EAPC 2015
14th World Congress of the European Association for Palliative Care

Building Bridges

8 – 10 May 2015
Copenhagen, Denmark

EUROPEAN ASSOCIATION
FOR PALLIATIVE CARE
www.eapcnet.eu

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FOR PALLIATIV MEDICIN
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Abstracts
Dear Congress participant,

**Welcome to the EAPC World Congress in Copenhagen!**

This Congress has adopted the motto of ‘building bridges’ and this is reflected in the spectacular images of beautifully designed bridges connecting the islands and mainland of Denmark, and across the sea to Sweden. The metaphor for bridges works well for the connections that we hope you will make during the Congress, perhaps to new people, teams and ideas. Palliative care is a multidisciplinary enterprise and we can gain much by our willingness to build bridges to those working in other health care areas.

The well-known song released by Paul Simon and Art Garfunkel on 26th January 1970 called ‘Bridge over Troubled Water’, has, to me, a special resonance with what we aspire to achieve in palliative care. It paints a picture of the importance of acknowledging the physical and psychological state of the person and being with them in their time of need:

\[
\begin{align*}
      &\text{’When you are weary, feeling small} \\
      &\text{When tears are in your eyes,} \\
      &\text{I will dry them all} \\
      &\text{I am on your side} \\
      &\text{When times get rough’}
\end{align*}
\]

It offers hope that palliative care will embrace all aspects of suffering, including pain management:

\[
\begin{align*}
      &\text{’When evening falls so hard} \\
      &\text{I will comfort you} \\
      &\text{I’ll take your part} \\
      &\text{When darkness comes} \\
      &\text{And pain is all around’}
\end{align*}
\]

The song ends on a positive note with the promise: ‘I will ease your mind’. This reminds us that palliative care is about helping to ease suffering in its broadest sense.

At the Congress, we will be reporting the outcomes of the Prague Charter which was launched at the EAPC World Congress in Prague as a joint action advocating for palliative care as a human right. This built upon previous EAPC initiatives such as Budapest Commitments and the Lisbon Challenge. We welcome you to join with us in an international united effort to improve access to high quality palliative care.

**Professor Sheila Payne**

President of the European Association for Palliative Care

**Acknowledgements**

I want to offer special thanks to Professor Irene Higginson and Professor Carlo Leget who have co-chaired the Scientific Committee and also acknowledge the important contribution of the members of the scientific committee. Grateful thanks are due to Fiona Wong who has worked closely with Professor Higginson. I am indebted to our international advisory board that have provided detailed and insightful reviews on all the proffered abstracts. For the first time we have obtained three independent reviews for each abstract. Special thanks go to Professor Per Sjoegren, Marlene Sandvad and the local organizing committee for their commitment to ensuring the success of this Congress. As always, the EAPC Head Office team, Heidi Blumhuber, Amelia Giordano and Dr Julie Ling have supported the Congress. Thank you to our efficient and hard working congress organisers, Interplan.
Dear Congress participant

It is a pleasure to welcome you to the 14th World Congress of the EAPC in Copenhagen. Palliative care practice is complex, challenging and developing rapidly in response to escalating international need. Its success depends on building bridges between different professional and non-professional groups, disciplines, cultures, regions and continents. The theme of the 14th World Congress therefore is ‘building bridges’.

With this theme, the EAPC also continues to strive for better access to palliative care for all those who need it, across the globe. To bridge the gap between suffering and palliative care the EAPC launched, in Prague 2013, a petition to urge governments to relieve suffering and ensure the right to palliative care https://secure.avaaz.org/en/petition/The_Prague_Charter_Relieving_suffering. This petition has been signed by more than 7,500 people, and we hope that this number can be increased further during this congress! Please sign if you have not already done so, and encourage your colleagues to do so.

In this 2015 EAPC World Congress we seek to assemble the most skilled and knowledgeable caregivers, clinicians, researchers and educators in the field of palliative care, along with the vibrant opportunities to meet friends, colleagues and experts, and gain new ideas and insights on how to improve care for patients and their families. Due to the geographic position of Copenhagen, bridging Scandinavia with central Europe, as well as the growing interest in palliative care, this conference brings together more than 3,000 participants from a wealth of professional and cultural backgrounds. We are delighted to be able to offer a programme mixing world-leading plenary speakers, early career researchers, clinical and academic experts, and hundreds of cutting edge presentations and posters. Over 1,200 abstracts were submitted for the scientific programme of this conference, the highest ever for an EAPC congress. We were delighted with the quality of submissions, and send our congratulations to all those accepted. Our patients and families deserve the very best in evidence-based practice, underpinned by high quality research, knowledge generation, innovation, education, skilled care and appropriate health and social care policies. We hope that this congress will help all those participating to further advance the field and their own practice or field of study.

Copenhagen – this premier capital of Northern Europe – offers an enchanting environment – with its mixture of old maritime charm and network of parks, public squares and green spaces. Since the completion of the Øresund Bridge, the metropolitan area of Copenhagen has become increasingly integrated with the Swedish province of Scania and its largest city, Malmö, known as the Øresund Region. With bridges connecting the various districts, the cityscape is characterised by parks, promenades and waterfronts. The city is one of Europe’s oldest capitals with a royal touch – the monarchy in Denmark is the oldest in the world! Therefore we are very proud that HRH Crown Princess Mary of Denmark, in her kindness, is not only patron of the congress, but will also bestow the honour of a Royal visit on us during the opening ceremony.

We are looking forward to meeting you during the congress!

Per Sjøgren
Chair of Organising Committee

Irene J Higginson
Carlo Leget
Co-Chair of the Scientific Committee
Co-Chair of the Scientific Committee
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The development of palliative care globally has adapted this concept of ‘building bridges’ to describe a range of efforts to expand palliative care implementation at local, national and international levels. One of the first clinical bridges built in palliative care was the one from people with cancer towards people with non-cancer diseases, and in frail elderly people. Research bridges were also built from medical and nursing research towards public health research and social sciences. There is a need for more bridges to be built in both clinical and scientific settings, in order to further advance palliative care on a global scale.

The field of palliative care is at a unique crossroad with multiple new global initiatives and new stakeholders calling for palliative care as a component of universal health coverage. The 2014 World Health Assembly Resolution 67.19 entitled ‘Strengthening of Palliative Care as a Component of Comprehensive Care throughout the Life Course,’ offers an extraordinary opportunity for building bridges, with an expansive range of collaborators to implement what the resolution calls for: ‘the strengthening of health systems to integrate evidenced based, cost-effective and equitable palliative care services in a continuum of care across all levels with emphasis on primary care, community and home-based care and universal coverage.’ An ad hoc WHO Advisory Group led by Dr. Xavier Gomez Batiste and the Barcelona WHO Collaborating Centre are advising the WHO Secretariat on the resolutions’ plan of action, country demonstration projects and a framework for reporting back to member states in 2016 on progress made.

These efforts emphasise the priority of investing in health and focusing on palliative care as an essential part of health care systems. How the palliative care community leads with innovation, shared learning, technical assistance, research and advocacy in these bridge-building experiments with policy experts will define a future that ensures the vision of palliative care for all in need, independent of country, care setting, age, gender or underlying disease.
Family members and friends (carers) play a crucial role in enabling people to be cared for at home towards the end of life, and to die there if this is their wish. They also undertake vital psychological and practical support and coordination. However, carers normally come to this role unprepared, learn by trial and error, and often suffer negative psychological, physical, social and financial effects from care giving. Interventions to support carers have so far shown limited impact on their well-being, and we need a better evidence-base and understanding of ‘what works’. However, to achieve wider impact, assessment of and support for carers needs to be integrated into regular healthcare practice. This poses challenges that have to be addressed at several levels, for instance; carers may not define themselves as ‘carers’ or feel their needs are legitimate; support for carers in their own right may require considerable changes in the way practitioners’ work; and service procedures and administrative systems may not easily accommodate carer assessment and follow up. Service providers also need to adapt to changes in family structure, an aging population and a multicultural society. Finally, to provide effective support for carers we must ensure that we truly gain their perspective, and that we address their needs both for supporting the patient (as co-workers) and for preserving their own well-being (as clients). This presentation will provide a broad overview of the wider carer literature, as well as examples from the presenter’s work on carer support needs assessment.
The challenges for palliative care in the context of recent austerity are considerable. More people are living into older age with multiple health conditions and there is increasing awareness of palliative care needs for people with non-cancer diagnoses, so demands are growing. With static or reduced resources there is a tendency to prioritise the urgent (not the important) and where resource allocation is based on cost-effectiveness there is the problem of limited evidence for many palliative interventions. Emerging evidence and understanding offers some pointers to how palliative care can prosper in the time of austerity. This presentation will focus on:

- Circumstances where palliative care can reduce costs as well as improve outcomes and experiences
- Circumstances where palliative care may cost more but be good value for money
- Strategies for building evidence on the cost-effectiveness of palliative care approaches.

It will be argued that we must recognise the diversity of palliative care activities, that we need to move beyond questions such as ‘is palliative care cost-effective?’, towards understanding the need to evaluate a range of complex interventions, within the ethos of palliative care. Austerity and very limited resources provide a challenge for the development of palliative care, but also an opportunity to question current patterns of health care and the possibility of shifting the focus onto meeting better the complex needs of people with increasingly complex combinations of chronic conditions. It will also be argued that challenges in evaluating palliative care interventions are common to other areas of complex care, and palliative care research can provide wider understanding of issues in measurement and evaluation.

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It doesn’t make sense, it is meaningless! What is the meaning of this? These statements and questions are frequently heard from palliative patients and their relatives. This often gives health professionals a feeling of insufficiency. A sense of meaning is essential to palliative patients and their relatives but is a relatively ignored aspect as a research topic.

The concept of meaning is a complex and paradoxical concept because meaning is often brought up when meaning is about to slip out of your hands. When palliative patients and their relatives talk about and experience meaninglessness, it is often because they have a clear understanding of what the meaning is, namely what they have lost or are about to lose. The meaning of life is to many people all the events where it is pointless to ask the question of meaning. And the reaction to the loss of meaning is often anxiety.

The presentation will reflect on meaning, loss of meaning and anxiety as a philosophical, existential and spiritual concept, and demonstrate how palliative patients are talking concretely about meaning and anxiety.

The presentation will identify different levels of meaning, global meaning and situational meaning, and demonstrate a framework for understanding meaning, spirituality and benefit finding in palliative care.
Few would disagree that acknowledgment of personhood – seeing people in terms of who they are rather than exclusively in terms of whatever ailment they have – ought to be foundational within the culture of medicine. And yet, healthcare is often characterised as impersonal and routinised, with almost exclusive focus on whatever ailment the patient has, and little attention to who the person is. While considerations such as these are often deemed the ‘soft side’ of medicine, their absence has hard-edged consequences, including patient and family dissatisfaction, individual practitioner and organisation reputational risk, confusion regarding the goals of care; reduced healthcare provider job satisfaction and heightened risk of professional burnout. So how does one go about getting personhood on the healthcare professional radar? What are the obstacles and barriers in doing so, and how can those be surmounted? While these are considerable challenges, the opportunities are worth pursuing and could help transform the culture of healthcare into one of health-caring.
Cancer related pain, fatigue, depression, anorexia, cachexia and nausea all share a potential biological aetiology, in systemic inflammation. Inflammation is now firmly established as a hallmark of cancer. Inflammation increases the risk of developing certain cancer types (bladder, gastrointestinal, prostate) and anti-inflammatory medications have been shown to delay or prevent certain cancer types.1

In the area of prognosis, systemic inflammation has been associated with decreased survival in cancer. In particular, biomarkers of the inflammatory response (C-reactive protein and albumin – combined in the Glasgow Prognostic Score) have been extensively studied and shown to independently predict outcomes in cancer patients at diagnosis.2 In advanced cancer, this has also been demonstrated initially in pilot work (n=100) and corroborated by an international biobank analysis (n=2500), and that systemic inflammation independently predicts survival in patients in the last six months of life.3,4 Symptoms have also been shown to be related to systemic inflammation in both basic science and clinical studies.5.

References:
Following the landmark randomised trial (RCT) showing quality of life and survival benefit of early SPC in metastatic lung cancer (Temel, NEJM 2010), and the cluster-RCT by Zimmermann (Lancet 2014), the need for additional randomised trials is well recognised. 

**Aim:** To determine whether patients with metastatic cancer, who reported palliative needs in a screening, would benefit from early SPC (i.e. referral to a palliative care team).

**Methods:** This multicentre RCT compared early SPC plus standard care vs. standard care (planned N=300). Consecutive metastatic cancer patients at five oncology departments with no prior contact with SPC were screened for palliative needs. Patients with scores exceeding a certain threshold for physical, role or emotional function, or nausea/vomiting, pain, dyspnoea, or lack of appetite in the EORTC QLQ-C30 questionnaire were eligible. The primary outcome was the change in the patients’ primary need (the most severe of the seven QLQ-C30 scales) to three and eight weeks follow-up, measured as area under the curve (AUC). Five sensitivity analyses were conducted. Secondary outcomes were change (AUC) in the seven QLQ-C30 scales and survival.

**Results:** In total, 145 patients were randomised to early SPC and 152 to standard care only. Early SPC had no significant effect on the primary outcome (difference favouring early SPC was -4.9 points (0-100 scale); p=0.14). The five sensitivity analyses showed similar results. The 95% confidence interval (-11 to +1.5 points) does not exclude the possibility of the hypothesised difference of -7.5 points favouring early SPC. Analyses of the seven secondary outcomes also showed no differences, maybe with the exception of nausea/vomiting, where early SPC might have a beneficial effect. We found no effect on survival.

**Conclusion/discussion:** We discuss whether the negative/neutral findings (see above) can be attributed to the selection of patients, outcomes, analytic strategy, the intervention, or to bias.

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**The Danish Palliative Care Trial (DanPaCT), a randomised trial of early palliative care in cancer: results of the primary analysis**


1. Bispebjerg University Hospital, Palliative Medicine Research Unit, Copenhagen NV, Denmark
2. University of Copenhagen, Public Health, Copenhagen K, Denmark
3. Odense University Hospital, Palliative Care Team, Odense, Denmark
4. Rigshospitalet, Copenhagen University Hospital, The Copenhagen Trial Unit, Copenhagen Ø, Denmark
5. King’s College London, Cicely Saunders Institute, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom
6. Aarhus University Hospital, The Palliative Team, Aarhus C, Denmark
7. Bispebjerg University Hospital, Dept. Palliative Medicine, Copenhagen NV, Denmark
8. Rigshospitalet, Copenhagen University Hospital, Section of Palliative Medicine, Copenhagen Ø, Denmark
9. Rigshospitalet, Copenhagen University Hospital, Dept. Oncology, Copenhagen Ø, Denmark
10. Vejle Hospital, Lillebaelt Hospital, Palliative Team Vejle, Vejle, Denmark

**Background:** Following the landmark randomised trial (RCT) showing quality of life and survival benefit of early SPC in metastatic lung cancer (Temel, NEJM 2010), and the cluster-RCT by Zimmermann (Lancet 2014), the need for additional randomised trials is well recognised.

**Aim:** To determine whether patients with metastatic cancer, who reported palliative needs in a screening, would benefit from early SPC (i.e. referral to a palliative care team).

**Methods:** This multicentre RCT compared early SPC plus standard care vs. standard care (planned N=300). Consecutive metastatic cancer patients at five oncology departments with no prior contact with SPC were screened for palliative needs. Patients with scores exceeding a certain threshold for physical, role or emotional function, or nausea/vomiting, pain, dyspnoea, or lack of appetite in the EORTC QLQ-C30 questionnaire were eligible. The primary outcome was the change in the patients’ primary need (the most severe of the seven QLQ-C30 scales) to three and eight weeks follow-up, measured as area under the curve (AUC). Five sensitivity analyses were conducted. Secondary outcomes were change (AUC) in the seven QLQ-C30 scales and survival.

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**Conclusion/discussion:** We discuss whether the negative/neutral findings (see above) can be attributed to the selection of patients, outcomes, analytic strategy, the intervention, or to bias.
Patients with multiple myeloma, an incurable cancer of the bone marrow, now live five years or longer with their disease. Severely impaired quality of life (HRQOL) has been described in this patient group, yet HRQOL is not yet routinely assessed or monitored in clinical care.

Aim:
The aim of this study was to validate a myeloma-specific HRQOL questionnaire suitable for use in clinical practice.

Method:
Patients were recruited from 18 haematological centres in the UK. Development and validation of the MyPOS comprised: a) item generation through 40 qualitative interviews and three focus groups with patients and health care professionals, b) cognitive testing and item reduction, c) cross-sectional psychometric evaluation to check internal consistency, acceptability/interpretability, structural validity (exploratory and confirmatory factor analysis, Rasch analysis to create unidimensional scales), known-group comparisons and correlational analysis, and d) longitudinal evaluation in the form of test-retest reliability and sensitivity to change.

Results:
A conceptual model of health-related quality of life in multiple myeloma formed the basis for item development. The initial 33-item version of the questionnaire was reduced to 27 items after cognitive interviews. Validation (n = 506) showed very good internal consistency (α = 0.89) and good test-retest reliability. A three-factor structure (Functioning/symptoms, Emotional problems and Health care factors/information) was confirmed. The MyPOS and its subscales showed a strong ability to distinguish between clinically relevant groups, good convergent and discriminant validity to hypothesised subscales of EORTC and EQ-5D, and sensitivity to change.

Conclusion:
The MyPOS is a reliable and valid instrument that can be used to assess and monitor HRQOL in clinical practice for multiple myeloma patients of all stages.

Funding:
Myeloma UK, St Christopher’s Hospice, National Institute of Health Research.

Background:
Patients with multiple myeloma, an incurable cancer of the bone marrow, now live five years or longer with their disease. Severely impaired quality of life (HRQOL) has been described in this patient group, yet HRQOL is not yet routinely assessed or monitored in clinical care.

Aim:
The aim of this study was to validate a myeloma-specific HRQOL questionnaire suitable for use in clinical practice.

Method:
Patients were recruited from 18 haematological centres in the UK. Development and validation of the MyPOS comprised: a) item generation through 40 qualitative interviews and three focus groups with patients and health care professionals, b) cognitive testing and item reduction, c) cross-sectional psychometric evaluation to check internal consistency, acceptability/interpretability, structural validity (exploratory and confirmatory factor analysis, Rasch analysis to create unidimensional scales), known-group comparisons and correlational analysis, and d) longitudinal evaluation in the form of test-retest reliability and sensitivity to change.

Results:
A conceptual model of health-related quality of life in multiple myeloma formed the basis for item development. The initial 33-item version of the questionnaire was reduced to 27 items after cognitive interviews. Validation (n = 506) showed very good internal consistency (α = 0.89) and good test-retest reliability. A three-factor structure (Functioning/symptoms, Emotional problems and Health care factors/information) was confirmed. The MyPOS and its subscales showed a strong ability to distinguish between clinically relevant groups, good convergent and discriminant validity to hypothesised subscales of EORTC and EQ-5D, and sensitivity to change.

Conclusion:
The MyPOS is a reliable and valid instrument that can be used to assess and monitor HRQOL in clinical practice for multiple myeloma patients of all stages.

Funding:
Myeloma UK, St Christopher’s Hospice, National Institute of Health Research.

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My interest in the field of palliative care research dates back to 2002, when I worked on a Palliative Care Needs Assessment in Ireland. The study highlighted the fear and stigma associated with palliative care, and in 2005 I was awarded the HRB/IHF Building Partnerships for a Healthier Society Research Award to further investigate attitudes toward palliative care from a range of perspectives. This study formed the basis of a PhD in psychology that aimed to (1) examine and compare the attitudes of health professionals toward palliative care; (2) examine and compare the attitudes and personal constructs of four key participant groups including patients receiving palliative care services, people living with cancer and their carers and (3) examine potential strategies for changing attitudes through education.

The outcomes associated with the study achieved far more than these original aims. The research provided a deeper understanding of the ethical complexities of research in this area; included the development of a new tool – The Health Professional Attitude Questionnaire (HPAQ); saw the development of both an e-learning package for health professionals and an intervention for people living with cancer; provided an eight-variable comprehensive framework to describe health professionals’ attitudes toward palliative care; examined how rep grid technique could be utilised in palliative care, but most importantly served as the catalyst to the development of Ireland’s first health promoting palliative care demonstration model at Milford Care Centre.

Since graduating, I have engaged in a variety of national research studies and in 2014 was awarded the AllHPC/ICS Postdoctoral Research Fellowship to conduct an exploratory delayed-intervention, randomised, controlled trial to assess the feasibility, acceptability and potential effectiveness of a volunteer-led model of social and practical support for community dwelling adults living with advanced life-limiting illness.
The perception of autonomy is a critical determinant in the delivery of good palliative care practice. Clinical decision-making reflects autonomy as the absolute and individual right of the individual to self-determination (the value of personal autonomy) or, the belief that autonomy is mediated by wider social- and community-orientated values (sometimes termed a relational autonomy).

Personal autonomy validates the right of the patient to be fully informed about treatment so that appropriate choices can be made; an overriding principle upon which other ethical decisions hinge. Its strength lies in the primacy of the patient, avoiding inappropriate interference in decision-making by family carers and clinical paternalism in care management. Given the need to make judicious decisions at a critical time in people’s lives, we need to establish this principle in the provision of care, and clinicians have a duty of care to support their patients to achieve this at all costs.

Conversely, there is also a growing argument that personal autonomy fails to appreciate the reality that most people in society make decisions within community and based on relationship, rather than only for themselves. The key issue is not autonomy but respect, endorsed through adopting a relational ethical stance. This approach contends that decisions can only be made in the context of engagement with those who hold meaning for the patient, challenges the paternalism of healthcare and may advocate for the patient and family to take appropriate actions, which may be contrary to the given system and culture. To this end, relational autonomy may be more meaningful for the practice of palliative care than current expressions of personal autonomy.

In this debate, Dr Carlo Peruselli and Professor Philip Larkin will argue the respective case for personal and relational autonomy with regard to palliative care. Using case exemplars from practice, they will provide a platform to consider how a ‘North–South’ divide in the place of autonomy and decide which has the most positive outcome for the patient, the discipline and the practice of the healthcare professional.

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Parallel Sessions

PS01 Debate: Hospices that provide comfort care only, undermine the palliative care commitment to individualised, goal-focused care
PS02 Controversies around palliative care for people with dementia: building bridges between palliativists and other specialists
PS03 Assessing and managing breathlessness in palliative care
PS04 Public health approaches to support evidence based palliative care practice
PS05 Sleep disorders, anxiety, depression: complex syndromes in advanced cancer patients and how we can manage them better?
PS06 Implementation of advance care planning
PS07 Implementing Patient Reported Outcome Measures (PROMs) in clinical practice: guidance and experiences
PS08 Bridging research and policy: economic evaluation in palliative care
PS09 Recruiting to palliative care studies in Europe – developing recommendations for best practice
PS10 Examining trends in place of death: methods, results and meaning
PS11 User involvement in palliative care – do we need bridges between the knowledge of professionals, patients and relatives?
PS12 Paediatric palliative care: moving forward
PS13 Palliative sedation in a European context: epidemiology, practice and guidelines
PS14 How to develop palliative care in the community throughout Europe
PS15 How to undertake research on meaning making and existential issues
PS16 Moving forward in bereavement care: emerging issues in service delivery in Europe
PS17 EAPC cancer pain management guidelines: update of pharmacological and non-pharmacological treatment recommendations, including guidance to assessment and classification
PS18 Improving quality of palliative care in long term care facilities in Europe: first results from an EU funded project PACE (FP7)
PS19 Moving forward spiritual care in Europe: the EAPC Spiritual Care Taskforce
PS20 Building bridges between countries: reporting research to have international resonance
Hospices that provide comfort care only, undermine the palliative care commitment to individualised, goal-focused care

Abstract number: PS01.1
Abstract type: Parallel Session

Hospices that provide comfort care only, undermine the palliative care commitment to individualised, goal-focused care: the argument for

Cherri N.L.
Share Zedek Medical Center, Oncology and Palliative Care, Jerusalem, Israel

This debate was triggered by a case of a 70-year-old man with advanced pancreatic cancer who referred for palliative care. He had a resolving cholangitis and was on antibiotics. The family was distraught to hear that the hospice did not provide antibiotics, do blood tests, administer blood or even check vital signs. I called to speak with the physicians in the hospice. They assured patients are comforted and not suffering, but don’t provide life-prolonging therapies (of any sort). In a subsequent discussion on the EAPC Blog it emerged that the model of demedicalised terminal care only in which only ‘comfort care’ is provided is common in German hospices and in sporadic settings elsewhere. This approach is at variance with the EAPC consensus definition of hospice which emphasises the provision of care based on individual need and personal choice. This approach harms the image of palliative care: it undermines the professional commitment to individualised, goal-focused care that is at the very heart of our professional enterprise. It negates the preservation of function and duration of survival as legitimate goals of care as patients approach their death. It reinforces the negative stereotype that palliative care is only about the care of the dying not about improving the lives of those with life-limiting disease and it projects palliative/hospice care and a medical subspecialty bereft of standards of practice, economic or infrastructural reasons one wants to maintain centers for demedicalised terminal care as a subspecialty of service of palliative (hospice) care; these units should be clearly identified as centres for terminal care, indicating their limited scope of palliative care services.

The Controversial Issues around Palliative Care in Demntia: observations from the EAPC White Paper Expert Panel

Abstract number: PS02.1
Abstract type: Parallel Session

The Controversial Issues around Palliative Care in Demntia: observations from the EAPC White Paper Expert Panel

van der Steen J.T.
VU University Medical Center, EMGO Institute for Health and Care Research, General Practice and Elderly Care Medicine, Amsterdam, Netherlands

People with dementia may benefit from palliative care, but in practice it may be unclear when ‘usual dementia care’ ends, or should be complemented by palliative care, and what palliative care in dementia means exactly. To define palliative care for dementia patients as distinct from palliative care for other patient groups based on evidence and consensus, the EAPC white paper on palliative care in dementia (published in 2014) employed a Delphi study design. It describes the important domains and for each domain it provides recommendations. Experts in palliative care, dementia care or both from 23 countries agreed on almost all domains and recommendations, but also identified controversial issues which are particularly relevant in dementia.

We will highlight three salient but sensitive issues. Applicability of palliative care through dementia stages, and treatment of food and fluid intake problems reached moderate consensus only, and prognostication was the most heavily revised domain that was perceived the least relevant. Regarding applicability of palliative care in dementia, some experts expressed concerns about bringing up end-of-life issues prematurely and about relabeling dementia care as palliative care. Recent analyses identified these experts as often being younger, more experienced, and more often their expertise in dementia dominated over palliative or other expertise. A shared understanding of palliative care in dementia may support effective collaboration between dementia care and palliative care specialists. Collaboration should not be limited to the last phase of life also because anticipation is a key issue in palliative and the dementia disease trajectory cannot be predicted well. Building bridges implies that we recognise sensitive issues and the specific contributions palliavists and dementia care specialists can make to optimise palliative care in dementia.

Estimating Prognosis in Dementia: why, when and how?

Sampson E.
University College London, Marie Curie Palliative Care Research Department, London, United Kingdom

We will highlight three salient but sensitive issues. Applicability of palliative care through dementia stages, and treatment of food and fluid intake problems reached moderate consensus only, and prognostication was the most heavily revised domain that was perceived the least relevant. Regarding applicability of palliative care in dementia, some experts expressed concerns about bringing up end-of-life issues prematurely and about relabeling dementia care as palliative care. Recent analyses identified these experts as often being younger, more experienced, and more often their expertise in dementia dominated over palliative or other expertise. A shared understanding of palliative care in dementia may support effective collaboration between dementia care and palliative care specialists. Collaboration should not be limited to the last phase of life also because anticipation is a key issue in palliative and the dementia disease trajectory cannot be predicted well. Building bridges implies that we recognise sensitive issues and the specific contributions palliavists and dementia care specialists can make to optimise palliative care in dementia.

Abstract number: PS01.2
Abstract type: Parallel Session

The Case against: Hospices that Provide Comfort Care Only, Undermine the Palliative Care Commitment to Individualized, Goal-Focused Care

Rodrich L.
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Modern hospice and palliative care have evolved in contrast to high-tech medicine, focusing on pain and symptom relief, but rejecting all therapies that were aimed at curing the underlying disease. When I came into contact with palliative care twenty years ago in Germany, palliative care units and hospices had made it clear that cancer patients would not be admitted unless it was definitely clear that they would not receive any chemotherapy or radiotherapy.

However, there has been a change of paradigm since then. Cancer patients with bone metastases will routinely be presented for radiotherapy. In Germany 13% of cancer patients treated in palliative care units receive chemotherapy. Blood transfusions and tube feeding are always discussed in the team, and if deemed beneficial will be offered to the patient. Potential benefits that are discussed in the team and with patient and family are not only symptom control but also life prolongation, for example if the patient has a specific reason to want that (such as a family celebration) and there is a realistic chance to achieve this individual goal.

In addition, the expansion of palliative care from cancer patients to other patient groups requires technical support in some cases. Patients with advanced motor neuron disease cannot be admitted unless respiratory support is available. In all, modern hospice and palliative care requires not only the knowledge, skills and attitudes for comfort care, but also access to interventions such as transfusions, antineoplastic therapies, tube feeding or respiratory care. This does not mean that these therapies should be used automatically, but rather that individualised care in some selected patients, after careful discussion with patients and significant others, may provide an indication for their use.

Do we Have the Evidence to Make Decisions about Artificial Hydration and Nutrition in People with Dementia?

O'Brien L.
University of South Florida, School of Aging Studies, Land O'Lakes, FL, United States

Severe dementia is a condition in which patients are not able to eat and drink by themselves. During their feeding two problems can occur:

1. Patients start choking and coughing. Cough does not mean that a patient aspirates but is a protective reflex that prevents aspiration. Some drugs which increase cough reduce occurrence of aspiration pneumonia. But even demonstrated aspiration does not always lead to aspiration pneumonia. Antibiotics may only prolong dying of patients with severe dementia. It is possible to keep the patient comfortable without antibiotics, by protective and analagic administration. Efficacy of antibiotics depends on the hydration status of the patient and with good hydration the survival is the same whether antibiotics are used or not.

2. Patients refuse to eat and drink. This refusal can be considered a sign that the patient wants to die. Stopping eating and drinking by people without dementia leads to a comfortable death by dehydration. Dehydration reduces respiratory and gastrointestinal secretions and the risk of respiratory distress, vomiting and diarrhea. Dehydration can also reduces sensation of pain. The only disadvantage is dryness of the mouth which can be treated with a small amount of liquid or artificial saliva spray. If somebody is going to die in severe dementia, he/she may state in advance directives that at some stage of dementia he/she does not want to be fed and given fluids.

Tube feeding is not indicated in either of two situations. It does not improve healing of pressure ulcers, prevent aspiration pneumonia or prolong life. However, it has a lot of drawbacks: discomfort from restraints of a patient who tries to remove the tube, loss of enjoyment of the taste of food and drinks, loss of contact with caregivers during feeding, and tube complications (obstruction, infection, vomiting). Tube feeding is not compatible with palliative care for patients with severe dementia, which is a terminal disease.
Assessment of Breathlessness in Clinical Practice
Simon S.T.
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Breathlessness is a burdensome and prevalent symptom in many life-limiting diseases. Although the management of the breathless patient as part of a first-line approach, alongside drug treatments, is the only one to have a substantive evidence base to support its use. This presentation will summarise the current evidence for drug approaches to the management of refractory breathlessness and reflect on clinical and further research implications. As there is more work in the area of opioids, there will be a focus on those which have already demonstrated benefits from the patients’ point of view as well as from a public health approach to palliative care. The key reasons behind their important application in palliative care will be described as well as how these ideas underpin and create prevention, healthcare claims data, when linked to disease registries, offer the opportunity to monitor the quality of end-of-life care in specific patient populations. If linkage is not possible, algorithms based on healthcare claims and drug prescriptions can be used to identify disease groups. The databases of the Belgian Cancer Registry and Belgian healthcare claims will be used to monitor the quality of end-of-life care in all deceased Belgian cancer patients, using validated quality indicators. Databases are complete and reliable because both health insurance and cancer registry is legally mandatory in Belgium.

Diffuse Approaches to the Management of Breathlessness
Maddock M.
King’s College London, Cicely Saunders Institute, London, United Kingdom

Dyspnoea is a prominent, distressing symptom in patients with advanced cardiorespiratory disease and associated with poor clinical outcomes. While the underlying cause is a mandatory treatment target, many patients have refractory breathlessness which persists despite optimal treatment of the causal condition, especially as their disease advances towards end of life. Many different non-drug treatments exist, which target how the breathless patient breathes, thinks and functions. These include breathing training, positioning, acupressure, relaxation, mobility aids and physical exercise. This presentation will appraise the latest developments in non-drug treatments to manage breathlessness, with an emphasis on those which can be easily adopted into clinical practice. It will also cover emerging non-drug treatments that, depending on further evidence, may become part of clinical practice in the future.

Drug Approaches to the Management of Breathlessness
Johnson M.
The University of Hull, Hull York Medical School, Hull, United Kingdom

Dyspnoea is a prominent, distressing symptom in patients with advanced cardiorespiratory disease and associated with poor clinical outcomes. While the underlying cause is a mandatory treatment target, many patients have refractory breathlessness which persists despite optimal treatment of the causal condition, especially as their disease advances towards end of life. Many different non-drug treatments exist, which target how the breathless patient breathes, thinks and functions. These include breathing training, positioning, acupressure, relaxation, mobility aids and physical exercise. This presentation will appraise the latest developments in non-drug treatments to manage breathlessness, with an emphasis on those which can be easily adopted into clinical practice. It will also cover emerging non-drug treatments that, depending on further evidence, may become part of clinical practice in the future.

PsO4
PS04 Public health approaches to support evidence based palliative care practice

Abstract number: PS04.1
Abstract type: Parallel Session

Monitoring the End of Life: Discussing the Use and Linkage of Existing Health Care Databases to Monitor the Quality of End of Life and Palliative Care
Houtekker D
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Routine collected databases offer the opportunity to monitor the quality of end-of-life care.

Results: The international place of death study (IPoD2) aims to monitor place of death within and across countries. High proportions of hospital death are considered an indicator of poor end-of-life care. Death certificate data (2008) were collected in 14 countries: Belgium, Canada, Czech Republic, England, France, Hungary, Italy, Mexico, the Netherlands (NL), New Zealand, Spain, South Korea (KOR), US, and Wales. Datasets were integrated into one international database to ensure uniform coding. In each country, death certificate data was linked to data on health care services in the catchment area of the deceased (hospital beds, nursing home beds, general practitioners) and the urbanisation level of the place of residence of the deceased.

Pharmaceutical approaches to palliative care
Maddocks M.
King’s College London, Cicely Saunders Institute, London, United Kingdom

Breathlessness is a common and distressing symptom for patients and their families. It is difficult to manage and clinicians often report concern around a lack of practical and effective interventions. They can add to the patient’s suffering and are difficult to assess in the management of the breathless patient as part of a first-line approach, alongside drug treatments, and when the symptom continues despite optimal drug treatment. Many different non-drug treatments exist, which target how the breathless patient breathes, thinks and functions. These include breathing training, positioning, acupressure, relaxation, mobility aids and physical exercise. This presentation will appraise the latest developments in non-drug treatments to manage breathlessness, with an emphasis on those which can be easily adopted into clinical practice. It will also cover emerging non-drug treatments that, depending on further evidence, may become part of clinical practice in the future.

Improving the Community Approach in Palliative Care: from Healthy Cities to Compassionate Cities. Inspired by the Public Health Policy Approach on ‘Health for All’ by the WHO, what Can Palliative Care Learn from it?
Killeyhia A
University of Bradford, Faculty of Health Studies, Bradford, United Kingdom

Much palliative care understanding about ‘community approaches’ to palliative care consists of simple understandings of community-based service provision and clinical ideas of ‘patients and families’. These ideas seldom embrace traditional public health ideas of community engagement, community development, and citizenship for health. However, despite these difficulties and challenges, the public health approach to palliative care is growing worldwide. This session will examine concepts of community as part of a public health approach to palliative care. The key reasons behind their important application in palliative care will be described as well as how these ideas underpin and create prevention, harm-reduction and early intervention strategies to address the social epidemiology of death, dying, bereavement and long-term caregiving. Current examples of these concepts and practices from the UK palliative care sector will be provided as well as a guide to the important literature and organisations representing this approach.
PS05 Sleep disorders, anxiety, depression: complex syndromes in advanced cancer patients and how we can manage them better?

Abstract number: PS05.1
Abstract type: Parallel Session

Advances in the Understanding of Assessment and Management of Sleep Disturbances in Advanced Cancer Patients

Yennurajalingam S.

