patients), inpatient PD specialist nurse (7%) and neurologists (4%).

Conclusion Prescribing practice in patients dying with PD needs improvement. Prescribing guidelines were disseminated locally and educational content developed to improve practice.


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Introduction The Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) process encourages collaboration between clinicians, patients, and relatives on emergency care wishes and resuscitation decisions. While the COVID-19 pandemic disrupted aspects of the ReSPECT process, the impact on clinicians’ views of ReSPECT was unknown.

Objectives The aim of this project was to examine whether there were changes in clinicians’ knowledge, skills, and attitudes regarding the ReSPECT process during the pandemic.

Methods We conducted a cross-sectional survey of senior clinicians at one acute hospital in the UK. We developed a questionnaire with a defined 5-point Likert scale and asked clinicians to recall their views on ReSPECT before the COVID-19 pandemic as well as report their current views at the time of survey distribution (last two weeks of May 2020, end of the first COVID-19 wave in the UK). We compared their retrospective self-rating of their pre-pandemic views and current views during the pandemic.

Results We analysed 171 questionnaire responses. During the pandemic clinicians’ self-reported knowledge in conducting ReSPECT discussions increased (pre-pandemic median 4, IQR 2; during pandemic median 4, IQR 1; p <0.001). Their skills (pre-pandemic median 3, IQR 1; during pandemic median 3, IQR 1; p <0.001) and confidence (pre-pandemic median 3, IQR 1; during pandemic median 3, IQR 1; p <0.001) in conducting ReSPECT discussions with relatives over the phone increased. Negative emotions whilst conducting these discussions with relatives increased during the pandemic (pre-pandemic median 1, IQR 1.5; during pandemic median 3, IQR 2; p < 0.001).

Conclusions There were differences in clinicians’ knowledge, skills, and attitudes scores on ReSPECT before and during the pandemic. Our findings highlighted that clinicians could benefit from training in remote ReSPECT conversations with relatives.

THINK LIVER: A QUALITY IMPROVEMENT PROJECT ON ANTICIPATORY MEDICATION PRESCRIBING FOR PATIENTS WITH ADVANCED LIVER DISEASE

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Introduction Advanced Liver Disease (ALD) is the second leading cause of premature death in 35–49-year-olds. Symptom burdens are high, and place of death is often hospital. Specialist advice in the form of guidelines is invaluable for junior doctors to provide timely, effective symptom management. At Royal Albert Edward Infirmary an ALD symptom management guideline was published in March 2022. A QIP was undertaken to increase junior doctor guideline awareness and confidence, and improve prescribing practice.

Methods Junior doctors were surveyed for awareness of guidelines and confidence in prescribing, with scores of 1–5. Concordance for anticipatory medication prescriptions was audited, including medication choice and dose (July 2021-November 2022). Interventions undertaken included: peer-teaching for rotating junior doctors, prescribing-aid posters, and reminder emails (June-October 2022). Awareness, and confidence levels were re-surveyed post-intervention and compared by T-test. Concordance was re-audited and trend and special cause variance assessed by run charts.

Results On a score of 1–5, awareness of guidelines increased from an average score of 1.29, to 4.78 (p<0.001) post-intervention. Prescribing confidence increased from an average score of 2.75 to 4.67 (p<0.001). Concordance with guidelines for all anticipatory medication choices significantly increased from 84.7% pre-intervention to 96.2% post-intervention (p=0.019). Run-chart data showed a significant positive shift in percentage of medication choices concordant with guidelines from July to October 2022. Concordance for opiate choices increased from 55.6% to 83.3%(p=0.050) but run-chart data showed no special cause variation. For anticipatory medication dosing, there was no significant change in prescribing performance, with concordance rising from 60.3% pre-intervention to 64.1% post-intervention (p=0.293) and run-chart data showed no special cause variation.

Conclusions Interventions resulted in greater junior doctor awareness, confidence, and improvement in anticipatory medication choices. Further work is required to highlight lower doses of anticipatory medications advised in ALD and to maintain awareness given junior doctor rotations.

