Data were analyzed via grounded theory and compared to the literature on staff-family conflict in general.

Results: It is known that, in general, physicians identify a situation less often as conflict-loaded than relatives, suggesting the presence of hidden conflicts during critical care [1-2]. However, in our studied multi-ethnic ICU conflicts were found to be explicitly recognized by both relatives as well as healthcare professionals, and to be very visible and auditable on the ward. Moreover where in general relative-staff conflict tend to be centered around crisis moments (end-of-life decision making, patients' death) [3], we found that in a multi-ethnic ICU conflicts tend to be present during various care phases (curative phase, end-of-life decision making, non-curative phase, patients' death) and concern a broad spectrum of care aspects (e.g. bedside care activities, seeking a second opinion), easily assaulting the core of actors' identity. Consequently, end-of-life decisions, often a difficult assignment in ICUs, might be even more problematical in a multi-ethnic context than in general, as tensions in the pre-end of life decision making phase might worsen conflicts in the end-of-life decision making phase.

Conclusions: In ICUs, staff-family conflicts tend to be more severe and overtly present in a multi-ethnic context than in general. Therefore we urge for the development of specific and effective staff-family conflict prevention strategies in a multi-ethnic ICU.

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P456

Does the source of admission to critical care affect family satisfaction?

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Introduction: The management of critically ill patients is often challenging for clinicians with most being sedated or too unwell to be actively involved in aspects of their care.

The quality of care received by patients can also vary between hospital locations, which in turn influences family perceptions of care provision. Family members are surrogates for patients and monitoring their experiences positively influences patient outcomes [1].

The aim of this study was to identify whether the source of admission to critical care had any impact family satisfaction.

Methods: This prospective study was conducted over a period of eight weeks on our critical care unit. Up to four relatives per patient prior to discharge from the unit, or after initiation of end of life care, were requested to fill in a modified (Family satisfaction Survey (FSS)-ICU questionnaire. The qualitative responses obtained using a Likert scale were transformed into numerical data for analysis.

Results: 34 completed surveys were analysed with majority of the respondents being female (65%).

46% of the patients were admitted from the emergency resuscitation department and whilst admissions from the inpatient wards accounted for 34%.

Of the patients admitted from the emergency department the level of satisfaction was excellent (56%) or very good (54%) in all aspects of the patient care, as opposed to 36% of patients from the ward

Conclusions: The results show that relatives are more likely to be satisfied when admitted from the emergency department than the from an inpatient ward. There is a correlation between inclusion in the decision-making process and overall satisfaction. The timely manner in which patients are admitted from the emergency department (RESUS) as well as the levels of staffing on initial management may account for the results seen.

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P457

A simple alternative to the family satisfaction survey (fs-icu)

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Introduction: We sought to evaluate whether the succinct Critical Care Family Needs Inventory (CCFNI) [1], a validated survey, may serve as a suitable alternative to the FS-ICU. Undertaking relative experience surveys annually was outlined as a quality indicator by the Scottish Intensive Care Society Quality Improvement Group in 2012. Over the past 5 years we have completed the FS-ICU annually. This is a lengthy survey covering aspects of care & decision making. The FSS has been previously validated in large US/Canadian studies [2]. More recently the Family Reported Experiences Evaluation (FREE) validated the FS-ICU in the UK, employing the survey across 20 different ICUs with approximately 7000 forms completed.

Methods: The audit was conducted across both hospitals in the trust. Over 4 weeks we distributed the CCFNI to relatives of patients on ITU/HDU once decision to step down to a ward was made. We included a section for open comments at the end of the survey.

Results: Over 4 weeks a total of 44 surveys were completed. Selected results are detailed below with comparison to results from similar questions in the FS-ICU survey.

Quality of care: CCFNI: 77% of relatives felt that the best possible care was being given to the patient almost all the time. FS-ICU: 72% felt the care received from doctors was excellent & 71% felt the care received from nurses was excellent.

Communication: CCFNI: 73% felt that explanations about the patient's condition were given in terms that they could understand almost all of the time & the remaining 27% felt explanations were understandable most of the time. FS-ICU: 69% felt staff provided understandable explanations excellently, 31% described this information as very good.

Empathy: CCFNI: 84% stated that staff members showed an interest in how relatives were feeling almost all of the time and most of the time. FS-ICU: 72% stated that ICU staff were excellent in showing interest & consideration to relative needs, and 28% said staff were very good.

Conclusions: Results suggest that relatives are satisfied with the care that their relatives received at the trust. The results appear to correlate well with those from the FS-ICU in several domains such as care, communication and empathy. We therefore propose that the CCFNI can be used as an alternative annual survey to measure relatives experience on ICU.

