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P-110 ABSTRACT WITHDRAWN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Aim This audit provides a retrospective collation of cases in which NIV was withdrawn in patients commenced on the treatment acutely in the hospital setting.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

clinicians in recognising dying, in particular how to distinguish dying from reversible acute deterioration.

Objectives To critically appraise the literature on biological factors that may be used as prognostic indicators in advanced cancer patients.

Methods A systematically structured review was conducted using three electronic databases. Studies reporting prognostic biomarkers in cancer patients with a median survival of ≤ 90 days.

Results 30 articles were included. Seven prognostic biological factors demonstrated Grade A evidence (lymphocyte count, white blood cell count, serum C-reactive protein, albumin, sodium, urea and alkaline phosphatase). An additional eleven prognostic factors were identified with Grade B evidence (platelet count, international normalised ratio, serum vitamin B12, prealbumin, bilirubin, cholesterol, aspartate aminotransferase, alanine transaminase, 40 lactate dehydrogenase, pseudocholinesterase and urate). A number of biomarkers were specifically identified in the last two weeks of life but limitations exist.

Conclusions The biology of dying is an important area for future research, with the evidence focused on signs, symptoms and prognostic factors. This review identifies a number of common themes shared amongst advanced cancer patients and highlights candidate biomarkers which may be indicative of a common biological process to dying.

P-114 THE ROLE OF THE INFECTION PREVENTION NURSE IN THE HOSPICE SETTING

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Introduction The role is often carried out by Infection Prevention Link staff who also have the role of providing care to the patients. LOROS changed this profile three years ago by employing a dedicated qualified infection prevention specialist. As most of the patients within the hospice are vulnerable to infection this role was to look at areas which could be improved and reduce the risk of hospice acquired infections and promote patient, staff and visitors' safety.

Aims The aims were to ensure that LOROS was compliant with national and local guidelines on Infection Prevention. To identify any areas for concern or non-compliance and how it could improve the patient's journey and ensure infection prevention and safety were everyone's business.

Method A review of national and local infection prevention literature was undertaken and the Infection Prevention Lead was part of the Infection Prevention Society (IPS) whose vision is that 'no person should be harmed by a preventable infection'. They have also produced a suite of infection prevention audits that can be used in all healthcare settings. These were used as a starting point for starting to identify any good/excellent areas of compliance and any areas which may need improvement.

The hospice also wanted to ensure compliance with the Department of Health's Health and Social Care Act 2008 The Hygiene Code. This Act established the CQC and sets out the overall framework for the regulation of health and adult social care activity. Outcome 8 of the CQC was the driving force for some of the changes that were implemented.

Conclusion From the initial audits areas of good practice were identified, for example the general cleanliness of building, staff

adherence to uniform/dress code and hand hygiene but they also identified area for improvement. The list below is an example of some of the changes implemented but it is not an exhaustive list and work continues to identify good practice and areas for improvement

- The purchase of all new commodes
- Fabric riser recliner chairs started to be phased out
- Green labels were introduced identifying equipment had been cleaned
- Detergent cleaning wipes
- Link Staff had a dedicated two day training day
- Oak Ward refurbishment
- Safer needles
- Introduction of Sepsis Pathway
- Patient leaflets
- Cleaning schedules and policy
- Development of an audit Programme.

P-115 TO FEED, OR NOT TO FEED, THAT IS THE QUESTION: MULTI – PROFESSIONAL TEAM TRAINING ON FOOD AND DRINK FOR THE DYING PATIENT

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Aim Whether or not someone can, or should, eat and drink in the last hours and days of life is a dilemma faced by patients, their families and staff. A perception that food or drink has been withheld, and consequently contributed to death, can cause significant distress to bereaved relatives. This project aims to equip Health Care Professionals (HCPs) with the skills to assess the wishes and needs of dying patients, and develop a plan of care with patients and their 'families' regarding eating and drinking.

Design Following review of local audits of care of the dying and initial training sessions with palliative care staff, a half-day interactive training session was developed focusing on:

- Clinical assessment and benefits
- Professional guidelines and the law
- Ethical decision making in clinical practice
- Conversations and documentation.

The session was refined following feedback from participants, a teaching resource pack developed and team-teaching utilised to ensure consistent delivery by different facilitators. Training was offered to all HCPs working across a locality in the North of England.

Results Training sessions were fully booked with 323 trained in the first six months. Participants were multi professional (nurse 38%, health care assistant 25%, doctor 24%, other 13%) and from a variety of settings (care home 43%, hospital 32%, community 11%, hospice 14%). Feedback was excellent and comments demonstrated the session had been thought provoking and enjoyable.

Lessons Learnt Participants report clinical decision making and the accompanying conversations about eating and drinking for dying patients is challenging. Differentiating between 'food and drink' and 'clinically assisted hydration and nutrition' is valuable.

Uniting staff with different experiences stimulated excellent reflective debate and shared learning. Staff report increased confidence to develop and review plans in accordance with