We identified 144 patients who met inclusion criteria. Common diagnoses were unclassifiable fibrosis (25.0%), hypersensitivity pneumonitis (21.8%), rheumatoid arthritis ILD (16.7%), and idiopathic non-specific interstitial pneumonia (14.7%).

56 (38.9%) patients permanently discontinued Nintedanib within the study period. Overall reasons for discontinuation included drug intolerability (55.4%), death (26.8%), and deranged liver function (14.3%). 28 (50%) patients stopped Nintedanib within 3 months of initiation. Mean duration of Nintedanib use was 4.83 months in the ‘Nintedanib Stopped’ group and 6.49 months in the ‘Nintedanib Continued’ group during the study period. Results of group comparisons are shown in figure 1.

There was a significant difference in BMI at treatment onset between the groups, with lower BMI associated with stopping Nintedanib. There was a borderline significant difference in the presence of UIP pattern fibrosis between the groups. No other significant differences were detected. Logistic regression analysis identified lower BMI (regression coefficient -0.84, p=0.020) at treatment onset to be independently associated with stopping Nintedanib, with no other independently associated variables. Sensitivity power analysis suggested our sample size was adequate to identify moderate effect sizes. Although patients in this study share a similar progressive fibrotic phenotype, they are a heterogeneous group incorporating a large range of ages, lung function, and duration of Nintedanib use. They also have a high incidence of domiciliary oxygen and additional medication use. In our cohort, only lower BMI was independently associated with stopping Nintedanib.

### M5 Table 1

<table>
<thead>
<tr>
<th></th>
<th>Nintedanib Stopped</th>
<th>Nintedanib Continued</th>
<th>P</th>
<th>value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients n</td>
<td>56</td>
<td>88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>69.84 (±11.16)</td>
<td>67.49 (±12.39)</td>
<td></td>
<td>0.203</td>
</tr>
<tr>
<td>Time taking Nintedanib (months)</td>
<td>4.83 (±4.45)</td>
<td>6.49 (±5.08)</td>
<td></td>
<td>0.012</td>
</tr>
<tr>
<td>FVC% predicted</td>
<td>65.14 (±16.91)</td>
<td>68.87 (±18.46)</td>
<td></td>
<td>0.175</td>
</tr>
<tr>
<td>TLCO% predicted</td>
<td>45.21 (±12.77)</td>
<td>46.59 (±14.18)</td>
<td></td>
<td>0.762</td>
</tr>
<tr>
<td>BMI</td>
<td>26.02 (±5.65)</td>
<td>29.03 (±6.68)</td>
<td></td>
<td>0.007</td>
</tr>
<tr>
<td>Oral steroids</td>
<td>22 (39.3%)</td>
<td>34 (58.6%)</td>
<td></td>
<td>1.000</td>
</tr>
<tr>
<td>Other additional</td>
<td>20 (35.7%)</td>
<td>35 (60.9%)</td>
<td></td>
<td>0.725</td>
</tr>
<tr>
<td>Domiciliary oxygen</td>
<td>29 (51.8%)</td>
<td>46 (52.3%)</td>
<td></td>
<td>1.000</td>
</tr>
<tr>
<td>UIP pattern fibrosis</td>
<td>16 (28.6%)</td>
<td>13 (14.8%)</td>
<td></td>
<td>0.056</td>
</tr>
</tbody>
</table>

Values are mean ± SD or n (%). FVC forced vital capacity. TLCO transfer factor of lung carbon monoxide. BMI body mass index. Additional immunosuppression included (not limited to) mycophenolate, azathioprine, methotrexate, hydroxychloroquine. UIP pattern includes definite or probable UIP.

**Background**

Interstitial lung diseases (ILDs) are a heterogeneous group of conditions causing inflammation and fibrosis of the lung parenchyma. Progressive fibrotic ILD is characterised by the development of irreversible lung fibrosis, causing progressive respiratory failure, which is associated with a poor prognosis.

**Aims**

This research study aimed to explore the experience of end of life for people with ILD and examine potential barriers to accessing palliative care services.

**Methods**

Semi-structured interviews were conducted with people with ILD (n=9), bereaved relatives (n=9) and healthcare professionals (n=12). Constructivist grounded theory methodology was employed for data collection and analysis.

