• Explore their individual experiences of caring for dying patients within clinical practice
• Develop an emerging theory to understand student nurses’ perceptions and the impact that this has on the care delivered to dying patients

Methods (Design, Data collection and Analysis)
A constructivist grounded theory approach was utilised, influenced by the theoretical perspectives of symbolic interactionism and social constructionism. Students enrolled on an undergraduate degree programme were approached to participate in the study. Using theoretical sampling, data was collected from 18 interviews. Data analysis utilised initial, focused, and advanced coding techniques, supported by constant comparative analysis.

Findings Preliminary findings that emerged from the data are:
Morality of Caring, Belonging, Socialisation of Dying and Antecedence. The theoretical insight gained from this study has provided a more detailed understanding of factors that prepare students to care for dying patients, an insight which will help to shape education delivery and practice support, as well as opportunities for future research.

58 WHAT SUPPORT DO CARE HOME RESIDENTS NEED FROM COMMUNITY SPECIALIST PALLIATIVE CARE?
James Davies, Marged Capel, Fiona Rawlinson, Terri Gad, Susan Rees. City Hospice
10.1136/spcare-2023-PCC.78

Objectives City Hospice is a community specialist palliative care (SPC) team caring for the population of Cardiff (372,000). A service evaluation was undertaken to review the scope of SPC input required for residents referred from care homes (residential and nursing homes).

Methods A mixed method evaluation was undertaken for all patients from care homes referred between 1st January 2019 and 31st December 2020. Key themes of the required input from the SPC team at first assessment were analysed by 2 Palliative Medicine Consultants. Data including demographics was entered into a Microsoft Excel spreadsheet, and statistical analysis performed.

Results 272 referrals (12% of total referrals) were from care homes during the specified time period, the majority with a non-malignant diagnosis (67%). 42 residents (15% of those referred) were not reviewed, dying from an acute deterioration before initial assessment. 81% of residents reviewed were deemed to have SPC needs, with only 5% of residents being discharged at first assessment. The main SPC needs identified at first assessment fell into the following categories: recognition of deteriorating condition; symptom control including ordering subcutaneous anticipatory medications in 69% of residents; Advance Care Planning (ACP) including DNACPR decisions in 89% of residents, establishing preferred place of death (PPD) in 94% of residents and completion of an ACP document in 58% of residents; facilitation of communication; supporting care home staff.

Conclusions Community SPC teams have an important role in supporting residents, care home staff and primary care in delivering high quality palliative care to care home residents approaching the end of life. This service evaluation has highlighted that the majority of care home residents have SPC needs and highlights the key themes of need. Meeting these needs resulting in achieving PPD in 96% of nursing home and 88% of residential home residents.

59 THE IMPACT OF ETHNIC BACKGROUND ON ACCESS TO COMMUNITY PALLIATIVE CARE SERVICES IN CARDIFF
Ellen Haire, Sue Rees, James Davies. City Hospice
10.1136/spcare-2023-PCC.79

A recent study describes inequitable end of life care was received by those from minority ethnic groups during the pandemic.¹ This supports existing literature describing disparities in care received by these groups including lower access to care and higher unmet needs.²

In Wales, Cardiff and the Vale has the highest proportion of Black, Asian and Minority Ethnic people. This service evaluation describes the current situation in the community palliative care service for people living in Cardiff. Quantitative data was collected in a cross-sectional, retrospective review of records for all patients who were known to the service and died in 2021.

Data included 818 patient records, of which 591 had documented self-reported ethnicity. 95% of patients were from White Ethnic background, compared to 84% of the Cardiff population. Data was compared between the White Ethnic group and combined Minority Ethnic groups. A number of data points were similar; average age (77.3 vs 74.2 years), time between referral and death (88.5 vs 82.4 days) and proportion who died at home (72% vs 75%). There were some differences, including diagnosis at death with 68% of those from the White Ethnic group dying from cancer compared to 44% of Minority Ethnic groups. Additionally, those from minority groups were less likely to have documented preferred place of death (81% vs 87%) but where discussions had taken place, were more likely to achieve this (92% vs 86%). Finally, religion was documented more often in Minority Ethnic groups (81% vs 59%).

This paper shows a difference in the expected proportion of people from different ethnic groups referred to the community palliative care team. Discussion examines the data more closely exploring reasons behind this. It concludes further in-depth qualitative data is needed on a local level to explore individual experiences of care and potential existing barriers to referrals.

REFERENCES

60 ENABLING EXCELLENT END OF LIFE CARE IN THE ICU
John Donaghy, Robert Maher, Timothy Bonniic, Emily Collis. University College London Hospitals NHS Foundation Trust
10.1136/spcare-2023-PCC.80

Background Prior to the COVID-19 pandemic, an estimated 10–20% of the UK population died in the intensive care unit...
(ICU). Approximately 70% of these deaths occur after decisions to withhold or withdraw life-sustaining treatments. 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. 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.

REFERENCES

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

Julia Pasztorova. University of Plymouth
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.

REFERENCES

62 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

Kate Atkinson, Helena Spriggs, Felicity Dewhurst , Donna Wakefield, Joanna Elverson, Robert McConnell, Katherine Frey. Health Education North East, Newcastle, Northumbria NHS Foundation Trust, St Oswald’s Hospice, Newcastle, Newcastle University, North Tees and Hartlepool NHS Foundation Trust, Newcastle Upon Tyne Hospital NHS Foundation Trust
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