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.

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

Matthew Doré, Phil Moore, Derek Willis. *Severn Hospice*

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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 has 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.

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.

73 DNACPR PRACTICE: HAS THE TRACEY JUDGEMENT MADE A DIFFERENCE?

Natasha Freeman, Beverley Clarke, Michael Macfarlane, Derek Willis. *West Midlands Collaboration Actioning Research in End of Life and Supportive Care*

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Background A study earlier this year¹ suggested that the 2014 Court of Appeals decision (The Tracey Judgement) had led to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions being discussed more frequently with patients and their families in the hospice setting but there was a lack of clarity on what physical or psychological harm these discussions could cause.

We aimed to survey current practice amongst non-palliative care doctors and Clinical Nurse Specialists (CNS) regarding making and communicating DNACPR decisions, the impact of the Tracey judgement on their practice and their interpretations of harm.

Method An online anonymous survey was distributed to GPs, Consultants and CNSs in the West Midlands.

Results 89 responses were received (68% GPs, 24% consultants, 7% CNSs). 90% reported making DNACPR decisions on a regular basis. Reasons for not making DNACPR decisions included lack of time (50%), responsibility lying with others (26%) and fear of medicolegal consequences (13%). Barriers to communicating DNACPR decisions included mental capacity of the patient (76%), fear of causing distress (24%) and lack of time (21%). 51% of respondents were aware of the 2014 Tracey judgement and 24% reported it had changed their practice. Common themes regarding harm included a physical aspect (26%), harm to patients (23%), psychological distress (18%) and emotional impact (9%).

Conclusions These results suggest there are significant barriers to making and communicating DNACPR decisions and a lack of awareness about the Tracey judgement amongst non-palliative care doctors. Although some common themes emerged regarding interpretations of harm, the variation within this group suggests individual beliefs and values may influence interpretation of harm.

REFERENCE

1. Macfarlane M, Shayler S, Nelms L, WM CARES Group, et al. Tracey judgement and hospice DNACPR orders: steady as she goes or seismic change? *BMJ Supportive & Palliative Care* 25 July 2018. doi:10.1136/bmjspcare-2018-001518

74 'IF I'M GOING TO DIE, I WANT TO DIE BY 4PM:' THE IMPACT OF A TREATMENT WITHDRAWAL SCENARIO ON A SPECIALIST PALLIATIVE CARE TEAM

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Distress occurred within the hospital Specialist Palliative Care Team (SPCT) following the withdrawal of high flow oxygen