P-107 IMPROVING THE EXPERIENCE OF PEOPLE WITH ADVANCED DEMENTIA AT THE END OF LIFE IN GREENWICH AND BEXLEY BOROUGH

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Background It is recognised that people with dementia have been poorly served by hospices and palliative care services, leading to lack of support, inappropriate hospital admissions and poor quality care at end of life. Previously our hospice supported only 50 people a year with dementia and our staff had little understanding or experience of their specific needs.

Aims The aim of the project was to enable more people with dementia to access quality specialist palliative care in the place of their choosing, improving their care at end of life.

Method With the support of a St James's Place Foundation grant, we employed one of our Clinical Nurse Specialists 2.5 days a week to focus on advanced dementia. In addition to managing a caseload of patients, she provided expert training, advice and support across the hospice. Facilitating improvements in the way we identified and supported people with dementia and ensuring they received appropriate care within our own and other services. We worked in close collaboration with local community Advanced Dementia Service, cross-referring patients and joint visiting. This enabled patients to have the most timely support and referral into all appropriate palliative care services.

Results Patients with dementia, supported by the hospice increased by over 200%. They were able to access all palliative care services and feedback was excellent. Hospital admissions were prevented and 94% of patients that died did so in their preferred place of death. Over 200 hospice and local community staff received education on dementia.

Conclusion Following the project, people with advanced dementia and their families have had greater access to palliative care services. More people have had support to enable them to stay where they wanted to die. The knowledge, skills and therefore confidence of staff and volunteers has increased, which supports better care. Dementia is firmly on our hospice agenda.

P-108 COMMUNICATING DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION DECISIONS WITH PATIENTS AND FAMILIES

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Background Current policy emphasises the importance of including palliative and end of life patients and their families in decisions about their care (House of Commons Health Committee, 2015; National Institute for Health and Care Excellence, 2017) with clear, sensitive and timely communication (Leadership Alliance for the Care of Dying People, 2014; National Palliative and End of Life Care Partnership, 2015). Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

conversations can help patients accept their predicament (Low et al., 2014) and may help to achieve a dignified death (Mack et al., 2012). However, there is little research detailing how these conversations take place or the terminology and approaches used.

Aims This research study explored the experiences of Clinical Nurse Specialists (CNSs) in palliative care when managing Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) conversations with patients and their families.

Methodology Six semi-structured interviews were conducted in a hospice setting. The results were presented using an autoethnographic approach, exploring the author's experiences in addition to those of colleagues (CNSs) selected by purposive sampling. Data was analysed using NVivo11 applying thematic analysis.

Results Four main themes emerged; learning from experiences, feeling responsible to get it right, how conversations are initiated and the barriers to DNACPR discussions. DNACPR conversations are particularly difficult where patients and families are informed inappropriately or insensitively about DNACPR and when there is little rapport established. CNSs are challenged in balancing sensitivity whilst also communicating clearly about key decisions that are essential to supporting a dignified death.

Conclusion Fears associated with communicating DNACPR decisions may lead to patients receiving information inappropriately, insensitively and without clarity. Raising awareness of these research findings amongst healthcare professionals can lead to enhanced communication provided in a clear, timely and sensitive manner by a healthcare professional with whom patients have an existing rapport.

P-109 HOSPICE NURSES' THOUGHTS AND FEELINGS OF 'DNACPR' DISCUSSION WITH PATIENTS

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Aims This study explored the thoughts and feelings of hospice nurses regarding Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussions and the potential extension of their role in this including formal documentation of the outcome of that discussion by signing the DNACPR form.

Methods Eight semi-structured interviews were carried out with senior hospice inpatient and day therapy nurses. Interpretive phenomenological analysis was used to explore the shared lived meaning of this phenomenon.

Results Four themes emerged:

1. Current practice around hospice nurses
2. How proposed changes to practice may enhance patient experience
3. The benefits to hospice nurses
4. The challenges of this change in role.

Participants appeared confident with the concept of nurses discussing and documenting DNACPR decisions. They could envisage that seamless advance care planning would enhance patient care, and that nurses' rapport with patients made them

best placed to have these conversations. Hospice nurses reported numerous potential barriers to extending their role including: impact on peer relationships and relationships with doctors; anxiety about having DNACPR discussions with some evidence of censoring of conversations and selection of which ones they would engage with; anxiety about the responsibility for such decisions if the patient changed place of care. Although participants did not perceive stable or prolonged illness trajectories as a barrier for discussing DNACPR, they did consider a patient's uncertainty about the prognosis to be a barrier.

