

Mean age 66.5 years
 Percent of female 50.47%
 Unplanned admissions 82.28%
 Over the following 365 days, of the 858:
 Number of patients that died 223 (25.99%)
 Number that died in CUH 51 (5.94%)
 Median number if A and E attendance 2
 The median bed days in the census year 40
 The median number of admissions in the census year 3
 Higher rates in geriatrics and oncology as expected. Data is being used to engage clinicians in End of Life Care and point out that hospitals are in a good position to provide advance care and EOLC planning

79 AN AUDIT OF DOCUMENTATION OF CARDIOPULMONARY RESUSCITATION (CPR) DECISION MAKING AND COMMUNICATION ON ADMISSION TO A HOSPICE INPATIENT UNIT

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Background CPR decisions are a significant part of advanced care planning. Clear communication with patients and those important to them, and documentation of decision making, is essential for good care and, following court cases, is now also a legal requirement.

Purpose The audit aim was to assess documentation of CPR decisions and communication on admission to Marie Curie Hospice Bradford and review CPR documentation on the patient's electronic palliative care co-ordination system (EPaCCS).

Methods Standards were set using Resuscitation Council (UK) and GMC guidance and the hospice's CPR policy. All admissions between 1 st-31st January 2017 were audited and results compared to an initial audit in 2016. The 2017 audit was extended to assess CPR decision making documentation on EPaCCS.

Results 38 admissions were audited. All had a CPR decision documented of which 32 were DNACPR. 22 were discussed with patients, 9 with relatives and 8 were not discussed. In 2016 of 37 admissions audited, all had a CPR decision. Only 13 DNACPR decisions were discussed with patients.

On EPaCCS, of the 10 DNACPR decisions not discussed at admission, 6 were discussed previously with patients and 2 were not discussed.

Conclusions and recommendations In both audits 2 audit standards were met:

- All patients should have a decision about CPR at the time of admission.
- CPR decisions and rationale should be clearly documented.

2 standards were not met:

- CPR should be discussed with all patients.
- CPR should be discussed with relatives/those important to the patient.

As the hospice moves to electronic patient records documentation will be modified. In addition to general advanced care plans, 3 specific sections are to be completed for CPR decision, discussion with patient and discussion with relatives.

The aim is to improve documentation of discussions and continuity with EPaCCS. A re-audit will be completed.

80 WHAT PREVENTS ADVANCE CARE PLANNING IN HAEMATOLOGY?

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Background Despite a clear emphasis in policy on the importance of advance care planning (ACP) for achieving quality end of life care, rates of ACP completion remain low. This is particularly apparent for patients with haematological malignancies and is associated with high rates of hospital death and patients receiving aggressive treatments at the end of life. This impacts on quality of life and family bereavement. Although patients tend to be receptive to ACP discussions they expect healthcare professionals to instigate them. Current evidence exploring barriers and facilitators to ACP from the healthcare professionals' perspective is limited.

Aim To explore what doctors and nurses identify as the barriers and facilitators to ACP for patients with haematological malignancies.

Method One-to-one semi-structured interviews were conducted with a purposively recruited sample of 5 doctors and 5 nurses working in a haematological malignancy setting. Thematic data analysis was conducted using a multi-perspectival Interpretative Phenomenological Analysis (IPA) approach. Demographic questionnaires were also used to capture key participant characteristics and provide a rich contextual description of participants.

Findings Six super-ordinate themes were identified: the problem with haematology; haematology team culture; approaching the patient; balancing hope and reality; managing patient psychology; opportunities for ACP; and staff awareness and training; each with associated subthemes.

Conclusion Though general claims are cautious, the findings of the study provide indications for future research exploring this phenomenon from the patient's perspective, as well as introducing prompts to trigger early ACP discussions despite prognostic uncertainty. It also poses potential clinical implications to improve holistic patient-centred shared decision-making by: addressing the hierarchical structure of haematology; inter-professional education and ACP awareness promotion; and empowering nurses to initiate ACP.

81 THE LIVING WELL GROUP: A PUBLIC PARTNERSHIP INITIATIVE TO IMPROVE END OF LIFE CARE IN AN ACUTE HOSPITAL

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Background Poole Hospital NHS Foundation Trust is participating in Building on the best (Botb) – a national initiative to improve end of life care in acute hospitals. The Ambitions Framework recognises the important role of partnerships between communities and professional services.