The phenomenology of demoralisation has been shown to have some points in common with depression (e.g., sadness, suicide ideation) but other points that seem to differentiate it from depression (e.g., sense of subjective incompetence). A number of studies have examined the role of demoralisation in impairing quality of life and the relationship with depression. Several instruments have also been recently developed (e.g., Diagnostic Criteria of Psychosomatic Research – Demoralisation module; Demoralisation scale, Subjective demoralisation). Data on validly studying the potential of these instruments in addressing the differences between demoralisation and depression. Because of the implications of demoralisation in terms of quality of life and dignity experience – irrespective of the fact that this condition has been described as a disorder, a syndrome or a clinical condition deserving medical attention – its assessment and treatment are necessary steps and the application of specific tools for demoralisation in oncology is an urgent need.

Abstract number: PS05.2
Abstract type: Parallel Session

Depression and Demoralization: Common Points and Differences

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Demoralisation, as a continuum state from discouragement to despair, characterised by the patient’s consciousness of having failed to meet his or her own expectations (or those of others) or being unable to cope with pressing problems and by feelings of helplessness, or hopelessness, or giving up, is an important dimension to be evaluated in medical settings for its relevance. In fact, demoralisation has been frequently described in the course of medical illnesses, including cancer, as a clinical condition affecting about one-third of the patients. The phenomenonology of demoralisation has been shown to have some points in common with depression (e.g., sadness, suicide ideation) but other points that seem to differentiate it from depression (e.g., sense of subjective incompetence). A number of studies have examined the role of demoralisation in impairing quality of life and the relationship with depression. Several instruments have also been recently developed (e.g., Diagnostic Criteria of Psychosomatic Research – Demoralisation module; Demoralisation scale, Subjective demoralisation). Data on validly studying the potential of these instruments in addressing the differences between demoralisation and depression. Because of the implications of demoralisation in terms of quality of life and dignity experience – irrespective of the fact that this condition has been described as a disorder, a syndrome or a clinical condition deserving medical attention – its assessment and treatment are necessary steps and the application of specific tools for demoralisation in oncology is an urgent need.

Abstract number: PS05.3
Abstract type: Parallel Session

Insights into Effective Communication: Addressing Distress in the Cancer Setting

Choinosaur H.M.
University of Manitoba, Psychiatry, Winnipeg, MB, Canada

Patients facing life-threatening and life-limiting cancer almost invariably experience psychological distress. Responding effectively to such distress requires therapeutic sensitivity and skill. Our research group examined therapeutic effectiveness within the setting of cancer-related distress, with the objective of understanding its constituent parts. Seventy-eight experienced psychosocial oncology clinicians from 24 health care centers across Canada participated in three focus groups each. A total of 29 focus groups were held over two years during which clinicians were asked to articulate therapeutic factors deemed most helpful in mitigating patient psychosocial distress. The content of each focus group was summarised into major themes, resulting in an empirical model of therapeutic effectiveness. This presentation will provide an overview of the Empirical Model of Optimal Therapeutic Effectiveness (EMOTE). This model consists of three primary, interrelated therapeutic domains, including 1) personal growth and self-care, 2) therapeutic approaches, and 3) creation of a safe space. Areas of domain overlap were identified, including therapeutic humor, therapeutic pacing and therapeutic presence. Understanding EMOTE and how it can be applied should improve clinicians’ communication skills and the psychosocial care they offer patients experiencing cancer-related distress.

PS06 Implementation of advance care planning

Abstract number: PS06.1
Abstract type: Parallel Session

Implementation of Advance Care Planning in Daily Practice

Hanneman BJ.
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Understanding an adult patient’s values, goals and preferences for medical treatment is one way to clarify treatment decisions. This is especially true as the patient gets sicker, becomes unable to make his or her own decisions and medical treatments start to have a limited benefit. Efforts to understand these preferences, by relying solely on advance directives documents, have not achieved this goal. The only documented successful approach has been to implement an advance care planning (ACP) system as part of the larger health care system. An ACP system involves organised interactions between health professionals and patients which ensures that five, successive activities are undertaken. These activities are: 1) ACP conversations are routinely initiated with all patients at some planned point in the care pathway; 2) if patients are willing, they will receive skilled assistance so that they are able to reflect on, understand, and discuss a plan of future care; 3) the plan created will be clear to both the patient and their family, and to any health professional; 4) the plan will be stored in a way that it is available to health professionals in the future; and 5) when it is needed, the plan will be used thoughtfully and respectfully by the treating clinicians. To create an ACP system that can achieve all five of these outcomes, specific design elements must be considered. Firstly, there must be system design. These include medical record systems, documentation systems, as well as work flows and responsibilities. Secondly, there must be a design of how ACP planning conversations will be conducted and certain health professionals must be trained to facilitate these conversations. Thirdly, there must be engagement materials and decision-aids to support good planning. Finally, there must be continuous, quality improvement to ensure that the other three elements are effective. When these four elements are successfully implemented it can lead to effective ACP and improved care.

Abstract number: PS06.2
Abstract type: Parallel Session

Competence in Discussing Advance Care Planning

Lunder U.
University Clinic for Respiratory and Allergic Diseases Golnik, Golnik, Slovenia

While it is recognised that it is time to move from the mere completion of an advance directive (AD) document to a broader process of communication, it is unclear what competencies those who facilitate ACP should have and which type of training interventions are most beneficial. The competence represents a cluster of related abilities, commitments, knowledge and skills that enable a person to act effectively in a certain role and situation. There are rare ACP models with standardised education program which entails an agreed content of ACP and therefore a clear set of competencies. In one of the most researched ACP models, the Respecting Choices (RC), the basic needed competencies to guide ACP facilitation are stated in the definition: a person-centred, ongoing process of communication that facilitates individuals’ understanding, reflection, and discussion of their goals, values, and preferences for their future health care decisions and to help loved ones be better prepared. The ACP interview themes proposed as a base framework for a competency development for facilitators are: individual’s experiences with illness, fears, religious or cultural beliefs and goals for living well, among others. Such themes can serve as a framework for patients to be able to make informed health care decisions. At later stages of an illness patients may need more specific guidance in making informed health care decisions, and facilitators need more specific competencies. Person-centred interview skills to encourage moving from precontemplation to action (from no interest in taking action to participating and making changes) are a promising missing link for a successful set of facilitators’ competencies in ACP process.

Abstract number: PS06.3
Abstract type: Parallel Session

Translation of the Intervention and Adapting it to Different Contexts

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Aims: To translate and adapt the US-developed advance care planning (ACP) intervention ‘Respecting choices’ to a different context (Europe instead of US, advanced colorectal/lung cancer patients instead of the general population) for use within the EU funded ACTION Project.

Methods: The first phase consisted of translation of the core document for recording of the patients wishes (‘My Preferences’), the interview guides, and additional materials. These materials were evaluated in the consortium and in interviews with experienced health care professionals (HCPs). The second phase was a testing of the revised intervention in 4–5 advanced cancer patients in each of the countries (Belgium, Denmark, Italy, Netherlands, Slovenia, UK). After the interviews, patients were interviewed about their experience and the facilitators made detailed notes. In parallel, HCPs were interviewed at the core documents.

Results: The first phase lead to several revisions in the My Preferences Form and interview guide, most importantly omission of some treatment options, which were deemed irrelevant in the new target population. New questions exploring the patients’
understanding of their disease and treatment were added.

The second phase in ongoing. Initial findings are large differences in the use of ACP prior to the study in the six countries, ranging from Belgium already having an ACP form in place to

blind, placebo-controlled trial of ketamine. (PaCCSC) trials such as the within trial cost-effectiveness analysis of the randomised, double-care, the advantages of conducting economic analyses, and evaluation design. Practical
care economic evaluations, introduce the fundamentals of economic evaluation in palliative
funders and policy-makers’ information needs.

using the best available clinical and cost-effective arguments needs to be provided to meet
of how such funds will grow services and provide better outcomes for patients and families
have been obtained; the greatest impacts on end of life seem to arise from support, love and
affection, and dignity. The ICECAP Close Person Measure has been developed for close
persons (n=27). Best-worst scaling with the general population (n approx 6000) has been
used to generate values for the patient measure; deliberative methods have been used with
focus group participants (n=38) to generate preliminary values for the close person measure.
The patient measure has been tested for feasibility using ‘think aloud’ interviews with 72
patients, close persons and health professionals. Focus groups are also being used to
generate values for combining across the measures.

Results: The ICECAP-Supportive Care Measure has been generated for patients. It assesses
choice, love and affection, physical suffering, emotional suffering, dignity, support, and
preparation. Think-aloud work suggests patients can complete the measure, and values
have been obtained; the greatest impacts on end of life seem to arise from support, love and
affection, and dignity. The ICECAP Close Person Measure has been developed for close
persons. It assesses communication, practical support, privacy and space, emotional
support, preparing and coping, and emotional distress, with highly valued attributes being
communication and practical support. Early analysis indicates that the public support a
positive weight for close persons when combining the measures.

Conclusions: New frameworks for the economic evaluation of end of life care can offer
greater richness than the current cost/QALY gained.

Abstract number: PS07.1
Abstract type: Parallel Session

Implementing Patient Reported Outcome Measures (PROMs) in clinical practice: guidance and experiences

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PROMs are increasingly being used in research, but less so in clinical practice. This might be
because there seems to be a lack of guidance on how to design and implement them and use
in clinical care. In this parallel session, organised with strong inputs from the Taiflorce on
Patient Reported Outcome Measures, we aim to help build the bridge between using
PROMs for research, to simultaneously using PROMs for clinical care and research (including
clinical care only).

We will first discuss the added value of outcome measurement in clinical palliative care. This
is followed by the presentation of developed guidance on how to use PROMs in clinical care,
using an 8-step framework and including concrete recommendations. Next, a detailed
example of a project using and implementing PROMs in clinical care (and research) will be
presented. Lastly, a discussion will be held including the public in which ideas and
experiences on implementing PROMs in clinical practice are discussed, and which can move
the field forward.

Speakers (3 presentations, with each presenter being the first author on one of them):
1. Prof Dr Claudia Bausewein – Munich University Hospital, Department of Palliative
Medicine, Munich, Germany – Outcome measurement in palliative care - do we really need
it? (Munich University Palliative Care Department)
2. Dr Lesditch van Vliet – Research Associate at Cicely Saunders Institute, London United
Kingdom – Guidance on the use and implementation of PROMs in clinical care
3. Dr Fliss Murtough – Reader and Consultant in Palliative Care, Cicely Saunders Institute,
London United Kingdom – Outcome Assessment and Complexity Collaborative (OACC): A
project on implementing routine outcome measurement into practice across settings.

Abstract number: PS08.1
Abstract type: Parallel Session

Economic Evaluation - Not Just Counting Beans

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No longer can governments be expected to treat palliative care as a charity case. Increased
financial pressure from the global economic recession and fiscal crisis on already stretched
budgets means tough decisions have to be made about how to wisely invest limited funds.
Consequently, the value of palliative care’s contribution to improving health needs to be
clearly demonstrated. Health economics is a vital component of planning and funding
future health services and providers increasingly rely on economic evaluations to inform
resource allocation decisions. However, such research is largely lacking for palliative care
services.

Palliative care, more than any other area of health care, can present in more extreme ways in palliative care. Drawing on evidence from the Economic Evaluation of Palliative Care study, IARE and other research, this
paper considers the issues in measurement in palliative care, and how these can best be
overcome.

It is common, but wrong, for economic evaluation studies to take the perspective of the
funders. Often this does not matter since most of the costs fall on the delivery of care.
Palliative care research shows that a significant part of the cost falls on families and informal
carers, as well as many of the benefits. More importantly, there are difficulties in measuring
outcomes and benefits in ways that are comparable with studies in other parts of the health
system. This is partly because palliative care is a complex intervention with complex effects
on many different parties. It is also because the objectives are not inherently measurable in
terms of duration of improved functioning – it is really to create a better (in many senses)
trajectory of wellbeing until the end of life (which may be a long period). This is a case where
the best may be the enemy of the good. Understanding the dilemmas and using the best
available tools and approaches can provide evidence that is useful in allowing better choices
around what to provide and how to provide it.

Abstract number: PS09.2
Abstract type: Parallel Session

Outcome Measurement in Palliative Care Economic Evaluations

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Methods: Economic evaluation standardly assesses outcome with Quality-Adjusted Life-Years (QALY’s) based on generic health instruments. For end-of-life care, this means ignoring
important non-health, non-patient outcomes. This presentation explores a new framework
for outcome measurement in economic evaluations of end of life care.

Conclusions: New frameworks for the economic evaluation of end of life care can offer
greater richness than the current cost/QALY gained.
PS09
Recruiting to palliative care studies in Europe – developing recommendations for best practice

Abstract number: PS09.1
Abstract type: Parallel Session

Reflections on 10 Years of Recruitment in the Palliative Care Setting

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Recruitment of patients to research is challenging in any setting, but particularly so in the context of advanced disease with the multiple gatekeepers of well-meaning clinicians and families who may wish to protect patients from study participation by controlling researcher access. Researchers have long appreciated the importance of the patients who meet the criteria for inclusion but not exclusion criteria, or opt not to support study recruitment out of concern for patient burden. This is despite a growing literature on the preferences of patients with advanced disease who benefit from participating, and the issue of patient autonomy. Additional restrictions are in place in the UK in relation to ethical and research governance approvals due to the UK interpretation of the EU Directive (Europe-wide legislation on data protection). Even within the UK the interpretation of the Directive varies with secondary care settings including clinical trials nurses in their definition of the ‘control team’, whereas community-based research nurses cannot necessarily access patient notes in primary care. The compounding impact of this on the delivery of studies (and costs) has been widely acknowledged, which in itself has ethical implications. This situation has changed little in the ten years since Ewing et al. 2004 published a UK paper entitled ‘Recruiting patients to primary care based study of palliative care: why is it so difficult?’ This paper will report empirical data on recruitment to UK palliative care studies for patients with advanced malignant and non-malignant disease in both primary and secondary care settings, and the strategies employed to facilitate that recruitment. Further it will present findings from a recent Cochrane review of strategies to improve recruitment of patients to palliative care and end of life care studies via healthcare professionals. Thus it will contribute to the debate on best practice in patient recruitment to palliative care and end of life care research.

Abstract number: PS09.2
Abstract type: Parallel Session

Recruitment in Italy

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The challenge of recruitment to palliative care studies is well documented, and include ethical and logistical issues related to the specificity of the population of interest: people at the end of their lives and their families. Recruitment refers to an active process of selecting individuals, or structures in some type of cluster trials, potentially eligible for a study. This presentation will assess strategies used in a sample of experimental Italian studies to improve recruitment, by analysing the studies and by interviewing the principal investigators. We will review procedures at study design level and procedures implemented during the study to improve the rate of recruitment. During the last three years at least three Italian trials successfully dealt with this challenge: the randomised trial on the use of non-invasive mechanical ventilation in four respiratory intensive care units (1); the randomised cluster trial on the use of LCP that recruited 16 hospitals (2), and the ongoing randomised trial assessing the effectiveness of early palliative care intervention in gastric and pancreatic cancers (3).

3. Maltoni M. The role of early systematic Best Care Versus on Request Palliative Care Consultation During Standard Oncologic Treatment for Patients With Advanced Gastric or Pancreatic Cancers: A Randomised, Controlled, Multicenter Trial. Registered with ClinicalTrial.Gov, as NCT01996540.

Abstract number: PS09.3
Abstract type: Parallel Session

Patient Recruitment in the Netherlands: What about the Law of Lasagna?

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In 2012, ZonMW (The Netherlands organisation for Health Research and Development) published a generic report addressing problems in patient inclusion. The report distinguished three phases in the inclusion process, namely the calculation phase to estimate the number of people needed, the phase in which researchers and health care professionals select potential responders, and the phase in which responders are actually asked for participation. Important obstacles are that power calculations are not realistic (phase 1); that researchers are too optimistic about the willingness of family members, and unclear prevalence data are expected to increase the risk at recruitment problems. Lasagna, a pharmacist, is said to have formulated a law stating that the incidence of available patients firmly decreases when an RCT starts and increases when it ends. Palliative care concerns physically and emotionally vulnerable patients, experiencing serious and often fast decline. This was noticed as a major limitation for research in a new Dutch publication on patient inclusion in palliative care (ZonMW 2014). Of 13 reviewed studies in palliative care, all had experienced problems with patient inclusion. Often, caregivers feel burdened to ask patients to participate in research and logistic problems arise when inclusion has to start and run with patients in advanced stages of life-limiting illnesses. Due to a limited time frame, administrative aspects of Good Clinical Practice may be difficult to implement, limiting participation. However, the report also offers a checklist to improve patient inclusion. Would it be possible to reverse Lasagna’s law in palliative care?

Abstract number: PS10.1
Abstract type: Parallel Session

Examining trends in place of death: methods, results and meaning

From Studying Inequity to Projecting the Road Ahead: A Historical Overview of Research on Where People Die and Implications for Care

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Debates about the place where people die have happened within and between countries since the beginning of the modern hospice movement. Research grew to help understand variations in place of death, with a view to enable patients to die where they wish with the best possible care. In January 2015, there were 1584 papers indexed in MEDLINE with keywords of place, location, site or home adjacent to death or dying. This talk aims to provide an historical overview of how trends in place of death has developed, from an initial focus on studying inequity in cancer to the latest developments on projections in several countries, from 2008 onwards. Data from analysis of trends in different countries will be compared, with a focus on European variations (countries include the UK, Belgium, Germany and Portugal). The extent to which clinical, individual and environmental factors (including policies) might explain the existing trends will be discussed. Implications for patients and families, health professionals, service management and policy will focus on projecting the road ahead, to ensure that future trends in the ‘microgeographies of death and dying’ are both sustainable and responsive to people’s preferences, addressing the social asymmetries that have been previously identified.

Funding: Calouste Gulbenkian Foundation.

Abstract number: PS10.2
Abstract type: Parallel Session

Using Routinely Collected Data to Understand and Improve End of Life Care in Dementia

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 Routinely collected data, gathered for clinical or administrative purposes, provides an attractive resource for studying end of life care. It is without many of the challenges associated with primary data collection in people who are dying, offers the potential to study large or even whole populations, and is relatively inexpensive.

One source of routine data that has been extensively used in palliative and end of life care is mortality data, derived from death certificates. Data will be presented from project GUIDEL_Care, a temporal and geographical analysis of place of death using whole population mortality data from England. Temporal trends in place of death among people with dementia will be presented, and the clinical implications considered. The advantages and limitations of mortality data, including the impact of variation in death certification and classification practices, will be discussed.

Looking beyond place of death, the wider potential of routine data to understand and improve palliative and end of life care policies will be explored using examples from different healthcare systems worldwide. For example, linking national datasets with clinical databases can provide opportunities to answer questions that single datasets cannot, while technological advances in natural language processing enable a far greater depth of understanding than previously possible. For frail and vulnerable populations, such approaches offer unique opportunities. For these approaches to be successful, close collaboration between clinical and academic sectors is essential.

Abstract number: PS10.3
Abstract type: Parallel Session

Trends in Place of Death in Belgium and Europe, Implications for Public Health

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Background: A high proportion of deaths in acute hospital settings is considered an indicator for poor quality of end-of-life care. Healthcare policies in many countries support out-of-hospital death. We aimed to examine trends in hospital death in Belgium and other European countries.

Methods: Data from death certificates of all deaths from chronic life-limiting diseases (1998–2007; Flanders, Brussels Capital Region, and representative samples of all deaths (2007, 2013; Flanders), were used to examine trends in hospital death in Belgium. Death certificate data from all deaths (2003; 2008) in Belgium, the Netherlands and UK were used to examine trends in hospital death in people who died from cancer and dementia related diseases. Data on the availability of beds in hospitals and nursing homes in the proximity of the deceased was linked to death certificate data.

Results: In Belgium, hospital death decreased in people who died from chronic life-limiting diseases from 55.1% to 51.7% between 1998 and 2007. In those living in nursing homes, hospital death fell from 31.0% to 21.5%, and was associated with the conversion of
residential beds to skilled nursing beds in nursing homes. Decrease in hospital death was less substantial in those living at home alone (from 68.6% to 68.2%) and those living in a multi-person household (from 63.1% to 60.5%), though not in people living alone (increase from 62.0% to 65.8%). In Belgium (1.1%), the Netherlands (1.2%) and England (4.3%), Wales (3.2%), hospital death decreased in people who died from dementia between 2003 and 2008. In patients who died from cancer, decrease was 2.1%, 3.2%, 5.5% and 3.5% respectively.

Discussion: Trends show a decrease in hospital death in Belgium and across Europe, possibly indicating better quality of end-of-life care.

(2) PC specialists from 6 countries were asked to collect the common beliefs in their countries. ‘Common’ included the beliefs of professionals as well as lay people. Countries were selected from Western, Eastern, Northern and Southern Europe (Denmark, Germany, Hungary, Italy, Serbia and the UK).

Results: Based on worldwide literature and own research, most common beliefs are very similar in almost every country. For example, there is no difference between palliative care and long-term care; ‘palliative care means that medically nothing will be done for you anymore’; ‘taking morphine: death is approaching’; ‘palliative care is not far from euthanasia’. Surprisingly, despite the different cultural, religious and political background people have similar beliefs. The difficulty around misperceptions appears to be only partially related to the confusion of commonly used terminology. In fact, people do not want to discuss or know more about PC, since death and dying are still taboos in society, despite our repeated efforts to change attitudes.

Conclusion: It seems that people do not want to embrace simple facts and real information related to PC due to the death-dying taboo. Conventional educational methods are not efficient. However, discussing good death and dying is essential.

PS11 User involvement in palliative care – do we need bridges between the knowledge of professionals, patients and relatives?

Abstract number: PS11.1
Abstract type: Parallel Session

User Involvement in Palliative Care

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Patient and public involvement (PPI) in research is promoted in UK policy and by research bodies. However, social care professionals are not as aware of the focus to the respect and design of research, and ways in which research is conducted. Involvement within health and social care research is described as ‘doing research with, or by, the public, rather than to, about or for the public’. This paper presents three examples of how user involvement has been developed with, or by, the public to support palliative care research. These represent different ways in which user involvement can be undertaken. The examples are: (1) the development of an on-going PPI group that has advised on other people’s studies; (2) an action research study designed and undertaken by an academic researcher and members of the public, researching the development of a local public awareness initiative about end of life; and (3) a prospective case study, which involved user-researchers undertaking fieldwork in six care homes for older people, supported by an embedded qualitative evaluation of PPI activity. The key principles and processes underlying user involvement and their application in these examples were explored. The challenges of user involvement learnt from this work are identified and ways to overcome them presented.

Abstract number: PS11.2
Abstract type: Parallel Session

Sharing Knowledge with Danish Citizens and Patient Organizations

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Background: One purpose of the Danish Knowledge Centre for Rehabilitation and Palliative Care is to share knowledge about suffering from life-threatening diseases, end-of-life care, death and dying – not only with professionals, but also with the users of palliative care (PC). We presume, that there is a correlation between shared knowledge and quality of care. Both internationally and in Denmark (DK), there is a need for more knowledge about the wishes and the experiences of the users of the health care system in general, and in PC in particular. For this reason (2012–2014) the centre asked some questions and tried to answer them in a systematic way:

Questions and methods: What do the Danes already know about severe diseases, death and dying? We did a survey. How can we create a platform of knowledge about PC available for lay-people? We created a ‘lay-person’s website: How can we be sure that the knowledge about PC gets to the people most in need of it? We created and evaluated a network cooperation with patient organisations.

Results: The Danes already know which diseases most people die from, and where the most people die. And they want it different for themselves and their beloved ones. The creation of the lay-person’s website is ongoing, but until now it has not been well visited. Patient organisations did not want to frighten their members with the knowledge about death and dying. After sharing and dealing with this barrier, several of the organisations now share information about pain relief with other members in different ways.

Discussion: Sharing knowledge is an important part of user involvement. We identified some challenges, that we would like to discuss with you.

Abstract number: PS11.3
Abstract type: Parallel Session

Common Beliefs and Reality about Hospice and Palliative Care

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Background: In 2011, after 20 years of palliative care experience, I started to collect the common beliefs about hospice and palliative care (PC), since I realised that many misconceptions hinder the PC development.

Aim: To learn more about the nature of common beliefs in order to bust them.

Methods: (1) Comprehensive literature searches with advanced keywords were completed through an online search of PsychINFO, Ovid, MEDLINE, Help the Hospices databases for articles published between 1980 and 2014.

The EAPC Core Competencies for Education in Paediatric Palliative Care

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Background: Education is an essential component in the development of paediatric palliative care (PPC), thus all healthcare professionals need to be trained to provide high quality PC for children and their families. Thus an EAPC white paper on core competencies for PPC training was developed.

Method: A multidisciplinary multinational group of PPC professionals collaborated on the development of the white paper. Information and materials were drawn from existing competency frameworks & curricula to complement documents such as the IMPCCT standards for PPC in Europe, the EAPC White paper on core competencies and on standards & norms for PC in Europe.

Results: Education programmes for PPC should be aimed at: (a) the acquisition of knowledge, (b) the development of specific skills, (c) the capacity of interdisciplinary thinking, (d) the cultivation of attitudes that promote quality of life, (e) the ability for self-awareness & reflective practice.

Programmes need to develop practitioners who are ‘competent’ to provide PPC. Core competencies are identified within the three-tiered approach to education: (1) The PC approach; (2) General PC, & (3) Specialist PC.

Basic education on PC approach focuses on the general principles & practices of PC, highlighting differences between paediatric & adult PC. General PPC education is aimed at
Abstract number: PS12.3
Abstract type: Parallel Session

Assessing the Population Need for Children’s Palliative Care
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Aims: The need for palliative care for children is different than for adults. Children have different diagnoses and trajectories of illness. Too often we try to use mortality data to estimate the number of children needing palliative care, which underestimates the need. The capacity to deliver Children’s Palliative Care (CPC) also varies widely around the world. Accurate data on the need for CPC and the capacity to deliver it is needed to advocate for closing the gap.

Methods: The International Children’s Palliative Care Network (ICPCN) in partnership with UNICEF recently developed a new methodology for estimating the population need for CPC using prevalence data in addition to mortality. This cross sectional research uses mixed methods to estimate the gap between the need for CPC and the capacity to deliver it.

Results: This method was tested in three African countries successfully and is now being expanded to eleven additional countries representing all four World Bank income groups in an effort to do a more accurate estimate of the global need for CPC. Rates per 10,000 child population will be presented.

Conclusion: The need for and capacity to deliver CPC has not been accurately measured globally. Preliminary findings from this ongoing research being done by ICPCN in cooperation with UNICEF are presented. More accurate evidence is needed to effectively advocate for CPC globally.

Abstract number: PS13.1
Abstract type: Parallel Session

Epidemiology of Palliative Sedation in Belgium and the Netherlands
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End-of-life sedation as an option of last resort in invariably dying patients is widely viewed as normal medical practice. However, the practice is the subject of some controversy given its potential for life shortening and misuse, particularly in its most far-reaching form of continuous deep sedation until death, and particularly in Belgium and the Netherlands where euthanasia is legally regulated. While a number of guidelines have laid down the parameters for good sedation practice, it is important to monitor the evolution of the practice in terms of its incidence and its decision making and performance characteristics. Depending on the definition used, the incidence of end-of-life sedation varies considerably both in the Netherlands and in Belgium. In both countries, application of the practice has been increasing. A comparative overview of the available estimates is given as well as differences across care settings and patient groups.

Levels of involvement of patients, family and other professional caregivers in the decision are covered, as well as the most frequently quoted (clinical) indications for end-of-life sedation. Performance characteristics of interest relate to the drugs used, the depth and duration of sedation, and artificial administration of nutrition and hydration. Not infrequently a life shortening effect, though limited, is recounted in both countries. Particularly in the Netherlands, research has found that national guidelines led to significant improvements in end-of-life sedation practice. Though end-of-life sedation is increasingly practised in the Low Countries, it seems to be performed with increasing diligence and respect of guideline criteria. Mandatory specialist consultation and mandatory documentation have both been proposed as further measures towards improving practice.

Abstract number: PS14.2
Abstract type: Parallel Session

Clinical Decision-making in Palliative Sedation Practice in the UK, Belgium and the Netherlands
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Background: Extensive debate surrounds the practice of continuous sedation until death to control refractory symptoms in terminal cancer care. We examined reported practice of UK, Belgian and Dutch physicians and nurses.

Methods: Qualitative case studies using interviews. Setting: Hospitals, the domestic home, and hospices or palliative care units.

Participants: 57 Physicians and 73 nurses involved in the care of 84 cancer patients.

Results: UK respondents reported a continuum of practice from the provision of low doses of sedatives to control terminal restlessness to rarely encountered deep sedation. In contrast, Belgian respondents predominantly described the use of deep sedation, emphasizing the importance of responding to the patient’s request. Dutch respondents emphasised making an official medical decision informed by the patient’s wish and establishing that a refractory symptom was present. Respondents employed rationales that showed different stances towards four key issues: the preservation of consciousness, concerns about the potential hastening of death, whether they perceived continuous sedation until death as an ‘alternative’ to euthanasia, and whether they sought to follow guidelines or frameworks for practice.

Conclusion: This qualitative analysis suggests that there is systematic variation in end-of-life care sedation practice and its conceptualisation in the UK, Belgium and the Netherlands.

Background: A multi-disciplinary EAPC Taskforce was established in 2012 to help integrate palliative care in primary care across Europe.

Aim: To document the barriers and facilitators for palliative care in the community; and to produce a resource toolkit that enthusiasts could use to facilitate the development of primary palliative care in different countries throughout Europe and possibly worldwide.

Design: Step 1) A survey instrument was sent to general practitioners with knowledge of palliative care services in the community in a purposely diverse sample of European countries. Barriers and facilitating factors relating to providing community palliative care were identified and analysed. Step 2) A draft toolkit was then constructed suggesting how individual countries might best address these issues and an online survey was then set up for general practitioners and specialists to comment on and develop the toolkit. Iterations of the toolkit were then presented at international palliative care and primary care conferences. An international systematic review of tools used to identify people for palliative care in the community was also conducted.

Results: A toolkit has been produced and refined, together with associated guidance, to help primary care and specialist palliative care leaders throughout Europe advocate for and develop palliative care in the community, ‘primary palliative care’.

Conclusions: The four domains of the WHO Public Health Strategy provided a robust framework to collate the resources and structure the toolkit. The taskforce toolkit usefully supplements previous work to help community based palliative care services to be established to ensure adequate population coverage.

Abstract number: PS14.3
Abstract type: Parallel Session

Using the EAPC Primary palliative Care toolkit to develop palliative care in the community throughout Europe: an overview
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Background: Access to specialist palliative care services remains limited in France and it does not rely on a community approach. Furthermore, there is no mention of primary care in the National Strategy for the Development of Palliative Care (2008–2012). Multiprofessional Primary Palliative Care Centers (MPPHCs) could represent an opportunity to develop the palliative approach in primary care.

Aims: To assess the impact of early identification, multidimensional assessment and anticipatory care planning (ACP) by interprofessional teams within MPPHCs, on the access rates to specialist palliative care services for patients with palliative needs.

Design: Based on the recommendations of the EAPC Toolkit, our project targets three dimensions: education, research and advocacy.

1) A simulation-based training is being developed to facilitate interprofessional coordination and ACP conversations in MPPHCs.
2) After a feasibility study conducted in a rural MPH in Picardy, a multicenter mixed-methods study (SCoP3) will evaluate the impact of a complex intervention in MPHcI s on the access to specialist palliative care.

3) Several meetings have been held at local and national levels (with health professionals, secondary care services, end of life care volunteers, regional health authorities, representatives of national ethics bodies and a member of the French Parliament), to advocate the development of palliative care in interprofessional primary care.

Results: The advocacy part of our project has reinforced the collaboration between our MPHcI, a palliative care network (at home) and a palliative care mobile team in a local hospital. Expected results of research should be a better access to palliative care for patients with palliative needs (with a general impact on quality and safety in care).

Conclusions: Interprofessional primary care might play a prominent role in access to specialist palliative care. A well-conducted assessment shall nevertheless precede any wider dissemination.

Abstract number: P514.3
Abstract type: Parallel Session

Building Bridges between the Delivery of Primary and Secondary/tertiary Palliative Care - Development of an Integrated Model of Palliative Care Service Delivery in Serbia

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Background: In 2009, the MoH in Serbia published a National Strategy for Palliative Care (PC), which acknowledged the need for PC services to be integrated into the government health system. This was developed throughout Serbia. Therefore a model of PC service delivery was developed to meet the needs of the culture, community and health system, whilst ensuring that it is provided at all levels of care.

Method: A process for the development of the model was agreed with the MoH and included: a review of the literature on models of PC delivery, the PC strategy, international and European standards and norms, a field study at primary and secondary levels; and a review of legislation.

Results: The model of care was developed by a group of PC and organisational development experts working alongside the MoH. The integrated model of PC service delivery includes the model document, a resource plan, quality indicators, standards of care, instruments for implementation and best practice guidelines. Thus the model addresses the essential elements of the setting/level of care, a description of services provided, types of patients seen, referral processes, linkage, staffing (eg, teamwork, management, co-ordination), institutional resources, access to medications, legislation, tools for implementation (eg, instruments, clinical protocols, standards, quality indicators), training and finance. These have been guided by the principles of access to palliative care for all, training on PC for all, the Government ensuring the policy and legislative frameworks needed, and that PC should be provided through inter-disciplinary teams.

Conclusion: An integrated model of PC service delivery has been developed for Serbia. Key components are the delivery of care at the different levels, with clear referral pathways between the primary and secondary / tertiary levels of care. The model has been officially approved by the MoH and work is ongoing for its implementation.

Abstract number: P514.3
Abstract type: Parallel Session

Developing and Evaluating Spiritual Care Training for Health Professionals

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Background: Many health professionals experience barriers to assessing spiritual needs, such as not having the right vocabulary. The Dutch ‘ans mortendi model’ might be a feasible tool for spiritual history taking in palliative care.

 Aim: To investigate the effect of a structured spiritual assessment on the spiritual wellbeing of palliative patients in home care.

Design: Cluster randomised controlled trial, conducted between February and October, 2013.

Patients and methods: Registered nurses and general practitioners approached eligible patients with an incurable, life-threatening disease for study participation. Health professionals allocated to the intervention arm of the study performed a spiritual assessment based on a mortendi model, following a training in spiritual assessment and the use of this model. Health professionals in the control arm provided care as usual. Patient-reported outcomes on spiritual wellbeing, quality of life, pain, and patient provider trust were assessed at two points in time.

Results: Two hundred and forty-five health professionals participated in the study (204 nurses and 41 physicians). Forty-nine patient-provider dyads completed the entire study protocol. The median age of the patients was 75 years (range 41 – 95 years) and 55% of the patients were female. There were no significant differences at any point in time in the scores on spiritual wellbeing, quality of life, pain, or patient provider trust between the intervention and the control group.

Conclusions: This cluster randomised controlled trial showed no demonstrable effect of spiritual history taking on patient scores for spiritual wellbeing, quality of life, health care relationship trust, or pain. Further research is needed to develop instruments that accurately assess the effectiveness of spiritual interventions in palliative care populations.

Abstract number: P515.2
Abstract type: Parallel Session

Assessment, Measurement, and Intervention: Learning from International Development and Validation of an EORTC Measure of Spiritual Wellbeing

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Background and aim: In 2002 the EORTC Quality of Life Group began an international project to develop a measure of spiritual wellbeing (SWB) for palliative cancer patients. The final phase, validation field-testing, ran in 2012–2014. The underlying theory for the study was SWB as subjective and individual, but with three broad domains: relationship with self, others, and religious, and existential. This paper considers some of the issues relating to data tools, collection, and analysis which arose for this international collaboration.

Methods: In initial study phases, collaborators translated all study documents into their own languages. For field-testing, collaborators translated all documents except the measure, which was professionally translated. Participants completed the provisional measure, then took part in a debriefing interview exploring their opinions regarding the items and asking them for their own definitions of a few items. Study collaborators translated data into English if needed.

Results: Collaborators and participants across the whole study were from 18 countries, with final field-testing involving 458 patients in 14 countries on four continents. The SWB measure was SWB as subjective and individual, but with three broad domains: relationship with self, others, and religious and existential; and distinctions between terms, eg, higher/greater. Items on God produced some polarised responses, notably in Japan and Iran.

Conclusions: Developing tools of this type is meaningful in multiple languages and contexts takes time and care, and a multi-cultural, multi-lingual focus from the outset. SWB is particular to each individual, and has some cultural distinctions. Thus the content of the measure cannot be exhaustive, but its qualitative traits prompt wider discussion and reflection on related issues.

