

Although hospital death may sometimes be unavoidable, these findings suggest that greater support may be needed to facilitate discussions and, where possible, enable patients to die in their preferred location.

37 USE OF ANTIBIOTICS IN DETERIORATING PALLIATIVE PATIENTS – A RETROSPECTIVE ANALYSIS

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Background In palliative care, 24–48hr antibiotic trials are prescribed in patients who have clinically changed and may be entering the last days of life(LDOL), but where infection is considered a possible reversible factor. Does this treatment benefit or burden patients?

Aim To determine the incidence of this in hospice practice, assess survival rates and identify common predictive factors of poor response.

Method Using SystmOne, a retrospective analysis of admissions to Marie Curie Hospice, Bradford Inpatient Unit between August-October 2018 was conducted. Data was collected for all inpatients starting antibiotics including diagnosis, OACC, details of antibiotic therapy, and admission outcome (discharge/death). Patients documented to be potentially entering LDOL when therapy was initiated were identified.

Results 78 patients were admitted, of which 40% (31/78) received antibiotics. Of those receiving antibiotics, 77% (24/31) had cancer and 25% (8/31) received multiple antibiotic courses. In 35% (11/31) cases, concerns the patient may be entering LDOL were documented when antibiotic therapy was initiated. Of these, 91% (10/11) died during the admission. Of those who died, all had cancer; the majority with metastatic disease(8/10), Karnofsky scores =40% (7/10), a 'Deteriorating'(5/10) or 'Unstable'(3/10) Phase of Illness and mean duration from antibiotic initiation to death was 5.4 days (range:1–12). In patients who received multiple antibiotic courses, 75%(6/8) died during admission.

Discussion Antibiotic use in this context appears relatively common and generally has a poor outcome, suggesting treatment could be an unnecessary burden for this patient group. Metastatic cancer, Karnofsky scores =40%, an 'Unstable' or 'Deteriorating' Phase of Illness and multiple antibiotics during admission may help predict a poor response.

38 GROWING NEED, GROWING COMPLEXITY: PROJECTIONS OF PALLIATIVE CARE NEED AND MULTI-MORTALITY IN SCOTLAND

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Background Due to population ageing, serious health related burden is rising. In England and Wales, the number of people requiring palliative care is projected to grow by 42% by

2040 (Etkind et al. 2017). We sought to estimate future palliative care need in Scotland, extending previous work by examining the contribution of multi-mortality (deaths from multiple conditions), to identify priorities for future service delivery.

Methods Simple linear modelling of deaths requiring palliative care from 2017–2040, using national death registry data (National Records of Scotland) and official mortality forecasts (Office of National Statistics). Palliative care need was estimated using previously defined chronic progressive illnesses, identified from i) leading cause of death; ii) contributory causes of death.

Results Using different methods, we projected that by 2040, the number and proportion of people requiring palliative care will increase, equating to between 75% (minimal estimate) and 94% (maximal estimate) of all deaths. Deaths due to >2 disease groups (cancer, organ failure, dementia, other) are projected to account for 42% of all deaths by 2040, up from 27% in 2017.

Deaths due to dementia and cancer will increase. Most deaths will occur for those aged >85. If current trends continue, care complexity will rise.

Conclusions Estimates of palliative care need using leading and contributing causes of death demonstrate the complexity and extent of care needs. The forthcoming rise of palliative care need in Scotland requires strategic action to prepare, including greater palliative care training provision for generalist health professionals where people reside and receive care.

39 WHAT CHARACTERISES A GOOD DISSEMINATION/ENGAGEMENT STRATEGY WHEN COMMUNICATING RESEARCH FINDINGS TO PATIENTS, STUDY PARTICIPANTS AND MEMBERS OF THE PUBLIC: A SURVEY OF UK-BASED RESEARCHERS' PERSPECTIVES

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Background Ethical research practice requires that researchers have a clear plan about how research findings should be reported back to patients, study participants and members of the public. Communicating results solely through research journal publications is no longer sufficient. The GIRASOL study covers three stages: a review of the literature, three surveys of the public, participants and researchers, and a consensus meeting. Here we report on researchers' views around the elements of a good dissemination/engagement strategy, on their perceptions of good dissemination/engagement strategies and on what would encourage them to get more involved in dissemination and other engagement activities.

Method Content and thematic analyses were used to analyse the three open-ended questions included in the on-line survey directed to UK-based researchers.