**Findings**

Four overarching categories were constructed from the research data: i) acknowledging uncertainty, ii) accessing and organising support, iii) avoiding discussion about an uncertain future, iv) accelerating symptoms at the end of life.

**Conclusions**

These findings highlight the requirement for increased explanation of prognostic uncertainty and acknowledgement that symptoms may deteriorate rapidly, meaning that end of life plans should focus on ensuring a peaceful death rather than on location of death.

Please refer to page A293 for declarations of interest related to this abstract.

### M7

**IMPROVING THE USE OF TREATMENT ASCALATION PLANS IN THE CARE OF RESPIRATORY INPATIENTS IN A LARGE TERTIARY CENTRE**

RSA Higginson, K Hamilton. Queen Elizabeth University Hospital, Glasgow, UK

10.1136/thorax-2023-BTSabstracts.396

**Introduction and Objectives**

A Treatment Escalation Plan (TEP) is a communication tool designed to improve quality of care for the deteriorating inpatient. TEPs aim to reduce variation caused by discontinuity of care, avoid harm from inappropriate treatment and promote patients’ priorities and preferences.

Despite evidence in favour of TEP use and regular morbidity and mortality (M&M) data demonstrating the case for TEPs in our 112-bedded respiratory unit, engagement with treatment escalation planning was consistently low. Our goal was to increase clinician confidence in using TEP forms and create a culture where TEP is a normalised part of the respiratory patient pathway, improving quality of care.
Methods We implemented a series of educational interventions at departmental and directorate level and made TEPs more visible/accessible on the respiratory unit. We also recruited ward managers, nurse specialists and junior clinical staff as ‘TEP Reps’ to regularly advocate for TEP use.

PDSA cycles were carried out with monthly re-audit of TEP use following each intervention.

Results Consistent improvement in TEP use was demonstrated across the respiratory unit (see figure 1). Baseline data December 2022 showed that, of those meeting criteria for consideration of TEP (as outlined on the healthboard TEP proforma) only 6% of patients had documented TEPs. By the end of PDSA cycle 5 in May 2023 this improved to 39%, sustained at 34% at 6 months. Qualitative data suggests a growing TEP culture amongst clinicians with increased awareness of TEP forms and confidence in OOH care delivery. Qualitative data about patient experiences of TEP conversations is awaited.

M&M data review showed that TEP use in the deceased respiratory inpatient population had increased from 25% December 2022 to 32% March 2023 (M&M data July 2023 awaited).

Conclusion We have demonstrated that TEPs can be incorporated into respiratory inpatient care, improving clinician confidence in management of the deteriorating respiratory patient.

REFERENCE

Abstract M7 Figure 1

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REFERENCE

THE ROLE OF SOCIETAL STIGMA IN ENGAGEMENT WITH PHYSICAL ACTIVITY FOR PEOPLE LIVING WITH A LUNG CONDITION


Introduction and Objectives Asthma + Lung UK carried out a survey into the experiences of people living with lung conditions. The findings included insights into how disability discrimination can affect life with a lung condition, from socialising to career opportunities and, of particular note to the medical community, people’s relationship with physical activity.

Methods The survey was conducted by Asthma + Lung UK from January to March 2023. We received 14,460 responses, of which 12,740 provided free-text responses. 20% of these were randomly selected for thematic analysis. Inductive coding was used to develop codes iteratively, and then grouped into themes and subthemes.

Results We asked ‘what is the one thing you would like everyone to know about living with a lung condition?’ Among the themes was the importance of regular physical activity. Respondents mentioned both positive and negative perspectives on physical activity, either expressing freedom to exercise within their limitations, or frustration with not being able to do more.

Frustration appeared linked to respondents’ perceptions of their own abilities, with those expressing negative perspectives often describing exercise as ‘difficult’ or that they ‘can’t exercise’.

We also asked respondents about experiences of discrimination due to their lung condition. Response themes included dismissive attitudes towards lung conditions, breathlessness not being taken seriously, and stigma around weight and fitness levels.

These themes were echoed in the negative perspectives on physical activity. For example, comments such as ‘I am not lazy, my lung condition makes it difficult for me to exercise or rush around’ reflect a self-consciousness of the judgement of others not seen in the positive perspectives.

Conclusions We found indications that experiences of stigma may be a limiting factor in engaging with physical activity. We suspect that an individual’s’ experience of societal stigma may increase the salience of the limitations of living with a lung condition.