Abstract number: P515.3
Abstract type: Parallel Session

Obtaining Funding and Developing Research in Existential Issues: An Example of a Programme of Research on Compassion in Canada

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Aims: Research investigating spiritual and existential issues has been identified as a research priority by palliative care researchers, clinicians and patients facing the end of life. Despite its putative centrality, obtaining funding, conducting original research, and translating research findings into clinical practice remains a persistent challenge. Compassion is recognised as a marker and medium of spirituality and humanism, by religious traditions and secular philosophers throughout the world. This session will describe the conceptualisation and implementation of an emerging program of research on compassion by a Canadian research team.

Methods: After providing a brief background of both the importance and challenges of conducting research within the spiritual/existential domains of palliative care, the rationale for a construct-based research approach will be provided. Two foundational studies, a qualitative study eliciting patients understandings and experiences of compassion and a scoping review of the compassion literature (in progress) will be utilised as case examples.

Results: A program of research on compassion serves as a potential model for conducting other construct based research on spiritual/existential issues by providing a common language that is accessible to patients and clinicians from diverse spiritual and philosophical backgrounds.

Conclusion: Compassionate care is a core principle of quality care, especially in palliative care. A construct-based research program on compassion, provides a focused, yet broadly applicable avenue for research and clinical practice into a domain of health that has been characterised as nascent, ephemeral and highly phenomenological.

Abstract number: P516.1
Abstract type: Parallel Session

Identifying Complicated or Prolonged Grief and the Role of Palliative Care Services in Supporting People

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Background/aim: Prolonged grief (PG) is proposed as a bereavement related diagnosis for the ICD-11 and treatments have shown increasingly effective. A framework for bereavement care based on evidence and equitable resource allocation seems to be supported. Yet, surveys of bereavement services show that bereavement programs struggle with few best practice models. The aim of our study was to assess prevalence of PG in relatives to deceased palliative care patients and investigate downstream effects of bereavement on healthcare utilisation to scrutinise the need for identification and treatment of CG.

Methods: This secondary analysis of the study on bereavement in consecutive patients receiving palliative care, conducted by our group over the past 10 years, will be presented. PG was defined using the PG diagnosis criteria of the DSM-V and prevalence was calculated. The impact of PG on health services utilisation to scrutinise the need for identification and treatment of CG, was performed by calculating the number of days in hospice care, emergency medical care visits, hospitalisations, days in intensive care, and days in nursing home. Differences were calculated using McNemar test.

Results: Data from 1560 patients was included (1072 non-CG and 488 CG (18.5%)). The prevalence of PG was found to be significantly higher in the CG group (26.4% vs 10.7%). The number of days in hospice care was significantly higher in the CG group (8 vs 2 days). The number of days in hospital care was significantly higher in the CG group (7 vs 3 days).

Conclusion: The prevalence of PG was significantly higher in the CG group. Further research is needed to develop instruments that accurately assess the effectiveness of spiritual interventions in palliative care populations.
Methods: A nationwide, population-based questionnaire study with the PG-13 scale was conducted to assess CP in a population losing a close relative to life-threatening illness. Furthermore, a nationwide, register-based case-control study was conducted to investigate the health care utilisation of persons losing a person to cancer.

Results: The first 1043 responses to the PG-13 showed a prevalence of N=64 (6%) according to diagnostic criteria and an additional N=49 (5%) with daily symptoms of bereavement-related distress (mean age=63 years (range 18-91), 69% women). The register-based study included 6.659 bereaved spouses and 66.590 matching controls (mean age=67 (range 23-89), 62% women). Healthcare utilisation showed a distinct increased use of general practice, referrals to psychologists and psychiatrists, as well as psychotropic medication for up to two years after the loss.

Conclusions: A questionnaire based identification, approximately 11% of bereaved relatives appear to be in need of treatment for CG symptoms. Further, register-based data show important downstream effects indicating serious effects on health and utilisation of services in the community. Bereavement care in palliative care settings seems to be in need of discussion of an organisational scope on how to ensure identification and treatment of bereavement-related distress.

Abstract number: PS16.2
Abstract type: Parallel Session

Reflections on the Effects of the Crisis in Greece on the Experience and Support of the Bereaved

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Over the past six years, Greece has experienced more extreme austerity than any other European country, a national budget deficit and a large debt, as well as a devaluation of the currency, which exposed Greece to the worst financial crisis in its modern history. The purpose of this presentation is threefold: (a) to briefly identify some new psychosocial phenomena in a population that is faced with several actual and ambiguous losses, incremental grieving, and uncertainty in their own reality and future; (b) to discuss how these phenomena seem to affect the grieving process of bereaved families; and (c) to raise awareness on the challenges that professionals encounter when caring for the dying and the bereaved, while facing personal and organisational threats or losses.

Reflections will be drawn from my experience at Metromm, a non-profit organisation for the care of children and families facing illness and death, which provides paediatric palliative home care services in Athens and family bereavement support across the country. Recommendations will address issues on how those of us who work in palliative and bereavement care can expand our thinking, our services, and collaborations in order to address the emerging needs of populations which encounter major hardships.

Abstract number: PS16.3
Abstract type: Parallel Session

Frameworks for Service Delivery

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Palliative care bereavement services developed in response to a largely unexpected demand from bereaved people for continuing support. Drawing on counselling models to prevent, or alleviate ‘complicated grief’, pioneering services typically involved volunteers as the main providers of counselling. The experience of grief following a close bereavement is a ‘normal’ part of life. In the UK a national framework developed recognising a need for information about grief for all, and a varying need for supportive or therapeutic counselling. In recent years attention has focused on recognising and responding to more complex expressions of grief and on increasing awareness and understanding of bereavement in the general public with the aim of developing more compassionate communities. This presentation will discuss the changing role of palliative care bereavement services in the context of: developments in our knowledge and understanding of bereavement and of grief trajectories; societal change; economic pressures. It will draw on experiences within the UK to help bereavement services to work together to provide a wide range of support across different settings to meet the diverse needs of bereaved people.

PS17
EAPC cancer pain management guidelines: update of pharmacological and non-pharmacological treatment recommendations, including guidance to assessment and classification

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Lack of standard diagnostic procedures is one important reason for inadequate cancer pain (CP). This underlines a need for standardisation of assessment and classification of CP. Two systematic literature reviews of CP assessment covering 1996–2003 and 2003–2008, respectively, and one on CP classification systems covering 1986–2006 have been conducted. A total of 91 pain assessment tools were identified. Six formal classification systems for CP were identified, however none of these were extensively applied in clinical practice or in research. For the basic assessment and classification of CP the following domains are at present recommended: pain intensity (by a 0–10 numerical rating scale), breakthrough pain, neuropathic pain, opioid response. Existing evidence and an international Delphi process resulted in consensus on 31 core variables for describing a cancer palliative care population including symptom assessment; the EAPC Basic Dataset. The EAPC Opioid Guidelines from 2012 did not include recommendations regarding assessment and classification. In the revised version of 2015 this topic will be covered. A new systematic literature review on CP assessment and classification is ongoing; results will be presented. Existing evidence and expert opinions will form the basis for recommendations on the most appropriate and the optimal number of domains to include, how they should be assessed, and the appropriate outcomes.

A comprehensive formalised system for CP assessment and classification applying international guidelines is expected to improve CP treatment in the future. A computer based communication tool and decision support system, Eir, will be important in its implementation into clinical practice.

Abstract number: PS17.2
Abstract type: Parallel Session

Latest Developments in the Evidence-based EAPC Cancer Pain Management Guidance on Pharmacological Therapies

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In this session I will update the development of the revised version of the EAPC cancer pain management guidelines, based on their previous version published in Lancet Oncology 2012, followed by the work done by the EAPC research network working Group on pain guidelines in the last three years. The EAPC guidelines are evidence-based and follow the GRADE system. After the last release of the EAPC opioid recommendations it was decided to broaden the scope of the guidelines to cancer pain management in all aspects, from assessment and classification to invasive analgesic techniques. The area of pharmacological therapies was made more comprehensive, including the use of non opioid anti-inflammatory agents, steroids, ketamine, tapentadol, bisphosphonates and decomumab. All other previously presented topics were updated to 2014 by systematic literature reviews and the related revised presentations will be in order to provide, together with the other speeches included in this EAPC cancer pain guidelines session, the whole content and the status of development of the next release.

Abstract number: PS17.3
Abstract type: Parallel Session

Latest Developments in Invasive Analgesic Therapy Recommendations for Cancer Pain According to the Updated EAPC Guidelines and Future Perspectives

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The presentation will be based on three systematic reviews: 1) analgesic efficacy and side effects of opioids +/- adjuvant analgesics delivered by spinal route in patients with cancer; 2) analgesic efficacy of sympathetic blocks in adult patients with cancer; 3) analgesic efficacy of peripheral nerve blocks in adults patients with cancer.

Methods: Search strategies were built with relevant terms and the search was performed in PubMed, EMBASE, and Cochrane to Feb 2014. All selected studies were analysed according to the GRADE recommendations.

Results: Ad 1) The number of abstracts retrieved for full reading was 84. The final selection comprised nine randomised controlled trials (RCTs). Sixteen combinations of opioids +/- adjuvant analgesics compared with spinal administration of opioids alone (n=4); single spinal drug in bolus compared with continuous administration (n=2); single spinal drug compared with spinal placebo (n=1); and spinal opioids without adjuvant analgesics compared with comprehensive medical management (n=2). Ad 2) Regarding cervical plexus block (CPB) 155 papers were retrieved out of which 27 controlled studies were considered for evidence examination. Forty four papers about different approaches for CPB were selected, but only one controlled study of superior hypogastic plexus block (SHPB) was found. Ad 3) The number of abstracts retrieved was 155. No controlled studies were identified. Sixteen papers presented a total of 79 cases. The blocks applied were paravertebral blocks (10 cases), blocks in the head region (2 cases), plexus blocks (13 cases), intercostal blocks (43 cases) and others (31 cases).

Conclusions: Ad 1) Heterogeneous characteristics and several methodological limitations resulted in evidence of low quality and a weak recommendation for spinal administration. Ad 2) CPB could be weakly recommended in patients with pancreatic cancer pain. Ad 3) Peripheral blocks is based upon anecdotal evidence.
Palliative Care Accessibility in Long Term Care Facilities (LTCFs) in Different EU Countries

Van den Block L., Deliens L., Froggatt K., Morley H., Payne S., Van Den Noortgate N.

Abstract number: PS18.2
Abstract type: Parallel Session

Challenges in Comparing Quality of Palliative Care in Long Term Care Facilities (LTCFs) in Different EU Countries


Abstract number: PS18.1
Abstract type: Parallel Session

An Innovative Intervention to Improve Palliative Care in Long Term Care Facilities in Europe: A Cross-cultural Adaptation


Abstract number: PS18.3
Abstract type: Parallel Session

Palliative Care Accessibility in Long Term Care Facilities (LTCFs) in Different EU Countries


Abstract number: PS18.2
Abstract type: Parallel Session

Building Bridges for Providing Better Education in Spiritual Care

Pais P.

Abstract number: PS19.1
Abstract type: Parallel Session

Improving quality of palliative care in long term care facilities in Europe: first results from an EU funded project PACE (FP7)

Abstract number: PS18.1
Abstract type: Parallel Session

Developing palliative care in long-term care settings: an innovative intervention to improve health care professionals’ spirituality and religious practice

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Since the 1980s, when publications focusing on the meaning, definition and assessment of spirituality began to emerge in health related literature there has been a significant rise in spiritual care training provided to health care professionals. Recent studies have pointed out that despite some ‘uncertainty and fear surrounding the boundaries between personal belief and professional practice’ healthcare professionals have genuine interest in providing spiritual care and building a relationship with their patients. Nevertheless, it remains a burning topic; how, when, to whom, and to what extent spiritual care training should be provided.

This presentation aims to appraise the evidence on aims and outcomes of spiritual care training in order to support the spiritual care curriculum development in an academic and clinical setting. It contrasts and combines the results from different studies in order to identify common challenges and advantages. Providing training in spiritual care to healthcare professionals is one way to integrate the aspect of spirituality in comprehensive patient care. Considering the need for a change in culture and development of an empirical basis for spiritual care, the Education Subgroup has proposed a list of recommendations for providing better education in spiritual care.

Accordingly, we encourage all the members of the EAPC to carefully review their provision of spiritual care education and invest time into the delivery of training in classrooms or on line and in on-going support through performance assessment and reflective practice.


Pais P, Legec G, Goodhead A, EAPC Enquiry on Spiritual Care Education. European Journal of Palliative Care, 2015. 22(2)
Parallel Sessions

literature to inform care planning and the developments of standards. The review demonstrates gaps in the evidence, but they make some salient recommendations. The EAPC Taskforce has offered a working definition for the term ‘spirituality’ and also completed a survey (Selman et al. 2014./Pain and Symp Mgt 48(4) 518–531) which sought to establish research priorities in spiritual care from the perspective of researchers and clinicians.

In addition to this survey an InSpirit International focus group study was developed (lead investigator Lucy Selman) with the aim of exploring experiences of spiritual care preferences of patients and carers, leading to further clarification of research priorities. Some of the findings from this study will be reported.

A future strategy? Key to developing an international evidence base will be:

- Agreement on research priorities and focus
- Clarification of appropriate methodological approaches
- Multi-professional collaboration
- The adoption of a pan European / global approach in order to further develop a network of key researchers in this field
- Funding, which may easier to attract if planned studies are multi-professional and international

Abstract number: PS19.3
Abstract type: Parallel Session

Spiritual Care Quality: The Measure of It

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Background: Spirituality is a dimensions inherent to the person. An individual’s health and well-being benefit when it is addressed. Spirituality receives great attention; attempts to define it having resulted in important advances to achieve consensus. Measurable Spiritual Care is fundamental to Palliative Care provision.

Aim: To conceptualise Spiritual Care by evaluating whether current definitions are fit for purpose and to assess whether its provision can be measured and by which means. A mixed methods study design approach was used: Systematic literature review between 1980 and 2014 focusing on Spiritual Care Quality Measurement; Descriptive analysis of European Implementation Survey; Retrospective Analysis of Spirituality fields in the Protocols of Electronic Palliative Care Medical Records; Analysis of survey undertaken by the 24Hour PC Team.

Results: We found that offering spiritual care is a top concern for professionals. Spiritual Care represents a variety of matters, from assessment to therapy and planning. Implementation efforts are hindered by culturally sensitive spiritual activity. 32% of patients had needs of such complexity that they needed specialist PC. 34% had data on spiritual sphere recorded (39% expressed through religious faith and belief). Its assessment is documented in 14% of cases.

Discussion: Questionnaires focused on spiritual activity, engage the focus of professionals. Spiritual Care demands excellent communication. Providing an objective account of the care provided demands flawless documentation within the extended team. Unresolved tension between the subjective and the objective aspects can be an obstacle.

Conclusion: Spirituality is well defined. Spiritual Care is not: internationally agreed definition and scope are needed. Implementation needs strong cultural background, combined with accredited activities and criteria. Documentation of all Spiritual Care activity guarantees robust outcomes measurements, contribute to improve its provision and quality care.

Abstract number: PS20.1
Abstract type: Parallel Session

The Editors’ Perspective

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Aim: To present the perspective of a journal editor on ensuring a submitted manuscript has international relevance.

Content: This presentation will draw from the presenter’s experience of editing the EAPC research journal ‘Palliative Medicine’, an international research journal. Palliative Medicine has readers from every continent, and in the last 6 years has received submissions from 53 different countries. However, not every submission is written to be suitable for this international audience.

Research findings may have broad international applicability and interest irrespective of the local or national context within which data were collected. It is important that the needs of a wide international readership are considered when reporting research findings. The editors can inform practice, policy and further research in wider contexts, and avoid needless duplication of research. This presentation will take an editor’s perspective to explore what journals look for and expect in a submitted manuscript to enhance its international relevance. Issues explored will include debates about language, claims; understanding the context of other readers; and drawing from international policy and research literature. The requirement for a clear message from your research will be discussed, and how to work with a journal to facilitate international dissemination including the use of social media. Researchers should be enabled to better draw out international learning from their own work.

Abstract number: PS20.2
Abstract type: Parallel Session

The Research Perspective: Planning and Conducting Research to Have International Resonance

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This presentation will draw from the researcher experience of planning and conducting palliative care research. Palliative care and hospice care can mean very different things across countries. It might refer to different services, to different professionals, to different educational backgrounds, to different patient groups, etc. In order to make a study and paper suitable for an international audience, a researcher has to know the international literature, but also has to understand similarities and differences between palliative care services and processes between different countries.

However, most palliative care practices share the same values, attitudes, knowledge, skills and competences. In order to set up research with international resonance, one needs to reflect about these ‘generic issues’ that are addressed in a palliative care study in a particular country. Hence, researchers need to reflect about the potential for generalisation of their results for other countries. But also when conducting international comparative research, the comparability of health services and processes between countries need to be made explicit in the research. In reporting the research, the researchers need to take these issues into account when developing the manuscript.

A number of issues will be highlighted in the presentation. How much (national) context do we have to present in the introduction section of the paper? How much context needs to be made explicit in the method section? How much international relevance of your study needs to be addressed in the discussion section? What is the advantage of conducting international research?

Planning: Research in palliative care involves a large amount of resources and time. Hence, making an effort in order to gain international resonance will be a marginal additional effort in the whole research process, but your work will have potentially a substantial higher impact.

Abstract number: PS20.3
Abstract type: Parallel Session

Building Bridges between Countries: Reporting Research to Have International Resonance. The Reviewers Perspective

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A journal with international readership and authors will have international reviewers and we all want our papers accepted into higher impact journals, yes even the reviewers. This presentation will use the experience of Palliative Medicine, the EAPC’s Research Journal to give perspective on what authors can do to assist in the review process. The review process starts with the Editors who in fact make a decision as to whether to send the paper out for external review. So ensure that the journal is a good match for your paper. Examples of both good and poor matches will be presented. Language is critical and discussions on the importance of this, especially in Europe will be given.

Dealing with issues: Are the reviewers understanding the context of your clinical situation. It is important to describe the context in your country and perhaps even make a comparison to another leading country in which other similar research has been conducted. This can be challenging in the face of a word limit. Review your own paper or have others who are not overly familiar with the work review it. Posing and answering the weaknesses and challenges within your paper, assist the reviewer. Stating the impact and importance of your paper on the international readership, can assist the reviewer in seeing the importance of your paper.
Meet the Expert

Sessions

ME01 Family carers: evidence based practice
ME02 Electronic palliative care coordination and decision support systems
ME03 Palliative care for people with heart failure
ME04 Developing the relationship between palliative care and neurology
ME05 How to implement evidence based medicine (EBM) into clinical practice. A clinical and health policy perspective
ME06 Quality improvement in palliative care with the help of indicators: the EU-funded IMPACT project
ME07 European Palliative Care Academy – Leadership Course
ME08 Core competencies in palliative care social work: key points from the EAPC White Paper; The roles and tasks of palliative care social workers: their views
ME09 Global palliative care development and the WHA resolution on strengthening palliative care
ME10 Improving spiritual care in clinical practice
ME11 What is known about specialist education for palliative medicine?
ME12 The science of planning and conducting clinical research in palliative care
ME13 The use of steroids in cancer patients with advanced metastatic disease
ME14 Integrated palliative care
ME15 Palliative care in prisons and correctional facilities
ME16 The future of hospice and palliative care from a volunteering perspective
Meet the Expert

ME01
Family carers: evidence based practice

Abstract number: ME01.1
Abstract type: Meet the expert

Family Carers: Evidence Based Practice

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Providing support for family carers is a core element of palliative care provision. However, systematic reviews have highlighted the need for more evidence based interventions to assist family carers. This expert session will focus on:
1) Why more needs to be done to improve family carer support
2) Challenges faced by family carers and health professionals associated with supporting family carers
3) Examples of evidence based family carer.

ME02
Electronic palliative care coordination and decision support systems

Abstract number: ME02.1
Abstract type: Meet the expert

EIR – An Electronic Decision Support Tool in Oncology

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The European Palliative Care Research Centre has recently conducted a clinical trial (Combat study) employing computerised clinical decision support tools developed in close collaboration with software engineers. Patients completed an electronic questionnaire on an iPad. This data was wirelessly transferred to the desktop PC employed by the clinician and this system also provided electronic decision support for the clinician. The results of this study will be published during 2014. We have further developed this software tool, called EIR, to the next level. In EIR, patients complete an electronic questionnaire by smart phone, tablet or desktop PC. The data is transferred and visualised on the desktop PC applied by the physician in a more intuitive and user friendly style compared to the initial version of the software tool. Additionally, we have developed more complex decision support tools. The content of the talk will focus on the advantages and pitfalls of computerised clinical decision support based on the EIR software tool.

Abstract number: ME02.2
Abstract type: Meet the expert

Coordinate My Care (CMC): A Pan London Clinical Service

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CMC is a clinical service created by NHS clinicians, for NHS patients. It offers a digital Personalised Urgent Care Plan to patients living in London and Surrey Downs. CMC was set up to improve the identification and coordination of care for palliative care patients who depend on multidisciplinary teams, across acute, community and the voluntary sectors. It is now offered to all vulnerable patients with complex needs. All patients consent to having a CMC care plan, or they may be consented in best interest if they lack capacity. CMC can be accessed by all the urgent care services 24/7, thus vital information is accessible during the out of hours period that represents two thirds of the week. When a CMC urgent care plan is created the Urgent care services are immediately alerted. These services include 111, the out of hours GP service covering the patient, the patient’s own GP and the Ambulance service. Currently 19,817 patients have CMC urgent care plans CMC records, of whom 7,970 have died. In England 54% of patients die in hospital1, however, for those with a CMC record the number drops to the lowest nationally at 17% dying in hospital and 79% dying in their preferred place. On average, there is a £2,100 saving per patient with a CMC plan by reducing unnecessary emergency admissions and hospital transfer costs.2 Patients will soon be able to access their care plans on their smart phones. CMC thus improves quality of care and decreases costs.

References:
[1] National End of Life Care Intelligence Network (2008-10)

ME03
Palliative care for people with heart failure

Abstract number: ME03.1
Abstract type: Meet the expert

Unmet Needs in Patients with Heart Failure at End of Life

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Heart failure is highly prevalent, particularly in resource rich countries. Throughout the world, heart failure without an identifiable aetiology carries an extremely poor prognosis despite the medications that are available to manage heart failure and the option in some settings of even considering transplantation. The needs of people with heart failure are not dissimilar to any other group within the community - symptom control is crucial, optimising function including mobility is important and ensuring that the other domains that are valued at the end of life are facilitated by excellent attention to detail. Likewise, caregivers of people with heart failure have very similar needs to other caregivers for people at the end of life. This suggests that there is a 'final common pathway' leading to death that generates similar issues for patients and their caregivers almost irrespective of the underlying disease process. Cachexia, fatigue, dyspnoea, pain and sleep disturbance are all prominent symptoms, however much more work needs to be done to understand their impact longitudinally in heart failure.

The next 10 years will bring enormous opportunity to understand in more detail through rigorous research the issues faced by people with heart failure as their life limiting illness.

Abstract number: ME03.2
Abstract type: Meet the expert

Patients with Implanted Electronic and Mechanical Devices Approaching Death

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Cardiovascular implantable electronic devices (CIED) encompass pacemakers, implantable cardioverter defibrillators (ICDs) and cardiac resynchronisation therapy (CRT) devices. Some of them function continuously; others monitor rhythm, and only intervene if the device recognises rhythm disturbances. These devices change the trajectory not only of life, but also death, often in a painful manner. The rate of ICD implantations exceeds 30,000 per month worldwide. Every person with a device will eventually die, the majority having a potentially recognisable terminal phase of life. Modification of the activity of the device may improve the quality of dying. Decision-making regarding modification device activity confronts patients, relatives and health care professionals with many challenges. The possibility of modifying device activity in situations where potential intervention no longer fits possible goals should be discussed in advance, optimally while obtaining consent for device implantation. Currently, less than 1% of patients with ICDs draw up advance directives embracing issues in respect of ICD activity. Most patients with an ICD approach death with a fully active device. About 20% of them experience shock therapies in the last few days or even hours of life. The deactivation of these devices is possible in an emergent manner using a magnet.

Implantable mechanical devices - ventricular assist devices (VADs) or artificial hearts – are becoming an increasingly common alternative to heart transplantation. They however, generate difficult end-of-life dilemmas. The appearance of a lethal pathophysiology defines permeability of withdrawing device support. Turning off a VAD is emotionally challenging, because it is a life-terminating intervention.

The European Society for Palliative Care and Heart Failure Association have created a Joint Task-Force to address palliative issues in adults with advanced heart failure.

ME04
Developing the relationship between palliative care and neurology

Abstract number: ME04.1
Abstract type: Meet the expert

Developing the Relationship between Palliative Care and Neurology

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A joint working group of the European Association for Palliative Care and the European Federation of Neurological Societies (now the European Academy of Neurology) has produced a Consensus paper on the available evidence for the palliative care in progressive neurological disease, including ALS, multiple sclerosis, Parkinson’s disease, stroke and primary brain tumours.

The seven main areas of recommendation are:
1. Palliative care should be considered early in the disease trajectory.
2. The assessment and care should be provided by a multidisciplinary team approach, with
access to specialist palliative care.
3. Communication should be open with patients and families and advance care planning is recommended. This should be as soon as possible in view of the likelihood of difficulties in communication and the development of cognitive changes in several neurological disorders.
4. Symptoms – physical and psychosocial – should be managed actively and appropriately.
5. Care needs should be assessed and cases supported before and after death. Professional carers should receive education, support and supervision to reduce the risks of emotional exhaustion.
6. There should be repeated and continued discussion about end of life issues and discussion of patients’ wishes and aims. The recognition of the deterioration and dying phase will allow appropriate management and intervention.
7. Palliative care principles should be included with the training and continuing medical education of neurologists and palliative care professionals should understand the issues for neurological patients.
These recommendations have been developed with the aim of improving knowledge and understanding of palliative care for patients with progressive neurological disease. There is now the opportunity to look at developing the relationship between palliative medicine and neurology to ensure that these principles are extended as widely as possible to support patients and their carers.

ME05 How to implement evidence based medicine (EBM) into clinical practice. A clinical and health policy perspective

Abstract number: ME05.1
Abstract type: Meet the expert

Hogston L1, Costantini M2
1King’s College London, Department of Palliative Care, Policy & Rehabilitation, London, United Kingdom; 2IRCCS Arcispedale S. Maria Nuova, Reggio Emilia, Italy

Evidence-based practice (EBP) is the conscientious and judicious use of current best evidence in conjunction with clinical expertise and patient values to guide health care decisions. Best evidence includes empirical evidence from systematic literature reviews, randomised controlled trials, descriptive and qualitative research. Lower levels of evidence, such as case reports and expert opinion, are also used. More than 20 years have passed since an evidence-based medicine working group announced this "new paradigm" for teaching and practicing clinical medicine. They proposed tradition, anecdote, and theoretical reasoning from basic sciences would be replaced by evidence from high quality studies, in combination with clinical expertise and the needs and wishes of patients. However, implementing evidence-based medicine in palliative care practice and policies encounters challenges including: level of available research evidence, judgement of evidence, keeping up to date, how evidence is balanced with clinical expertise and patient values, too much evidence, distortion of the brand and the suitability for those with multi-morbidity and/or approaching the end of life.
This meet the expert’ session will discuss how approaches in evidence-based medicine compare with the seven common alternatives: eminence based medicine, vehemence-based medicine, eloquence-based medicine, providence-based medicine, diffidence-based medicine, nervousness-based medicine and confidence-based medicine. The session will then go on to debate how fit for purpose evidence-based medicine is for palliative care and the implementation of real evidence-based medicine into practice and policy. Participants are encouraged to bring current challenges for discussion.

ME06 Quality improvement in palliative care with the help of indicators: the EU-funded IMPACT project

Abstract number: ME06.1
Abstract type: Meet the expert

IMPACT: Improving the Organisation of your Palliative Care Setting
Engels Y1, Radbruch L2
1Radboud UMC, Anesthesiology, Pain, Palliative Medicine, Nijmegen, Netherlands; 2Universitystiklinikum Bonn, Zentrum für Palliativmedizin, Malteser Krankenhaus Seliger Gerhard Bonn, Germany

Background: In the past decade, several sets of quality indicators (QIs) for palliative care have been developed. Yet, mostly these indicators are meant for one type of setting (e.g. intensive care units), one patient category (patients with cancer), focus on clinical outcome or clinical processes (e.g. pain level), are limited to the terminal phase and are developed in one specific country. Besides, just developing QIs does not change practice. A structured improvement project is needed.
Methods: We took account of all above-mentioned considerations in our European IMPACT project, in which professionals in palliative care and researchers collaborated. We performed a literature study, focus group interviews, a modified Rand Delphi procedure, a pilot with implementation processes in 40 settings in five European countries (NL, D, I, No, UK) and a nominal group session.
Results: We developed models for the organisation of palliative care, developed QIs for the organisation of palliative care settings, and strategies to improve the organisation of the setting (primary care, hospice, nursing home or hospital). The QIs were used to select topics and aims for quality improvement projects, and to monitor change, in several types of settings and for several patient categories in five countries, and anticipated further dissemination and implementation of our tools.
Conclusions: Theory and practice were combined in this project, as well as cancer and dementia palliative care. We did not stop after QIs were developed, but also developed strategies to use them for quality improvement. With the results of this project we provide scientifically sound, practice-friendly tools to improve the organisation of settings that deliver palliative care all over Europe.

ME07 European Palliative Care Academy – Leadership Course

Abstract number: ME07.1
Abstract type: Meet the expert

The European Palliative Care Academy: Creating Leaders in Palliative and End of Life Care
Koffman J1, Ubic B2, Mosso D3, Knakevoo P4
1King’s College London, Palliative Care, Policy and Rehabilitation, London, United Kingdom; 2University Hospital Cologne, Department of Palliative Medicine, Cologne, Germany; 3Hospice Casa Sperantei, Brasov, Romania, 4Nicolaus Copernicus University, Torun, Poland

Across Europe, palliative care is an increasingly important public health issue due to population ageing, the increasing number of older people dying from advanced diseases, and insufficient attention to their complex needs, and their families. Developing a highly skilled workforce is critical if we are to best serve this population. The European Palliative Care Academy represents a joint venture to train emerging leaders in palliative care across Europe to advance palliative care, and to address future challenges in this important field. Generously funded by the Robert Bosch Foundation, it comprises four highly acclaimed European academic centres: University Hospital Cologne (Germany), Nicolaus Copernicus University in Torun (Poland), Hospice Casa Sperantei in Brasov (Romania) and King’s College London (United Kingdom). In this session we will explain the philosophy and content of this exciting new course, describe the successes of our first cohort of course participants, and address any questions from prospective students.

ME08 Core competencies in palliative care social work: key points from the EAPC White Paper; The roles and tasks of palliative care social workers: their views

Abstract number: ME08.1
Abstract type: Meet the expert

Core Competencies in Palliative Care Social Work: Key Points from the EAPC White Paper; The Roles and Tasks of Palliative Care Social Workers: Their Views
Hughes S1, Birsna KAW1
1Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom; 2Caritas Vorarlberg (Austria), Hospice Austria, Feldkirch, Austria

The EAPC Task Force on Palliative Care Social Work was set up to examine the diverse roles and tasks of palliative care social workers across Europe. This task was conceived as a prelude to developing core curricula for the education of all social workers with a palliative care remit. To that end, members of the Task Force consulted with social workers across the European continent, looked at the developments and history of social work as a specialism within palliative care – where this had occurred, and considered the emerging literature on the role, particularly that from North America but also further afield. The resulting paper:

Meet the Expert Sessions
Core competencies for palliative care social in Europe: an EAPC White Paper, was published in two parts in recent months. A White Paper is essentially a discussion document meant to stimulate debate and is not intended as the final word on the subject. In his session, Sean Hughes, one of the co-authors of the paper, will begin by outlining some of the key concepts within the article and highlight some areas for debate and consideration. Karl Bitchou will follow with a short presentation on more recent developments led by the Task Force, in surveying social worker views on their palliative care tasks and roles. He will summarise key findings from this work and will conclude with an outline of next steps in the process. We anticipate that these two presentations will stimulate much discussion and will therefore allow time in this short session for comments, questions and participation from the audience. This session will be of particular interest to social workers, but in a spirit of collegiality we welcome colleagues from all our partner disciplines to join us in our deliberations.

ME09

Global palliative care development and the WHA resolution on strengthening palliative care

Abstract number: ME09.1
Abstract type: Meet the expert

Global Palliative Care Development and the WHA Resolution on Strengthening Palliative Care

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In this expert session participants will hear about the latest developments and plans for the WHO to implement the recent resolution “Strengthening of Palliative Care as a Component of Comprehensive Care Throughout the Life Course.” This resolution, passed at the World Health Assembly (WHO’s governing body) last May, is a major turning point in the global development of palliative care. Countries agreed to call on themselves to include palliative care in all major health policies, to improve the availability of essential palliative care medications, to bring palliative care education into health care professional training at all levels, to begin to fund palliative care program implementation, to do more research on palliative care and more. WHO itself is called on to provide guidance to countries on palliative care development and the WHA resolution on strengthening palliative care. An Ad Hoc Technical Advisory Group has been formed to assist WHO in plans for implementation and a strategic plan has been developed to guide work in the coming years. Learn what other countries are doing, and how you can use this opportunity to spur palliative care development in your own country, how to monitor progress and how to use the Global Atlas of Palliative Care at the End of Life to benchmark progress.

ME11

What is known about specialist education for palliative medicine?

Abstract number: ME11.1
Abstract type: Meet the expert

What is Known about Specialist Education for Palliative Medicine?

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Where is palliative medicine (PM) a specialty? Is it currently a specialty in any country in Europe? PM professionals have heard such questions before. The worst of all is that often the answers have been vague and we had no clear idea of where and how doctors working full-time in PM could obtain advanced training qualifications. PM is a new, growing specialty addressed to oncological and non-oncological patients. The session presents the results of a pan-European WHO region (53 countries) expert survey promoted by University of Navarra and Accademia delle Scienze di Medicina Palliativa in Bologna, through a comparative analysis of the programmes on specialisation in PM (published as a Supplement of the EAPC Atlas of Palliative Care in Europe and by the Journal of Pain and Symptoms Management). In Europe, 18 countries had official specialisation programmes. Advanced training in PM is formally recognised by awarding the qualifications of specialist, sub-specialist or other equivalent qualifications. There is a tendency not to create new specialties in Europe. On average, it takes one to two years of clinical training for formal recognition of the specialisation. There is a tendency to obtain certain posts in health services only with specialisation.

The session will strengthen the debate on this issue, believing that achieving an official qualification for medical practice represents a huge step forward for palliative care as a discipline, for its formal introduction at universities, and for the defence of professionals and the safety of patients. Although 18 countries is a fair number, there are still 35 countries in which no specialisation process has been established. The session, along with the scientific publications on this issue, may encourage those health services to progress in this direction. Moreover, the session may explore the interest of pursuing optional quality evaluations in clinical practice or European qualifications.

ME10

Improving spiritual care in clinical practice

Abstract number: ME10.1
Abstract type: Meet the expert

Improving Spiritual Care in Clinical Practice

Busch C., Leget C.
1Ghent University, Medical Oncology, Gent, Belgium, 2Norwegian University of Science and Technology (NTNU), Trondheim, Norway
Presenting author email address: luc.deliens@vub.ac.be

In this session we begin with a short introduction on the state of the art of spiritual care in clinical practice as observed by the spiritual care taskforce of the EAPC. Subsequently, we will present some examples of how to improve spiritual care in clinical practice. Those who are present are invited to share their experiences from different contexts and exchange questions and answers.

ME12

The science of planning and conducting clinical research in palliative care

Abstract number: ME12.1
Abstract type: Meet the expert

The Science of Planning and Conducting Clinical Research in Palliative Care

Deliens L.
1Ghent University, Medical Oncology, Gent, Belgium, 2Norwegian University of Science and Technology (NTNU), Trondheim, Norway
Presenting author email address: luc.deliens@vub.ac.be

Planning: Research in palliative care involves a large amount of money and one or more grant preparations and applications. The process of building a consortium or research team, designing grant application(s) and reviewing(s) and negotiating contracts will take at least a year. When you have mobilised enough resources, researchers have to be recruited and selected, a full protocol written, and all procedures for data collection developed and tested, and you have to prepare and get approval from ethics committees and sometimes from other data protection agencies. At that stage, you have still not collected any data for your study, and another year may have passed. If it is your aim to conduct a full PhD trajectory, this will require three to five years in general. Hence, planning of research in palliative care requires time.