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A study to explore the experiences of patient and family volunteers in a critical care environment: a phenomenological analysis

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Introduction: ICU survivors suffer persistent physical, psychological and social problems in the months and years after discharge from critical care (1). Caregivers of these patients also suffer similar problems (2). As a result, an innovative, peer supported rehabilitation programme- Intensive Care Syndrome: Promoting Independence and Return to Employment (InS:PIRE) was created in Glasgow Royal Infirmary. This 5 week multi disciplinary programme, which is co facilitated by patient and family volunteers further along the recovery trajectory, aims to empower patients and caregivers to take control of their health and wellbeing. The objective of this study was to explore the experiences of the volunteers who participated in InS:PIRE. It also

sought to identify the support required by volunteers from healthcare professionals involved in the project.

Methods: Six in depth semi structured interviews were undertaken with volunteers (both patients and family members) involved in the InS:PIRE clinic by an assistant psychologist. A predetermined topic guide was utilised to guide interviews. Interviews were audio recorded and transcribed verbatim. Interpretative Phenomenological Analysis was used to analyse the transcripts (3). Peer Review was undertaken to ensure credibility of the findings.

Results: Findings: Six key themes were identified from these interviews: the social impact of volunteering, shared experiences; supporting others; personal boundaries; support needs and personal gain. The importance of peer support and having a shared understanding of participants needs were key themes for the volunteers. Volunteers described the need for further support in areas such as: confidentiality; listening skills and understanding boundaries.

Conclusions: The use of peer volunteers in this ICU rehabilitation service has been successful within this local context. Further, larger scale research studies, which explore further the impact of volunteering for ICU survivors are required.

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P459
Prevalence and risk factors of anxiety and depression in relatives of burn patients.
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Introduction: Intensive care unit is one of the most stressful places in a Hospital. Relatives are exposed to many factors that may cause symptoms of anxiety and depression.
The aim of this study was to determine the prevalence of anxiety and depression symptoms 72 hour and 90 days after ICU adimssion, and identify factors associated with this symptoms.

Methods: Relatives of Patients admitted to the National Burn Center in Montevideo between february and october 2015 were invited to participate in this study.
72 hours and ninety days after ICU admission, family members completed a survey that included the Hospital Anxiety and Depression Scale.

Results: 95 and 45 relatives reponded the survey at 72 hours and 90 days after ICU admission repectively.
The prevalence of Anxiety symptoms were 60% and 28% 72 hours and 90 days after ICU admission respectively.
Symptoms of depression were present in 47% of relatives at the third day and 18% at 90 days after ICU admission.
72 hous after ICU admission, a longer time lived with the patient was associated with anxiety 18 (3-26) years vs 2 (0-23) years (p = 0,02), and with depression 18 (7-26) years vs 4(0-23) (p = 0,02). At this moment, a higher total burn area 27% (18-37) vs 19% (10-27) (p = 0,02) was associated with depression.
Factors associated with anxiety 90 days after ICU admission were: felt that treatment information was incomplete (80% vs 22%,p = 0,02), and not being able to return to work (80% vs 22%p = 0,02).

The only factor associated with depression symptoms 90 days afetr ICU admission was not being able to return to work (38% vs 11%, p = 0,04).

Conclusions: Prevalence of Anxiety and Depression among relatives was very important after 72 hours of ICU admission, and remained elevated 3 months later. This study shows factors associated with the apearence of anxiety and depression.

P460
Guidance of visiting children at an adult intensive care unit (icu)
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Introduction: St Elisabeth Hospital has a 30 bed ICU for critically ill adult patients. We facilitate family centred care, but in earlier years children were not allowed to visit family members in our ICU. The objective of our project was to facilitate paediatric visitation and to provide support related to the distress and needs of children with a relative in our ICU.

Methods: Practical aids were developed for our caregivers. An information leaflet was made with practical information for parents. This was subdivided in developmental stages. Furthermore we created a book in which a child visits his father at our ICU. Pictures show what children can expect, which helps prepare the child for visiting. An instruction box is included with ICU materials (Fig. 108). These materials are used to give children a more tactile experience of the ICU. Guidance materials for when a patient may die were developed included. For example: there are little boxes that can be decorated by the children to put in a memory or a token of grief. Pedagogical staff are available to support parents, children and staff. If there are more profound problems there will be referral to our children's psychologist. Our hospital photographers can be called upon to commemorate the last moments (Fig. 109). We instructed our nurses and doctors on how to use these materials and how to guide children. We held a survey among our staff to inquire if this met their needs.

Results: There's an increasing awareness to the needs of children among our staff. Children and parents are welcomed and guided by our staff. Our survey amongst our staff showed a great appreciation for the materials we developed. When relatives of children die, children can be included in the farewell visit.

Conclusions: When a child is confronted with a sick or dying parent, loss and sorrow are inevitable. We, as care givers, can be more than bystanders and can help parents guide their children in difficult times.

Fig. 108 (Abstract P460). Our instruction box.