

the event of a life-threatening deterioration. However, when patients were asked about EOL communication with their in-hospital care providers, only 8 (6.5%) reported receiving a disclosure of prognosis, 37 (30.1%) received information about comfort measures to control symptoms, 15 (12.2%) were asked what was important to them when considering decisions about EOL care, and 16 (13.0%) had discussed the risks and benefits of life-sustaining treatments (LST) with a physician. In family members who were asked about EOL communication regarding their relative (the patient), 12 (15.6%) received a disclosure of prognosis, 24 (31.2%) received information about comfort measures, 12 (15.6%) were asked what was important to them when considering decisions about EOL care for their relative, and 11 (14.3%) had discussed risks and benefits of LST with a physician. There are many opportunities to improve the quality of EOL communication and decision-making with seriously ill hospitalised patients and their families.

77 **OPPORTUNITIES TO IMPROVE END-OF-LIFE COMMUNICATION AND DECISION-MAKING FOR SERIOUSLY ILL HOSPITALISED PATIENTS AND THEIR FAMILIES**

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In face-to-face interviews with seriously ill patients and/or their family members, we used a validated questionnaire to assess key components of in-hospital end-of-life (EOL) communication and decision-making at 11 Canadian hospitals. We report preliminary data from 123 seriously ill hospitalised patients (age 80 ± 9 years, mean \pm SD) and 77 family members (age 62 ± 13 years). Patients rated being comfortable and minimising suffering as 8.8 ± 2.5 (1=not at all important; 10=very important) and avoidance of being attached to machines as 7.5 ± 3.5 . Nearly 50% of participants reported that a decision was made in hospital about the use of life-sustaining treatments (LST) in