A Public Partnership Group was created to support delivery of the projects comprising Botb.

Methods The group was recruited to following an article in the local press entitled: ‘Poole Hospital wants to improve its end of life care. Can you help make it even better?’ The public were invited to respond to the article by email. Respondents were screened and if thought suitable for inclusion in the group, were invited along for the inaugural meeting in January 2017.

The group collectively decided to name themselves The Living Well Group and have continued to meet on a six weekly basis for a two hour meeting facilitated by a Palliative Care Consultant and Transformation Manager in End of Life Care.

Results The Living Well Group has evolved into a dynamic source of opinions and ideas to represent the local population. They have contributed to the following initiatives:

- Raising awareness and promoting dignity and compassion in dying
- Design of a new Advance Care Planning document
- Ideas for a befriending service at end of life in the hospital
- Involving families in the care of dying patients – touch, mouth care and hearing
- Feasibility of creating a standard of time to administration of analgesia
- A patient experience of care questionnaire at end of life

Conclusions The public are willing to contribute directly to the development of end of life care initiatives and it is possible to create an effective working group following advertisement in the local press.

82 TREATMENT ESCALATION PLANS – SUPPORTING INDIVIDUALISED CARE

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Background Failure to plan and document an appropriate ceiling of care can lead to treatment decisions being made urgently, out of hours, by a team unfamiliar with the patient; unwanted hospital admissions; investigations and treatments which do not contribute positively to the individual’s experience of care. To address this, we developed an electronic Treatment Escalation Plan (TEP) as part of the Electronic Patient Record. TEPs were implemented trust-wide in July 2015.

This is part of a wider project to improve end of life care: Poole Hospital is part of ‘Building on the best’ in partnership with NCPCC, Macmillan, and locally funded by Forest Holme Hospice Charity.

Methods

- Electronic notes review of 40 consecutive adult inpatients who died within 100 days of hospital admission (index admission October 2015), using a standardised proforma (documentation of TEP or DNACPR, involvement of patients and families in discussions during the index admission).
- Run chart of TEP documentation showing how many electronic TEPs are created in EPR each month.
- Comparison with in-hospital mortality review in which notes of people who have died are reviewed by senior clinicians.

Results

- Of 40 patients, 17 died during the index admission, with documented discussion of prognosis for 88%, electronic TEP for 29%, DNACPR for 100%. Of 23 who died subsequently, discussion of prognosis had been documented in the index admission for 17%, electronic TEP for 4%, DNACPR for 30%.
- There has been a significant increase in the median number of TEPs created: 44 per month (2015/16) to 140 per month (2016/17).
- In 2017, 90% of adults dying in hospital have a documented ceiling of care.

Conclusion Treatment escalation plans are one way to improve decision making and documentation. TEPs are now widely used throughout the hospital, contributing to effective individualised care for people approaching the end of their life.

83 EVIDENCING CARE OF THE DYING ADULT IN A DISTRICT GENERAL HOSPITAL

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Background The Five Priorities of Care highlight the importance of individualised care planning for the dying adult. Ashford and St Peter’s NHS Trust is a district general hospital with over 1000 deaths per year. Over the last year, an individualised care plan based on the 5 priorities of care has been implemented across all wards. The initial baseline audit of care of the dying adult, lessons learnt from implementation and the re-audit of care are presented.

Methods A ward based training program was developed alongside a Priorities- individualised care plan document and communication sheet for family and loved ones.. An audit tool based on the 5 priorities of care was used to assess care of the dying before and after implementation across the acute hospital medical wards. Two weekly projects meetings were held during the implementation phase and data collected on the use of the ‘Priorities-individualised care plan’. The care of 50 patients before and after implementation was audited for comparison.

Results The initial audit showed recognition of dying on the wards ranged from 50%–100% however most patients were not recognised as dying until the last 48 hours, thus almost 80% of patients were unable to participate in decision making about their care. 5% of patients had adequate individualised care planning in the last days of life. Three months after implementation 31% of all medical deaths were supported with a Priorities care plan, however uptake varied across wards with the care of the elderly wards using it for over 60% of deaths compared to 15% on the acute medical unit.

Conclusion This quality improvement project highlights that implementing high quality end of life care through individualised care planning requires extensive training, resource and a culture shift for professionals. The post implementation audit findings will also be presented.