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**

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**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 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...
were the preferred methodology, whereas only half of patients would want further investigations or additional medications and fewer still wanted to participate in online activities, lifestyle change or group activities.

**Conclusions** Palliative care inpatients welcome the opportunity to be involved in research and should not be excluded on the grounds of advanced disease, poor prognosis and low performance status. Research into end-of-life care should incorporate study designs that would be acceptable and tolerable to patients with advanced disease, rather than exclude them.

**Method** A GSF document is completed on the hospital electronic patient record following identification and there is one document per admission which is used to record if advance care planning has been offered, commencement of priorities for care and preferred place of care documented.

**Results** From previous audits completed in the Trust we have confirmed approximately 30% of patients at anyone time are in the last year of life and this can also be reported by ward to support individual wards. The percentage of patients identified as GSF is increasing and as of June 2022 this was 14% and the percentage of GSF red patients with Priorities for care communication document has improved to 49% and the target is 70%.

**Discussion** A number of initiatives are being used to improve identification of patients in the last year of life including introduction of level 2 priority training and also working with Deteriorating patient group on a bespoke 12 week course to support wards with the timely identification and appropriate management of deteriorating patients.

**Introduction** A third of hospital patients are in their last year of life and almost 50% of people die in hospital. At Dudley Group NHS Foundation Trust (DGFT) we have implemented the Gold Standards Framework (GSF) to support identification of patients in the last year of life and almost 50% of people die in hospital. At Dudley Group NHS Foundation Trust (DGFT) we have implemented the Gold Standards Framework (GSF) to support identification of patients in the last year of life and almost 50% of people die in hospital. We plan to complete this review of DNACPR in 6 months.

**Methods** An end of life care document is completed for patients identified as GSF on the EPR used at DGFT and the DNACPR is also recorded on the EPR. Therefore, on the 8th June 2022 we reviewed all adult wards to see the number of patients with a DNACPR but no GSF document.

**Results** The results demonstrated that on the 8th June 120 adult inpatients had a DNACPR but no GSF document. This was broken down by wards and shared with the wards to support discussions/education by the specialist palliative care team with regards to GSF implementation.

**Conclusion** The GSF implementation across DGFT aims to improve the identification of people in the last year of life and the development of an individual plan of care. Working together with the deteriorating patient group we have now developed a prompt that when a DNACPR discussion has taken place on the patient record our GSF group can be notified. This will then be escalated to ward and the ward team with regards to GSF implementation.

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