Successfully conducting: Research in palliative care is difficult and requires good organisational conditions and personal research knowledge and skills (e.g. creativity, questionnaire development, sampling techniques, statistics, data analyses, scientific writing, multidisciplinary collaboration and team work). Being embedded in an academic multidisciplinary research environment is helpful, and implies supporting services (statistics, IT support, research methods training, PhD training etc). Furthermore, researchers need a positive attitude towards research in general, but also towards guidance from their supervisors. Above all, they will need perseverance.

In this meet the expert session, two experienced researchers will exchange and share their experiences with the participants. A number of issues will be highlighted and discussed. What do we have to know before planning a study? How can we optimise the team and research environment? How do we draft a good research protocol? What kind of specific problems and pitfalls are related to research in palliative care, and how can we best deal with these?
ME15
Palliative care in prisons and correctional facilities
Abstract number: ME15.1
Abstract type: Meet the expert
Palliative Care in Prisons and Correctional Facilities: Sharing Learning From Practice and Research
Turner M.1, Kolawoq R.2
1Lancaster University, Faculty of Health and Medicine, Lancaster, United Kingdom, 2Nicolaus Copernicus University, Torun, Poland
This session will present two examples of prison palliative care from the United Kingdom (UK) and Poland. In the UK, prisoners over the age of 60 are the most rapidly growing section of the prison population, and currently number over 1,500. Many older prisoners have multiple, complex health problems and increasing numbers of them will die in prison. Providing appropriate care for dying prisoners poses substantial challenges for health and discipline staff. Some prisoners have begun to respond by developing palliative care in a variety of ways; this presentation will draw on current research in considering recent developments and the implications for staff and prisoners. In Poland, a different initiative is underway in some correctional institutions to train selected prisoners to work as palliative care volunteers, providing care for patients in hospice-palliative care centres. When required, their fellow prisoners are placed in these facilities at the end of their lives. Key elements of this innovative development and research regarding prisoners as hospice volunteers will be presented.
Discussion will cover a range of issues relating to the challenges of providing palliative care in custodial settings and volunteering of prisoners. Suggested discussion topics will include:
- How the expectations of the volunteers themselves are changing
- Similarities and differences between countries are also discussed in terms of volunteering
- How the involvement of volunteers can be transformative, both in others there is still tension around whether and how they should be involved. Whilst there is some evidence to suggest that the involvement of volunteers can be transformative, both to their own lives and to the lives of those they support, volunteering in hospice and palliative care is still not well understood.

ME16
The future of hospice and palliative care from a volunteering perspective
Abstract number: ME16.1
Abstract type: Meet the expert
An Overview of Volunteering in Hospice and Palliative Care in Europe - Similarities and Differences
Scott R.
University of Dundee, Education, Social Work and Community Education, Dundee, United Kingdom
Presenting author email address: rscott@btinternet.com
Introduction: The aim of this session is to report on the work of the EAPC Task Force on Volunteering as it strives to develop a clearer understanding of volunteering and its demographics, structure and importance to hospice and palliative care in Europe. Volunteering in many countries in Europe has a close and integral relationship with hospice and palliative care. In some countries, volunteers have been the instigators of services whilst in others there is still tension around whether and how they should be involved. Whilst there is some evidence to suggest that the involvement of volunteers can be transformative, both to their own lives and to the lives of those they support, volunteering in hospice and palliative care is still not well understood.
Approach: Drawing upon the literature and early outcomes from Task Force work this session will consider:
- Various factors that influence the complex phenomenon that is volunteering, such as society, culture, demography, legislation and organisational structure and attitudes
- How the expectations of the volunteers themselves are changing
- How regulation can empower or inhibit
- Similarities and differences between countries are also discussed in terms of volunteering definitions and constructs, legislative and regulatory requirements, volunteering roles, activities, frameworks and training. Challenges that face volunteering in hospice and palliative care are also briefly considered.
Conclusion: As both hospice and palliative care and volunteering continue to develop, the changes in each have the potential to significantly influence the other. As volunteering is to be further developed and sustained, in the future, professionals and organisations must have a better understanding of this important component of hospice and palliative care and how the valuable contribution of volunteers can be maximised.

ME13
The use of steroids in cancer patients with advanced metastatic disease
Abstract number: ME13.1
Abstract type: Meet the expert
The Use of Steroids in Cancer Patients with Advanced Metastatic Disease
Fallon M.1, Soehn T.S.2
1Western General Hospital, University of Edinburgh, Edinburgh, United Kingdom, 2Norwegian University of Science and Technology St. Olavs Hospital, Trondheim University Hospital, Cancer Department, Trondheim, Norway
The use of steroids to treat multiple symptoms blindly, but based on the assumption of systemic and/or local inflammation, has been very common practice in palliative care. While in individual cases this can be a successful strategy, there is not a good evidence base for this approach. Commonly used will be discussed in this session.
The Challenges for Volunteering in Hospice and Palliative Care in Europe. What Does the Further Development of Volunteering Mean to the Hospice and Palliative Care Movement and its Core Values?

Pelttari L.
Hospice Austria, Vienna, Austria
Presenting author email address: leena.pelttari@hospiz.at

Introduction: Volunteers offer the gift of presence, different skills, experience and time. In some countries, they are, and will continue to be, essential to providing hospice and palliative care services, whilst in some, like Germany and Austria, they are an integral part of a comprehensive highly professional hospice and palliative care setting. However, hospice and palliative care faces many challenges and alongside this a new generation of volunteers have different expectations of volunteering and some want to use their skills in different and more meaningful ways.

Approach: Based on the work of the EAPC Task Force on Volunteering in Hospice and Palliative Care, the aim of this session is to explore some of the challenges for volunteering and volunteers in hospice and palliative care by considering:

• How well volunteering values and principles are understood and how closely these relate to hospice and palliative care values
• The place of volunteers within the team and the relationships between volunteers and paid staff
• How to match the changing expectations of volunteers with the changing needs of organisations

This session will also reflect on how well the value of volunteering is recognised and whether enabling volunteers to use their skills to best advantage could add to the quality of life for patients and families. Often, the social support that volunteers can offer to patients and their loved ones is an important aspect of holistic care. How well is this considered as part of a package of care?

Conclusion: If volunteering is to be developed successfully in the future we must be able to match the changing needs of our patients, their families and our organisations with the changing expectations of the volunteers of tomorrow. If we succeed in doing this, we will retain the large and important contribution made by volunteers and may be able to embrace fully the values of hospice and palliative care.
Meet the Expert

Sessions

ME01 Family carers: evidence based practice
ME02 Electronic palliative care coordination and decision support systems
ME03 Palliative care for people with heart failure
ME04 Developing the relationship between palliative care and neurology
ME05 How to implement evidence based medicine (EBM) into clinical practice. A clinical and health policy perspective
ME06 Quality improvement in palliative care with the help of indicators: the EU-funded IMPACT project
ME07 European Palliative Care Academy – Leadership Course
ME08 Core competencies in palliative care social work: key points from the EAPC White Paper; The roles and tasks of palliative care social workers: their views
ME09 Global palliative care development and the WHA resolution on strengthening palliative care
ME10 Improving spiritual care in clinical practice
ME11 What is known about specialist education for palliative medicine?
ME12 The science of planning and conducting clinical research in palliative care
ME13 The use of steroids in cancer patients with advanced metastatic disease
ME14 Integrated palliative care
ME15 Palliative care in prisons and correctional facilities
ME16 The future of hospice and palliative care from a volunteering perspective
Meet the Expert sessions

ME01
Family carers: evidence based practice

Abstract number: ME01.1
Abstract type: Meet the expert

Family Carers: Evidence Based Practice

Providing support for family carers is a core element of palliative care provision. However, systematic reviews have highlighted the need for more evidence based interventions to assist family carers. This expert session will focus on:
1. Why more needs to be done to improve family carer support
2. Challenges faced by health professionals associated with supporting family carers
3. Examples of evidence based family carer.

ME02
Electronic palliative care coordination and decision support systems

Abstract number: ME02.1
Abstract type: Meet the expert

EIR – An Electronic Decision Support Tool in Oncology

The European Palliative Care Research Centre has recently conducted a clinical trial (Combat study) employing computerised clinical decision support tools developed in close collaboration with software engineers. Patients completed an electronic questionnaire on an iPad. This data was wirelessly transferred to the desktop PC employed by the clinician and this system also provided electronic decision support for the clinician. The results of this study will be published during 2014. We have further developed this software tool, called EIR, to the next level. In EIR, patients complete an electronic questionnaire by smartphone, tablet or computer. This data is transferred and visualised on the desktop PC applied by the physician in a more intuitive and user friendly style compared to the initial version of the software tool. Additionally, we have developed more complex decision support tools. The content of the talk will focus on the advantages and pitfalls of computerised clinical decision support based on the EIR software tool.

ME03
Palliative care for people with heart failure

Abstract number: ME03.1
Abstract type: Meet the expert

Unmet Needs in Patients with Heart Failure at End of Life

Heart failure is highly prevalent, particularly in resource rich countries. Throughout the world, heart failure without an identifiable aetiology carries an extremely poor prognosis despite the medications that are available to manage heart failure and the option in some settings of even considering transplantation. The needs of people with heart failure are not dissimilar to any other group within the community - symptom control is crucial, optimising function including mobility is important and ensuring that the other domains that are valued at the end of life are facilitated by excellent attention to detail. Likewise, caregivers of people with heart failure have very similar needs to other caregivers for people at the end of life. This suggests that there is a final common pathway leading to death that generates similar issues for patients and their caregivers almost irrespective of the underlying disease process.

ME04
Developing the relationship between palliative care and neurology

Abstract number: ME04.1
Abstract type: Meet the expert

Developing the Relationship Between Palliative Care and Neurology

A joint working group of the European Association for Palliative Care and the European Federation of Neurological Societies (now the European Academy of Neurology) has produced a Consensus paper on the available evidence for the palliative care in progressive neurological disease, including ALS, multiple sclerosis, Parkinson’s disease, stroke and primary brain tumours.

The seven main areas of recommendation are:
1. Palliative care should be considered early in the disease trajectory.
2. The assessment and care should be provided by a multidisciplinary team approach, with...
access to specialist palliative care. 3. Communication should be open with patients and families and advance care planning is recommended as soon as possible in view of the high likelihood of difficulties in communication and the development of cognitive changes in several neurological disorders. 4. Symptoms – physical and psychosocial – should be managed actively and appropriately. 5. Care needs should be assessed and carers supported before and after death. Professional carers should receive education, support and supervision to reduce the risks of emotional exhaustion. 6. There should be repeated and continued discussion about end of life issues and discussion of patients’ wishes and aims. The recognition of the deterioration and dying phase will allow appropriate management and intervention. 7. Palliative care principles should be included with the training and continuing medical education of neurologists and palliative care professionals should understand the issues for neurological patients.

These recommendations have been developed with the aim of improving knowledge and understanding of palliative care for patients with progressive neurological disease. There is now the opportunity to look at developing the relationship between palliative medicine and neurology to ensure that these principles are extended as widely as possible to support patients and their carers.

ME05
How to implement evidence based medicine (EBM) into clinical practice. A clinical and health policy perspective

Abstract number: ME05.1
Abstract type: Meet the expert

How to Implement Evidence Based Medicine (EBM) into Clinical Practice: A Clinical and Health Policy Perspective

Hogstonon ly, Costantini M. 1

1King’s College London, Department of Palliative Care, Policy & Rehabilitation, London, United Kingdom, 2IRCCS Arcispedale S. Maria Nuova, Reggio Emilia, Italy

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ME06
Quality improvement in palliative care with the help of indicators: the EU-funded IMPACT project

Abstract number: ME06.1
Abstract type: Meet the expert

IMPACT: Improving the Organisation of your Palliative Care Setting

Engels Y.1, Radbruch L.1
1Radboud UMC, Anesthesiology, Pain, Palliative Medicine, Nijmegen, Netherlands, 2Universitätsklinikum Bonn, Zentrum für Palliativmedizin, Malteser Krankenhaus Seliger Gerhard Bonn, Bonn, Germany
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Background: In the past decade, several sets of quality indicators (QIs) for palliative care have been developed. Yet, mostly these indicators are meant for one type of setting (e.g intensive care units), one patient category (patients with cancer), focus on clinical outcome or clinical processes (e.g. pain level), are limited to the terminal phase and are developed on one specific country. Besides, just developing QIs does not change practice. A structured improvement project is needed.

Methods: We took account of all above-mentioned considerations in our European IMPACT project, in which professionals in palliative care and researchers collaborated. We performed a literature study, focus group interviews, a modified Rand Delphi procedure, a pilot with implementation processes in 40 settings in five European countries (NL, D, I, FR, UK) and a nominal group session.

Results: We developed models for the organisation of palliative care, developed QIs for the organisation of palliative care settings, and strategies to improve the organisation of the setting (primary care, hospice, nursing home or hospital). The QIs were used to select topics and aims for quality improvement projects, and to monitor change, in several types of settings and for several patient categories in five countries, and anticipated further dissemination and implementation of our tools.

Conclusions: Theory and practice were combined in this project, as well as cancer and dementia palliative care. We did not stop after QIs were developed, but also developed strategies to use them for quality improvement. With the results of this project we provide scientifically sound, practice-friendly tools to improve the organisation of settings that deliver palliative care all over Europe.

ME07
European Palliative Care Academy – Leadership Course

Abstract number: ME07.1
Abstract type: Meet the expert

The European Palliative Care Academy: Creating Leaders in Palliative and End of Life Care

Koffman J., Ulbrtzke R., Mosoy D., Kniazevsk P.
1King's College London, Palliative Care, Policy and Rehabilitation, London, United Kingdom, 2University Hospital Cologne, Department of Palliative Medicine, Cologne, Germany, 3Hospice Casa Sperantei, Brasov, Romania, 4Nicolaus Copernicus University, Torun, Poland

Across Europe, palliative care is an increasingly important public health issue due to population ageing, the increasing number of older people dying from advanced diseases, and insufficient attention to their complex needs, and their families. Developing a highly skilled workforce is critical if we are to best serve this population. The European Palliative Care Academy represents a joint venture to train emerging leaders in palliative care across Europe to advance palliative care, and to address future challenges in this important field. Generously funded by the Robert Bosch Foundation, it comprises four highly acclaimed European academic centres: University Hospital Cologne (Germany), Nicolaus Copernicus University in Torun (Poland), Hospice Casa Sperantei in Brasov (Romania) and King’s College London (United Kingdom). In this session we will explain the philosophy and content of this exciting new course, describe the successes of our first cohort of course participants, and address any questions from prospective students.

ME08
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Abstract type: Meet the expert

Core Competencies in Palliative Care Social Work: Key Points from the EAPC White Paper; The Roles and Tasks of Palliative Care Social Workers: Their Views

Hughes S., Bistrzychna K.A.
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The EAPC Task Force on Palliative Care Social Work was set up to examine the diverse roles and tasks of palliative care social workers across Europe. This task was conceived as a prelude to developing core curricula for the education of all social workers with a palliative care remit. To that end, members of the Task Force consulted with social workers across the European continent, looked at the development and history of social work as a specialist within palliative care - where this had occurred, and considered the emerging literature on the role, particularly that from North America but also further afield. The resulting paper:
Core competencies for palliative care social in Europe: an EAPC White Paper, was published in two parts in recent months. A White Paper is essentially a discussion document meant to stimulate debate and is not intended as the final word on the subject. In his session, Sean Hughes, one of the co-authors of the paper, will begin by outlining some of the key concepts within the article and highlight some areas for debate and consideration. Karl Bittchnau will follow with a short presentation on more recent developments led by the Task Force, in surveying social worker views on their palliative care tasks and roles. He will summarise key findings from this work and will conclude with an outline of next steps in the process. We anticipate that these two presentations will stimulate much discussion and will therefore allow time in this short session for comment, questions and participation from the audience. This session will be of particular interest to social workers, but in a spirit of collegiality we welcome colleagues from all our partner disciplines to join us in our deliberations.

**ME09.1**

Global palliative care development and the WHA resolution on strengthening palliative care

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**ME11.1**

What is known about specialist education for palliative medicine?

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**ME12.1**

The science of planning and conducting clinical research in palliative care
ME13

The use of steroids in cancer patients with advanced metastatic disease

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The use of steroids to treat multiple symptoms blindly, but based on the assumption of systemic and/or local inflammation, has been very common practice in palliative care. While in individual cases this can be a successful strategy, there is not a good evidence base for this approach. As consequence of this, the long-term side effects of steroids may reduce the quality of life.

A recent RCT of steroids in pain published in JCO 2014, was negative1. In cancer cachexia, there are so far limited treatment options. Systemic steroids seem to improve appetite, while weight often is not significantly affected2. Unfortunately are side effects of long-term use of steroids severe.

The mechanism of action of steroids versus mechanism of symptoms where steroids are probably not helpful need to be investigated in individual cases this can be a successful strategy, there is not a good evidence base for this approach. While in individual cases this can be a successful strategy, there is not a good evidence base for this approach. As consequence of this, the long-term side effects of steroids may reduce the quality of life.


ME14

Integrated palliative care

Abstract number: ME14.1
Abstract type: Meet the expert

Towards Practice Based Evidence for Integrated Palliative Care

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Integrated care mostly focuses on giving the right care, at the right moment, at the right place, by the right caregiver. Integration can be focused on:
(a) delivery system integration, namely the barriers and opportunities in regulations and financing within the care system,
(b) functional integration, involving integration of the organisational structures that facilitate caregiving, eg collaborative teams, and
(c) clinical integration, aiming at integration at the level of daily care, e.g. joint work protocols.

The World Health Organization (WHO) definition of palliative care addresses integration by referring to psychological and spiritual aspects of patient care, a team approach to address the needs of patients and their families, and the applicability of palliative care early in the course of illness, in conjunction with other therapies. But exactly how elements of this definition can drive integrated care in practice needs further investigation in order to be able to identify good examples and best practices.

Our Integrated Palliative Care project (InsUpC; EU FP7) started with reviewing the literature, investigating the integration of palliative care in European guidelines for cancer and non-cancer as well as underlying care models. After that, a taxonomy of integrated care was developed. Currently, an international prospective multicenter patient study is performed. The experiences of patients, proxies and caregivers with integrated palliative care are investigated. This descriptive study also explores the caregiver network of patients. The data of this study will be mirrored against predefined propositions to identify good examples of integrated palliative care in Europe. Finally, an e-learning module will be developed to give a broad audience access to the results from the project and the lessons learnt.

Abstract number: ME14.2
Abstract type: Meet the expert

Building a Taxonomy of Integrated Palliative Care Initiatives: Results from an Expert Focus Group

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Background: Empirical evidence suggests that integrated palliative care (IPC) increases the quality of care for terminal patients and supports care givers. Existing IPC initiatives in Europe vary in their design and are hardly comparable. InSUpC, an EU research project, aimed to build a taxonomy of IPC initiatives applicable across diseases, health care sectors and systems.

Methods: The taxonomy of IPC initiatives was developed in cooperation with an international and multidisciplinary focus group. In a consensus conference, experts revised a preliminary taxonomy and adopted the final classification system.

Results: Consisting of eight categories, with two to four items each, the taxonomy covers the process and structure of IPC initiatives. If two items in at least one category apply to an initiative, a minimum level of integration is reached. Categories range from the type of initiative (items: pathway, model or guided to patients’ key contact); type of integrated care (items: non-PC specialist, PC specialist, GP); Experts recommended the inclusion of two new categories: Level of care (items: primary, secondary or tertiary) indicating at which stage palliative care is integrated and focus of intervention including IPC giver’s different roles (items: treating function, advising/consulting or training) in the care process.

Conclusion: The expert focus group broadened the scope of the InSUpC research team by co-creating a flexible and robust tool to evaluate IPC. Empirical studies will have to investigate how the taxonomy is used in practice and whether it covers the reality of patients in need of palliative care. InSUpC-C will use the taxonomy to identify initiatives of IPC that will be examined empirically.

ME15

Palliative care in prisons and correctional facilities

Abstract number: ME15.1
Abstract type: Meet the expert

Palliative Care in Prisons and Correctional Facilities: Sharing Learning from Practice and Research

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This session will present two examples of prison palliative care from the United Kingdom (UK) and Poland. In the UK, prisoners over the age of 60 are the most rapidly growing section of the prison population, and currently number over 1,500. Many older prisoners have multiple, complex health problems and increasing numbers of them will die in prison. Providing appropriate care for dying prisoners poses substantial challenges for health and discipline staff. Some prisoners have begun to respond by developing palliative care in a variety of ways; this presentation will draw on current research in considering recent developments and the implications for staff and prisoners. In Poland, a different initiative is underway in some correctional institutions to train selected prisoners to work as palliative care volunteers, providing care for patients in hospice palliative-care centres. When required, their fellow prisoners are placed in these facilities at the end of their lives. Key elements of this innovative development and research regarding prisoners as hospice volunteers will be presented.

Discussion will cover a range of issues relating to the challenges of providing palliative care in custodial settings and volunteering of prisoners. Suggested discussion topics will include: how the needs of dying prisoners can best be met within the constraints of a custodial environment, how the Polish model of prisoner volunteers might be used in other countries, training and support of prisoners and staff around palliative care, and whether prison can ever be an appropriate place to die.

ME16

The future of hospice and palliative care from a volunteering perspective

Abstract number: ME16.1
Abstract type: Meet the expert

An Overview of Volunteering in Hospice and Palliative Care in Europe - Similarities and Differences

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Introduction: The aim of this session is to report on the work of the EAPC Task Force on Volunteering as it strives to develop a clearer understanding of volunteering and its demography, structure and importance to hospice and palliative care in Europe. Volunteering in many countries in Europe has a close and integral relationship with hospice and palliative care. In some countries, volunteers have been the instigators of services whilst in others there is still tension around whether and how they should be involved. Whilst there is some evidence to suggest that the involvement of volunteers can be transformative, both to their own lives and to the lives of those they support, volunteering in hospice and palliative care is still not well understood.

Approach: Drawing upon the literature and early outcomes from Task Force work this session will consider:
- Various factors that influence the complex phenomenon that is volunteering, such as: society, culture, demography, legislation and organisational structure and attitudes
- How the expectations of the volunteers themselves are changing
- How regulation can empower or inhibit
- Similarities and differences between countries are also discussed in terms of volunteering definitions and constructs, legislative and regulatory requirements, volunteering roles, activities, frameworks and training. Challenges that face volunteering in hospice and palliative care are also briefly considered.

Conclusion: As both hospice and palliative care and volunteering continue to develop, the changes in each have the potential to significantly influence the other. As volunteering is to be further developed and sustained in the future, professionals and organisations must have a better understanding of this important component of hospice and palliative care and how the valuable contribution of volunteers can be maximised.
Introduction: Volunteers offer the gift of presence, different skills, experience and time. In some countries, they are, and will continue to be, essential to providing hospice and palliative care services, whilst in some, like Germany and Austria, they are an integral part of a comprehensive highly professional hospice and palliative care setting. However, hospice and palliative care faces many challenges and alongside this a new generation of volunteers have different expectations of volunteering and some want to use their skills in different and more meaningful ways.

Approach: Based on the work of the EAPC Task Force on Volunteering in Hospice and Palliative Care, the aim of this session is to explore some of the challenges for volunteering and volunteers in hospice and palliative care by considering:

- How well volunteering values and principles are understood and how closely these relate to hospice and palliative care values
- The place of volunteers within the team and the relationships between volunteers and paid staff
- How to match the changing expectations of volunteers with the changing needs of organisations

This session will also reflect on how well the value of volunteering is recognised and whether enabling volunteers to use their skills to best advantage could add to the quality of life for patients and families. Often, the social support that volunteers can offer to patients and their loved ones is an important aspect of holistic care. How well is this considered as part of a package of care?

Conclusion: If volunteering is to be developed successfully in the future we must be able to match the changing needs of our patients, their families and our organisations with the changing expectations of the volunteers of tomorrow. If we succeed in doing this, we will retain the large and important contribution made by volunteers and may be able to embrace fully the values of hospice and palliative care.
Free Communication sessions

FC01 Family caregivers
FC02 Pain and symptom management
FC03 Assessment and measurement tools
FC04 Children and international developments
FC05 Spirituality and social work
FC06 Ethics and concepts
FC07 Palliative care in non-cancer
FC08 Development and organisation of services
FC09 Older people, dementia and multimorbidity
FC10 Dignity, psychology and bereavement
FC11 Policy and economics
FC12 Medical sociology
FC13 Quality of life and symptoms
FC14 Communication and education
FC15 Healthcare evaluation and needs
FC16 International developments and research
FC17 Symptom management
FC18 Palliative care for older people
FC19 Improving support for caregivers
FC20 Health services research and public health
**FC01 Family caregivers**

**Abstract number:** FC01.1  
**Abstract type:** Oral

**Struggling for Normal**: Self-management of Family Caregivers in Palliative Home Care. A Longitudinal Qualitative Study  

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**Background:** Family caregivers play a key role in palliative home care for persons with advanced cancer. Research has shown numerous burdens and strains of family caregiving, nevertheless families are dealing day-to-day with terminal illness at home. There is limited evidence on self-management strategies for family caregivers at home. The concept of self-management may well apply to the context of palliative home care.

**Aims:** This study aims to understand family caregivers’ experiences and self-management strategies in palliative home care over time.

**Methods:** A qualitative longitudinal design was chosen. Data collection consisted of serial in-depth interviews with family caregivers during ongoing palliative home care and after the death of the caregiving patient. Data were systematically engaged in conversations about their needs, priorities and solutions. Palliative home care should adopt a family-centred approach.

**Results:** Palliative home care disrupts everyday life of families by being unpredictable to them. To deal with uncertainty, family caregivers aim to maintain or regain normality. A key self-management strategy in this process is taking responsibility for all aspects of caring as well as balancing family relationships and job requirements. In an ongoing process of attention and adaptation, caregivers seek to gain confidence in dealing with terminal illness. Maintaining normality is an important request.

**Conclusions:** Fostering self-management means to actively recognise the endeavours of family caregivers to struggle for normality and to refer to their resources and problem-solving skills. Palliative home care should adopt a family-centred approach.

**Abstract number:** FC01.2  
**Abstract type:** Oral

**Family Carers’ Support Needs in End-of-Life Care: Translation into Practice**  

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**Background:** The Carer Support Needs Assessment Tool (CSNAT) encompasses the physical, psychological, social, practical, financial and spiritual support needs that government policies in many countries emphasise should be assessed, addressed and delivered to family caregivers (FCGs) of an end-of-life care patient.

**Objectives:** To describe the experience of FCs and nurses of terminal illness people with the CSNAT intervention in home based specialist palliative care.

**Methods:** This study was conducted during 2012–14 in Silver Chain Hospice Care Service in Western Australia. 233 FCs and 44 nurses participated in translating the CSNAT intervention using a stepped wedge cluster design (which included 89 in the control group). FCs’ feedback was obtained via telephone interviews and nurses via a questionnaire. Data were subjected to a thematic content analysis.

**Results:** The overwhelming majority of FCs found the CSNAT needs assessment process validating, reassuring and empowering. They appreciated the value of the intervention in systematically engaging them in conversations about their needs, priorities and solutions, which were timely and responsive to their needs. The majority of nurses reported that using the CSNAT was effective at eliciting FC concerns, prompted them to review/assess the support and recommended integrating it in their routine practice.

**Conclusions:** CSNAT provides a formal structure to facilitate discussions with FCs to enable needs to be addressed in a timely manner. Such discussions will provide service providers with an evidence base for the development of their support services, ensuring the new or improved services are designed to meet the explicit needs of FCs and by consequence relieve their strain and distress.

(Funded by an Australian Research Council Linkage Grant and Silver Chain.)

**Abstract number:** FC01.3  
**Abstract type:** Oral

**Family Members’ Sense of Support within the Family in the Palliative Care Context – What Are the Influencing Factors?**  

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**Background:** Mutual support within the family can be a valuable resource to the members of the family when confronting with impending death.

**Aim:** Based on a family system approach, the aim was to evaluate which factors are associated with family members’ sense of support within the closest family in the palliative care context.

**Methods:** We interviewed 231 adult family members (76% of eligible family members) of adult patients who had non-curable disease with an expected short-term survival from six palliative home care units. The individual factors were evaluated using GLM (generalised linear model), ordinal multinomial distribution and logit link.

**Results:** The family members’ ratings of their sense of support within the family ranged from 1 (never) to 6 (always), with a mean value of 4.82 (SD 1.11). The family members who less frequently sensed such support were mostly characterised by living in a family and with children, and not being a pensioner. They rated lower quality of life, and higher attachment anxiety, more often anxiety, pain or discomfort. Furthermore, family members who less frequently sensed support within the closest family rated higher negative impact and lower positive value of being a family member to a severely ill person, and they received worse quality of support. They also reported more difficulty in the possibility of respite, less often sense of security with the palliative care provided, less often support for themselves as well as for the patient from family, relatives and friends other than the closest ones. The patients with those family members who less frequently sensed support within the closest family were more often living with children, and had changed beliefs about the decision making process and, if home care is favoured, are then adequately supported by healthcare professionals to assume the caring role.

**Conclusions:** The identified factors may help palliative care teams to identify family members at risk of perceiving a low sense of support within the family and to alleviate suffering.

**Abstract number:** FC01.4  
**Abstract type:** Oral

**Family Caregiver Coping in End of Life Cancer Care: Results from a Mixed Methods Multi-site Study in Palliative Home Care**  

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**Abstract type:** Oral

**Background:** Placeing a heavy burden on family caregivers (FCGs). Yet research shows that some FCGs cope relatively well with caregiving whereas others do not. There has been little research examining why some FCGs seem to deal better with caregiving at home than others.

**Aims:** To understand the factors that influence FCGs’ ability to provide end of life cancer care at home and to determine predictors of quality of life (QOL) and depression.

**Methods:** A mixed methods study including semi-structured interviews with 29 current caregivers and a structured questionnaire administered to 317 FCGs recruited from 3 urban settings in Canada. Analyses were guided by a theoretical model to test the relationships between primary and secondary stress mediators, primary and secondary appraisals and primary or secondary outcomes of QOL and depression. Statistically significant variables were entered in a hierarchical regression analysis.

**Results:** High care demands are significantly associated with lower QOL and higher levels of depression, especially for FCGs appraised as having low levels of resilience and optimism. QOL was higher for FCGs who were resilient and optimistic, who had good quality family relationships, and who had a strong sense of cohesiveness within the family. FCGs who were satisfied with health services and felt better prepared for caregiving had significantly higher QOL scores than FCGs who were not satisfied or not prepared. Findings also suggest greater depressive symptoms and lower QOL among FCGs who had health problems, felt that caregiving interfered with lifestyle and perceived caregiving as stressful.

**Conclusions:** Findings provide insights into FCG characteristics related to personality, family functioning, and family caregiving and patient illness experiences, which can help guide interventions for FCGs at risk of depressive symptoms and reduced QOL in the context of home-based palliative care.

**Funding:** Canadian Cancer Society Research Institute

**Abstract number:** FC01.5  
**Abstract type:** Oral

**Family Caregivers’ Preferences for Place of Care at Patients at the End of Life: Implications of a Systematic Review for Policy and Practice**  

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**Background:** Government policies stress the importance of patients’ and their families’ preferences when deciding on place of care at the end of life. While patients’ preferences are well documented and often favour care at home, the preferences of their families are less well known. Due to the nature of long-term conditions, families are often involved in the care of patients at the end of life. To ensure families receive appropriate support to care for patients in their preferred location, it is important to understand family caregivers’ preferences.

**Aims:** To systematically search and synthesise the qualitative literature exploring family caregivers’ preferences and perceptions surrounding place of care of their relatives at the end of life.

**Methods:** Ten databases and key palliative care journals reference lists were searched in January 2014. Article titles, abstracts and full-text papers were reviewed by two researchers and included studies (n=18) were appraised for quality. The final inclusion set was then synthesised.

**Results:** Family caregivers reported feeling advantaged by patients and healthcare professionals to provide care for their relatives at home, which was considered the preferred place of care. Hospitals were considered unsuitable for palliative care, with hospices favoured. However, preferences could change over time and hospitals preferred, in particular if the patient experienced distressing symptoms. Feeling unplanned and unsupported made caregiving challenging, while resilience and good family relationships eased the process.

**Conclusions:** It is vital to ensure that family caregivers feel supported during the decision making process and, if home care is favoured, are then adequately supported by healthcare professionals to assume the caring role. It is thus essential to consider what interventions work best to support relatives caring for patients at home at the end of life.
Background: Pain is a prevalent need in palliative care and, especially with severe pain, opioids such as morphine can be critically used. However, country healthcare system characteristics may impede medical use of these essential medicines.

Aims: For the first time, multivariate modeling determines how various country factors explain the most current opioid use in the EURO region, and how these influences vary between the East/West designation.

Methods: The International Narcotics Control Board provided 2012 opioid use data for European countries. Aggregate amounts of five opioids indicated for severe pain were converted to a total morphine equivalence (ME) for each country, adjusted for population – this was the outcome variable. We examined 5 predictor variables:

1) Human Development Index (HDI)
2) HIV/AIDS deaths
3) Cancer deaths
4) Palliative care development
5) Government health expenditures.

In addition to descriptive analyses, three multivariate regression models were constructed – one each for the EURO region and for the Eastern- and Western-European country groups – to ascertain important parameter differences among the models. Adjusted R² values based on all included variables demonstrated explanatory variability as a function of each model.

Results: Cancer and AIDS death rates and HDI predicted medical opioid use in the EURO region, but integrated palliative care was variable across Eastern countries. The EURO region model was highly explanatory (R²=0.49%) and conformed largely to the Eastern country model (R²=0.85%). These models converged from the Western country model (R²=0.31%) having no significant parameters.

Discussion: Recent availability of pain medicines and palliative care services differ substantially between Eastern- and Western-European countries, but also depend on other healthcare system features. Some countries are noteworthy as outliers for certain factors.

Acknowledgment: LIVESTRONG, Open Society Foundations
Isherwood R.J.

Abstract number: FC02.5

Abstract type: Oral

How Do Patients Experience Opioid Toxicity?

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Background: It is well recognised that patients who are on opioids will experience side effects and that these side effects may limit titration of the opioid. Some patients will experience opioid toxicity and, although this usually resolves with dose reduction of the opioid or an opioid switch, the experience can be significant for both the patient and family.

Aim: The aim of this study was to describe the patient experience of opioid toxicity.

Methods: Seventeen patients with cancer who were prescribed opioids and who had previously been opioid toxic were recruited. Interviews were recorded and transcribed. Quantitative description was used in order to stay true to the descriptions given by the patients. Saturation was reached after 17 interviews. Data was analysed and themes extracted. Analysis was confirmed by a second researcher.

Results: Several themes of interest emerged from the data. The patients described significant impact on themselves and were aware of an increased burden of care for their families. Patients modified their behaviour in order to maintain safety. This was particularly important to those with myoclonic. Those who were cognitively impaired during the episode described memory loss and mental slowing. They described open eyes and rapid breathing as a way to manage the cognitive impairment. Patients felt stigmatised by the cognitive impairment. Several of the patients reported a heightened pain sensitivity which resolved when opioid doses were reduced, along with use of non-pharmacological methods of pain control.

Conclusion: This study is the first description of the patient experience of opioid toxicity. The impact of the symptoms on the patients is clear. Patients develop coping strategies. The findings of the altered pain experience are new and suggest opioid-induced hyperalgesia is part of the spectrum of opioid toxicity.

Abstract number: FC02.6

Abstract type: Oral

Economic Evaluation of the Randomised, Double-blind, Placebo-controlled Study of Subcutaneous Ketamine in the Management of Chronic Cancer Pain

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Background: Ketamine is widely used to treat cancer-related pain and until recently economic evaluation of the management of chronic, uncontrolled pain in advanced cancer patients. Following a previous multicentre study in the UK, the current prospective study involved 10 centres, to check centre-to-centre variability, and included a cost-utility analysis of ketamine and placebo.

Aim: To evaluate the incremental resource use, cost and consequences of ketamine treatment versus placebo when used in conjunction with opioids and standard adjuvant therapy in the management of chronic, uncontrolled pain in advanced cancer patients.

Methods: A within-trial cost-effectiveness analysis of the Australian Palliative Care Clinical Studies Collaborative randomised, double-blind, placebo-controlled trial of ketamine was conducted from a health care provider perspective. Censored adjusted mean costs (AUS $) and effectiveness were calculated from participant-level data (ketamine n=93, placebo n=92) over the five-day treatment period including: positive response; toxicity; quality of life (QOL); ketamine costs; medication usage and inpatient stays. Missing data were estimated using multiple imputation methods and bootstrapping was applied to assess multivariate uncertainty.

