

Introduction NICE guidance recommends that doctors need to identify patients who are approaching their final year of life, through the utilisation of tools such as the Clinical Frailty Score (CFS). The 'Getting it right first time' (GIRFT) document recommended that all local health systems identify older people in the last phase of life and offer them Advanced Care Planning (ACP). Wigan has a large population of frail patients who would benefit from ACP discussions.

Aim Initiate a strategy for identifying patients with severe frailty and establish a process for implementing ACP.

Method Retrospective discharge data was used to identify patients aged >65 years, with a CFS of >7, over an 12-month period. The cohort was examined to see if they had been recognised as a patient who would benefit from ACP, or if an aspect of ACP had been completed during their admission. In total, 50 patients were selected.

Results Initial data showed that we were poor at identifying and completing ACPs for patients with severe frailty. No advanced care planning decisions (0%) were taken during this period. Education (PDSA cycle 1) on ACPs for the ward doctors led to an improvement regarding ACP discussions. However, we were still poor at identifying severe frailty. Education (PDSA cycle 2) for nursing staff was undertaken, which highlighted inaccuracies with calculating CFS. Further PDSA cycles included a geriatric frailty score assessment, introduction of Electronic Palliative Care Coordination Systems (EPACCS) and frailty posters and cards.

Conclusion Severe frailty is an end-of-life state and should trigger a healthcare professional to identify and sensitively discuss end of life needs and preferences. Despite the best intentions of the medical team, implementing a sustained and successful approach to ACP remains challenging within an inpatient setting.

133 END OF LIFE CARE ON ICU

Rebecca Newell, Charlotte Richardson, Valerie Potter. *Newham University Hospital, Barts Health NHS Trust*

10.1136/spcare-2023-PCC.153

Background End of life care (EOLC) on intensive care units (ICU) comes with a number of challenges. This includes rapidly deteriorating patients, complex decisions regarding the withdrawal/cessation of medical interventions, specific care needs for sedated patients, and psychological considerations for grieving family and friends.

Methods A multiple cycle QIP was carried out at Newham University Hospital. EOLC in 'expected deaths' was audited against local guidance. This is summarised in the Barts Health individualised care plan for the dying patient; Compassionate Care Plan (CCP). Data was collected through review of mortality lists and electronic patient records. Further cycles were completed following interventions; firstly, EOLC trolleys with information for staff, patients and families, alongside creating a designated EOLC champion nursing role. Secondly teaching sessions on EOLC.

Results Initial data was taken from the two month period May-June 21. There were 14 expected deaths: 4 patients were referred to palliative care (29%); 2 patients were supported with the CCP; 2 patients had documentation into

consideration of spiritual support. For patients not sedated, medications for symptom control were not always prescribed.

Following the first interventions, Jan-Mar 2022 was analysed. There were 23 expected deaths: 8 (35%) were referred to palliative care; 6 patients (26%) were supported with the CCP; 12 patients had documentation pertaining to symptom control; 9 (39%) patients had documentation of their spiritual needs, with chaplain visits.

Following the second intervention, a further two-month period was assessed. There were 14 expected deaths: 50% were referred to palliative care; 6 patients had documented considerations into spiritual care; un-sedated patients had their symptoms assessed through documented discussion with them.

Conclusions This QIP demonstrated interventions such as education, a designated EOLC champion and easily accessible resources increased spiritual care considerations, improved management of patient's symptom control needs and increased referrals to the palliative care team.

134 RESTRUCTURING THE HOSPICE MDT MEETING: WHAT DO HOSPICE HEALTHCARE PROFESSIONALS WANT AND NEED FROM THEIR MDT MEETINGS?

Adeola Akindele, Richella Ryan. *Arthur Rank Hospice Charity*

10.1136/spcare-2023-PCC.154

Background Multidisciplinary team (MDT) meetings are important in various specialties to ensure organised and collaborative care for patients. In palliative care, the MDT includes but is not limited to doctors, nurses, therapists, psychologists, chaplaincy staff and social workers. Understanding the collective goal and individual roles within MDT meetings is important to ensure efficient delivery of patient care.

Method(s) We conducted a survey of staff expectations and experiences of the MDT meetings held in the inpatient unit of a 21-bed hospice. The survey consisted of 15 multi-choice questions, with space for free-text responses.

Results There were 20 responses from doctors, nurses and allied health professionals out of 44 recipients. The most highly ranked professional benefits from the MDT meeting were: improved continuity of care between professionals (ranked as the top benefit by 42%), improved communication between professionals and collegiality. 41% of people felt that MDT meetings helped them save time. Where respondents felt that MDT meetings did not save time, it was because they felt decisions were delayed until the meeting. There was no consensus on whether the integrated palliative care outcome scale (IPOS) should be reviewed in weekly MDT meetings. Respondents attending remotely highlighted that they sometimes did not feel part of the meeting with the hybrid video format which served to reinforce a medical/nursing dominance over other disciplines. To achieve more effective MDT meetings, suggestions focused on the need to value the contributions from all disciplines.

Conclusion(s) The respondents acknowledged the role of MDT meetings as an important tool to communicate the care of patients between members of the team. Making these meetings truly multidisciplinary remains a challenge and more work is needed to explore ways of promoting and achieving this.