accepted it (74.6% of those offered). 238 patients accepted a research pack, with 105 returning questionnaire 1 (44.1% response rate), and 26 returning questionnaire 2 (24.8% of initial respondents). Questionnaire 1 (patients) – 40% found it difficult or burdensome repeating information to HCPs, and almost 70% were interested in a PHR to reduce repeating information. Questionnaire 2 (patients) – 74% found it the passport easy to use, but only a few actually used it regularly. Some felt the passport helped conversations with family and HCPs about day-to-day and future care. Over 60% stated the PHR was ‘very’ or ‘quite’ useful, and would recommend it to others. Questionnaire and focus group with HCPs indicated it was mainly patients and relatives who used the passport, not non-palliative HCPs. Half felt the passport was initially well received, but only 4 (22%) felt it was used regularly by patients or their families. More found it useful to talk about facilitation discussion about future care compared with day-to-day care.

Conclusions While initial uptake of the passport was high, use appeared low. This evaluation does not support widespread use of a PHR in palliative care, but it may be helpful to individuals, especially earlier in their disease trajectory.

In the second initiative, run charts demonstrated statistically significant improvements in the rate of assessment, reassessment and evaluation of terminal agitation (p<0.05). Routine review and dissemination of data with the frontline teams in these initiatives enhanced collaborative engagement, motivation and success.

Conclusion SPC and run charts can be used to measure the impact of interventions, and contribute to improvements in EOLC.

Abstracts

**116 MEASURING THE IMPACT OF END OF LIFE CARE QUALITY IMPROVEMENT (QI) PROJECTS**


Aim To demonstrate the application of QI methodology to improving end of life care (EOLC), using improvement data (run charts/statistical process control charts (SPC)) to measure the impact of interventions.

Background QI methods are applied widely across healthcare. SPC and run charts are employed to demonstrate if interventions can lead to sustained and significant improvements. Identifying variables that suit themselves to measurement by repeated data points is more of a challenge for interpersonal aspects of care (such as palliative and EOLC) than for technical interventions (Conry M, 2012).

Methods QI methodology and measures were employed in two QI EOLC initiatives in a large acute NHS trust. The first was a multidisciplinary collaborative to improve the care of patients at risk of clinical deterioration to reduce avoidable deterioration and/or inappropriate cardiopulmonary resuscitation. The second was an intervention led by the Palliative Care Team to improve the assessment and management of terminal agitation on designated wards. SPC and run charts were created for these initiatives, with baseline data pre-intervention and on-going data collection during the testing, implementation and sustainability phases.

Both initiatives were developed following identification of local need; were led by frontline teams and empowered ward level innovation.

Results In the first initiative SPC charts demonstrated sustained, significant 25% reductions in cardiac arrest calls across the trust, and on 14 pilot wards a 125% increase in patients with a treatment escalation plan and 75% increase in documented CPR decisions.

In the second initiative, run charts demonstrated statistically significant improvements in the rate of assessment, reassessment and evaluation of terminal agitation (p<0.05). Routine review and dissemination of data with the frontline teams in these initiatives enhanced collaborative engagement, motivation and success.

Conclusion SPC and run charts can be used to measure the impact of interventions, and contribute to improvements in EOLC.