Results: Positive response rates were similar between ketamine (31%) and placebo (27%). Mean changes in QOL scores from baseline measured with the FACT-P (total score 184) were small and in favour of placebo (ketamine -1.9 (5.4, 1.4), placebo -4.7 (2.0, 7.5)). Estimated total mean costs were approximately $800 higher per ketamine participant ($3692 vs $2892). When incremental costs and effects (QOL) were jointly considered, ketamine was dominated (i.e., it was less costly and less effective). There was almost no chance of ketamine being cost-effective versus placebo when jointly considered, ketamine was dominated by placebo, i.e. was more costly and less effective. There was almost no chance of ketamine being cost-effective versus placebo when jointly considered, ketamine was dominated by placebo, i.e. was more costly and less effective.

Conclusion: This study is the first description of the patient experience of opioid toxicity. The impact of the symptoms on the patients is clear. Patients develop coping strategies. The findings of the altered pain experience are new and suggest opioid-induced hyperalgesia is part of the spectrum of opioid toxicity.

Abstract number: FC03.2

Abstract type: Oral

Validation of Three Different French Forms of ESAS

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Background: The Edmonton Symptom Assessment System (ESAS) is a brief, widely adopted, multidimensional questionnaire to evaluate patient-reported symptoms. No validated French version is available.

Aims: To develop a French version of the ESAS (F-ESAS), to perform a psychometric analysis in French speaking patients and to define what form (visual [V], verbal [VE] or numerical [NU]) is more adapted.

Methods: In a first pilot study with patients (n=20) and health professionals (n=20) the most adapted terms in French (F-ESAS) were selected and an adapted translation was created. In a prospective multicentre study, palliative care patients completed the three forms of F-ESAS (F-ESAS-VE, F-ESAS-NU and the Hospital Anxiety and Depression Scale (HADS)). Amount of food eaten on the plates was measured. All patients had a test-retest evaluation during the same half-day. Standardised distraction material was used between each scale.

Results: 142 patients were included (mean age [±DS]: 68 ±13, 82 F; 61 M 126 patients with cancer). Test-retest reliability was high for all 3 F-ESAS and the correlation between these scales was nearly perfect (Spearman r=0.71-0.92; p<0.05). F-ESAS-VE and -NU performed similarly and were equally reliable, although there was a trend towards poorer lower reliability for F-ESAS-NU. Correlation between respective F-ESAS depression and anxiety and HADS depression and anxiety were positive (Spearman r=0.41-0.46 for depression, Spearman r=0.53-0.67 for anxiety, p<0.001). Correlation between respective F-ESAS appetite and amount of food eaten was positive (n=0.32-0.43; p<0.05). Respectively 66 (46%), 45 (31%) and 22 (14%) preferred to assess their symptoms with F-ESAS-VE, F-ESAS-NU and F-ESAS-NU respectively.

Conclusion / Discussion: The F-ESAS is a valid and reliable tool for measuring multidimensional symptoms in French speaking patients with an advance disease. The F-ESAS-VE is the most reliable scale, the preferred scale and should be promoted.
FC03.6

Glaspow prognostic score predicts prognosis for cancer patients in palliative settings – A Subanalysis of the Japan-Prognostic Assessment Tools Validation (J-ProVal) study

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Background: Local and systemic inflammation are important components in the pathophysiology of cancer. The Glasgow prognostic score (GPS) includes inflammatory protein and albumin levels, offers a good predictor of prognosis in cancer patients undergoing anti-tumor therapy. However, the relationship of GPS to prognosis in cancer patients in palliative settings has not been described.

Aim: The objective of this study was to investigate the correlation between GPS and survival among cancer patients in palliative settings.

Methods: This was a subanalysis of a multicentre prospective cohort study of 16 palliative care units, 19 hospital palliative care teams, and 23 home-based palliative care services in Japan. Patients not receiving anti-tumor therapy were eligible. Clinical features, including patient characteristics, symptoms, prognostic index and nutritional index, were analysed to investigate prognostic factors.

Results: A total of 1160 patients were enrolled in this study (41.6% female; mean age, 70.4 years). In multivariate analysis, the predictors were a GPS score of 2 (hazard ratio (HR), 1.36; 95% confidence interval (CI), 1.01–1.87; p = 0.046), presence of liver metastasis (HR, 1.21; 95% CI, 1.03–1.41; p = 0.041), dyspnea (HR, 1.35; 95% CI, 1.31–1.59; p < 0.001), edema (HR, 1.25; 95% CI, 1.06–1.48; p = 0.009), prognostic performance index > 6 (HR, 1.56; 95% CI, 1.27–1.92; p = 0.001), neutrophil-lymphocyte ratio > 4 (HR, 1.43; 95% CI, 1.17–1.75; p = 0.001), and a mean survival time with GPS scores 0, 1 and 2 were 58, 43 and 21 days, respectively (p < 0.001).

Conclusion: The present results indicate that GPS offers a good predictor for cancer patients in palliative settings.

FC04.1

Children and international developments

Abstract number: FC04.1

Abstract type: Oral

The Childrens Experience of Living with a Parent with Amyotrophic Lateral Sclerosis, May Emmanuelle, SUC Agen, TIMSPATRICE, CINTAS PASCAL (Toulouse, France)

May E.1, Suc A.1, Timsp P.1, Cintas P.1

1CHU Toulouse - Pierre Roux Lepicard, Toulouse, France, 2CHU Toulouse - Hôtel des Enfants, Toulouse, France

Background and aim: Amyotrophic lateral sclerosis (ALS) is a neurodegenerative disease of unknown origin which affects the lower and upper motoneurons. The only existing treatment aims to slow down the progressive rate of physical impairment. It is currently incurable and the support given falls within the palliative care model. Due to the rarity of this pathology, in our experience, a lot of families met expressed relational difficulties which led us to explore the children’s psychological state. Moreover, the parents asked the care team how to announce the disease to their children, to talk about death, disease evolution and the handicap itself.

Methods: First, a survey was conducted with the affected families, in order to assess the psychological state of both children and parents. The surveys inclusion criteria were parents...
14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015

with minor children and/or parents who questioned the team about families’ problems. 23 patients were selected and 11 responded to the survey. The 28 children were 4–3 years old, 13 of 6–18 years old, 22 were less than 14 years old. 12 years.

Secondly, we organised preliminary interviews with families, in order to evaluate their needs.

Results: The first part of the study shows that parents want to convey a positive message to their children and to explain to them the incurability of the disease. They express their difficulties during the announcement. Children asked questions about the disease’s aetiology, the transmission, the cure and of mortality. Behavioural changes were observed in children who were more supportive, but also more anxious. These results seem to be confirmed by the second part of the study when meeting other families in which children displayed sleep disorders, distraction problems and regular weeping.

Conclusion: This study has highlighted the presence of psychological consequences for children with ALS parents. The variability of behaviour and reaction, and the difference depending on the age, shows up the necessity to propose various therapeutically responsive opportunities.

Abstract number: FC04.2
Abstract type: Oral

Advance Care Planning in Children and Adolescents with Life-limiting Diseases: The View of Parents and Professionals

Latz LD1, Jos Rü2, Borasio GD1, Fühner M1

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8 children attended by PPC unit died from January to September 2014. 5 died at home and 3 support from a PPC team. Health policies should implement PPC teams that attend 24/7 for children being accompanied by the pediatric palliative care team.

Introduction: End-of-Life Care at Home: Qualitative Evaluation from the Families

End-of-Life Care at Home: Qualitative Evaluation from the Families Attended by the Palliative Care Team in the Balearic Islands

Savina Tilm M1, Fullana Tuduri R.M.1, Daviu Puchades A.M.2, Mir Peñol C1, Jordà Martí S1, Bennet Nuñez A1

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Introduction: Palliative care teams go along with the family and the children during the process of a life limiting or life threatening disease, especially in the end of life when the presence of the team is very important for the symptom and to attend the emotional and spiritual needs of the family and the dying child.

Our team is formed by a paediatrician, a nurse and a psychologist and gives home care when the family and the child want to stay at home. We accompany them and give care until the children die.

Aim: This study aimed to describe how many children died at home in our unit and to explore the satisfaction of the families that preferred home as the place of death for their children being accompanied by the pediatric palliative care team.

Methods: A qualitative research design including individual interviews was used to obtain information about the satisfaction and the feelings of the parents whose children died at home during this year.

Results: The PPC team attended in person 4 of the 5 home deaths and the other one by telephone because they had returned to their country of origin. 100% of the parents interviewed who spent end-of-life at home were satisfied by the preference of the place of death and would take the same decision again provided they had 24/7 support from a PPC team. All of them felt well supported by our PPC team and were very grateful.

Conclusions: Qualitative findings from this study suggest that most of the families that attended by the PPC unit preferred home as place of death because they have the support from a PPC team. Health policies should implement PPC teams that attend 24/7 for giving end-of-life care at home and support the dying child and their families.

Aim: This study aimed to examine the life issues of young adults with life limiting conditions and to develop an end-of-life care tool.

Methods: A longitudinal case study approach, clinical case note reviews and semi-structured interviews, conducted in 2 months intervals across a 6 month period between April and Oct 2014.

Findings: 33 participants took part: 12 young adults (17 and 23 years), professionals (n=11) and family members (n=10) were nominated by the young adults. A total of 58 interviews were conducted.

Results: Themes: Dependent autonomy: physical and health restrictions created an often unwanted dependence, but equally independence created its own tensions in terms of preparedness, confidence and socialisation skills to engage with the wider community, generating challenges for professionals.

In addition, tocentripetal forces brought families/carers together to cope with the situation, whereas the equilateral forces were not always able to be re-established within the family, resulting in family/individual sacrifices, even with support from professionals.

Biographical uncertainty: young adults and families had been living with uncertainty, often for many years, with professionals not always able to supply answers; impacting on lack of focus and direction for the young adults as well as loss and grief reactions for family members.

Controlling integrity: young adults, families and professionals acted to preserve the integrity of the young adults by supporting social, personal and structural elements in their lives, within the context of living with the life limiting illness. The findings will inform local and national policy in children’s hospices in Scotland.

Abstract number: FC04.3
Abstract type: Oral

The Irish Childhood Bereavement Care Pyramid: A Guide to Support for Bereaved Children and Young People

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Aim: In the absence of a national approach to childhood bereavement care in Ireland, the Irish Childhood Bereavement Network (ICBN) sought to design a childhood bereavement framework to guide professionals and concerned adults in identifying and responding to the needs of children and young people who have experienced a loss.

Design, methods and approach taken: An expert group working in the area of childhood bereavement was convened to review the adult and child bereavement literature and pertinent local and international policies, in order to establish existing models of bereavement care and core dimensions of best practice. From this review and building on practice experience, a framework was created and piloted with medical, social, educational and professionals and parents views differ, and significant barriers exist. These results may inform the development of future pediatric ACP programs.

Abstract number: FC04.4
Abstract type: Oral

Understanding the End of Life Clinical Problems of Younger Adults and its Impact on their Parents, Siblings and Health Professionals within the Context of Life Transtion for their Younger Child with a Life-limiting Condition

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Background: There has been very little research examining the issues of young adults with life limiting illnesses; existing research often fails to acknowledge that young adults may have needs and issues that are distinct and different from other younger children.

Aim: This study aimed to examine the life issues of young adults with life limiting conditions known to a children’s hospice association in Scotland.

Methods: Longitudinal case study approach, clinical case note reviews and semi-structured interviews, conducted in 2 months intervals across a 6 month period between April and Oct 2014.

Findings: 33 participants took part: 12 young adults (17 and 23 years), professionals (n=11) and family members (n=10) were nominated by the young adults. A total of 58 interviews were conducted.

Results: Themes: Dependence dichotomy: physical and health restrictions created an often unwanted dependence, but equally independence created its own tensions in terms of preparedness, confidence and socialisation skills to engage with the wider community, generating challenges for professionals.

In addition, tocentripetal forces brought families/carers together to cope with the situation, whereas the equilateral forces were not always able to be re-established within the family, resulting in family/individual sacrifices, even with support from professionals.

Biographical uncertainty: young adults and families had been living with uncertainty, often for many years, with professionals not always able to supply answers; impacting on lack of focus and direction for the young adults as well as loss and grief reactions for family members.

Controlling integrity: young adults, families and professionals acted to preserve the integrity of the young adults by supporting social, personal and structural elements in their lives, within the context of living with the life limiting illness. The findings will inform local and national policy in children’s hospices in Scotland.

Abstract number: FC04.5
Abstract type: Oral

The Development of European Consensus Norms for Palliative Care of People with Intellectual Disabilities: An EAPC White Paper

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Background: There is growing evidence that people with intellectual disabilities (ID) lack
equal access to palliative care services. The EAPC approved a 2-year Task Force on palliative care for people with ID (2012-2014).

Aims: To develop core norms for palliative care of people with ID in Europe.

Methods: Draft norms were agreed with a steering group of 14 experts in nine countries. Delphi methods were used to assess cross-country agreement with these draft norms, via an e-platform. Experts were invited to provide comments to each norm. The norms were accepted if there was sufficient agreement among all respondents (80% or more).

Results: The draft norms consisted of 52 items in 13 categories: equity of access, communication, recognising the need for palliative care, assessment of total needs, symptom management, provision of care, collaboration, support for families and carers, preparing for death, bereavement support, education/training, and developing/managing services. Eighty usable survey responses were received from 17 European countries. There was strong consensus among survey respondents, with none of the items scoring less than 86% agreement. Following the free text comments, several suggested changes in wording were agreed with the steering group.

The final norms are awaiting approval from the EAPC Board of Directors. Challenges included the disparity in service provision for people with ID across Europe, as well as difficulty in available palliative care services.

Conclusion: The paper describes the norms described in this White Paper serve as guidelines for best practice that are accepted across Europe. Further study is needed to assess the barriers and enable to achieving these consensus norms throughout Europe.

Abstract number: FC05.1

Funding information

Free Communication sessions

Key points

- Development of a spiritual wellbeing (SWB) measure for palliative cancer patients.
- Final norms are awaiting approval.
- Challenges included the disparity in service provision for people with ID across Europe.
- Further study is needed to assess the barriers and enable to achieving these consensus norms throughout Europe.

FC05 Spirituality and social work

Understanding Cultural Dimensions of Spiritual Care: A Qualitative Study of Spiritual Care Providers in South Africa, Uganda and Denmark

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Background: Understanding the nature of spiritual care (SC) in multi-cultural populations was found to be a major research priority in the EAPC Task Force study. As spirituality is expressed via culture and religion, this evidence is needed to inform SC.

Methods: A secondary analysis was conducted of in-depth qualitative interview data from two studies of SC providers (SCPs) in South Africa, Uganda and Denmark. Semi-structured interviews were conducted in English and Danish with self-identified SCPs in a range of PC settings, recorded and transcribed. Interviews covered personal background, experiences of providing SC, patients’ spiritual needs and challenges encountered in SC provision.

Comparative thematic analysis explored the nature of patients’ spiritual concerns and how different cultural contexts influence SC provision.

Results: In South Africa and Uganda, 21 SCPs were interviewed, including pastors, volunteers, social workers and nurses from 4 PC services. All were Christians except for one Zen Buddhist. In Denmark, 14 interviews were conducted with 12 pastors and 2 imams at 11 PC services. Universal spiritual problems faced by patients were described (e.g. loneliness, meaninglessness, anger) and specific problems related to cultural context (in Africa, HIV stigma, conversion of witchcraft; in Denmark, aversion to preConversion). Among SCPs, two main approaches were identified: pastoral care from a religious perspective and care with an existential focus. Both approaches were culture-specific in the way they used language and supported patient’s meaning-making.

Conclusion: Comparing SC in different cultural contexts highlights the universal and culturally-specific features of SC, demonstrating ways in which SC is multi-dimensional, individualised and, and engaged with cultural context. This evidence informs SC and SC research internationally.

Abstract number: FC05.2

Abstract type: Oral

Qualitative Investigation of Understandings of Spiritual Wellbeing (SWB) Collected During Cross-cultural Validation of An EORTC Measure of SWB

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Background: Understanding cultural dimensions of spiritual wellbeing (SWB) is important for palliative care. However, there is a lack of understanding of how SWB is understood and measured cross-culturally.

Methods: The EORTC Quality of Life-Cancer (QLQ-C30) SWB module was translated into 13 languages. A cross-cultural validation study was conducted in 14 countries representing 4 continents. A qualitative research approach was used to explore the understandings of SWB. Semi-structured interviews were conducted with 458 patients in 14 countries on 4 continents taking part: 188 Christian, 50 Muslim, 23 Buddhist, 158 no religion. Most could define SWB, some with just one word or concept, others using more than one. Several broad themes were identified, largely relating to the hypothesised domains and/or specific items, e.g. living well, good relationship with God, good relationships with others, being at peace with self and/or others. All items emerged across all participants’ responses, but most participants with active religious faith (and often) without defined SWB in relation to God; some just this, others together with other themes.

Conclusions: Each study participating had a particular understanding of SWB, but common themes emerged from all participants’ responses, which mapped onto the hypothesised domains. The understandings of SWB of those participants with religious faith mostly, although not universally, included God.

Abstract number: FC05.3

Abstract type: Oral

From Insights to Outlooks – An International Study Week on Volunteers in Hospice and Palliative Care

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Background and aims: As demographic and epidemiological issues have an impact on palliative care needs of populations, societal changes and the spectrum of diseases addressed by palliative care may require a revision of the role of volunteers. In a multi-professional and interdisciplinary discourse with international experts and scholars we wanted to discuss sustainable concepts of voluntary work (VW) for the future and identify topics for research.

Design: An interdisciplinary study week on ethical, social and legal aspects of the modern life-sciences was funded by the German Federal Ministry of Education and Research (BMBF).

Submitted abstracts of young scholars were reviewed by a scientific advisory board and thematically categorised for discussion into:

1) motivation, attitude of volunteers
2) challenges in ageing societies
3) society and volunteers
4) bereavement and spirituality.

Eight international experts were invited to present and lead workshops.

Results: Thirteen applicants (D, A, P, U, EAU) were selected. The interdisciplinary discourse demonstrated the need to focus on at least three fields of interest:

- 1) Terminology – what does it mean when we talk about volunteers, VW professional, volunteers, civic engagement?
- 2) Guidelines – There seems to be a need for guidance, for example with the definition of standards and guidelines, how much do standards impact the flexibility that is a core element of VW in hospice and palliative care?
- 3) Core competencies – What are the core competencies of volunteers in hospice and palliative care, across settings and systems? Experts and participants of the study week will work on these topics as part of the work of the EAPC Task Force on Volunteer.

Significant outcomes will be published.

Conclusion: Research on volunteers, especially in an international context, is sparse. The discourse was very enriching, showed potential lessons to be learned from international and intercultural exchange of experiences and approaches.

Abstract number: FC05.4

Abstract type: Oral

Dancing to a Different Tune: Living and Dying with Cancer, Organ Failure and Physical Frailty

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Background: The ‘danske macabe’ has been depicted in Europe since medieval times. Providing good end-of-life care for all patients, whatever form their last dance takes, is a recognised global challenge.

Aims: To see if there are typical narratives of living with and dying from advanced illnesses, to provide insights into providing effective care.

Methods: A synthesis of data from 2 qualitative longitudinal studies: 3 cancer; 3 organ failure; 1 frailty;

- 1 year South African participants from all 3 trajectories. Participants were interviewed up to 4 times over 18 months. Researcher had a personal relationship with participants.

- 71 Likert scale.

Results: The dataset was 828 in-depth interviews with 156 patients. Cancer narratives had a clear beginning, middle and anticipated end, giving a well-rehearsed account of the illness, with dual themes of hope and fear of dying. People with organ failure struggled to tell their story, being unclear when the illness began, or how one event linked to another. Fewer spoke about death, hoping instead to avoid further deterioration. Many
attributed their poor health toold age! Frail older people’s narratives often began with a specific event in combination with ageing to make sense of their situations yet lost salience amidst increasing losses and future fears. Death was only fully anticipated very near the end, and feared less than nursing homes or dementia.

**Conclusions:** Patients from different illness groups give very different accounts. Consequently the cancer-based model of end of life care seems poorly suited to the needs of those dying in other ways. Understanding how different patient groups perceive their deteriorating health and approaching death can inform appropriate palliative care.

**Abstract number:** FC05.5
**Abstract type:** Oral

**Outcomes of an EAPC White Paper on Core Competencies for Palliative Care Social Work in Europe**

**Aim:** An EAPC Social Work Task Force was established in 2009 to consider the diversity of roles of social workers in palliative and end of life care across Europe and make recommendations on the care competencies necessary for high-quality practice.

**Methods:** The authors drew on the practice experiences of social workers across Europe, combined with a scoping of the international literature on social work competencies from Canada and Ireland. Other sources included the International Federation of Social Workers and survey work with palliative care social workers in the United Kingdom.

**Results:** This White Paper explores the place of social work in palliative care from a range of perspectives and against the backdrop of variable service provision in Europe. It examines the historical development of the specialism in relation to some of the challenges presented by an ageing population and shrinking resources across the continent. Ten core competencies for palliative care social work are presented which address:

- Principles
- Assessment
- Decision making
- Care planning
- Advocacy
- Information sharing
- Evaluation
- Interdisciplinary working
- Education and research
- Reflective practice

Each detail the values, attitudes, knowledge and skills required for competent work at this specialist level and provide the first opportunity to consider these in a wider European context.

**Conclusion:** This White Paper will enable all interested parties to engage in a debate that seeks to advance the practice of palliative care social work in Europe. In addition, it will form the basis for the development of new curricula for the on-going education of current practitioners and for those coming into this specialised field in the future. Further, it will be an aid to employers seeking to engage specialist social workers in palliative care.

**Abstract number:** FC05.6
**Abstract type:** Oral

**Social Work in Palliative Care in Germany - Presence and Main Foci of Activity**

**Aim:** This study explores how present social workers are in the differing palliative care settings in Germany and what their main foci of activity are.

**Methods:** Directors of all palliative care units, of all hospices and of all hospice services in Germany were asked to fill out a questionnaire about elements of psychosocial care, involved team members, the particular role of social work, as well as key data of the service providers.

**Results:** The response rate ranged from 41% (PCUs) to 52% (hospices) and 40% (hospice providers). PCUs were present in 86% of the ICUs, in 48% of the hospices and in 22% of the hospice services. In PCUs, social workers were seen as mainly responsible for psychosocial care. In hospices and in hospice services, nurses respectively hospice volunteers are the main providers. In all three settings, the most frequently named tasks of social work are common aspects of clinical social work (e.g. counselling on social assistance laws). In addition, in PCUs social work is responsible for the assessment of personal and social history, individual data and other tasks related to other care providers. In hospices, mediation between patient, family and team, arranging services for bereaved persons and organising voluntary work are further tasks and in hospice services coordination activities and other tasks that do not directly concern patients (e.g. fundraising).

**Conclusion:** Social work is the third professional pillar in palliative care, responsible for a wide range of tasks. Data analysis is still ongoing. At the congress, we will be able to present the results in more detail.

**Abstract number:** FC06.1
**Abstract type:** Oral

**Muslim End of Life Ethics: Patiently Respecting Allah’s Plan**

**Background:** In just a few decades Islam has become the second largest religion in most European countries. This evolution constitutes an important challenge to European health care (including palliative care), as it is still deeply influenced by secular Western and/or Christian approaches.

**Methods:** The exploratory research programme (2002-2014, 3 PhDs) presented here aimed to analyse and compare contemporary international normative muslim end of life ethics and real world end of life views and attitudes of elderly Muslims in Flanders, Belgium.

**Results:** (1) A systematic review of the available empirical studies on Islam and end of life issues (PubMed, snowball) (2) A content review of the international Islamic discussion on end of life ethics (key authors, international Muslim organisations, e-forums on international Islamic websites) (3) Semi-structured interviews with elderly Morrocan men (20 interviews), elderly Turkish and Morrocan women (60) and specialists (20). All interviews were transcribed, coded and categorised using Grounded Theory methodology.

**Conclusion:** We found hardly any differences between the guidelines in the international normative sources and the actual attitudes of our respondents. Euthanasia and assisted suicide are strongly rejected, non-treatment decisions and the refusal of treatment are only allowed in exceptional circumstances; pain control does not pose an ethical problem. God controls illness and health, life and death; it is unacceptable to interfere in this divine plan. Patience is the central virtue.

**Discussion:** The attitudes of the generation of Belgian Muslims studied here are deeply influenced by a shared religious framework. Nevertheless, even in these very homogeneous groups a few dissenting voices were found. In palliative care it remains essential to start from the ethical and religious views of the unique individual in front of you, not from the views that are typically associated with the community he/she belongs to.

**Abstract number:** FC06.2
**Abstract type:** Oral

**To Explore the Relationship between the Use of Sedative Drugs and Cessation of Oral Intake in the Terminal Phase of Hospice Inpatients: A Retrospective Case Note Review**

**Aim:** To establish whether oral intake is related to the use of sedative drugs in the last week of life.

**Methods:** Design: A retrospective case note review of 84 inpatients at a palliative care unit in London. Data collection: The data was obtained from nursing records and medication charts of the last 7 days of life of 84 consecutive inpatients that died from 01/07/2012. Oral intake was classified:

- 0 – no intake
- 1 – mouthfuls/ sips
- 2 – small meals
- 3 – good appetite

Daily doses of midazolam (≥ 1mg) were recorded.

**Results:** 51 patients received midazolam on one or more days (Midazolam Group MG), 33 received no midazolam (Controls CG).

Terminal agitation was the commonest reason for midazolam use.

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**Conclusions:** Mean oral intake was already markedly reduced 7 days prior to death in all patients and continued to decline progressively over subsequent days whether or not a sedative was used. Patients in the MG were lower in quality of life, suggesting they were more unwell. The number of patients requiring midazolam increased closer to death and most patients (63%) received midazolam for less than three days. Mean doses of midazolam used were low. Study limitations are its retrospective nature and reliance on nursing records.
How and Why Did Belgium Come to Allow Euthanasia for Minors? A Descriptive and Ethical Analysis

Methods: This study concerns an analysis of the various official written reports of the Belgian Senate and House of Representatives which give first hand insight into how the law came to pass and when it was proposed and passed during this process. From these reports the process of drafting the amendment is sketched and the most raised ethical arguments are identified and analysed using existing international research and literature.

Results: It was found that while minor cases are allowed to be asked to request euthanasia has been debated in Belgium since the passing of the initial euthanasia law in 2002. Though controversial, the amendment that was passed is the result of significant compromise as more radical and far-reaching proposals were made. As regards the arguments, the most often voiced arguments in favour of the new amendment are that it would avoid discrimination and would give legal security. Critics most often point to the fact that the law may be unclear and contains significant uncertainties, and is inattentive to the fact that minors are often not fully competent to make such big decisions. These arguments will be analysed for their ethical validity.

Conclusion: A review of within Belgium the 2014 amendment was far from uncontroversial. Debate was fierce and many voices were voiced both for and against, though a significant number of these are, ethically speaking, invalid. In short, this presentation will give an insight into how Belgium came to pass such a controversial amendment.

Abstract number: FC06.4
Abstract type: Oral

Ethical Decisions in Palliative Care: A Burnout Risk Factor? Results from a Mixed-methods Multicentre Study in Portugal

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Background: Ethical decision-making in end-of-life care is perceived as stressful. Making ethical decisions is related to higher levels of burnout among health professionals.

Aims: To identify the most common ethical decisions made by Portuguese palliative care professionals and understand how the making of such decisions relates to burnout.

Methods: Mixed methods study in 9 palliative care teams. Data was collected through questionnaires of socio-demographic and profession-related variables, and work-related experiences; Maslach Burnout Inventory; interviews; observations. Quantitative data analyses included descriptive, uni and multivariate logistic regressions; qualitative data was analysed inductively with themes/categories emerging from data. Triangulation ensured reliability. A total of 88 professionals (66% response rate) were included, 11 nurses and 9 physicians were interviewed and 240 hours of observations were fulfilled.

Results: The most common ethical decisions were caused by communication issues, forgiving treatment and terminal sedation. Although perceived as a burnout risk factor by the respondents, quantitative data showed that making ethical decisions was not significantly associated with burnout. These findings were explained through the analysis of the transcripts of semi-structured interviews. The decision-making process using an interdisciplinary team approach and consulting ethical committees were identified as protective factors against burnout.

Conclusion: Making ethical decisions is not associated with burnout among professionals working in Portuguese palliative care teams. This is explained by the ethical deliberation and decision-making process followed by these teams. Promoting palliative care skills among professionals and decision-makers in other settings might be useful to diminish burnout related to making ethical end-of-life decisions.

Acknowledgments: Fundação Grunenthal and Fundação Merck, Sharp and Dohme.

Abstract number: FC06.5
Abstract type: Oral

Can Saving Money Be Unethical? Managing Conflict of Interest in Advance Care Planning

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Background: While advance care planning (ACP) primarily aims at realising patient autonomy during the last phase of life, it may also reduce the costs of care. Given the increasing economic pressure on most health care systems, the sensitive ACP communication process might be unduly influenced by cost-considerations.

Aims: To analyse potential conflicts of interests resulting from the cost implications of ACP programs and discuss corresponding ethical safeguards.

Approach: We assessed (1) the cost-implications of ACP by a systematic review and (2) the resulting conflicts of interest by analytical ethical investigation.

Results: Six of seven studies included in the review demonstrated cost reductions through ACP ranging from $1,041 to $64,830 per patient, which lets ACP appear an attractive tool for payers and policymakers (despite open questions regarding the direct and also the indirect costs of ACP). This involves, however, a considerable potential for conflicts of interests: incentivised facilitators might undermine the openness of the planning process, or individuals might feel obliged to opt “autonomously” for less costly care. As a consequence, safeguards for patient autonomy are required first of all, research must reveal financial gains and losses caused by ACP programs in payers’ and policymakers’ potential goals become transparent. The primary goal must remain to realise patient autonomy (and high quality care) near the end of life, even if this increases costs of care. Most importantly, quality and thereby openness of the facilitation process must be preserved. Furthermore, facilitators should be specifically trained to manage potential conflicts of interest.

Conclusion: The potentially conflicting goals of ACP realising patient autonomy and containing costs, require safeguards to guarantee the openness of the facilitation process.

Abstract number: FC06.6
Abstract type: Oral

A Palliative Approach: A Concept in Need of Clarity

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Background: Much of what we understand about the design of healthcare systems to support care of the dying comes from our experiences with caring for dying cancer patients. It is increasingly recognised, however, that in addition to cancer, high quality end of life should be an integral part of care that is provided for those with other advancing chronic life-limiting conditions. A palliative approach has been articulated as one way of conceptualising this care but there is a lack of conceptual clarity regarding its essential characteristics.

Aims: To delineate the key characteristics of a palliative approach found in the empirical literature in order to establish conceptual clarity.

Methods: We conducted a mixed-methods knowledge synthesis of empirical peer-reviewed literature. Established knowledge synthesis procedures were implemented. Search terms pertaining to ‘palliative care’ principal and ‘chronic life-limiting conditions’ were identified. A comprehensive database search yielded 73 studies. Narrative synthesis methods and thematic analysis were used to identify and conceptualise key characteristics of a palliative approach.

Results: Our review revealed a burgeoning body of knowledge. Three overarching themes were conceptualised that characterise a palliative approach:

(1) Upstream orientation towards the needs of people who have life-limiting illness and their families.
(2) Adaptation of palliative care knowledge and expertise.
(3) Operationalisation of a palliative approach through integration into systems and models of care that do not specialise in palliative care.

Conclusion: Our findings provide much needed conceptual clarity regarding a palliative approach and its delimitation from palliative care. Such clarity is of fundamental importance for the development of knowledge regarding the integration of a palliative approach in the care of people with chronic life-limiting illnesses.

Funding: Canadian Institutes of Health Research

Abstract number: FC07.1
Abstract type: Oral

Preferences for End of Life Care and Treatment for Advanced Chronic Obstructive Pulmonary Disease (COPD) Patients: Results from a Discrete Choice Experiment

Ferguson M.1,2, Barge P.3, Lu K.1, White P.1, Living G.1, Booth S.1, Hawson S.1, Mahadeva R.1, Moore C.4, on behalf of the Living with Breathlessness Study Team
1University of Cambridge, Public Health & Primary Care, Cambridge, United Kingdom; 2RAND Europe, Cambridge, United Kingdom; 3King’s College London, London, United Kingdom; 4University of Cambridge, Cambridge, United Kingdom; 5Cambridge University Hospitals NHS Foundation Trust, Cambridge, United Kingdom; 6Cambridgeshire Community Services, Cambridge, United Kingdom

Background: COPD is a chronic progressive condition with high symptom burden accounting for 26,000 deaths annually in England alone. Little is known about patients’ preferences for care and how they change in advanced disease.

Aims: To identify patients’ preferences for care in advanced COPD, and explore how these preferences change with deterioration in condition.

Methods: A discrete choice experiment was developed and included in a postal questionnaire. 305 patients with COPD, recruited from GP surgeries in Eastern England and South London, participated in a three-wave six monthly postal survey. In the choice experiment, each respondent considered five different vignettes describing different health states, and for each indicated their preferences for the type of health care they would expect to experience an exacerbation. Both the health states and the care options available were varied within the survey. Twelve different versions of the questionnaire were used, enabling coverage of sixty different care choice contexts.

Results: The discrete choice model estimated from this data provides insight into the weight that respondents put on different aspects of care: whether to receive care at home or at hospital care in most severe cases; who leads the care decisions in each setting; the support available outside of routine appointments; and the time to access this support. Respondents’ demographics, exacerbation history and quality of life are incorporated into the model, revealing that these factors have a statistically significant influence on patients’ preferences for both who makes the care decisions and the location where the care is provided.

Conclusion: This research provides new evidence enabling appropriate end-of-life care and support of advanced COPD patients living in rural and urban inner-city regions. It will help health service providers to identify possible service modifications to meet COPD patients’ needs.

Funders: Marie Curie Cancer Care and NHRI
Towards Integration of Palliative Care in Patients with Chronic Heart Failure and Chronic Obstructive Pulmonary Disease: A Systematic Literature Review

Lowther K.1, Harding R.

Background: The challenge of pervasive uncertainty in advanced liver disease is a growing global public health problem and the 2nd largest cause of death in the UK. Health policy for this patient group primarily centres on prevention, paying minimal attention to improving end of life care for those affected. Aims: To provide patients with cirrhosis in the last year of life, plotting healthcare use and identifying barriers to good end of life care. Methods: Retrospective review of purposively selected case notes (30 cirrhotic patients) referred to a tertiary London liver unit. Pathways of care were modelled, by combining clinical data and service utilisation information extracted from case notes, and qualitative focus groups/ interviews with 20 liver health professionals, about barriers to good end of life care. Results: During the last 12 months of life, medical crises often precipitated unplanned emergency admissions to hospital. Patients experienced high symptom burden and were repeatedly treated intensively to aid recovery. Although clinicians recognised that limited care planning discussions were rarely held with patients about their future wishes; care planning conversations occurred late in the patient trajectory and were more likely to occur with the patient's family. Specialist palliative care referral occurred within the last few days of life. Conclusions: Clinicians have difficulties identifying when to initiate end of life care for patients with cirrhosis, when prognosis is uncertain and active treatment may afford a degree of short term recovery. Earlier integration of palliative care would facilitate care planning discussions and better inform patients and families of the choices available, in the knowledge they may be entering the dying phase.

FC07.3
Abstract number: FC07.3
Abstract type: Oral

TOPCare: Results from a Mixed Methods RCT Testing a Nurse-led Intervention to Reduce Symptom Burden and Improve Quality of Life for People on ART in Kenya


Background: The 2MWT is a safe and effective measure of exercise capacity. High correlation coefficients between 2MWT, 6MWT and BODE strongly suggests its potential to replace the 6MWT in advanced COPD. By itself, it shows good potential as a screening tool to discard frail COPD patients for early palliative intervention.

FC07.5
Abstract number: FC07.5
Abstract type: Oral

The Challenge of Pervasive Uncertainty in Advanced Liver Disease

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Background: The number of patients dying with advanced liver disease is rising rapidly, yet little is known about the experiences and support needs of these patients and their carers. Palliative care services are increasingly recognising the needs of non-cancer patients, but liver disease remains relatively neglected. Aims: To explore the dynamic physical, psychological, existential and information needs of patients and their lay and professional carers, and to review their use of health, social and voluntary services.

