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

Mary Johnston, Louise Free, Ruth Bacon, David Barday. St Wilfrid’s Hospice, Eastbourne, UK

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 died 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

1Seamus Coyle, 2Victoria Louise Reid, 3Rachael McDonald, 4Amara Callistus Nwosu, 5Stephen R Mason, 3Chris Probert, 1John E Ellershaw. 1The Marie Curie Palliative Care Institute Liverpool, University of Liverpool, Liverpool, UK; 2Renal Medicine, Andrew University Hospital NHS Foundation Trust, Liverpool, UK; 3Department of Gastroenterology, University of Liverpool, Liverpool, UK

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...