Results 89 out of the 106 respondents addressed the open-ended questions. 80% of these respondents have at least six years of research record and around 30% are/were members of funding committees. Researchers agree that when communicating results to patients/study participants, adhering to

a principal of integration with the relevant end-users of the research findings is of paramount importance. Mechanisms which enable capture of end-users' preferences for mode, timing, content and ways for seeking feedback around dissemination/engagement strategies should be in place. In addition to this, communicating/engaging with members of the public requires careful consideration of the targeted audience and mode of delivery. Lack of time, resources, training and support (both at institutional and senior staff level) hinders the development of good dissemination/engagement strategies.

Conclusions Alongside time and resources, support and cultural shifts are needed to allow a full implementation of the principles of a good dissemination/engagement strategy.

40 WHAT'S IN A NAME? THE INTENSIVE AND PALLIATIVE CARE UNIT

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Death in the Intensive Care Unit (ICU) is common (Angus 2004) and critical care admissions in the last month of life are becoming more frequent. (Teno 2013) Traditional views on the ICU as a place to only support 'good candidates' with deranged physiology while awaiting resolution of underlying pathology appear to be changing. An ageing and increasingly co-morbid population, alongside medical and surgical advances, have seen ICUs admit older and sicker patients year on year. Determining which patients are likely to die or to survive can be fraught with difficulty, especially early into admissions. Prognostic models, using population-level data, are fallible and reduce poorly to the individual level. As admissions progress clinical opinion constellates on clearer views of patients' trajectories however it is likely that most will have been experiencing severe and distressing symptoms for some time. (Puntillo 2010) Relatives are also profoundly affected and represent a major area of clinical interaction and discussion. (McAdam 2010).

While it may initially appear that Intensive Care and Palliative Care clinicians have divergent aims, the amelioration of distressing symptoms and focus on quality of life are in fact shared goals. What is lacking is a truly shared space to address these aims. It is time to formally acknowledge the value of bringing the Hospice to the ICU, grasping the value overlapping skillsets can bring, and anchoring the goal of bringing quality to life and dignity to death in a new name: The Intensive and Palliative Care Unit.

41 FROM PAPER TO PAPERLESS: DO ELECTRONIC SYSTEMS ENSURE SAFE AND EFFECTIVE COMMUNICATION AND DOCUMENTATION OF DO NOT ATTEMPT CARDIO-PULMONARY RESUSCITATION (DNACPR) DECISIONS?

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Introduction and aim With NHS Trusts making the transition from paper to paperless; it is vital that integration of

electronic systems are safe for patients. Following introduction of an electronic-DNACPR toolbar, this project aimed to improve the quality of documentation and communication of DNACPR decisions.

Method A singled centered, closed loop quality improvement project was performed January - June 2018 including all inpatients with a DNACPR on three gerontology wards. Data was collected over a four week period. The DNACPR toolbar, e-form, medical notes and discharge letters were reviewed. The documentation of discussions with patients, families, senior doctors, nursing staff and the MDT were recorded. Retrospective discharge analysis was performed to review communication to the GP. Chi Squared analysis was used to assess statistical significance of the raw measure improvements after the second cycle.

Interventions (Figure 1)

Results (Figure 2)

January cycle, all 181 patients had a resuscitation status and treatment escalation plan (TEP). 73% had a DNACPR (86% by senior doctor). 85% had a valid e-form. 68% evidenced a discussion patients/relatives, 13% had a documented discussion with the MDT. 79% were communicated on discharge through comprehensive geriatric assessment (CGA). Following interventions, all measures improved. Of 176 patients; 72% a DNACPR decision (93% by senior doctor), 100% an e-form. 71% evidenced discussion with patients/relatives, 57% had documented discussion with the MDT.

Conclusion A critical finding was poor communication, increasing risk of inappropriate resuscitation. Process revision and staff training has led to improved communication and documentation, increasing patient safety. DNACPR decision inclusion in discharge letters via CGAs has improved care co-ordination on discharge.

42 EVALUATING CHANGES TO THE WAY PSYCHOLOGICAL SERVICES ARE DELIVERED WITHIN A HOSPICE

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Background There is a growing evidence base for the role of Clinical Psychology within Palliative Care. To improve provision within their local hospice, Newcastle upon Tyne Hospitals NHS Trust secured an agreement with Marie Curie for funding a Clinical Psychologist to be physically based at the local hospice for two days a week. This change in service has now been provided since July 2017.

Aims and objectives The project evaluates the impact of having a Clinical Psychologist onsite at the hospice, I comparison to the previous service provision from the wider Specialist Palliative Care Clinical Psychology service that provides input to the two hospitals, hospices and community palliative care team from a base in the community. The project was completed with a view to informing future service development.

Summary of project Healthcare professionals at Marie Curie Hospice were interviewed about their experiences of this change in provision, with respect to the benchmarks for quality care defined by the British Psychological Society. A thematic analysis of these interviews was then conducted to provide a descriptive account of staff perceptions.