Methods: Qualitative, multi-perspective, in-depth interviews. Patients with different types of liver disease were recruited in hospital. They and their lay carers were interviewed up to 3 times over one year. Case-linked professionals were interviewed once. Interviews were recorded, transcribed and analysed using grounded theory techniques and NVivo 9. Results: 15 patients and their carers were recruited and 64 interviews conducted. Uncertainty emerged as the central factor dominating experiences across all domains, at all stages of the illness, and for all participants: patients, lay carers and professionals. The uncertainty related to the nature of the illness, the unpredictability of the disease pathway and prognosis, poor communication and information-sharing, and complexities of care. Coping strategies sought to manage, rather than reduce, uncertainty. Pervasive uncertainty makes care planning especially important, yet impedes this very process. Conclusion: This is the first serial interview study of people with advanced liver disease. It locates uncertainty at the heart of the experiences of patients, lay and professional carers. Given its critical impact on the patient experience, professionals must address this uncertainty while recognising its role in patients' coping. More needs to be done to ensure that people with advanced liver disease receive appropriate and equitable supportive and palliative care. Study funded by the ESRC.
A Shared Electronic Record for Personalised End-of-Life Care: Factors Associated with Achieving Preferred Place of Death

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Background: A patient’s preferred place of death (PPD) is a key quality indicator for end-of-life care. We have established an electronic care record to document patient care wishes and personalised care plans. The care plan can be accessed electronically by all legitimate providers of urgent care including ambulance staff, general practitioners, hospitals, nursing and care homes, hospices and community nursing teams.

Aims: To measure the proportion of patients included in this electronic care system who have achieved their PPD and to identify any factors that may be associated with achieving PPD or not.

Methods: A retrospective data analysis of patients who had an electronic care record created between April 2013 and March 2014. Statistical analyses were performed using SPSS. Descriptive statistics was used.

Results: There were 1379 patients included in the study. 80.9% of patients achieved their PPD. Most of the patients PPD was usual place of residence (82.6%), home (62.1%) and care home (20.5%). Older age (p<0.001), female (p=0.001), a non-cancer diagnosis (p<0.000), poor pain status (p<0.01) and poor performance status (p<0.001) were all associated with a higher likelihood of achieving PPD (p<0.01). Care home residents with the PPD being the care home was associated with achieving PPD (p<0.0001). A higher proportion of patients for whom a discussion about end-of-life issues had not been made with the family, died without their PPD (p<0.0001). Having just-in-case medication was also associated with patients achieving PPD (p<0.0001).

Conclusion: A high proportion of patients with an electronic care record and personalised care plan in our system achieved their PPD. There are clear factors which are associated with a greater likelihood of achieving PPD and these need to be explored further in order to increase overall PPD for this population.

Abstract number: FC08.2

Type of abstract: Oral

Preferred Priorities of Care Document in the United Kingdom: Does it Always Facilitate a Good Death?

Oates S.G.

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Background: In the United Kingdom, a key measure of success of end-of-life strategy is the proportion of deaths that occur at home, as opposed to in hospital. To facilitate this, the ‘Preferred Priorities of Care’ (PPD) document was introduced. However, there have been cases where the spirit of this measure is compromised by ignoring the clinical need or appropriateness of surroundings. This paper reviews case studies when PPC was the reason for confusion was used against the patient’s or family’s wishes.

Aim: To review cases where PPC did not contribute to high-quality care for all adults at the end of life as defined in the end of life strategy.

Methods: Hospice patients’ notes were reviewed manually.

Results: 561 new community referrals were received over one year. 265 deaths were observed. 67% had their PPD documented. Critical cases were noted with following themes:

1. Disagreement between patient and family about place of care
2. Family’s unawareness of patient’s preferred place
3. Patient’s unawareness of the right of being able to be cared for at hospital for other health-related reasons that they decided that preferred place of care was home
4. Family over-ruling of patient’s choice when patients lost capacity
5. Family’s unwillingness to support preferred place of care as preferred place of death
6. Lack of services in community to meet preferred place of death
7. Lack of education of community staff to achieve a good death at home
8. Staff coercion to alter paperwork to achieve death in another place, as not achieving preferred place of death was perceived as failure!

Conclusion: Evidence suggests that although achieving death at a place of choice is a tool for ‘good death’, it is not always a rule. If not handled sensitively, it can lead to difficult decisions. Open and honest discussions are needed with training for staff to hold such discussions.

Also, discussion about preferred place of death should be a part of discussion of advanced care planning rather than an isolated discussion.

Abstract number: FC08.3

Type of abstract: Oral

The Art of Interweaving Clinical Activity to Strengthen Care Provision: The Tapestry Reflecting Technology Use in End of Life Care

Garcia-Baquero Merino M.T., Santos Puebla D.D., Pineda F., Pinto Garzon M., Quiros Navas E., Molina Cara C.

*Garcia-Baquero Merino M.T., Santos Puebla D.D., Pineda F., Pinto Garzon M., Quiros Navas E., Molina Cara C.

Abstract number: FC08.4

Type of abstract: Oral

No One is Joining all the Dots: Partnerships between Patients, Family Caregivers and Health Professionals in the Transition to Palliative Care

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Background: The transition to palliative care is a complex process. Best practice incorporates comprehensive support of patients and family caregivers incorporating a patient centred team approach.

Aim: We present this paper to explore the process of transition to palliative care within an acute care setting to make visible the contextual conditions within which the transition is constructed and negotiated. A preliminary analysis that identified tensions between the theory and practice of palliative care was previously reported.

Methods: A critical approach informed the research. The methods involved semi structured interviews with sixteen patients and family caregivers and thirteen health professionals thus ensuring a broadly based view of the complexities of the transition process.

Results: The key findings depict a complex intersection between acute and palliative care. Despite the rhetoric of multi and inter professional teamwork in acute palliative care, the findings indicate that the teamwork boundaries restricted the provision of continuity of care. Furthermore, in the acute setting, palliative care was constructed around the political and professional interests of different specialties and as such there were no clear pathways for patients. The research findings depict a conflicting interplay between oncologists as generalists in providing a palliative approach and specialist palliative care services. The timely identification of patients and initiation of conversations about palliative and end-of-life care were found to be critical for generalist clinicians.

Conclusion: The findings point to the need for stronger and more coherent partnerships between patients, family caregivers and health professionals. This would mean more permeable professional boundaries that allow for an efficacious interdisciplinary approach to the transition to palliative care. The findings will inform the service development needed to improve palliative care services in the acute care setting.

Abstract number: FC08.5

Type of abstract: Oral

A National Approach to Palliative Care Education: Developing a Harmonised Suite of Courses Logo Style for Different Settings, Specialties and Disciplines

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Patients facing life-limiting illnesses often experience sub-optimal care. Symptoms and psychosocial-spiritual needs are inadequately addressed and honest discussions regarding prognosis and end-of-life care preferences are done too late or not at all. Palliative care (PC) is misperceived as only end-of-life care, missing opportunities to reduce symptom burden and improve treatment choices earlier in the illness. Health professionals including family physicians and specialists should play a role. To assess the current practice on PC education and topics per discipline.

A Learning Essentials Approaches to Palliative Care Workshop will present an inter-professional introduction to PC that describes core modules on key topics and a constructivist approach to design that incorporates theory bursts, case and problem solving, learning and trigger videos. Courseware redesign reflects new evidence and encompasses different settings/specialties. Competencies common and unique to different settings and a series of new ‘building block’ themes will address specialties of care include: long term Care hospitals; Department of LongTerm Care, Acute Care Hospitals, Oncology, Surgery, Hospices, Aboriginal communities and end-stage organ diseases. A peer-reviewed referenced Palliative e-packet book/app will be showcased. Through a website portal certified facilitators can tailor-make their workshops to specific learner-need, using a logo block and learning journey approach.

Course evaluations on curriculum content, design and large scale implementation, plus PhD research found significant improvements in pre-versus post-course assessments of palliative care education.
Older people, dementia and multimorbidity

Abstract type: Oral

Living Well with Dementia: Enhancing Dignity and Quality of Life, Using a Novel Intervention, Dignity Therapy

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Background: Maintenance of dignity and enhancement of quality of life are key, integral elements of care for people with dementia. Meaningful communication with people who have a cognitive disorder as the most difficult as the communication may have a positive effect on the person's quality of life, with individualised approaches being strengthened by the use of existing strategies such as memory/life story approaches. Dignity therapy is a short psychotherapeutic intervention that uses a trained therapist to take the person through a recorded, guided interview process, to produce a life story as a means of communicating their personal desires, experiences, values and beliefs. The aim of this study was to assess the feasibility, acceptability and potential effectiveness of modified dignity therapy to improve the quality of life and reduce psychological and spiritual distress in older individuals with early stage dementia.

Methods: This mixed-methods feasibility study. Data were collected via standard outcome measures, standard demographic measures and a qualitative interview pre and post the intervention (dignity therapy) over a twelve month period, August 2013–August 2014, from a total of 7 people with early stage dementia (9 who completed dignity therapy), 7 family members, 6 key stakeholders and a focus group with 8 people with dementia.

Results: This study has shown that dignity therapy is feasible, acceptable and potentially effective for older individuals with dementia: the outcome measures have the potential to indicate changes in quality of life and psychological and spiritual distress as a result of dignity therapy, and are therefore relevant for use in further larger scale study that will evaluate effectiveness. Dignity therapy can prove vital to inform care for the person with dementia. The provision of care that is informed by dignity therapy has the potential to be more person-centred, and therefore enhance dignity for people with dementia.

A Successful Intervention to Improve Quality of End-of-Life Care (QoC) and Quality of Dying (QoD) for Patients with Advanced Dementia

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Most patient with advanced dementia die in long term care institutions. There is a growing consensus that, the more advanced the dementia, the more relevant is palliative care. Aim: To assess a multidimensional intervention to improve QoC and QoD in patients with advanced dementia (stage 7 Reisberg Scale).

Methods: The intervention consisted of training the nursing staff and physicians as well as families to the option of symptomatic care approach for end-stage pneumonia and feeding difficulties. Early detection of pain with an observational scale (PACSLAC), early systematic use of mouth care and family support for decision-making were the main components of this intervention. Family values and beliefs were respected in the decisional process. A local nurse trusted by her colleagues and by physicians worked full time as a consultant to implement this approach. The intervention was tested in 4 nursing homes (2 with intervention and 2 with usual care). Primary outcomes were quality of end of life care assessed by family members (Family Perceptions of Care Scale) and quality of dying (CAD-EOL/Comfort Assessment in Dying) assessed by families and nurses. In order to understand which part of the intervention was most useful, four focus groups with nursing staff members were held after completion of the project.

Results: In the experimental group, there was a large increase in the proportion of families highly satisfied with care. CAD-EOL scores were also significantly better and compared very favourably with similar measurements in Netherlands, Belgium and USA. Focus group participants mentioned that educational training sessions were not sufficient to induce those changes and that the consultant nurse was very helpful in translating new knowledge into actions.

Conclusion: This multidimensional intervention has improved QoC and QoD in advanced dementia. A trained local nurse acting as a consultant appears to be the key element in this intervention.

**The Clash of Cultures between Generalists and Specialists in Hospital: An In-depth Ethnography to Improve Access to Specialist Palliative Care for Older Adults**

**Abstract number:** FC09.4  
**Abstract type:** Oral

**Background:** Globally about 20 million people, of which 69% are over 60 years old, need palliative care at some point in their life. This includes people with a dementia-related disease or as place of death for patients with dementia, although they are frequently identified as needing palliative care receive it. Evidence-based recommendations informed by clinical expertise on how best to enable generalists to refer to specialist palliative care (SPC) is needed.

**Aims:** To identify lead clinical team cultures in hospital settings which may hinder or help access to SPC for older patients.

**Methods:** An ethnography in three hospitals in London, UK was conducted, involving in-depth, semi-structured interviews with SPC and generalist staff sampled purposively, transcribed verbatim, and analysed using open and axial coding.

**Results:** Three lead clinical team cultures were identified that may hinder or appropriately access: curative, where curative treatment is prioritised and access to SPC is limited until the end of life; self-sufficient, where palliative care is provided by the lead clinical team and SPC is not readily consulted, and over-reliant, where SPC is too readily consulted when staff feel out of their depth, restricting service allocation to others. One lead clinical team culture supported access: collaborative, where a clear partnership is apparent between the lead clinical team and SPC.

**Conclusions:** Cultural change requires a multi-pronged approach that focuses on values, attitudes and knowledge as well as structure, processes and outcomes. To begin, staff education is needed to ensure access to patients who benefit from SPC alongside disease-modifying treatment for curative cultures. Clear SPC referral criteria and service scope is required for self-sufficient and collaborative cultures. Dissemination of the success of the collaborative model is recommended.

**Funders:** Atlantic Philanthropies, Cicely Saunders International

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**国际隔阂的普遍性：对晚期疾病的死亡时有效的多学科团队**

**Abstract number:** FC09.5  
**Abstract type:** Oral

**International Variation in Place of Death of Older Persons Who Died from Dementia-related Disease**

**Methods:** A systematic search was conducted in October 2014 of five major electronic databases: PsychInfo, Medline, Web of Science, Scopus, and Cochrane Library. Meta-analysis was used to integrate the results.

**Results:** Of 4.8% of all deaths (n=264,604), the underlying cause of death was a dementia-related disease. Of those identified as needing palliative care receive it. Evidence-based recommendations influenced by clinical expertise on how best to enable generalists to refer to specialist palliative care (SPC) is needed.

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**The Bereavement Experience of Lesbian, Gay, Bisexual and/or Transgendered (LGBT) People:**

**Abstract number:** FC10.1  
**Abstract type:** Oral

**Bereavement Services in Palliative Care in Europe: A Survey Study by the EAPC Bereavement Taskforce**

**Methods:** A questionnaire was developed based on previous studies and piloted by bereavement coordinators. A link to the online questionnaire was distributed via the EAPC to 56 national associations in 32 countries during December 2013 and January 2014. The questionnaire consisted of 54 questions and was available in English and Spanish. It was structured into six sections: background information, activities, personnel, access, community links and funding.

**Results:** There were 370 responses from 25 countries (78%), and 302 (82%) provided bereavement service. Formal guidelines informed organisation of service in 98 (33%) units, and 75 (25%) used a formal risk assessment tool to access support needs. Bereavement coordinators were employed in 135 (45%) of services, and a wide range of activities were provided, e.g. telephone support 254 (84%), bereavement counselling 244 (81%) and support groups. 169 (31%), reflective 135 (25%), religious 134 (27%).

**Conclusions:** This study presents the first overall picture of bereavement support in palliative care services in the EAPC. One fifth of services did not prioritise bereavement care as an integrated part of the palliative service. The healthcare system faces a number of challenges and activities, however only one third of services used validated risk assessment or formal guidelines. It seems timely for the EAPC and palliative care services to formalise their approach to bereavement to secure quality of care.

**Abstract number:** FC10.2  
**Abstract type:** Oral

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**Abstract number:** FC10.1  
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**Abstract type:** Oral

**Bereavement Services in Palliative Care in Europe: A Survey Study by the EAPC Bereavement Taskforce**

**Methods:** A questionnaire was developed based on previous studies and piloted by bereavement coordinators. A link to the online questionnaire was distributed via the EAPC to 56 national associations in 32 countries during December 2013 and January 2014. The questionnaire consisted of 54 questions and was available in English and Spanish. It was structured into six sections: background information, activities, personnel, access, community links and funding.

**Results:** There were 370 responses from 25 countries (78%), and 302 (82%) provided bereavement service. Formal guidelines informed organisation of service in 98 (33%) units, and 75 (25%) used a formal risk assessment tool to access support needs. Bereavement coordinators were employed in 135 (45%) of services, and a wide range of activities were provided, e.g. telephone support 254 (84%), bereavement counselling 244 (81%) and support groups. 169 (31%), reflective 135 (25%), religious 134 (27%).

**Conclusions:** This study presents the first overall picture of bereavement support in palliative care services in the EAPC. One fifth of services did not prioritise bereavement care as an integrated part of the palliative service. The healthcare system faces a number of challenges and activities, however only one third of services used validated risk assessment or formal guidelines. It seems timely for the EAPC and palliative care services to formalise their approach to bereavement to secure quality of care.
Free Communication sessions

**Adapting Meaning-centred Psychotherapy for a Palliative Care Setting: Results of a Pilot Study**

Rosenfeld B.1, Pezin K.2, James K.1, Tobias K.1, Breitbart W.1

Fondham University, Psychology, Bronx, NY, United States; 1Memorial Sloan Kettering, Psychiatry and Behavioral Sciences, New York, NY, United States

**Background:** The effectiveness of meaning-centred psychotherapy (MCP) as an intervention for helping improve quality of life and reduce psychologist distress among patients with cancer is steadily growing. However, applying mental health interventions to the palliative care setting raises a number of challenges, including the role of fatigue, confusion, and even denial.

**Aims:** The goal of this study was to investigate the feasibility, acceptability and effectiveness of an abbreviated version of the palliative care setting (MCP-PC). Unlike past research using MCP, which involved 7–8 weekly sessions, we developed a treatment manual that underwent pilot intervention.

**Methods:** The participating patients were admitted to a palliative care hospital for end-of-life care participated in a 3-session intervention aimed at helping improve psychological and spiritual well-being. Patients were administered the Distress Thermometer (DT) and the Hospital Anxiety and Depression Scale (HADS) prior to study entry, and completed a post-treatment questionnaire assessing their perception of the treatment. Only those patients who were sufficiently alert and deemed by the treating physician to be appropriate for study participation were eligible.

**Results:** Preliminary results (n=7) indicate a high degree of acceptability and perceived utility for MCP-PC. Pre-treatment DT scores ranged from 0 to 10 and HADS scores ranged from 4 to 23. 3 participants had clinically significant levels of distress. All patients completed the sessions, but requests to reschedule sessions occurred frequently, typically due to fatigue or the presence of visitors. All participants reported considerable benefit from the intervention.

**Conclusions:** The need for effective, rapid and feasible interventions for palliative care patients is clear, but fraught with logistical challenges. This presentation will discuss the results of this pilot intervention.

Abstract number: FC10.5
Abstract type: Oral

**Multi-layered Learning – A Mechanism to Translate End of Life Policy into Practice**

Kinley J.1, Froggatt K., Preston N.1

1St Christopher’s Hospice, Care Home Project Team, London, United Kingdom; 2Lancaster University, Faculty of Health and Medicine, Lancaster, United Kingdom

**Presenting author email address:** j.kinley@stchristophers.org.uk

**Background:** The implementation of end-of-life care interventions is promoted within English healthcare policy to improve care delivery within different settings. How these interventions are best implemented is less clearly promoted. One end-of-life care intervention recommended by the English Department of Health is the Gold Standards Framework in Care Homes (GSFCH) programme. Only a small number of homes complete the programme when asked questions about the implementation process.

**Aims:** To identify the role of facilitation when implementing the GSFCH within nursing care home practice.

**Methods:** A mixed methods study was undertaken within 38 nursing care homes

Abstract number: FC11.1
Abstract type: Free Communication

**Policy and economics**

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**Methods:** Patients with stage IV cancer admitted to a palliative care hospital for end-of-life care participated in a 3-session intervention aimed at helping improve psychological and spiritual well-being. Patients were administered the Distress Thermometer (DT) and the Hospital Anxiety and Depression Scale (HADS) prior to study entry, and completed a post-treatment questionnaire assessing their perception of the treatment. Only those patients who were sufficiently alert and deemed by the treating physician to be appropriate for study participation were eligible.

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**Aims:** To identify the role of facilitation when implementing the GSFCH within nursing care home practice.

**Methods:** A mixed methods study was undertaken within 38 nursing care homes

Abstract number: FC11.1
Abstract type: Free Communication
undertaking the GSFCH programme in England. Qualitative and quantitative data were collected from staff employed within (home managers and GSFCH coordinators) or associated with (external facilitators); these nursing care homes and included interviews, surveys, Facilitator Activity Logs and a researcher’s diary. Following separate quantitative (descriptive) and qualitative (themematic template) data analysis the data sets were then integrated by following a thread. Utilisation of a system-based framework enabled the wider context of the participating nursing care homes to be considered.

**Results:** Three approaches of facilitation were provided to nursing care home staff when implementing the GSFCH programme: ‘filing it in’ facilitation; ‘as requested’ facilitation; and ‘being present’ facilitation. Completion of the GSFCH programme, through to accreditation, was significantly influenced by the approach of facilitation that was provided. Implementation of the programme required an external facilitator who could mediate multi-layered learning at an appreciative system level, an organisational level and at an individual level.

**Conclusion:** Multi-layered learning was required to achieve cultural change. It enabled the translation of end-of-life care policy into practice.

**Abstract number:** FC11.2
**Abstract type:** Oral

**What Concept of Good Death Is Motivating English End-of-Life Care Policy?**

**Background:** The National End of Life Care Strategy (NEOLCS) for England and Wales was released in 2008. A guiding principle within it is that people should be able to have a good death. Services are being redesigned to accommodate this goal. Yet, the concept of good death can be contested and is not universally accepted.

**Aims:** To identify the qualities of a ‘good death’ according to end-of-life care policy.

**Methods:** Discourse analysis of the NEOLCS, policy events related to the NEOLCS, and interviews with 10 policy makers involved in creating and implementing the NEOLCS (primary data collection conducted from 2010–2012). Analysis focused on the values attributed to different kinds of categories and dying death represented in the text and narratives.

**Results:** The NEOLCS includes an explicit definition of a good death focused around the individual. The wider discourse presents a more complex definition of what a good death looks like. This includes the place of death, awareness of dying, control of dying, maintaining personhood, and teamwork. Whilst the individual is still important, this definition is more interactionist as it involves the dying person, their family and carers, health and social care professionals, and the general public. At times, the different values may conflict one another.

**Conclusion:** What values are attributed to a ‘good death’ extend beyond the explicit definition of good death within the NEOLCS. This wider definition, which at times includes contradictions, is being used to shape healthcare services. It is being used to create a standard to evaluate the care of the dying.

**Abstract number:** FC11.3
**Abstract type:** Oral

**The Processes for Modifying Narcotic Regulations towards Increasing Access to Pain Relief – An Indian Experience**

**Background:** India is the biggest producer of narcotic substance for pain medications, but its needy millions with severe persistent pain do not have access to these medications. This is due to negligible availability and the lack of awareness and training amongst professionals regarding medical usage of opioids. The fact that India’s Narcotic Drugs and Psychotropic Substances (NDPS) Act retained many of the restrictive clauses from the pre-independence Opium policy, was a chief contributor. Several strategies were developed and succeeded in amending the NDPS Act in 2014. The new law is expected to improve the situation of access to pain relief to 1/6th of world’s population.

**Aim:** To describe systematically, the processes involved in successfully amending the narcotic regulations in India.

**Method:** Qualitative analysis based on interviews of key persons involved, analysis of official documents, reports and letters.

**Results:** Five sequential strategies emerged from the analysis: clarity on narcotic policy being the barrier and the decision to amend the regulatory language, identification of the critical gaps within the Act, modifying it to expand the scope including medical and scientific usage, getting the proposal for the Amendment admitted for parliamentary review, advocacy and follow up of the amendment bill during successive parliamentary sessions until its successful passing.

**Additional dynamics that facilitated the process were also recognised such as the role of an international coalition working to create an additional submission to the issue at the Supreme Court, support from the high offices of ‘National Advisory Committee’, unified efforts from various sectors in the country and committed participation of international agencies.

**Conclusion:** The processes of changing an archaic law in a large democratic country can be understood analytically through its processes and may be used as a model for other countries.

**Abstract number:** FC11.6
**Abstract type:** Oral

**Dilemmas in Palliative Care Development: A Comparative Enquiry in the USA and England**

**Background:** Delivering optimal and equitable care to people with palliative care needs is an international challenge.

**Aim:** To evaluate the current status of palliative care (PC) development in the USA and England, drawing attention to differences and similarities in: service organisation, key concepts, challenges perceived by stakeholders and future directions.

**Methods:** The authors had exchanged visits to the USA and England, spending 4–6 months evaluating PC development in their host country via informal interviews with key stakeholders, who included policy makers and grass roots leaders (n=20 in the USA and n=35 in England) and a narrative review of relevant research and policy documents.

**Results:** There is conceptual confusion in both countries about the meanings of ‘palliative’, ‘hospice’ and ‘end of life care’ and their relationship. While the organisation, delivery and funding of hospice care is radically different, in both countries hospice care remains closely associated with terminal care, although there are signs of reform. Formal palliative care plays a minor role in delivery of end of life care for the majority of those who die in the ongoing...
health and social care of people with life limiting/ threatening conditions. This has major implications for the adoption and development of public health strategies for palliative care.

Conclusions: Despite fundamental differences in the financing and ownership of healthcare in the two countries, many policies, practices and challenges for PC are comparable. Lessons learned can be applied not just in these two countries but for many others as well.

Abstract number: FC12.1

Room for Death – Museum-visitors’ Preferences Regarding the End of their Life

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Data is lacking on how the general public conceptualises ‘good death’ at this time in history. This presentation aims to discuss such data, generated from an international general public. Data derives from a project which teamed 5 pairs of artists and craftsmen together to create prototypes related to space for difficult conversations in end of-life (EoL) settings. These prototypes were presented in an exhibition, ‘Room for Death’, at the Architecture and Design Center in Stockholm from June–September 2012. Through their role as project consultants, palliative care (PC) researchers contributed a question directed to the public viewing the exhibition, to explore their responses: ‘How would you like it to be around you when you are dying?’ This question, in Swedish and English, was placed in a central place at the exhibition, for documenting reflections if so desired. The 512 responses were obtained from visitors from 46 countries, with most from Sweden, followed by the US, France, Germany and Italy. While preliminary analysis pointed to many similarities in idealisations of death across countries, continued analysis with a phenomenographic approach allowed us to distinguish different facets in how ideal death is conceptualised. Of the responses analysed, nearly 95% were categorised in one or more of the following eight categories: the ‘lone’ death, the ‘mediated’ death, the ‘familial’ death, the larger-than-life death, the calm and peaceful death, the ‘troublesome’ death, the ‘green’ death, and the ‘distanced’ death. These categories of conceptualisation will be further elaborated in relation to what is and is not seen in these data, and implications for the development of palliative care research and practice discussed.

Abstract number: FC12.2

Abstract type: Oral

The ‘Message’ of Palliative Care in Spain. A Mix-method Analysis of the Printed and On-line Press

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Background: Mass media are the main agents in the process of building public opinion and frequently deal with Palliative Care (PC) thereby contributing to its image and public understanding.

Aims: To explore and describe the circulating ideas and messages about PC in Spanish print (PT) and on-line (OL) media.

Methods: Attending to dissemination criteria and plurality of editorial lines, four national PT (El País, El Mundo, ABC, La Vanguardia) and four OL newspapers (ElConfidencial.es, Lainformacion.es, Publico.es, LibertadDigital.com) were selected. Through a repository of all national newspapers (MyNews) and each newspaper database, all articles published between 2009 and 2014 including the terms ‘palliative care’ or ‘palliative medicine’ were identified and full-text obtained. Two analyses on the articles collected were performed: 1) quantitative analysis of the news (through a questionnaire) and 2) qualitative content analysis.

Results: 524 articles were identified (260 PT, 264 OL). PT articles were included in the ‘National’ (37%), ‘Society’ (33%), ‘Opinion’ (18%), ‘Letters to the Editor’ (8%) and ‘Health’ (3%) sections, respectively. Meanwhile, OL articles with social message (85%) and nearly half of them include professional testimonies (57%). Qualitative analysis showed how rarely articles address or provide specific information about PC (purpose, activity, etc), being used in an instrumental way to address issues related to health management and policy/social context. The message and ideas related with PC focus principally on the process of death and often occasionally on the benefits for patients, often eclipsed by social debates related to issues such as euthanasia or the concept of dignity in dying.

Conclusions: Although there is a substantive presence of PC in the Spanish press, ideas and messages associated with it are far from clinical practice and rarely linked to the contributions it can make to patient’s quality of life and their environment.

Abstract number: FC12.3

Abstract type: Oral

Living Alone, Dying at Home? A Retrospective Data Analysis of a Specialist Palliative Home Care Team (SPHCT)

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Background: There is an increasing number of patients living alone. Palliative care aims to support patients to die in their preferred place of death irrespective of their living situation. Aim: The aim of this study was to compare the preferred place of death from a SPHCT of patients living alone or with relatives. Methods: Retrospective chart review of patients, followed by the SPHCT of the University of Munich from 10/2009 to 12/2013. We compared patients living alone or with relatives using non parametric Mann-Whitney-U-Test for the following items: preferred place of death, who was present during the terminal phase, the influence of the SPHCT on support, number of on call contacts with the SPHCT and number of emergency doctor visits. The significance level was p<0.05. Results: Of 796 patients cared for by our team, 44 were living alone. Of the latter, 30 patients (75%) died at home. During the terminal phase, 14 patients were supported by their children (46.7%), 4 by friends (13.3%), and 2 by a 24h nurse (6.7%). 10 patients had nobody in the house and died alone (25%). The preferred place of death was fulfilled in 36/44 patients (81.8%). In the group with relatives, the preferred place of death was fulfilled in 639 patients (80.3%). Time of support by the SPHCT (days) was longer in the group of patients living alone (140.7 ± 214.8 vs 54.7 ± 87.3; p<0.003). The two groups did not differ in care intensity measured in average hours of contact per day (0.95 ± 0.79 vs 0.87 ± 0.70; p=0.752), number of on call duties per contact (0.15 ± 0.34 vs 0.08 ± 0.29; p=0.102), and number of emergency doctor visits per day (0.022 ± 0.027 vs 0.16 ± 0.681). Conclusion: Patients living alone can still die at home if this is the preferred place of death. Although the support from a palliative home care team might be necessary for a longer time, the care is not more intense or more complicated.

Abstract number: FC12.4

Abstract type: Oral

Space and Place for End-of-Life Care: A Photo-elicitation Study

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In our prior research, palliative care (PC) staff documented many activities they carried out in end of life care related to ‘treating an esthetic, safe and pleasing environment’. However, little is written about how patients’ perceive their surroundings at the end of life (EoL). We therefore aimed to learn about people’s perspectives about their surroundings in EoL care by using photo-elicitation interviewing (PEI).

Twenty three people in 3 PC inpatient units in 2 Swedish cities, 1 PC home care service, and 1 residential care home participated in the study. Participants were given a digital camera and asked to take 3 pictures of that which was meaningful for them in their surroundings. The interviewer later viewed the photographs with the participant, initiating an interview by asking: “what is this picture of?” and “why did you take it?” Data was analysed qualitatively, focusing on ‘space’, i.e. the physical, analysed as the researchers’ view of the photographs’ content, and ‘place’ i.e. lived experience of the setting, based on framework analysis of interviews with participants about their photographs.

The space most often captured in photographs was private space around the sick person, often within reach of the bed. Analysis of place as described in participant interviews indicated the salience of three themes: an integrated experience of ‘Aesthetics of place’, ‘Negotiating space’, related to how changes in physical function are supported, compensated and overcompensated for; and connecting time, expanding space, involving connections to places beyond physical reach and involving the past, present and future. PEI provided explicit examples of how people creating meaning in relation to and through their surroundings. These themes will be elaborated, and we will conclude by discussing limitations and strengths of PEI in EoL settings, including offering an alternative form of communication as verbal ability decreases and fatigue and symptom burden increases.

Abstract number: FC12.5

Abstract type: Oral

A Doctor’s Dilemma: Is It Appropriate to Attend a Patient’s Funeral?

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Background: The death of a patient poses several dilemmas to medical practitioners. Among these is the appropriateness of attending a patient’s funeral. Despite anecdotal accounts, as well as general surveys on professional bereavement practices, little is known about why doctors choose to attend, or not, the funeral of their patients. This study sought to understand the factors associated with funeral attendance.

Methods: This work is based on data from a survey study of 1098 Australian health professionals. The presentation focuses on doctors who participated in the survey (n=437). An online questionnaire developed by the researchers was distributed through several Australian health professional organisations between June and December 2013. Responses were voluntary, anonymous and confidential.

Results: The majority of doctors were from palliative medicine (25%), general practice (GP) (25%), surgery (19%) and intensive care units (ICU) (17%). Comparing to GP’s, 67% of oncologists, 63% of palliative medicine specialists, 52% of surgeons, and 22% of intensive care specialists had attended funerals. Significant differences in demographics and between specialties were identified in terms of barriers and benefits associated with funeral attendance. A logistic regression predicted the likelihood of funeral attendance by a) the belief that attending funerals was an aspect of self-care, b) age, c) ...
The Role of Code Status in the Triage of Hospitalised Seriously Ill Patients to Intensive Care: A Qualitative Study of Internists’ and ICU Doctors’ Experiences

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Aims: Triage to intensive care for seriously ill patients is complex. When doctors don’t know the patient they rely on code status (CS) to help the decision. We explored internal medicine (IM) and intensive care (ICU) doctors’ experiences about the role of CS during the admission process.

Methods: Individual, in-depth interviews with 12 IM and 12 ICU doctors. Doctors reflected on their experiences of ICU admission decision-making. The analysis focuses on CS as a factor influencing the process.

Results: Determination of CS is based on patient preferences, assessment of the context, and preferably on discussions with other colleagues. CS is considered as a catalyst in the triage process, especially at night and during the week-end. Both IM and ICU doctors expect the doctor in charge to routinely discuss goals of care and to write the CS. When the admission is delayed, doctors meet with difficulties if there is no CS or if the CS is discrepant with their assessment of the clinical situation. When the patient is full code, going against the instruction is perceived to be difficult for three reasons: the referring IM and the ICU doctors do not know the patient, whereas the doctor in charge decided on the code after careful consideration, and intensive care is the patient’s only chance of survival. Strategies to solve the associated tension are: 1) reliance on the ICU doctor’s expertise 2) shared decision making 3) recognition that questioning the CS is legitimate 4) existence of a general consensus about situations when ICU is justified (default decision in the absence of CS, acute event linked toiatrogenicity, some diseases (e.g. malignant hemopathies).

Conclusions: Code status is central to the time-pressed decision making about admission of a seriously ill patient to intensive care. Doctors feel uncomfortable if it is absent or perceived to be unreliable. Goals of care should be clearly documented to substantiate a patient’s code status.

Abstract number: FC13.1

Disease and Patient Characteristics’ Associations with Quality of Life in Patients with Advanced Cancer

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Aims: The overall aim of palliative care is to ensure best possible quality of life (QoL). We investigated disease and patient characteristics’ relationship with QoL in a large sample of patients with advanced cancer.

Methods: OF 1051 patients with advanced cancer in the international European Palliative Care Research Collaborative-Computer Symptom Assessment Study (EPCRC-CSA), 453 had complete data sets. Disease and patient characteristics associated with QoL includes: Disease load, CRP, albumin and hemoglobin, length of survival and physical performance (Karnofsky performance scale). Patient characteristics: age, gender, pain severity (IP worst pain last 24h) and depression score (PHQ9, range score). Global QoL was measured with the EQ-5D-5L QLQ-C30 item. We used a multiple hierarchical regression model to test the effects of these characteristics on QoL.

Results: Better quality of life was associated with older age, lower CRP, longer survival and higher KPS, lower pain and lower depression (see Table 1).

Abstract number: FC13.2

Prevalence, Development and Treatment of Delirium in a Palliative Care Unit

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Background: Delirium (D) is a common symptom in palliative cancer patients at the end of life (EOL). It is essential to address the causes and factors that can be modified to minimise the suffering associated.

Aims: To determine the frequency of D. Describe the patients characteristics with D and compared with those who did not develop, treatment received, survival after diagnosis, and if sedation is needed.

Methods: We conducted a retrospective study with cancer patients admitted in a 6 months period and has criteria for D at admission (DI), or during hospitalisation (DII), or at the EOL (DT), based on data collected in the clinical history. Patients dying within 24 hours of admission were excluded.

Results: n=213 patients, 54% male, mean age 74, 80% with metastases and with 20 days average stay. Develop D 134 (63%) 69% DI, 34% DII, with a median of 9 days after admission. Present DT 85% (113 of the total, 75 DI and 38 DII). Exceeded the DI episode and not died with 15%. We found differences regarding the type of tumor: lung cancer in the group that develops D is higher, 19%, 4%. The most prominent pharmacological factors in D are: opioids, sedative and metabolic, 7, 3, no delirium, hypoxia, renal failure. In patients who did not die with D has less steroid drugs and less metabolic factors. Haloperidol was most common used drug. In 197 patients who died, 113 (57%) did so in a state of DI. Sedation in the EOL was 66 (31%) in 32 (79%) the indication was delirium. Need sedation 39% of DT. Treatment of sedation was midazolam (83%). In 89 patients with DI develop DI at 98% with a median survival of 6 days.

Conclusion: The prevalence of D in our unit is very high due to the low survival rate. Reversibility is low and sedation is unnecessary in 39% cases, although DT is the most important cause of sedation at the EOL. It seems that patients with lung cancer and taking steroids are more likely to develop delirium in our sample.

