

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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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

and practice development. Nurses and family carers are faced with different challenges when providing care to patients at the end of life. Therefore, it became imperative to explore the factors perceived to promote care at the end of life from the perspective of nurses, patients, and family carers.

Method A qualitative ethnographic case study design was employed for the study. Participant observations consisting of 188 hours of observation, and semi-structured interviews with 40 participants (nurses-14, patients-12, and family carers-14) were used as tools for data collection. Data analysis follows an inductive thematic approach using NVivo 11 qualitative data management programme.

Findings Six overarching themes emerged: Enhanced communication skills, Increase drug supply, improve manpower, reward or incentives, training of staff, and improve logistics supplies.

Conclusion Basically, these factors were directly related to the poor managerial processes and hospital's policies. If the hospital management increases drug supply, improve manpower, revive decayed infrastructure, improve logistics supplies, provide reward or incentives to staff, and encourages staff training and development, certainly the quality of palliative and end of life care will be improved.

58 AN ANALYSIS OF THE QUALITY OF ADVANCED CARE PLAN AND DNACPR DOCUMENTATION PRIOR TO THE INTRODUCTION OF THE RESPECT PROCESS

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An Advanced Care Plan (ACP) allows discussion and documentation of patient preferences for their future medical care which is not limited to resuscitation only. Despite national guidance, there remains poor communication and inconsistent documentation of ACP and DNACPR decisions, potentially resulting in inappropriate treatment and hospital admissions for patients. ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) is a newly introduced emergency care plan which aims to help support advanced care discussions and record recommendations. We aimed to assess the quality of ACP and DNACPR documentation at a UK District General Hospital before introducing the ReSPECT form.

Retrospective data was collected on all patients from two elderly care wards in March 2018 through case note review. Section headings on the ReSPECT form were used as the basis for collection. Data was also collected on ACP/DNAR decision communication on discharge documentation.

87 patients (52 male and 35 female). 25% (22) had ACP and 72% (63) had DNACPR agreed. Those with DNACPR, 79% (50) had discussion documented in clinical notes, and 57% (36) on discharge documentation. Those with ACP agreed, 68% (15) of discussions were documented in clinical notes, 95% (21) had ACP on discharge documentation completed by junior doctors.

ACP and DNACPR decisions are individual to each patient and our initial data shows they are not always clearly documented. Interestingly, ACP decisions are found more on discharge summaries than recorded in medical notes. Discharge summaries are completed by junior doctors and therefore need support by clear senior decision making in the notes. This is currently missing for 27% of ACP decisions and

highlights that discussions required for the ReSPECT process are not currently routinely documented. The ReSPECT form alongside web-based training was introduced in October 2018. The next step is to re-audit and assess its impact on documentation and communication.

59 PLANNING AHEAD: RETURNING HOME ON VENTILATORY SUPPORT FOR END-OF-LIFE CARE

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Background The Intensive Care National Audit and Research Centre UK (ICNARC) revealed that approximately 20% of patients admitted to the Intensive Care Unit (ICU) will die there. End of life care decisions are a fundamental aspect of care on ICU, particularly given that 70% of the deaths that occur are following the withholding or withdrawal of life-sustaining treatments. Palliative care is increasingly accepted as an essential component of comprehensive care for critically ill patients. Most deaths are managed independently on the ICU, as such, patients preferred place of death (PPD) is not often explored or fully established.

Aims

1. To highlight the importance of end-of-life care and early palliative care team input to everyday practice and training for anaesthetists and intensivists.
2. To actively consider whether transfer home may be a component of end-of-life care for some patients.

Methods Our patient population are those inpatients receiving additional respiratory support on the ICU, non-invasive or invasive ventilation, who's expressed their PPD as home. We recognise that collaborative and innovative working between teams within the acute and community sector is key to facilitating a safe and efficient transfer home for end-of-life care for patients requiring ventilatory support.

Results At our hospital, we have facilitated two patient transfers from ICU to home for withdrawal of ventilatory support and end-of-life care. Following these transfers, a comprehensive discharge checklist has been implemented, with key focus to ensuring a safe but time efficient transfer.

Conclusions To conclude, we are not asserting that transfer home at end-of-life is desirable or feasible for all critically unwell patients. However, we want to highlight the important of exploring patient wishes at this crucial stage of patient care.

60 A REVIEW OF CODE STATUS DOCUMENTATION IN PATIENTS REFERRED TO THE PALLIATIVE CARE INPATIENT CONSULT SERVICE

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Background Inpatient Palliative Care consult services see a wide range of acutely admitted patients, many of whom are critically ill. Due to the nature of an acute admission, code status clarification or discussion is often overlooked and can affect patient's clinical course and outcome.