VIEWS OF CARE AT END OF LIFE: A SECONDARY ANALYSIS OF ONLINE FEEDBACK USING CARE OPINION

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Introduction In Scotland, there is an increasing focus on patient experience as an aspect of patient safety and quality improvement. However, there are limited studies specifically investigating the content of online public feedback about palliative and end-of-life care services. This study sought to understand experiences of end-of-life care provided in hospitals in the West of Scotland by exploring the main themes within the content of stories posted on a nationally endorsed nonprofit feedback online platform, Care Opinion, within a 2-year period.

Methods An ‘Appreciative Inquiry’ lens was chosen to guide this study to determine what works well in end-of-life care, while also identifying areas for further improvement. We gathered and thematically analysed public feedback stories, and their associated staff responses, posted on Care Opinion Scotland over a 24-month period (March 2019 to 2021) relevant to end-of-life care provided in acute hospitals the Greater Glasgow and Clyde area.
Introduction Caring for the dying is a multidisciplinary team (MDT) model of care, with nurses providing the most direct patient care. Providing end-of-life care to meet the person-centred needs of individuals and families is complex and relies on effective clinical decision-making (CDM) skills. Little is known about how healthcare professionals (HCPs) inform complex decisions for care intervention when the patient is unresponsive at end of life. The cognitive continuum theory (CCT) has been used to examine CDM in healthcare. This systematic review aimed to critically synthesize empirical links between theory, research, and practice to address the following questions: how has the CCT been used in research, and to what extent has it been integrated in research processes and clinical practice?

Methods A systematic review was undertaken searching five databases from inception. A range of key concepts were mapped to each electronic database. Pre-eligibility screening criteria were applied, and methodological quality appraisal was conducted. A meta-aggregative synthesis was conducted using Joanna Briggs methodology.

Findings Five synthesised findings related to the CDM processes were informed by the CCT. These included: CDM varied depending on the decision-making capacity of the individual HCP, their level of experience, availability of decision tools, access to senior staff and peers, and availability of resources such as time and staffing. The visibility of the CCT was variable, with only two studies rigorously applying the CCT to all stages of the research.

Discussion This review identified a gap in providing a person-centric approach to CDM. This finding was dependent on multifactorial considerations which impacted individual HCPs. Complex DM should be safely embedded in the MDT to sustain the team and improve patient care. Further education and support is needed, particularly in the context of the unresponsive dying. Impacts of time, resources and workplace culture on CDM need to be addressed.

Background Multiple tools exist to aid prognosis at end of life, yet predicting the length of time to death once the person is unresponsive and deemed to be ‘imminently dying’ remains fraught with uncertainty. Knowing approximately how many hours or days their dying loved one has left is crucial for both families and clinicians to guide decision making and planning end-of-life care. Previous research has produced useful indicators, but definitive data on length of time from unresponsiveness to death are not reported in the literature. This research sought to determine the length of time between becoming unresponsive and death.

Method A retrospective clinical audit of electronic records of 786 patients receiving specialist palliative care as inpatients, at home, and in aged care homes was conducted across a 10-month period. We analysed the time from the first Karnofsky 10 score to death and used Kaplan-Meier survival analysis to determine the duration of patient’s final phase of life, taking into account variation across age, sex, diagnosis, and location of death.

Results From the first time the patient was scored as Karnofsky 10, 49% of patients were unresponsive for longer than one day, with a median duration of 2 days. Regardless of age, the probability of not surviving is identical across all age groups on day two. Having adjusted for age, malignancy, gender, and location, the likelihood of death within 4 days is over 75%. The data also reveals that, regardless of diagnosis, there is a tipping point at around 20–30 days prior to death, from where there is a notable decline.

Conclusion This new data will have a major impact on clinician’s confidence when responding to the ‘how long’ question and can be used to inform decision-making at end-of-life. Findings demonstrate that the Karnofsky 10 score is a highly reliable prognostic indicator.

Teaching Ethics within Palliative Care: Identifying Priority Topics and Preferred Learning Styles

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