Abstract number: FC13.3

Caring to Know Palliative Care

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Background: There is growing awareness of the need to apply quantitative measures to nursing interventions involved in Palliative Care (PC), which focuses on the quality of life of patients and their families coping with life-threatening illnesses. This research study seeks to develop reliable and valid tools to measure knowledge, attitudes, emotional coping abilities and intentional behavior in PC clinical situations.

Aims: The aims are to assess the emotions, attitudes and knowledge of nurses providing PC, accounted for 6% and 10.5% respectively.

Conclusion: Increased disease load, pain and depression were all detrimental to QoL, with depression being the strongest predictor of QoL. This underscores the importance of attending to depression symptoms in palliative care settings to ensure best possible QoL.

Abstract number: FC13.4

Standard Operating Procedures in Palliative Care for Somatic and Psychiatric Symptom Management – Pilot Assessment of Feasibility and Efficacy

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Background: In the care for patients in a palliative care situation it may help to standardise repeating processes like pharmacological symptom oriented treatment. Therefore a multidisciplinary panel of experts in the field developed standard procedures (SOP) for symptom oriented treatment of dyspnea, pain, anoxia and nausea. The SOPs are used primarily in the palliative care unit and are based on the best existing evidence and clinical experience. Feasibility and efficiency were assessed in daily care.

Methods: In a pilot survey, all patients admitted to our ward between February and September 2014 (n=108) were either treated according to SOP or the reasons for deviation from the SOP was recorded. Symptom burden was routinely assessed by proxies (HOPES Symptom & Problem Checklist) and by patients (MIDOS, 2). Both tools use a 4-point Likert scale (0=none, 1= mild, 2=medium, 3= strong).

Results: Treatment according to SOP was possible in the majority of patients (93%; n=98/108). In both cases of deviation from SOP patients refused treatment according to SOP and were treated according to his/her wishes by continuing treatment form before.

In most of the patients following the SOP led to therapeutic success ameliorating symptom burden significantly: pain (mean: 1.35 to 0.78 to 0.35, p<0.001), nausea (mean: 0.3 to 0.7 to 0.4, p<0.005), dyspnea (mean: 1.13 to 0.7 to 0.35, p<0.01) anorexia (mean: 2.13 to 1.7 to 1.13, p=0.003) and 1.39 to 0.52, p<0.001).

Conclusion: Treatment according to our proposed SOPs is feasible and seems to be efficient in a palliative care concept and may foster symptom oriented treatment. More research is needed.
Depression Predicts Pain Intensity: Prospective findings from the European Palliative Care Symptom Study (EPCCS)

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Background: Depression and pain often coexist in patients with advanced cancer. However, few studies have investigated how this relationship is influenced by pain treatment.

Aims: To investigate if depression status predicts self-reported pain intensity in a sample of palliative patients, for analyses of longitudinal pain changes.

Methods: The EPCCS is an international prospective collection of symptoms and clinical data in 30 centres and 12 countries. 898 patients scoring >3 on a 0-10 NRS on average pain intensity (PI) past 24 hours were assessed at inclusion (T1) and after 4 weeks (T2). Multiple regression analyses were used with PI at T2 as the dependent variable. Depression, measured by the sum score of the major depression criteria (mood and anhedonia) in the Patient Health Questionnaire-9 (range: 0-6), and analgesic treatment (Y/N) assessed at T1 were predictors. Age and sex were adjusted for in the analyses.

Results: Mean age was 65.1 (SD 12.4); 51% were women. Mean depression sum score at T1 was 2.6 (1.9). PI at T2 was 3.9 (1.9). Analgesic treatment either opioid or non-opioid analgesia, Average PI at T1 and T2 was 5.3 (1.9) and 3.8 (2.5), respectively. There were no sex differences regarding depression, PI scores or analgesic treatment. The following variables uniquely predicted PI at T2: Age (β=0.04, p=0.01), depression (β=0.13, 0.03-0.24, p<0.05) and analgesic treatment (β=1.36, 0.71-2.0, p<0.01). In a multivariate regression model, all three variables remained significant predictors of PI at T2: age (β=0.03, 0.04-0.01, p<0.01), depression (β=0.11, 0.001-0.22, p<0.05) and analgesic treatment (β=1.44, 0.89-2.08, p<0.01).

Conclusions: Baseline depression exerts an independent effect on pain intensity assessed after 4 weeks irrespective of analgesic treatment and controlled for age and sex. This suggests that mood should be routinely assessed together with pain in palliative care patients.

Abstract number: FC13.6
Abstract type: Oral

Risky Recruitment: Feasibility of Recruiting Patients to a Cancer Associated Thrombosis Clinical Trial - Insights from an Embedded Qualitative Study

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Background: Cancer associated thrombosis (CAT) clinical guidelines advise six months’ low molecular weight heparin (LMWH), but beyond six months there is a lack of evidence. The ALICAT (Anticoagulation Length in Cancer Associated Thrombosis) randomised controlled trial (RCT) aimed to establish the feasibility of recruiting patients to compare: LMWH against no anticoagulant for further six months (intervention) with canceling LMWH at six months (control). A qualitative study was embedded in the RCT, a novel approach in palliative care research. Aim: The embedded study aimed to explore patients’ and clinicians’ perspectives of the ALICAT RCT. This paper presents attitudes to recruitment reported by clinicians and patients who declined randomisation.

Methods: Focus groups (n=3) were conducted with oncology, haematology and primary care clinicians. Patients (n=8) with CAT who declined randomisation into the RCT were interviewed. Data were analysed using the Framework approach.

Results: Patients’ declined randomisation due to perceived risk of entering the RCT, ceasing LMWH and experiencing further thrombosis. Dislike of injecting LMWH (and thus concern about balancing the risk of thrombosis and haemorrhage). Despite the need for evidence guiding ongoing CAT treatment, this study suggests reluctance towards a RCT comparing continuing or ceasing LMWH beyond six months. There is thus a need to design and pilot further research to guide CAT management beyond six months.

Funding: NIHR HTA

Conclusions: These attitudes to risk indicate participants are not confident that the RCT is equitable. Interestingly patients are motivated by thrombosis risk, while clinicians are concerned by bleeding risk. Despite the need for evidence guiding ongoing CAT treatment, this study suggests reluctance towards a RCT comparing continuing or ceasing LMWH beyond six months. There is thus a need to design and pilot further research to guide CAT management beyond six months.

What Happens after Breaking Bad News: The Process of Sharing A Cancer Diagnosis with Adult Family Members and Friends

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Background: Worldwide over 1.6 million people are diagnosed with lung cancer each year. Extensive research exists on how such news is broken by physicians to patients. Little is known about the subsequent stage, when patients go home and share that news with family members and friends, although this is a difficult experience for patients. Aim: To understand the experience of sharing news of a lung cancer diagnosis with wider family members and friends (adults) to inform a supportive intervention to prepare patients for sharing bad news.

Methods: Qualitative interviews with 20 patients with lung cancer and 17 family members/friends present at diagnosis-giving consultations to explore experiences of receiving a cancer diagnosis and how news was then shared with wider family/friends. A time line was created from participant’s maps to the timing of news sharing. Data were digitally recorded, transcribed verbatim and a thematic framework analysis conducted.

Results: There were three key findings,

1) Patients received a series of news events from clinicians along their cancer trajectory: it was not a discrete event. Sharing that news also happened over time, at any point along the trajectory: again, it was a process, not a discrete event.
2) Timing of sharing bad news was very individual. Participants reported that they needed to prepare themselves for sharing the news and needed to feel ready to share.
3) Regardless of when news was shared it had consequences in terms of the reactions of those told. Illustrative timelines of processes of early and later sharing of bad news will be presented.

Conclusion: Understanding sharing bad news as a process which happened over time was a significant finding for the design and delivery of a supportive intervention. Preparing patients to share bad news of a lung cancer diagnosis, which often presents at an advanced stage, is highly relevant for palliative care.

Funder: Cambridgeshire Cancer Care

Abstract number: FC14.1
Abstract type: Oral

Pushing up Daises, Slipping Away or Dying – A Qualitative Study on the Expressions of Death and Dying among Family Members of Palliative Patients

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Background: Good communication is a core activity in palliative care. To be able to adapt end-of-life discussions to the individual, it seems important to study how family members (FMs) actually communicate about death and dying.

Aims: To examine FMs’ use of expressions when writing about death and dying.

Methods: This study was based on a secondary analysis of data collected in a cross-sectional study of FMs’ experiences of powerlessness during palliative home care. The responses from 233 FMs to open-ended questions were analysed with qualitative content analysis.

Results: The analysis resulted in three themes of expressions of death and dying. 1) Explicit expressions were e.g. ‘dying’, ‘dying’ and ‘to decease’, and they were often used in rational descriptions without apparent emotional turmoil, often describing an acceptance of what had happened. 2) Metaphorical expressions were focusing on different aspects of death such as loss, gradual deterioration, a calm rest, e.g. ‘it went to sleep’. 3) Those using implicit expressions avoided direct expressions aiming at death or dying, and instead used very diffuse terms or even skipped writing an expression at all, just leaving a blank space in the text. Those using an implicit language often described great personal psychological suffering.

The FMs described discontentment arising from bad communication with health care staff about death and dying. Some had experienced that health care staff had been too direct and explicit about death and dying, which was perceived as offensive and distressing. However, others experienced that communication about death and dying had been too indirect and implicit, and therefore difficult to understand, which had made the patient and family unable to comprehend and plan according to the situation, which in hindsight was saddening.

Conclusion: Important aspects of how FMs communicate about death and dying are identified and these have implications for clinical practice and future research.

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Free Communication Sessions

Abstract number: FC14.3
Abstract type: Oral

Preparing Family Caregivers of Nursing Home Residents with Dementia for the End of Life: Development of a Question Prompt Sheet

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Background: Research examining family members’ perceptions and satisfaction with end-of-life care provided in nursing homes demonstrates that family caregivers have significant unmet information needs and often feel unprepared for the death of the resident. Though they often have questions about death and dying as their relative’s illness progresses, research suggests that they are reluctant to ask questions for fear of being perceived as ignorant, and feeling overwhelmed pose barriers to families talking with clinicians.

Aims: The goal of this study was to develop an empirically derived communication tool aimed at facilitating dialogue between family caregivers and care providers concerning the end-of-life care of nursing home residents with dementia.

Methods: Using qualitative research methods, a convenience sample of bereaved family members of residents with dementia (n=17) and palliative care (n=6) were interviewed regarding their experiences, knowledge, and care of residents with dementia. Coding of interview transcripts focused on generation of themes and questions that were important to include on a question prompt sheet (QPS) about end-of-life care for residents with dementia. The items generated were reviewed by the participants for clarity, relevance, and importance and vetted by an international advisory panel.

Results: Analysis identified 6 themes and 31 questions were developed to cover the information respondents deemed critical for families to have conversations with care providers about, in order to understand quality care along the dementia trajectory.

Conclusion: The QPS-AD aims to improve communication between families and care providers around the progression of dementia in the context of the nursing home; a prerequisite for improving the palliative care of dementia in this setting. Funding received by the Canadian Institutes of Health Research and Manitoba Health Research Council.

Abstract number: FC14.4
Abstract type: Oral

Using a Novel Approach Training in End of Life Care: Evaluation of a Multidisciplinary (MDT) Simulation Based Training Course

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Background: Care of the dying requires healthcare professionals to have substantial technical, clinical knowledge and a refined understanding of end-of-life care. The families of terminally ill patients may require care that is sensitive, skilled and excellent communication skills.

Aims: To develop and pilot an MDT simulation course focused on care in the last hours or days of life and to evaluate the impact of the training.

Methods: The bespoke course consisted of an e-learning component & one study day focusing on scenarios simulating the last days of life of a patient and family in hospital. The course was piloted on 2 occasions in one hospital. The evaluation included pre and post course questionnaires & a thematic analysis of post course focus group interviews.

Results: 12 participants completed the and 4 nursing assistants (NAs); median age 33 years, 41% female; 11 participated in focus groups immediately following the training. Participants were overwhelmingly positive about the course, valuing the realism, small group size and MDT nature of the training. Feedback and the opportunity for reflection including the use of video recording were also highly valued. The participants were fairly knowledgeable and had generally positive perceptions of dying patients prior to the training. However, the greatest shift pre to post training was seen in the reduction of participants level of perceived helplessness when caring for dying patients. Confidence in all three domains (communication, management of the Patient, MDT working) was relatively high (around 60%) pre-training, particularly for MDT working. It rose immediately post training (T2) to between 70–80% in all domains but especially with regard to communication with the family and the provision of and referral for spiritual care.

Conclusions: Though the sample for this evaluation was very small, the course was universally valued by participants. Findings from the evaluation have been used to refine the course content and further courses are planned. Work is also underway to refine the evaluation tools.

Abstract number: FC14.5
Abstract type: Oral

A Change Is Needed in the Understanding of Anticipatory Grief: A Systematic Review of Existing Studies

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Background: Family caregivers of terminally ill cancer patients may experience anticipatory grief before the actual loss of the patient. Anticipatory grief has formerly been thought to improve bereavement outcome; but recent studies have indicated that it may, in fact, have a negative impact.

Aims: The aim was to investigate: 1) the definitions and quantitative measurements of anticipatory grief and 2) the effect of anticipatory grief on bereavement outcome.

Method: The study used a systematic approach to literature reviews in line with the PRISMA statement. Databases were searched for publications from 1990 to 2013. Studies on adult caregivers of adult cancer patients with advanced illness were included, if a quantitative measurement of anticipatory grief had been used. Definitions, measurements and results related to anticipatory grief were identified and key points were extracted.

Results: In the eleven included studies, anticipatory grief was described as either a ‘reaction’, a ‘feeling of grief or stress’ or ‘complicated grief’ occurring death. Therefore, anticipatory grief can be defined as ‘pre-loss grief’. Anticipatory grief symptoms of caregivers were measured on seven different scales in the eleven included studies. In four out of six included follow-up studies, the presence of anticipatory grief was associated with worsened bereavement outcomes e.g. depressive symptoms or complicated grief, while two studies found no association.

Conclusions: Anticipatory grief was reported as pre-loss grief and was associated with worsened bereavement outcomes. However, only few eligible studies had been carried out, and included measurements were inconsistent. The concept of anticipatory grief must thus be questioned, and the term ‘pre-loss grief’ may apply better to caregivers’ grief before the death of the patient. Targeted support should be directed to caregivers experiencing pre-loss grief, as this is associated with worsened bereavement outcomes.

Abstract number: FC14.6
Abstract type: Oral

Professional Communication about Advance Care Planning in Community Care Settings

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Aim: This paper reports findings from a UK study of communication about advance care planning (ACP) in community care. ACP is a key component of current policy to improve the experience of death and dying by enabling patients to consider options and preferences for future care. Limited evidence indicates that professionals and patients find such discussions difficult and that they are uncommon.

Methods: Qualitative study involving 1) longitudinal case studies of patient, carer and professional triads and 2) interviews with health professionals.

Thematic analysis of data using a comparative method.

Results: Professionals reported communication about ACP to be difficult and tended to avoid it. They cautiously searched for, and laid down, cues that patients were ‘ready’ and receptive to discussion, expecting patients to reject this invitation. Tentative approaches were couched in vague and euphemistic language. When they occurred, ACP discussions tended to focus on documentation of a few key decisions, such as resuscitation and place of death, rather than wider discussion of patients’ goals and values. ACP tended to be reactive, rather than anticipatory, and prompted by the recognition that death was imminent. Discussion focused on engendering a sense of ‘realism’ rather than promoting precedent autonomy.

Conclusions: Vague language and gentle cues enable patients to respond selectively to offers of ACP discussion, but risk perpetuating evasion and misunderstanding. When ACP occurs, professional agendas and assumptions can impose a subtle pressure on patients and caregivers to conform to normative expectations about the best and appropriate way to die. ACP discussions were often challenging for patients and professionals, and frequently lacked salience. The distance between ACP policy and its translation in clinical practice reflects the scarcity of translation about its purpose, based on greater understanding of patient perspectives and priorities for end of life care.

Exploratory Analyses of the Danish Palliative Care Trial (DanPaCT), a Randomised Trial of Early Specialised Palliative Care (SPC) versus Usual Care in Cancer Patients

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Background: Patients with metastatic cancer often experience considerable symptoms and problems. Aim: To investigate whether early SPC reduces symptoms and problems and increases satisfaction with the health care system (explorative outcomes).

Methods: The trial is a multicentre, parallel-group, superiority clinical trial with 1:1 randomisation conducted at six SPC centres. Consecutive patients with metastatic cancer were included if they had symptoms or problems measured with the EORTC QLQ-C30 questionnaire that exceeded a predefined threshold. In total, there were one primary and eight secondary outcomes (reported elsewhere). Explorative outcomes were the changes in the EORTC QLQ-C30 scales cancer pain, fatigue, global health status, insomnia, depression, anxiety and dyspnoea, and the FAMCARE p-16 single items measuring sleeplessness, constipation, diarrhoea, and financial difficulties; the Hospital Anxiety and Depression Scale anxiety and depression; and the FAMCARE p-16 single items measuring
Early Palliative Care for Patients with Metastatic Lung Cancer Receiving Chemotherapy: A Feasibility Study of a Nurse-led Screening Program


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Background: Providing early palliative care (EPC) is important, but it is unclear how this should be provided.

Aims: This study aimed to assess the feasibility of a nurse-led screening program for EPC interventions.

Methods: Patients with metastatic lung cancer undergoing first-line platinum-based chemotherapy (CTx) in an inpatient setting were eligible. The intervention was to promote receiving EPC using a screening questionnaire, followed by a comprehensive program which included certified nurses’ visiting, identifying problems, and arranging intervention of each profession if necessary. The primary endpoint was the completion rate of the assessment questionnaires after the second course of the first-line CTx (T2). The secondary endpoints included changes in scores of the Functional Assessment of Cancer Therapy-Lung (FACT-L), the rate of depression and anxiety assessed using Patient Health Questionnaire-9 and Hospital Anxiety and Depression Scale, and the contents of the EPC provided.

Results: From August 2012 to March 2014, 50 patients were enrolled. The median age was 66 years (range, 48–78), and 84% were men. Thirty-eight patients had stage IV non-small cell lung cancer, 17 had extensive disease small cell lung cancer. The completion rate was 70% (95% CI 56.0–81.0). The mean duration between baseline and T2 was 5.1±2.4 days. The reasons for non-completion were not receiving platinum-based CTx (n=2), switching to outpatient CTx (n=2), changing to second-line CTx (n=2), discontinuation of CTx (n=3), poor physical condition (n=2), and unwillingness (n=4). Forty-four patients received specialised palliative care. The FACT-L scales and the rates of depression and anxiety tended to improve from baseline.

Conclusions: This EPC intervention is feasible and potentially useful. Our results justified a further randomised control trial.

Abstract number: FC15.3
Abstract type: Oral

CaNoPy: A Study of the Care Needs of Patients with Idiopathic Pulmonary Fibrosis and their Carers

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Background: Idiopathic pulmonary fibrosis (IPF) is a chronic interstitial lung disease with varying clinical course, no proven treatment and median three year survival. Symptoms burden is high and quality of life (QoL) poor. Guidelines promote patient-centred appointments, including discussions of palliative care. However it is known of patient and carer experiences in order to guide care pathways.

Aims: To identify changes in individuals’ and carers’ perceived palliative and supportive care needs after the completion of IPF to inform future service interventions and delivery.

Methods: Multi-centre mixed-methods study across four stages of the IPF trajectory. Interpretative Phenomenological Analysis was used to analyse eight sets of semi-structured interviews with patients (n=2) and carers (n=10) and the completed validated questionnaires exploring QoL and symptoms.

Results: Patients and carers outlined key transition points where IPF made significant impact, representing triggers for focalised palliation. These related to diagnosis, changes in health status e.g. symptom progression, and introduction of oxygen, and loss of normality. Participants perceived a lack of relevance of PF clinic assessments to their lived experience, emphasising the burden of living with prognostic uncertainty and the active role of carers. Disparities in information needs and coping styles over time highlight the need for individualised patient and carer interventions.

Conclusions: CaNoPy is the first study to explore perceived care needs over the IPF trajectory and to examine care perception in detail. Key triggers for palliative interventions relate to roles, function and life events rather than to objective clinical based assessments necessitating a shift in focus of clinical encounters. Study outcomes will inform training and practice of IPF multidisciplinary teams, including timing of access to palliative care.

Abstract number: FC15.4
Abstract type: Oral

A Comparative Observational Study of the AMBER Care Bundle: Care Experiences of Clinical Uncertainty and Deterioration, in the Face of Limited Reversibility


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Background: Clinical uncertainty is emotionally challenging for patients and carers, and creates additional pressures for clinicians in acute hospitals. The AMBER care bundle was designed in the UK to improve care for patients identified as clinically unstable, deteriorating, with limited reversibility, and at risk of dying in the next 1-2 months.

Aims: To explore whether there were differences in care experience between patients who were cared for supported by the AMBER care bundle and those receiving standard care.

Methods: Comparative, non-randomised non-blinded mixed-methods study of AMBER Care Bundle (n=99) and standard care (n=108) patients. Interviews and focus groups (n=4) and one additional item measuring overall satisfaction, to the 3- and 8-weeks follow-up measured as area under the curve. All analyses were made as complete case analyses. Relevant sensitivity analyses will be reported at the conference.

Results: Totally 145 were randomised to early SPC versus 152 to standard care only. Early SPC should be provided.

Conclusion: This EPC bundle is feasible and potentially useful. Our results justified a further randomised controlled trial.

Abstract number: FC15.5
Abstract type: Oral

Access to Palliative Care of Homeless People: Perceived Barriers and Facilitators from Different Viewpoints

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Background: Homeless people may have various physical, psychosocial and psychiatric problems, including substance abuse. They have a shorter life-expectancy (< 20 yrs) in comparison with the general population and often avoid help for the problems mentioned. They relatively often suffer from progressive diseases like COPD, chronic heart failure and lung cancer. Little is known about how palliative care for this target group is organized and can be improved.

Aims: The aim is to describe the characteristics of palliative care for homeless people in the Netherlands and what barriers and facilitators exist for palliative care from the perspectives of the patients, their relatives and professionals.

Methods: In this qualitative study fifteen cases of homeless people needing palliative care are intensively studied. For each case we interview on average 3 people, including patients, relatives/friends, doctors, nurses and social workers. The interviews are transcribed verbatim and analysed inductively. Interviews are held in 2014 and 2015.

Results: Preliminary data show that different organisations and professionals are involved with homeless people. It is difficult to maintain long-lasting relationships with the patients. Their social network is often not stable and unable to give sufficient support. Mental health professionals generally feel insecure. Professionals in palliative care feel inadequately trained in deal with psychiatric problems and challenging behavior. Cooperation between palliative care professionals and mental health professionals who have much experience in supporting this target group, is needed to improve care for homeless people at the end of life and to realise better access to palliative care.

Conclusion: As far as we know this is one of first studies describing palliative care practices for homeless people. Cooperation between palliative care professionals and medical health professionals, who have much experience in supporting this target group, is needed to improve care for homeless people at the end of life and to realize better access to palliative care.

Abstract number: FC15.6
Abstract type: Oral
Free Communication sessions

Abstract number: FC16.6
Abstract type: Oral

Which Everyday Activity Problems Do People with Advanced Cancer Living at Home Prioritise - And Can Types of Activity Problems Be Predicted?

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Background: Worldwide people live longer with advanced cancer, and research shows that many have problems with everyday activities. Yet it is not known which types of activities they have problems with and prioritise. When planning interventions it would be useful to be able to predict which types of activity problems subgroups have.

Aims: To investigate which everyday activity problems people with advanced cancer have and prioritise, and to identify predictors for different types of activity problems.

Methods: In the cross-sectional part of ‘The Cancer Home Life Project’ 164 adults diagnosed with advanced cancer (median age 68 years, 52% men, different cancer diagnoses) were enrolled consecutively from two hospitals. Demographic and health data were collected in addition to data on prioritised activity problems using ‘The Individually Prioritised Problems Analysis’ (IPPA). Activity problems were grouped according to the ICF. Associations between activity problems and possible predictors (age, gender, living situation, cancer diagnosis, and symptoms) were accomplished using regression analyses of variables identified in bivariate analyses. Poisson was considered statistically significant.

Results: The most frequently prioritised activity problems concerned move around; transportation; prepare meals and do housework; maintain dwelling and vehicle; take care of daily living; personal hygiene; social relationships; and holidays. Out of 120 tested associations, 23 were statistically significant in the bivariate analyses and 10 in the regression analyses with no trends in prediction of subgroups’ prioritised activity problems.

Conclusion: The prioritised activity problems mostly concerned fulfilment of social roles, maintaining everyday life, and enjoying leisure activities. The fact that it was only possible to predict few prioritised activity shows that these are individual, and interventions should be based on dialogue.

Abstract number: FC16.1

Palliative Care Integrated in the Policy Architecture, Health Infrastructure, Service Delivery and Culture of a Nation: Defining Potential Models through Lessons from Four Countries in Sub-Saharan Africa

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Background: Islands of excellence of palliative care provision exist in many African countries. There is limited evidence on the process and the effects of what full integration into national health systems could deliver.

Aims: To build models of integrated hospital to community care based on the vision, workforce capacity, community need and services, and to capture their evolution and impact.

Methods: A 3 year (2012-2015) THETF funded multi-country partnership project on Strengthening and Integrating Palliative Care into National Health Systems led by the University of Edinburgh; the African Palliative Care Associations, working with national Ministries of Health and in-country organisations developed 12 models of integration in 12 hospitals, 3 each in Rwanda, Kenya, Uganda and Zambia. Based data was shared with hospital, community vision and national strategies to build an investment plan focused on basic training for different cadres of health workers, specialist training, clinical and pharmacy protocol and service development, community care training and infrastructure of services. Training was followed by a south-south and north-south mentoring programme.

Results: 12 hospitals have developed models of care ranging from inpatient bedded units, link nurse programme, shared hospice and hospital programmes and outpatient services. 1033 staff have been trained at various levels, 12 palliative care protocols have been adapted into national health systems, national strategies have been adapted, and morphine availability has increased. Staff have increased confidence in believing in palliative care as a service, as a system and as an approach to care that honours life and dying.

Conclusion: Palliative care integration into national health systems can only be achieved with integration of the training, management, and infrastructure needs of a hospital working with, in and through its community.

Abstract number: FC16.3
Abstract type: Oral

Systematic Review of Foci, Designs and Methods of Palliative Care Research Conducted in Sweden between 2007 and 2012

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Background: In order to guide further development of palliative care research, national reviews regarding characteristics of national PC research is suggested. In Sweden, a previous review of national palliative care from the 1970s to 2006 provided a useful source for comparison with research conducted during the subsequent six years.

Aims: To systematically examine palliative care research from Sweden between 2007 and 2012, with special attention to research foci, designs and methods.

Methods: A systematic review was undertaken. The databases Academic Search Elite, Age Line, Ahmed, Cinahl, PsychInfo, Pub Med, Scopus, Soc abstracts, Web of Science and Libris were reviewed for Swedish palliative care research studies published from 2007 to 2012, applying the same search criteria and inclusion criteria.

Results: A total of 263 papers met the inclusion criteria, indicating an increased volume of research compared to the 133 articles identified in the previous review. Common study foci were symptom assessment and management, experiences of illness, and care planning. Targeting non-cancer specific populations and utilisation of population-based register studies were identified as new features. There was continued domination of cross-sectional, qualitative and mono-disciplinary studies, not including ethnic minority groups, non-verbally communicable people, or children under 18 years of age.

Conclusion: Palliative care research has increased in Sweden, from 2007 to 2012 compared to during the 1970s to 2006, and there is an increased trend for research targeting non-cancer specific populations. A domination of qualitative approaches and small, cross-sectional studies were identified as new features. Targeting non-cancer specific populations and utilisation of population-based register studies were identified as new features. There was continued domination of cross-sectional, qualitative and mono-disciplinary studies, not including ethnic minority groups, non-verbally communicable people, or children under 18 years of age.

Abstract number: FC16.3
Abstract type: Oral

Oral Presentations Sessions

FC16 International developments and research

Abstract number: FC16.5
Abstract type: Oral

Recommendations for Political Decision Makers Based on Results from a Pre-test on the Use of Quality Indicators across 4 Settings in 5 Countries

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Background and aims: The overall aim of the IMPACT study is to develop tailored strategies for the implementation of quality indicators (QIs) to improve the organisation of palliative cancer and dementia care in Europe. For this purpose, the literature was systematically searched for organisational QIs in palliative care (PC). A set of 23 QIs was derived using a RAND Delphi. A pre-test on the use of this QI set was conducted among 40 services across 5 European countries (ENG, D, IT, NL, NO). The aim of this part of the study is to derive recommendations for political decision makers in order to facilitate political support for the implementation of QIs.

Methods: Quantitative data from the questionnaire with the consented and operationalised QIs were searched for measurements of low performance. Qualitative data from the participating services (field notes, transcripts of audiotaped sessions, categorisations of audiotaped sessions and interviews) were searched for aspects that address preconditions for better performance.

Results: Six most important recommendations for political decision makers emerged and will be presented along with suggestions for steps to be taken. These include:

• Promotion of 24/7 availability of specialised PC teams in all relevant settings
• Electronic patient files that are accessible 24/7 for professional carers in charge
• The use of regular assessment of pain and other symptoms in all settings caring for patients in need PC
• Multi-professional team meetings to be held on a weekly basis in all settings
• The necessity of family (and patient) satisfaction assessment; and accredited training for all professionals in the delivery of PC.

Conclusion: Data from the pre-test and discussions with the participating services in this study on the implementation of QIs strongly suggest that there are barriers which cannot be overcome without support from political decision makers.

Funding: EU FP7/2007-2013, grant agreement 258883
A Population-based Single-centre Study

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End-of-Life Chemotherapy in South Western Finland during 2003-2014: A Meta-review

Kovács L.1, Seyednasrollah F.1, Hirvonen O.1,2, Laitinen T.1,4, Jyrkkiö S.1, Elo E.L.1,2

Aims: To study place of death of older people in 13 countries; to evaluate if nursing home death rates increase with increasing old age, to identify factors associated with nursing home death in this population. Methods: Death certificate data for the full population of deaths in 14 countries were collected and pooled into one database. Descriptive and multivariable binary logistic regression analyses were performed to evaluate place of death patterns across four age groups: 80–84, 85–89, 90–94, ≥95. Three models of analysis were conducted to explain dependent factors of nursing home deaths among the oldest population. Results: Home deaths and deaths in hospitals and hospices varied from 9% (Chile) to 62.8% (Mexico); nursing home deaths varied from 2.9% (Korea) to 52.8% (Netherlands). The chances of a home death strongly increased and the chances of a nursing home death strongly increased with more advanced older age. This age-effect was particularly strong in Wales. Determinants of nursing home deaths were older age, being female, Alzheimer disease as cause of death and higher availability of nursing home beds in the region. These variables only partially explain country variation. Conclusions: Large cross-national differences were found concerning place of death in the oldest population. In all countries, hospital and nursing home were the best performing places in the end-of-life process of care for more advanced older age, highlighting the growing relevance of promoting palliative care in these settings in all ageing societies.

Abstract number: FC17.1

Symptom management

Using Palliative Care Quality Network Core Data to Drive Quality Improvement in Pain

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Background: Standardised data collection and outcome assessment in palliative care can define best practices and promote quality improvement (QI). Aims: Describe how the Palliative Care Quality Network (PCQN) dataset drives QI in pain management.

Methods: The PCQN core dataset consists of 23 data elements including demographics, processes of care and patient outcomes. The database generates automated reports with comparison across sites. We analysed PCQN data on pain to drive QI.

Results: To date, 12 sites have submitted data on 7080 patients. Of the 3120 patients who could rate pain, 30% (n=923) had moderate/severe pain at first assessment. Pain management was a reason for consultation for only 54% (n=494) of patients with moderate/severe pain. For these patients, the mean time from admission to PCS consultation request was shorter than for those not referred for pain management (4 vs 5 days). Overall, 65% (162/250) of patients with moderate/severe pain reported an improvement by the second assessment within 72 hours. Younger patients and those with moderate or severe pain, cancer, and improved anxiety were more likely to report improved pain.

Multivariate analysis, age, and diagnosis were no longer associated with improvement. Across PC sites, 10.5% of patients with improved pain ranged from 5.6% to 21.5%. The best performer saw patients sooner after admission (4 days) compared to the worst performer (7 days).

Conclusions: Standardised data collection by PCQN sites informs QI initiatives and identifies targets to improve care. Only half of patients with moderate/severe pain had pain management identified as a reason for consultation. Screening patients for pain at admission may improve care. PCQN data show that age and diagnosis were not associated with improved pain and need not be specific targets for QI efforts. There is variation in performance across sites. Understanding structure and processes of best performers could enhance care at other sites.

Abstract number: FC17.2

Blinded Patient Preference of Morphine in Chronic Refractory Breathlessness - More Than Meets the Eye

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Background: Little attention has been given to patients' preference for morphine therapy in the setting of chronic refractory breathlessness. However, this is one important factor in considering a longer term therapy.

Aims: To explore blinded patient preference of morphine compared to placebo in the setting of chronic refractory breathlessness and to establish predictors of preference. Methods: This was an aggregation of data from three randomised, double-blind, cross-over studies of morphine vs placebo (4 weeks each) in the setting of chronic refractory breathlessness. Blinded preferences were chosen at the end of the study. A multivariable regression model was used to establish patient predictors of preference.

Results: Sixty-five patients provided data (60 males). Median age 74 years, heart failure 55%, median (ECOG 2). Twenty-four percent of participants preferred morphine (32.3% placebo and 24.6% no preference). Younger patients preferred morphine and young age (p<0.001). There was also an inverse correlation between morphine preference and sedation (p<0.05). An inverse correlation between nausea and morphine preference was seen in the univariable model only (p<0.05). No correlation was seen between cross over from morphine preference and breathlessness intensity, either at baseline or change from baseline.

Conclusions: Participants preferred morphine over placebo for the relief of chronic refractory breathlessness.
breathlessness. Younger age is associated with preference. Absence of nausea and sedation also appear to influence choice. Preference was not correlated with quantitative improvement of breathlessness.

Abstract number: FC17.3
Abstract type: Oral

Effects of Melatonin on Physical Fatigue and Other Symptoms in Patients with Advanced Cancer in Palliative Care: A Double-blind Placebo-controlled Crossover Trial

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Background: Patients with advanced cancer often suffer from fatigue, pain, depression and other symptoms that negatively impact quality of life. Previous research suggests that melatonin could have a potential in treating these symptoms.

Aims: To investigate the effect of melatonin on fatigue and other symptoms in patients with advanced cancer.

Methods: Patients who were at least 18 years, had a histologically confirmed stage IV cancer and who were at least quite a bit tired were recruited from our palliative care unit. This was a double blind, randomised, placebo-controlled crossover trial. Patients received one week of 20 mg melatonin or a placebo orally each night, before crossing over and receiving the opposite treatment for one week. Between the two periods, a wash out period of two days was employed. St. Gallen Oncology Palliative Medicine Group, Section Oncology, Dept. of Internal Medicine and Palliative Care, St. Gallen, Switzerland, ‘National’ University Hospital, Departments of Medicine, Trondheim, Norway, ‘St. Olav Hospital, Trondheim University Hospital, Cancer Clinic, Trondheim, Norway,

Results: 72 patients were randomised. 50 patients completed the intervention. 44 were complete compliers. No significant differences between melatonin and placebo period were found for the primary outcome physical fatigue (mean difference=2.8 ± 0.0-100 scale, p=0.60) or for any secondary or explorative outcomes. This finding was supported in the sensitivity analyses.

Conclusion: Oral melatonin 20 mg for one week did not improve fatigue or other symptoms in patients with advanced cancer.

Abstract number: FC17.4
Abstract type: Oral

Late Breaking Abstract: Cancer Cachexia Classification in a Large Longitudinal Patient Cohort

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Background: Cachectic patients (C) are frequently used in palliative care. Patients using CS are at risk of side effects including poor sleep quality. The impact of CS on sleep has not been evaluated in palliative care patients. We conducted a double-blind randomised controlled trial evaluating the analgesic effect of corticosteroids in cancer patients. A secondary aim was to evaluate the effect of CS on sleep quality.

Methods: Adult cancer patients with average pain intensity last 24 hours ≥ 4 (NRS 0–10) and a history of poor sleep quality were included. Patients were randomised to either continuation of current opioid treatment or randomisation to one of 3 tapering strategies. Randomisation, patients received methylprednisolone 16 mg or placebo twice daily for seven days. On day six patients received a corticosteroid on top of their opioid dose. On day seven there was no difference between the groups in PSQI global score: CS group: 9.21 (7.14 –11.28); placebo group 8.32 (6.62 –10.01) (p=0.50). Also the change from baseline was similar: CS group: 0.33 (-0.48 –1.15), placebo group -0.53 (-1.12 –0.01) (p=0.50). Changes were not significant.

