Method In May 2018 there was a 'Hard Reset' week: senior trust management required the PEOLC Champion in each service to lead a review of the Systm1 clinical record of every adult on the community caseload and inpatients, using the surprise question and document the outcome on Systm1. They were supported by locality managers, clinical leads and specialist palliative care nurses. Data was captured from Systm1.

Results In May there was a considerable increase in number of people newly identified as being in the last year of life (857) which was most noticeable in non-cancer services, such as heart failure service (171) and speech and language therapy service (55). Overall there was a 43% increase in people newly identified in the three months following the hard restart (1065) compared with the three months before (745).

Conclusion The Hard Reset method increased numbers of people identified as being in the last year of life which has been sustained several months later.

Next steps To sustain this improvement and ensure that those identified are able to access PEOLC.

52 HOSPITAL ADMISSION, TREATMENT ESCALATION AND PREFERRED PLACE OF CARE FOR PATIENTS WITH HAEMATOLOGICAL MALIGNANCIES IN THEIR LAST YEAR OF LIFE

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Background Haematological malignancies encompass a range of heterogeneous conditions. Despite treatment advances the prognosis of several patient cohorts remains poor. Such individuals more commonly receive active treatment in the weeks prior to death, require inpatient admission and die in hospital compared to those with non-haematological cancers. However, this has been shown to contradict patient expectations of end of life care.

Methods A retrospective audit of 30 deceased patients with haematological malignancies was conducted in a tertiary department. Patient notes informed the number of hospital admissions, clinician exploration of preferred place of care, treatment escalation decisions and involvement of palliative care services within the 12 months prior to death.

Results Patients died from their underlying malignancy in 83% of cases. At the time of death 97% had a DNACPR *in situ*; 55% of forms were signed in the 2 days prior.

Patients required a mean of 4 admissions. Dependence on supportive blood products, a higher incidence of neutropenic sepsis and aggressive treatments were several reasons thought to be accountable. Achievement of preferred place of care was associated with initiating these discussions earlier. Of the 26% of patients asked, none specified hospital. Involvement of palliative care services was highest in the 5 days before death; 40% of referrals were for end of life support.

Conclusions Clinicians recognise when patients with haematological malignancies are imminently approaching their last days of life. However, the repeated pattern of admission in those with a poor prognosis may represent missed opportunities to initiate earlier advance care planning which has been linked to an increase in achieving preferred place of care. Focus groups exploring the barriers to initiate such conversations and empower earlier communication was felt to be a more

effective intervention than the introduction of a paper proforma. A subsequent re-audit to assess their value is recommended.

53 INCREASING STAFF CONFIDENCE AND COMPETENCE TO DELIVER INDIVIDUALISED END OF LIFE CARE ON ELDERLY CARE WARDS: IMPLEMENTATION OF A SYMPTOMS OBSERVATION CHART AND CARE PLAN GUIDE

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Background Following the withdrawal of the Liverpool Care Pathway concerns were expressed about staff confidence and competence to deliver end of life care. In response to locally identified needs and the recommendations for individualised care plans underpinned by the Five Priorities for Care of the Dying Person we have designed and implemented a Quality Improvement Project(QIP) within our NHS Foundation Trust.

Method We have introduced two tools, a symptom observation chart and care plan guide modelled on the Five Priorities. The tools were piloted initially on an acute medical admissions ward and have now been cascaded across four elderly care wards. Implementation was tracked and supported using QI methodology to include Run charts and PDSA cycles. Our aim is that all patients on elderly care wards who were recognised as being in the last days of life have 60% of their nursing care plans completed in line with the Five Priorities and 5/7 of symptoms listed on the symptom observation chart recorded and managed appropriately every 4 hours.

Results Over 22 weeks we identified 57 patients with End of Life Notifications. During this period 0%–70% of patients had 60% of their nursing care plans in line with the Five Priorities and 0%–100% of patients had 5/7 symptoms listed on the symptom observation chart recorded and managed appropriately every 4 hours. The variation in the use and completion of both tools may be explained to some extent by the small sample size and missing data (59% of charts in PDSA1 and 50% in PDSA2 were missing).

Conclusion Staff on these wards require ongoing education and efforts to promote engagement and investment in the tools. Data collection to assess the adherence to standards with regards to the timing of bedside assessments and escalation of concerns to senior staff where applicable is currently ongoing.

54 THE VIEWS OF A DISTRICT GENERAL HOSPITAL COMMUNITY ON TALKING ABOUT END OF LIFE WISHES

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Dying matters is a coalition which aims to help people talk more openly about death and dying. This includes raising awareness with the hope that more people will make plans for the end of life (EoL). As part of awareness week 2018