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

there was an online poll asking the question 'How you would feel talking to someone close to you about their EoL wishes?'

Ashford and St Peter's NHS Foundation Trust (ASPH) is a District General Hospital in Surrey, England. This year as part of Dying Matters week we sort to explore what the ASPH community felt about talking about their EoL wishes.

Aim To explore how comfortable the ASPH community is talking about EoL, and to encourage people to express their wishes on a 'Before I die' board

Method The Specialist Palliative Care Team held a 'Dying Matters' stand at the front entrance of the hospital and encouraged the ASPH community to complete a questionnaire regarding how they would feel talking about their EoL wishes and add a 'think bubble' to the ASPH 'Before I die' board.

Results There were 146 responses to the questionnaire and 90 think bubbles added to the board. Responses came from 125 HCPs (86%), 8 patients (5%), 7 carers (5%) and 6 visitors (4%).

108 (74%) felt it was very important to talk about EoL wishes, 130 (89%) felt happy to talk to someone close, 125 (86%) to a HCP and 97 (66%) to a faith or religious leader. The think bubbles centred around 3 main themes; comfort, family wellbeing and achieving life goals.

Conclusion Most people say they would feel happy to discuss EoL wishes with someone close or a HCP more so than a faith or religious leader. It is important to note that the number of responses from patients/carers was low.

55 NURSING CARE INITIATIVE TO ASSIST INDIVIDUALIZED CARE PLANS FOR THE DYING PATIENT

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10.1136/bmjspcare-2019-ASP.78

Background The priorities of the dying patient should be a priority of the healthcare team caring for them. To facilitate this, effective and open communication is key. The aim of this initiative was to focus on patients' priorities and to enhance care for patients and those important to them.

Methods CQC reports highlighted initiatives used in palliative care settings. Discussions with colleagues brought out recurrent themes – namely privacy and practical support for family members. Relevant publications were also discussed.

Results The use of an End of Life symbol is prevalent in other hospitals, displayed once a patient has died. On this unit due to factors such as withdrawal of treatment, patient deaths can be expected, therefore, the use of a symbol during this period to alert the multidisciplinary team (MDT) – including of course domestic staff – minimize unnecessary interruptions and enhance the patients (and family's) overall care was implemented. Policy, guidelines and consent forms were developed and agreed upon with the help of the wider MDT. Teaching for all staff commenced, copyright obtained from the Irish Hospice Foundation for the use of this particular symbol. The first audit received a response rate of 17% (from the MDT). This showed 91% reported minimized disruption, 82% felt family were cared for and 100% found it useful.

Conclusions The over-riding comment from the patient, their families and friends when consenting for use of the symbol was 'anything as long as it means peace and quiet'. The worry that the symbol would stop people entering was unfounded. It

enhanced the essential care and enabled the patients' individual preferences to be carried out. Feedback obtained through conversations with relatives and questionnaires completed by staff has been overwhelmingly positive.

56 PARAMEDICS' UNDERSTANDING AND INTERPRETATION OF ADVANCE CARE PLANNING: A PILOT QUESTIONNAIRE-BASED STUDY

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Background Paramedics are often the first healthcare professionals to respond to changes in a patient's condition. However, there has been no previous studies into paramedics' understanding of legislation relating to advance care planning (ACP), or how they interpret ACP documents. The aim of this pilot study was to find out what knowledge paramedics had about ACP legislation, and how uniformly they interpreted ACP documents.

Methods We invited paramedics to complete a questionnaire about ACP. There were four true-or-false questions about the legal aspects of ACP. The questionnaire also included a hypothetical scenario and simulated Do Not Attempt Cardio-Pulmonary Resuscitation form related to the scenario. The paramedics were asked whether they would, or would not, start CPR in that scenario.

Results Fifteen paramedics completed the questionnaire. Five reported that they had previously been taught about legal aspects of advance care planning. The correct answers to the true false questions varied between 67% and 87%. Six paramedics completed the scenario question. Five indicated that they would not start CPR. One paramedic indicated that they would start CPR.

Conclusions This pilot study indicates that up to third of paramedics might misunderstand some of the legal aspects relating to ACP. It also indicates a lack of uniformity in how paramedics interpret ACP documents. This study should raise awareness that ACP documents might not always be interpreted as intended. We will use these finding to explore the interpretation of ACP documents in a larger cohort.

57 STRAIGHT FROM THE HORSES' MOUTH: PERCEIVED FACTORS FOR PROMOTING PALLIATIVE AND END OF LIFE CARE; PERSPECTIVE OF NURSES, PATIENTS AND FAMILY CARERS

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Background Evidence-based approach to the care at the end of life will decrease the danger placed on traditional and familiar policies in hospitals of Sub-Saharan Africa. Palliative care has different characteristics within Africa, there are diverse attitudes to palliative and end of life care informed by multiple meanings and traditions. Although there is insufficient information documented on palliative and end of life care provision in Nigeria and other Sub-Saharan African countries, and there is only weak evidence upon which to build policy