim of this study was to understand the experiences of palliative care nurses delivering PEOLC in acute settings and how they make meaning of those experiences following the loss and death of their patients

Methods An Interpretive Phenomenological Analysis (IPA) methodology was used to understand the lived experience of the participants to illuminate and reveal their meaning making.

Results Following analysis of the findings, four main or super-ordinate themes were revealed which demonstrated that nurses

are sentient thinking beings whose lived experiences and feelings affect their thoughts and emotions.

Conclusions This in turn impacts not only on their personal life but also their professional identity and perceptions of good quality care. The caring processes they enact shapes and informs their understanding of the world and their experiences therein.

Impact The findings of this study point towards a need to understand and acknowledge that nurses can experience professional grief for their patients and it is necessary therefore to consider effective supportive mechanisms such as reflection and formal clinical supervision for generalist and palliative care nurses delivering PEOLC in acute settings.

Challenging inequity in palliative and end of life care

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ACCESS TO PALLIATIVE CARE FOR ACHD PATIENTS – A JOINT SERVICE REVIEW

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Introduction Adults born with congenital heart disease represent a remarkable success in the field of cardiology with a huge improvement in survival rates. However, many challenges remain and many adults with Adult Congenital Heart Disease (ACHD) are considered to have a chronic condition with associated reduced life expectancy.

Aims To set up a joint ACHD-palliative care service to increase earlier access.

Methods We designed a new joint service which consisted of simplification of the referral process, joint multidisciplinary team (MDT) discussion and a joint clinic. We recognised the value in a dedicated 'link' palliative care physician who had a specialist interest in this cohort. A multidisciplinary stakeholders group met, and key feedback gathered. A joint multidisciplinary meeting (MDM) between the ACHD team and a palliative care consultant and clinical nurse specialist was trialled; this was modified upon feedback to discussion of patients within a dedicated section of the palliative care MDM. After discussion, selected patients would be seen in ACHD clinic by both cardiology and palliative care. Inpatients were referred via the usual referral pathway but also with direct ACHD – palliative care discussion.

Results Service audit was between June 2021 – September 2022. 8 patients were reviewed by hospital palliative care; 2 of these were MDM reviews alone and 6 were with inpatient and/or outpatient reviews in addition. 100% had a symptom control and psychosocial assessment and 100% had an introduction to ACP discussion. 7 were referred to their local community palliative care service. 4 patients have died.

Conclusions It is recognised that palliative care needs to be offered early. Studies have demonstrated many ACHD patients recognise the value of this but it is often under-utilised. Our project demonstrates the benefits that a joint service can offer.

Impact This joint service is improving access to the benefits of earlier palliative care.