an agreed decision to deactivate the ICD with the patients/ their family.

In these situations, patients and families placed different weights to the clinical team on the benefits and harms of leaving the ICD active versus deactivated, often because of strong preferences or intrinsic values related to pursuing treatments.

National guidance exists about factors to consider when making decision about deactivation of an ICD at end-of-life. However, staff experienced conflict between their wish to deliver medically appropriate but personalised care.

The teams were fluently able to discuss the harms that can occur as a result of leaving an ICD active including the pain from shocks and distress witnessing this. However, further consideration of real-time harms that were occurring as a result of deactivation discussions was crucial to reaching a shared decision to leave these ICDs active, unless preferences changed or the ICD fired causing distress.

The particular harms included: deactivation becoming the focus of encounters rather than other issues such as symptoms (often patient led); loss of trust in patient-clinician relationships because of (perceived) failure to recognise the importance of the individuals values/perspective; time taken for further discussions in context of time as a scarce resource/precious in end of life situations.

Our experiences and practice evolve with each case, but being mindful of current versus potential future harms, and articulating these, has been helpful in reaching shared agreed decisions to leave some ICDs active at end-of-life.

Conclusion There’s considerable heterogeneity in the understanding of the terms; ‘Choice’, ‘Preference’, and ‘Rights’, and even more so between the terms ‘Choice’ and ‘Preference’. Given this is conducted upon hospice staff this gives a measure for concern as potentially conflicting messages and understanding could be communicated.

ADVANCE CARE PLANNING: STAFF PERCEPTIONS OF PATIENTS RIGHTS, CHOICES AND PREFERENCES

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Background Advance care planning (ACP) is a process of formal decision making and documentation for future reference. For this to be communicated effectively nuances such as the difference between; ‘Choice’, ‘Preference’ and ‘Rights’ are paramount for decision making and understanding. This communication need to be present on both sides of the consultation table.

Aim To explore the perception and understanding of the terms; ‘Choice’, ‘Preference’ and ‘Rights’ of the palliative care multidisciplinary team in relation to aspects of ACP.

Methodology An electronic survey completed by clinical staff within Severn Hospice over a week period.

Results There were 32 respondents from 8 different job roles. 69% (22) stated ‘place of death’ as a ‘Preference’ with 28% (9) stating it a ‘Choice’. Exploring ‘DNACPR’ demonstrated; ‘Choice’ 39% (12)‘Preference’ 29% (8)‘Right’ 35% (11). Decisions regarding ‘refusing care’ were mostly seen as a ‘Right’ (62% n=20) whereas ‘requesting aspects of care’ such as admission and medications were perceived as ‘Choice’ (40% n=13) or ‘Preference’ (37% n=12).

The qualitative aspect asked for perceived definitions of ‘Choice’, ‘Preference’ and ‘Rights’ of which we split into multiple themes. ‘Choice’ had a predominance of the themes of ‘options’ and ‘information’. ‘Preference’ had predominant themes of ‘options’ and ‘if possible’. Rights had a more legal focus/aspect.