Conclusion Hospice nurses exhibited cognitive dissonance; they had discord between knowing what good practice was and completing it in action. They appeared to value 'niceness' over honesty and their censoring of conversations resonates with communication awareness theories.

P-110 ABSTRACT WITHDRAWN

P-111 WITHDRAWAL OF NON INVASIVE VENTILATION IN PATIENTS WITH RESPIRATORY DISEASE IN A HOSPITAL SETTING

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Background Withdrawal of non invasive ventilation (NIV) in patients with motor neurone disease has been well documented. However, little is published about the process in patients using it acutely for respiratory failure associated with a primary respiratory disease.

Aim This audit provides a retrospective collation of cases in which NIV was withdrawn in patients commenced on the treatment acutely in the hospital setting.

Methods Cases were identified using the search function of the electronic palliative care notes between April 2016 and April 2017. Patients identified as undergoing withdrawal of NIV or discussion about NIV withdrawal had hospital notes obtained for analysis. Nine patients fitted the criteria. Six underwent a planned withdrawal of treatment. Hospital notes and drug charts were reviewed to provide data on the withdrawal process.

Results Average length of hospital stay was 8.5 days. Palliative care referrals were made on average 2.57 days prior to withdrawal with 57% of cases being referred the same day. Decision to withdraw was documented on the same day withdrawal took place in 100%. The decision was discussed with 50% of patients and 83% of families by a range of healthcare professionals. Ventilator weaning took place in 50%. Medication administration demonstrated a range of practice. Pre-medication was documented in 33%, post withdrawal bolus doses were required in 50%. Administration route was a mix of IV bolus, SC bolus (dose range of 1–7.5 mg of midazolam and 3–7.5 mg of morphine) and syringe driver (average starting dose 13.5 mg midazolam and 12.5 mg morphine). 71% of patients died within 24 hours of ventilation withdrawal. No patient survived >48 hours. All died in hospital.

Conclusion Decision making and treatment withdrawal in this patient group is rapid. Practice of withdrawal and

pharmacological intervention is varied. This highlights the need to develop guidance for the process of NIV withdrawal in the hospital setting and the need for clear standards of documentation when undertaking withdrawal decisions discussions.

P-112 INDIVIDUALISED CARE PLANNING FOR DYING PATIENTS – AUDITS TO IMPROVE PRACTICE

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Background Recognition of dying is an integral part of best practice in end of life care. The Dying Phase (DP) is included in the Outcome Assessment and Complexity Collaborative (OACC) suite of measures. Individualised care plans for dying patients have been a key initiative since the demise of the Liverpool Care Pathway. At our hospice Phase of Illness has been captured on our electronic patient record (Crosscare) for two years and a new care plan for the dying window introduced in November 2016. The care plan was created to be used across clinical settings with a printable option for patients cared for in the community.

Aim To review patient records in a 15-bedded hospice inpatient unit and evaluate if DP was recognised in a timely manner and appropriate care plan commenced.

Method All patients who died or were identified as dying in the two months following the initiation of the new care plan were included. Notes were retrospectively reviewed including dates DP was recorded and care plan created. An Excel toolkit was used to analyse the quantitative data. A separate quality review of care plans was conducted by a senior nurse.

Results 37 patients were included in the audit. 32 had DP completed, of these two did not have individualised care plans completed as they died quickly. Only 29 had OACC phase updated. Mean length of time in DP was three days (range <1 day to 8 days). Quality of care planning was generally good and used as feedback for training.

Conclusion Incorporating Phase of Illness and individualised care plans for the dying person is important in the hospice setting with electronic records. This audit informed amendments to improve practice including retrospective entry of care plan if patient dies quickly and embedding Phase of Illness update into the care plan window.

P-113 BIOMARKERS OF DYING IN CANCER PATIENTS; AN EXPLORATION OF THE BIOLOGY OF DYING

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Background The Neuberger review made a number of recommendations to improve end of life care, including research into the biology of dying. An important aspect of the biology of dying is the identification of biomarkers as indices of disease processes. Biomarkers have the potential to inform the current, limited understanding of the dying process and assist