Conclusion: This study was powered to show a difference of 1 point in PSQI global score, but was not powered to detect a difference in sleep quality.

Abstract number: FC17.5
Abstract type: Oral

Cancer Related Fatigue - Are We Offering Enough?

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Background: Cancer related fatigue (CRF) is a prevalent but under documented symptom. There is a misconception that little support can be offered. A fatigue interest group was established in a large cancer centre to raise awareness, (staff education and talking to patient support groups), to develop a fatigue pathway and improve patient experience.

Methods: 2 surveys were conducted 1) 68 case notes were examined to determine the level of reporting of CRF and 2) 146 outpatients were given a questionnaire and the EORTC Fatigue measure (FA13) to determine the incidence, severity and impact of CRF and what interventions were routinely offered to cancer patients.

Results: 29 (43%) of notes recorded patients experiencing CRF on at least one occasion but in only 2 cases was there evidence that patients had been given advice. From the 108 respondents in the prospective study 93 (86%) reported being advised to expect CRF during treatment, feeling to 67% being asked again during treatment. 84 patients reported physical CRF; 55 emotional CRF and 43 cognitive CRF. 55% of patients experiencing CRF were offered advice. 0.02% were not offered a readily available booklet and of those 18 would have liked to see it. Despite the growing counter-intuitive evidence that exercise is a useful intervention there was no evidence to suggest its promotion. As a manifestation of their CRF, several patients expressed anger and frustration from being told to exercise.

Conclusions: A gap remains in the support offered to patients. Lack of awareness of CRF was the primary reason; patients expressed anger or frustration at being told to exercise. They also commented on the CRF’s cyclical nature linked to treatment schedules.

Abstract number: FC17.6
Abstract type: Oral

Does Melatonin 20 mg Affect Sleep Quality in Advanced Cancer Patients with Pain? A Randomized, Controlled Trial

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Background: Fatigue and sleep disturbances are common among cancer patients and significantly impact their quality of life. Despite this, the effects of melatonin on fatigue and other symptoms in patients with advanced cancer are not well understood.

Methods: In this cohort, 35 out of 49 cancer patients with advanced disease and pain reported poor sleep quality. Melatonin 20 mg daily for 7 days did not affect the sleep quality as measured by PSQI.

Funding: Telemark Hospital Trust

Abstract number: FC17.7
Abstract type: Oral

Promoting awareness and education of CRF to patients, carers and health care professionals, could improve the overall patient experience of this distressing symptom.
**FC18 Palliative care for older people**

**Abstract number:** FC18.1  
**Abstract type:** Oral

Symptom Burden in Elderly Patients Admitted to Hospice Care. A Cross sectional Study  

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Elderly have less and later access to specialized palliative care services due to difficulties in palliative phase marking and identifying palliative care needs.  

**Aim:** To investigate differences and similarities of symptom prevalence and intensity of hospice patients in different age-groups.  

**Method:** A cross sectional study. Patients admitted from June 2007 to December 2014 to a high care hospice facility in the Netherlands, able and willing to self-assess symptom intensity between the first week after admission, enrolled in this study. Prospectively collected data from the Utrecht Symptom Diary (USD), a Dutch adapted translation of the PainDETECT (PD) and the Symptom Assessment System, were used, measuring symptom intensity of 12 symptoms and well-being on a 0–10 numerical scale.  

**Outcomes:** Symptom prevalence (USD>0) and symptom intensity.  

**Data analysis:** Patients and those with severe pain were excluded. Significance: < 0.05.  

**Results:** A total of 227/342 (66.4%) patients were included: 38% men, median age 74 (31–96), SD 12.782. Ineligible patients were more likely to be >85, life expectancy <7 days, ECOG performance status <1, and unable to survive <2 weeks. Patients suffered from 6.3 symptoms concurrently, 4.6 scored >3 on USD. Fatigue, dry mouth and anorexia were most prevalent and intense in all age-groups, except for <65 in which pain was more prevalent than anorexia. Patients <65 suffered from pain more often (p = 0.01) and intense (p = 0.05), and patients >85 suffered from anorexia more often (p = 0.47).  

**Conclusion:** Little differences between age-groups, underpin the need for individualised palliative care for all patients despite age. However, old and severely ill patients were less able to self-assess their symptoms, indicating a need for innovative strategies to assess symptoms and specific needs of elderly by collaboration with geriatric and primary care specialists.

**Abstract number:** FC18.2  
**Abstract type:** Oral

Factors Associated with End of Life Transition for Older Adults Living at Home: Analysis of Carers’ Post-bereavement Survey  

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**Aim:** To describe patterns of multidimensional change in the experience of frail older adults towards the end of life.  

**Methods:** 76 in-depth qualitative interviews were carried out with 13 frail older participants and their key formal and informal carers repeatedly for 18 months. Participants were cognitively intact, community dwelling adults considered to be moderately or severely frail. The interviews were participant led, audio-recorded and fully transcribed. The voice centered relational narrative method of analysis was used to complete case studies highlighting physical, social, psychological and existential change to suggest narrative trajectories.  

**Results:** Three patterns of change emerged alongside a gradual physical deterioration:  

1. The stable narrative represented a maintenance of psychological and existential well-being punctuated by brief dips that corresponded to physical changes or events. A gradual social decline mirrored physical deterioration.  

2. The regressive narrative differed in showing a descent in psychological and existential well-being.  

3. The tragic narrative showed a marked downturn in social, psychological and existential well-being just before death.  

**Conclusion:** Patterns of multidimensional change for frail older people suggested by the narrative accounts differ from those described for deaths from organ failure or cancer. Understanding these patterns may highlight how to alleviate psychological, social and existential distress as frail older people reach the end of life in order to enable them to die before their stories become tragic. ESRC funding.

**Abstract number:** FC18.3  
**Abstract type:** Oral

Patterns of Multidimensional Change towards the End of Life for Frail Older People  

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**Background:** Patterns of physical decline have been proposed for those dying with cancer, organ failure and frailty. These have been expanded to include change across the other palliative care dimensions for those with cancer and organ disease but not for frailty. An understanding of changes across these dimensions would help to assess how a palliative approach could help frail older people.  

**Aims:** To describe patterns of multidimensional change in the experience of frail older adults towards the end of life.  

**Methods:** 76 in-depth qualitative interviews were carried out with 13 frail older participants and their key formal and informal carers repeatedly for 18 months. Participants were cognitively intact, community dwelling adults considered to be moderately or severely frail. The interviews were participant led, audio-recorded and fully transcribed. The voice centered relational narrative method of analysis was used to complete case studies highlighting physical, social, psychological and existential change to suggest narrative trajectories.  

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3. The tragic narrative showed a marked downturn in social, psychological and existential well-being just before death.  

**Conclusion:** Patterns of multidimensional change for frail older people suggested by the narrative accounts differ from those described for deaths from organ failure or cancer. Understanding these patterns may highlight how to alleviate psychological, social and existential distress as frail older people reach the end of life in order to enable them to die before their stories become tragic. ESRC funding.
Abstract number: FC19.1

Improving support for caregivers

Abstract type: Oral

Shifts in Care Approaches and Attitudes at the End of Life of People with Intellectual Disabilities: From Activating Towards Caring and Letting Go

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Background: The focus in the care for people with intellectual disabilities (ID) is predominantly self-reliance and participation. An increasing number of them will have life-limiting illnesses and will need palliative care, that requires another care approach.

Aims: The aim is to describe how and who professionals and relatives change their care approach and attitudes when palliative care is needed.

Methods: Twelve cases of deceased people with ID were reconstructed from the perspective of a relative, doctor, nurse and or social worker. Half of them died of cancer, while the others died from other chronic diseases or ‘old age problems’. The interviews were transcribed for content analysis.

Results: Five major shifts in care approach were found:

1) Care staff change their care approach and attitudes to adapt a focus on comforting care, taking over tasks and symptom relief.
2) The interweaving of emotional and professional involvement increasingly became a challenge for care staff.
3) There was heavy reliance on the joint interpretation of signals expressing distress and pain, as symptom relief became urgent and communication with the person with ID was often difficult.
4) The dependency of the person with ID became magnified in the perception of relatives, and medical decisions in particular led to relatives having an overwhelming feeling of responsibility.
5) The awareness grew that the person with ID actually had ‘two families’ who were letting go: relatives and the care staff.

Conclusion: Palliative care for people with ID involves curtailed expectations of participation and skill acquisition, and an increase in teamwork featuring intensified comforting care, symptom management and medical decision making. ID care services should invest particularly in the emotional support expertise level of care staff, and in the collaboration between relatives and professionals.

Abstract number: FC19.2

The Carers’ Alert Thermometer (CAT): An Instrument to Identify Family Carers’ Needs Whilst Providing End of Life Care in the Home


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Background: General international policy promotes the choice of a home death for dying patients placing substantial demands on family carers. Recognising the burden on carers, research has highlighted the need for effective support of family carers. To prevent crisis situations & avoid unnecessary hospital admissions, which are of global concern, it is necessary to identify carer needs and provide appropriate interventions to support them in their role. There are no evidence-based instruments used by non-specialist staff going into patients’ homes to assess carer needs whilst they provide end of life care.

Aim: To explore what professionals and carers of patients in their last year of life find burdensome & develop an alert system for use by non-specialist staff.

Methods: A mixed-method, multi-phase, consensus study sequentially utilising qualitative and quantitative data to develop and pilot the CAT involving 245 participants (117 carers & 128 professionals) across a range of health & social care settings in the North West of England (2011-2014).

Results: Participants identified a complex range of burdens across eight domains which fit within two overarching themes: the support needed by the carer to provide care and the support needed for the carer’s own health and well-being. There was high agreement between carers and professionals on the priority burdens for detection by the CAT, which was supported in the pilot.

Conclusion: The varied and complex needs of carers are often unmet until a crisis is reached. The CAT is an evidence-based, short screening instrument of 10 questions with a traffic light system for risk of each alert and a visual thermometer to identify the extent of the carer’s unmet needs. The guide lines can be tailored to local practice, and has been successfully used in an action plan to monitor use interventions. Preliminary piloting of the CAT found it was valued, fit for purpose and could be administered by a range of staff. This paper will present the findings and ongoing implementation of the CAT.

Abstract number: FC19.3

Piloting a New Approach to Identifying, Assessing and Supporting Carers of People with Palliative Care Needs in Primary Care

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Abstract type: Oral

Background: UK general practices are incentivised to have a protocol for the identification of carers and a mechanism for referral for social services assessment. This is rarely done systematically and very few carers of patients with palliative care needs are identified. Thus they fail to receive support.

Aim: To model and pilot a systematic approach to identifying, assessing and supporting carers of people with palliative care needs in primary care.

Methods: The intervention was modelled on the MRC complex intervention framework which incorporates a preliminary theoretical phase. These findings are reported elsewhere. Four general practices which varied in size were recruited to pilot the intervention over 12 months. Each practice nominated a carer liaison to lead on carer identification and support.

Results: The practices varied in size from 5480 to 10832 patients. The carer liaisons were in clinical, administrative and management roles. In total, 83 carers were recruited to the protocol, 40% were using formal carer practices vs registers; illness; 13, palliative care (12), carer (11); (2) advanced care plans (12) or opportunistically (28) at GP appointments or at home. Posters encouraging self-identification were displayed in waiting rooms and 7 carers self-identified. There were 55 female and 28 male carers. 33 cared for someone with dementia.

Overall, 81 carers received the intervention and 25 returned the Carer Support Needs Assessment Tool (CSNAT). On average, carers each identified 4/14 areas of need. 11 carers received a follow up call from the practice to discuss support. 12 carers were also referred for support.

Conclusion: Findings suggest that this new approach to identifying and supporting carers is deliverable in a primary care setting and works most effectively when embedded within the whole GP practice. A key challenge is the reluctance of carers to identify as such and to accept offers of support, although many felt better equipped to seek help in the future.

Abstract number: FC19.4

Short- and Long Term Effects of a Randomised Psycho-educational Intervention for Family Caregivers in Specialised Palliative Home Care


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Abstract type: Oral

Facility (68.5% & 84.7%) or documentation of end of life wishes (71.4% vs 72.4%). While there was no difference in the number of transfers to hospital in the last week of life (18.9% vs 21.6%), residents who died had lower levels of stress (κ=0.070, p<0.000). There were significant differences in the number of residents who had a palliative care care conference (45.5% vs 59.7%, χ²=10.79, p<0.001) and commenced on an end-of-life care pathway (κ=16.12, p<0.001) after the model of care was implemented.

Conclusion: The Palliative Approach Toolkit assists clinicians translate knowledge into practice and has reduced length of hospital stay in the last week of life and improved care planning through the use of case conferences and an end-of-life care pathway.

Abstract number: FC18.6

Older Adults’ Preferences for Accessing Specialist Palliative Care Services for Improvement

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Abstract type: Oral

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Background: Older adult’s access to specialist palliative care (SPC) services in acute settings is not ideal. Not all that require specialist input receive it. The extent to which patients’ understanding of SPC, preference for SPC, and associated behaviour results in accessing SPC is unclear.

Aim: To explore how older patients’ understanding of SPC, their preferences for SPC, and their behaviour influences access to SPC services in acute hospitals in Ireland.

Methods: Principles of grounded theory analysis of interviews with patients over the age of 65 who had successfully accessed specialist palliative care in Ireland and that were sampled purposively as one component of an international study involving studies in the UK, Ireland and the USA.

Results: Limited awareness of SPC and its role influenced, although did not determine, SPC access. However, awareness of SPC did influence whether patients could request SPC referral to their local hospital. Additional factors which influenced the access included: the patient’s level of engagement with healthcare professionals (HCPs); previous experience with or accurate communication about SPC, staff prioritising relational aspects of providing care, which led to the identification of patient SPC need; and, open communication about prognosis between health care professionals, patients and unpaid caregivers.

Conclusion: Improved understanding of the patients’ perspective can help HCPs to tailor communication and information-sharing in a manner that addresses barriers to expressing needs and preferences. This can help HCPs identify palliative care needs and initiate access to SPC services. Additionally, improved public awareness of palliative care services would help ensure that patients are sufficiently informed about the availability and suitability of such input.

Funders: Atlantic Philanthropies and Cicely Saunders International
a burden of caring for a person with incurable illness. Research has shown that there is a need for intervention studies to make family caregivers more prepared and competent for their situation.

Aim: To investigate the short- and long-term effects of a randomised psycho-educational intervention for family caregivers in specialised palliative home care.

Methods: A randomised control trial in 7 public hospitals in the Netherlands. The 14 intervention group (IG) was delivered as a psycho-educational intervention programme, whereas the 14 control group (CG) received usual care. Participants were hospitalised patients who agreed to participate in the study and were randomised to an intervention group with three sessions or to a control group with standard care. Family caregivers were required to answer to questionnaires at baseline, upon completion and two months following the intervention. The questionnaires comprised instruments concerning family caregivers’ feelings of preparedness, competence, reward, burden, health, anxiety and depression. A regression model based on robust variance estimates was conducted for all tested outcomes.

Results: 177 family caregivers completed all three measurements. Results showed that in the short-term both family caregiver groups had significantly better self-rated competence for caregiving and experience of health. In the long-term follow-up, the intervention group had significantly better self-rated preparedness for caregiving compared to the control group.

Conclusion: The results add to previous research that short psycho-educational interventions could have important positive short- and long-term effects on family caregivers.

Funding: This study was supported by the Erling-Persson family foundation.

Abstract number: FC19.5

Abstract type: Oral

Everyone his “Own Truth”; Comparison of Experiences Concerning the Last Days of Life in the Hospital

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Background: When patients die, relatives and health care professionals may appreciate the quality of the dying phase differently, but comparisons are rare.

Aims: Comparison of experiences of bereaved relatives, physicians and nurses concerning the care in the last days of life.

Methods: A cross-sectional study (June 2009–July 2012), in a Dutch university hospital, among the relatives of patients and nurses of patients dying in the hospital. Outcomes were the extent to which participants agree on patients’ quality of life during the final 3 days of life (QOL3) and quality of dying (QOD) (both on a 0–10 scale), on awareness of impending death, and on end-of-life communication, and the relation between end-of-life communication and preparedness for life closure. Multilevel regression analyses, Cohen’s Kappa, and Spearman’s Rho were used for analyses.

Results: Data on all three perspectives were available for 200 patients (mean age of 69 years, 59% male and 54% dying from cancer). Concordance was in general poor. QOL3 scores from relatives (median IM: 7; Inter Quantile Range [IQR] 1–6) were lower than those from physicians and nurses (both M 5; IQR 3–6; p < 0.001). Relatives’ scores for QOD (M 7; IQR 5–8) were also lower than physicians’ and nurses’ scores (both M 7; IQR 6–8; p = 0.002). 48% of relatives, 77% of physicians and 73% of nurses had been aware of the patient’s impending death. Physicians more often reported to have informed patients and relatives of end-of-life issues than relatives indicated. When both physicians and relatives reported that physicians had discussed the patient’s prognosis, relatives had more often been aware of impending death and present at patient’s deathbed.

Conclusion: Relatives, physicians and nurses seem to have their ‘own truth’ about care for the dying. Professional caregivers must place more emphasis on collaboration with relatives, on timely communication about impending death, and on verification of relatives’ understanding.

Abstract number: FC19.6

Abstract type: Oral

Carers at Risk: Anxiety and Depression in Carers of Patients with Advanced COPD and the Relationship to the Caring Role

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Background: Chronic obstructive pulmonary disease (COPD) is a progressive condition which can lead to high carer burden. Anxiety and depression are higher in informal carers of patients with advanced COPD than in the general population. But we lack robust evidence of patient- and carer factors that may be associated with poorer carer psychological health and how best carers can be supported.

Aims: To identify the rates and severity of anxiety and depression in informal carers of patients with advanced COPD and how they relate for key carer’s of the caring role size to identify and support at risk carers.

Methods: Mixed method interviews with a cohort of 115 informal carers of patients with advanced COPD recruited from a primary care population base (East of England). Carer data includes duration and hours of caring, relationship caring, carer health, carer support from services, patient factors, Hospital Anxiety and Depression Scale (HADS: anxiety and depression), Preparedness for Caregiving Tool, and Care Support Needs Assessment Tool. Quantitative data analysed with descriptive statistics. Purposively sampled qualitative data analysed using framework approach.

Results: HADS identified probable clinical anxiety in 27% of carers and probable clinical depression in 10%. The results of our ongoing analyses will report the relationship these higher than population norm rates with key variables in the caring role (such as hours and duration of caring, socioeconomic status, patient factors, preparedness of carers to care, and carer support needs in advanced COPD) to enable identification of at risk carers.

Conclusion: This analysis will provide new evidence on the psychological health and support needs of informal carers of patients with advanced COPD to enable identification of at risk carers and the development of services to enable support for those providing informal care in advanced non-malignant disease.

Funder: NHRI and Marie Curie Cancer Care

Abstract number: FC20.1

What Are the Patterns of Dying in Acute Stroke?

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Background: Implementation of stroke professionals’ palliative care role outlined in the UK National Clinical Guidelines for stroke is challenged by uncertainty about prognosis. Creating knowledge about the typology of dying in acute stroke (defined as the first 28 days after stroke onset) may usefully complement models that predict mortality.

Aims: To identify the patterns of dying in acute stroke services, and explore patient and family carer experiences.

Methods: An observational study prospectively identified dying trajectories within acute stroke. Biographical, stroke and care episode data, including the type of dying trajectory for deceased patients, were collected from consecutive admissions. We classified death trajectories as sudden; rapid; episodic; slow; or other, particularised to an acute stroke context. Interviews were conducted with a sample of patients, family carers and bereaved relatives, exploring narratives of experience and initiation of end of life care. The study was undertaken over a 6 month period in 4 UK acute stroke and heart failure services.

Results: Of 868 admissions screened; 627 (71.4%) were eligible for inclusion. Six patients, nine family members and two bereaved family members took part in interviews. There were 91 deaths during the study period (14.3% of stroke patients) with dying trajectories classified for 72 deceased patients. Five (7.3%) were classed as sudden deaths; 64 (88.6%) as rapid (2.3% as episodic and 1.0% as slow). Qualitative findings highlighted the significance that patients and families attach to clinical geography, including the type of care setting, in making sense of prognosis. A range of helpful messages from staff around planning for end of life care within a context of hope were reported.

Conclusions: The pattern of dying that acute stroke service staff encounter most is a rapid decline in a patient’s condition, with a distinct terminal phase, although not set within a general context of deterioration.

Abstract number: FC20.2

Abstract type: Oral

End-of-Life Hospitalisation for Patients Dying of Chronic Obstructive Pulmonary Disease, Heart Failure, and Cancer: A Nationwide Study

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Background: Most patients prefer to remain at home as much as possible at the end of life. Hence, hospitalisations in the last months of life may be seen as adverse events. More knowledge is therefore needed on the characteristics and determinants of hospitalisations among terminal ill patients. The role of the underlying disease is of particular interest in this context as previous findings suggest that end-of-life care to non-cancer patients is suboptimal compared to patients with malignant diagnoses.

Aims: To compare use of hospital admissions within six months before death among patients who died of chronic obstructive pulmonary disease (COPD), heart failure, or cancer using the Danish Registry of Causes of Death. Data on all hospital admissions within six months before death were obtained from the Danish National Registry of Patients.

We computed the median number of days spent in hospital within the six months period. Finally, we compared the total length of hospitalisation adjusted for age and gender using linear regression.

Results: For deceased patients with COPD, heart failure, and cancer, the median number of days spent in hospital during the last six months before death was 14, 13 and 20 days, respectively. This corresponded to 7.2%, 7.8%, and 11.1% of the days within the last six months. The adjusted relative length of stay was 0.59 (95% CI, 0.57; 0.62) for COPD patients, and 0.51 (95% CI, 0.48; 0.54) for patients with heart failure when compared with patients with cancer. Certain factors that may be chronic obstructive pulmonary disease and heart failure spend less time at hospital at the end of life than cancer patients. More knowledge is warranted on differences in end of life care patterns among cancer and non-cancer patients.

Funding: Danish Heart Association.
Economic Evaluation of Palliative Care Consultation Teams for Patients Admitted to Hospital with Advanced Cancer

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Background: The average cost-saving effect of palliative care consultation teams (PCTTs) for hospital inpatients with serious illness is well known. This effect is not homogeneous but varies according to a complex interaction of individual and service factors. Evidence on the relationship between patient-level determinants, PCTT process and cost will further inform organisation of hospital care to patients with serious illness.

Aims: To evaluate the impact of PCTTs on hospital cost, incorporating time-to-consult following admission and individual clinical factors.

Methods: Using a prospective, observational design, clinical and hospital cost data were collected for adult patients with an advanced cancer diagnosis admitted to five hospitals in the United States in a four-year period. The final sample was 969 patients; 256 saw a PCTT during their hospital admission, 713 received usual care only. Propensity score weights were calculated to balance treatment and comparison arms. Generalised linear models (GLMs) with a gamma distribution and a log link were applied to estimate association between treatment, patient covariates and cost.

Results: Earlier consultation is associated with a larger effect on hospital cost: an intervention within six days is estimated to reduce total costs by 13% (p=0.04) compared to no intervention and within two days by 23% (p=0.005) compared to no intervention. PCTT treatment effect also varies according to selected baseline covariates; effect on cost is larger for patients with a higher number of comorbidities.

Conclusion: PCTT treatment effect on costs is not homogenous. Our results complement a growing body of research on quality, survival and cost suggesting that early palliative care should be more widely implemented, particularly for patients with multi-morbidity. The potential for cost-saving through PCTTs is yet to be fully realised: only a quarter of patients in our study saw a PCTT promptly upon hospital admission.
Abstract number: PA-1
Abstract type: Poster Prize

Analysis of Determinants of Impaired Role Functioning Across Prevalent Cancers
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Background: Cancers are associated with role functioning impairment, but its determinants are not well known.
Aims: To assess the determinants of role functioning in patients with prevalent cancers such as lung, breast and colorectal.
Methods: Observational study performed on subjects with one of the cancer types mentioned above and who agreed to participate. Role functioning was evaluated with the specific domain of the EQ-5D-5L questionnaire along with other variables including age, gender, quality of life, presence of clinically significant fatigue. This latter was defined as having the score of at least 4 as assessed with the Edmonton Symptom Assessment System (ESAS).
Results: The sample included 79 (34 with lung cancer, 24 with breast cancer and 21 with colorectal cancer), with a mean age of 63.3, 37 females and a mean role functioning (RF) score of 54.4. RF was comparable in older versus younger patients, was more impaired in males versus females (39.6 versus 71.1, p< 0.001) and in lung cancer subset versus breast or colorectal cancer (40.9 versus 50.5 versus 77, p< 0.001 for first versus second or third). It was also significantly decreased in patients with clinically significant fatigue compared to those without (39.8 versus 78.3, p< 0.001). Multiple regression analysis determined that clinically significant fatigue was the strongest predictor of impaired role functioning (r partial -0.48 p< 0.001) and that cancer type was also a significant predictor (r partial 0.32, p=0.0043).

Discussion: Previous analyses focused on psychological, and social variables and none took into account clinical factors.
Conclusion: Among determinants of role function fatigue and type of cancer were found to be strong predictors and this should be taken into consideration especially in a palliative care setting.

Abstract number: PA-2
Abstract type: Poster Prize

Survival Time after Diagnosis of Terminal Illness: A Nation-wide Danish Cohort Study
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Introduction: Life threatening illness may be incurable in some patients. When the survival time for a patient with life-threatening disease is estimated as short, Danish patients may be granted drug reimbursement. The final stage of life is determined by a clinical assessment, and eligibility for drug reimbursement may be a key marker of this stage. To decide when a life-threatening illness has become terminal is an on-going challenge, which may vary according to diagnosis.
Aims: To describe the survival time, according to diagnosis, in patients for whom life-threatening illness has been assessed as terminal.
Method: The design was a historical cohort study of terminally ill patients >18 years of age, who had been granted drug reimbursement in 2012 (inclusion year). Patients were included from the date they were granted drug reimbursement. In total, 10,453 patients were followed until death or end of follow-up in June 2014. Survival curves were calculated using the Kaplan-Meier method. Patient survival time was then dichotomised, according to diagnosis, at a survival time cut point of 30 days, and data were analysed using a logistic regression model.
Results: Included patients had an overall median survival time of 56 days; the median survival time was 59 days for lung cancer, 81 days for prostate cancer, 75 days for breast cancer, 68 days for colorectal cancer, and 19 days for non-cancer disease. Compared to lung cancer, the crude odds of surviving longer than the first 30 days were 23% higher for prostate cancer, the same for breast and colorectal cancer, but 63% lower for non-cancer disease.
Conclusion: The vast majority of patients die during the first few months after receiving drug reimbursement, although the short-term survival differs according to diagnosis. Non-cancer patients are assessed to have terminal illness particularly shortly before their actual death. These findings underline the difficulties in predicting the survival time at the end of life.

Abstract number: PA-3
Abstract type: Poster Prize

Family Cohesion after Losing a Parent to Cancer as a Teenager and Long-term Health and Wellbeing
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Purpose: To investigate self-perceived family cohesion the first year after a loss of a parent to cancer and its association to long-term health and wellbeing among youths that were bereaved six to nine years earlier, in teenage.
Method and participants: In this nationwide population-based retrospective study, 622 of 851 (73%) youths (aged 18-23) responded to a questionnaire six to nine years after losing a parent to cancer at the age of 13 to 16. Associations were assessed with univariable and multivariable logistic regression.
Results: Cancer-bereaved youths who perceived poor (no/little) family cohesion the first year after the loss, were likelier to have moderate to severe depression 6-9 years after losing a parent to cancer in comparison with those reporting good (moderate/good) family cohesion. They were also likelier to report low wellbeing, symptoms of anxiety, problematic sleeping, emotional numbness and dammed-up grief. This remained statistically significant after adjusting for a variety of possible confounding factors.
Conclusion: Perceived poor family cohesion the first year after losing a parent to cancer was strongly associated with long-term negative health-related outcomes among bereaved youth. To give attention to family cohesion and provide support, if needed, to strengthen family cohesion in bereaved to-be families, might prevent long-term suffering in their teenage children.
Poster Sessions
(Poster Exhibition Set 1)

Pain
Breathlessness
Fatigue/weakness/cachexia
Other symptoms
Assessment and measurement tools
Audit and quality improvement
Basic and translational research
Bereavement
Communication
Development and organisation of services
Education
Ethics
Family and care givers
International developments
Medical sociology
Health services research
Policy
Public health and epidemiology
Spirituality
Social care and social work
Psychology and psychiatry
Research methodology
Volunteering
Cancer
Non-cancer
Palliative care for older people
Palliative care in children and adolescents
Second Signatory for Controlled Medications: Can it Cause Hindrance to Good Breakthrough Pain Management?
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Abstract type: Poster
Abstract number: P1-003
Background: For many haematological cancers, Peripheral Blood stem cell transplant (PBSC) therapy is used. This can be from the patient themselves or from a donor. PBSC7 can give debilitating and severe side effects such as mucositis, diarrhoea, nausea and vomiting, which can impact on the patient’s recovery and wellbeing.
Methods: To establish the prevalence of symptoms in patients who receive PBSC. To establish whether the Palliative care team is being involved for symptom management.
Results: Twenty five (78%) patients had some degree of mucositis post-transplant and only 7 (28%) of these had palliative care involvement. Eight (25%) patients had grade 3 or 4 mucositis (fluid only diet or unable to swallow due to pain) and 50% of these were referred to the palliative care team for symptom management. 35% of alopecia PBSC patients and 17% of autologous SCT patients had grade 3 or 4 mucositis. The mucositis severity was worst around day 12 post-transplant. Diarrhoea was a fairly common symptom with 13/32 (40%) patients having diarrhoea more than twice, 8/32 (25%) patients having diarrhoea more than 5 times and 5/32 (15%) patients having diarrhoea more than 10 times post-transplant. Vomiting was less common with 17/32 (53%) patients vomiting more than twice and 5/32 (15%) patients vomiting more than five times post-transplant.
Conclusions: Symptom prevalence is high among patients who undergo PBSC. However only a small proportion of these patients get referred to palliative care. Our recommendations include a specific guideline for management of PBSC related symptoms and early referral to palliative care to reduce symptom burden and potential quicker recovery.

Management of Neuropathic Pain (NP) Using the Capsaicin 8% Patch in Patients at a Tertiary Cancer Hospital
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Abstract type: Poster
Abstract number: P1-004
Background: Pain is common in patients with advanced and progressive disease. Evidence suggests that pain remains under-treated. There is guidance on effective prescribing of opioids for pain in palliative care patients but what do prescribers really do and how confident are they in prescribing?
Methods: Aims: To assess medical/non-medical prescriber practices and confidence in prescribing opioids to palliative care patients in hospital and community settings. Methods: All medical and non-medical prescribers (NMP), site-specific and community nurses at East Sussex Healthcare NHS Trust (joint hospital and community NHS Trust) are invited to complete an online survey (with reference to own prescribing, or advice given to prescribers). Survey questions derived from task group discussion are also adapted from a previous survey. Survey responses were sent out at periodic intervals. Responses were collated and summary statistics reported.
Results: 115 responses were received from a wide variety of staff (includes 30% consultant; 37% junior doctor; 5% pharmacist; 17% NMP; specialist nurse; 16% other). More than half (53%) looked after palliative care patients on at least a weekly basis. 54% of respondents had initiated strong opioids in the last month. Nearly a quarter of all respondents were not confident in prescribing opioids. Only 20% provided patients with written information. More than 60% felt they would use standard release morphine initially. Over 60% co-prescribe regular laxatives, 70% trimetaphan and 20% naloxone. Only 36% had received specific training in initiation of strong opioids for adult palliative care patients. 60% of all respondents would welcome future e-learning education and 52% lectures.
Conclusions: Opioids are commonly prescribed for pain in palliative care patients but few prescribers reported receiving specific training and there was a lack of confidence in prescribing opioids for some. Resources and further education will be developed to improve confidence in prescribing and information given to patients.

Poster Sessions (Poster Exhibition Set 1)

Poster Sessions (Poster Exhibition Set 1)
The Effective Dose Ranges of Fentanyl Buccal Tablets Depending to the Buccal or Sublingual Route of Administration (RoA) and Reason of Sublingual RoA Choice - A Meta-Analysis, Observational Study in Palliative Cancer Patients with Breakthrough Cancer Pain

Background: Breakthrough cancer pain (BCP) is a transient exacerbation of pain that occurs either spontaneously, or in relation to a specific predictable or unpredictable trigger, despite relatively stable and adequately controlled background pain. Fentanyl buccal tablet (FBT) is commonly used in buccal or sublingual (SL) regimen for BCP treatment. Aims: Primary objective: determine effective dose range of FBT according to the route of administration (RoA) due to the patient's state. Secondary objective: identifying the reason of sublingual (SL) RoA choice.

Methods: Multicenter, open-label, single arm, observational study performed in Q4 2013-Q1 2014 in 58 pain centers over 16 weeks. In total, 621 patients were included in the study. The patients were divided into three groups according to the route of administration: sublingual (SL), buccal (BU) or both (both) routes of administration. The McNemar-Bowker and Wilcoxon paired tests were used. Results: For the 82.6% of patients (n=251) the eFBTd was ≤200 µg at V2 and for 73.7% (n=194) at V4. There was no statistical difference in eFBTd depending on the RoA. The SL RoA was chosen in 11.8% patients (n=36) and only 0.9% (n=3) of them received FBT > 200 µg. At V2 the buccal RoA was used in 87.9% (n=261) and 18.7% of them received FBT > 200 µg. Patient's preference was the reason for choosing SL RoA in 91.9% (n=251). The mean BFTcP decreased from 7.2 (V1) to 5.7 (V4) on a 1-10 visual analog scale (VAS). The BFTcP decreased significantly from V1 to V4 with 70.4% of patients reporting ≥3 episodes at V1 and only 42.5% at V4 (p<0.001). Conclusion: The eFBTd increased over time. There was no statistical difference in eFTcP between buccal and SL administration. BFTcP decreased (p<0.001), mFTcPi was reduced by 21% on VAS 0-10 (p<0.001) between V1-VA. SL RoA was mainly used due to patient's preference. Disclosure: It was the company sponsored study.

Clinically Significant Drug-drug Interactions Involving Opioid Analgesics Used for Pain Treatment in Patients with Cancer: A Systematic Review

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Aim: To identify studies that report clinically significant DDIs involving opioids used for pain treatment in adult cancer patients. Methods: Systematic searches were performed in Embase and MEDLINE through OvidSP and in the Cochrane Central Register of Controlled Trials, from the start of the databases (Embase from 1980) through January 2014. Additionally, reference lists of the papers read in full text were hand-searched. Results: Of 901 retrieved papers, 112 were considered potentially eligible, and finally 17 publications were included after full-text reading. In addition, 15 papers were identified from the reference lists. All of the 32 included publications were case reports or case series. On the base of their analysis, DDIs related to opioids were grouped into: 1/ sedation and respiratory depression (11 papers), 2/ other CNS symptoms (15 papers), 3/ impairment of pain control and/or opioid withdrawal (7 papers), 4/ other symptoms (4 papers).

Opioids most frequently reported to cause DDIs were morphine, fentanyl, and methadone. The most common mechanisms eliciting DDIs were alteration of opioid metabolism due to the effect on CYP450 activity, and pharmacodynamic DDIs due to the combined effect on opioid, dopamine, cholinergic, and serotonergic activity in the CNS.

Conclusions: Evidence for DDIs associated with the use of opioids in the treatment of pain in cancer patients is well-established. Still, the cases identified in this systematic review give some important suggestions for clinical practice. Physicians prescribing opioids should recognise the risk for DDIs and if possible avoid polypharmacy.

The research received no financial support.

Poster Sessions (Poster Exhibition Set 1)
Spinal Analgesics to Intractable Cancer Pain: A Systematic Review

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Background: Pain in patients with cancer is often related to a combination of nociceptive and neuropathic mechanisms. Studies show that compared with nociceptive pain, patients with neuropathic pain (NP) suffer higher pain intensity, experience worse quality of life and report greater difficulties in living even after cancer treatment. So far NP has only been studied in less detail in patients with cancer. Our hypotheses are that cancer patients admitted to a Center of Palliative Care (CPC) are often suffering from clinically evidenced NP and are often receiving inadequate medication for this pain.

Methods: Aims of this study are to assess:

1) The prevalence of NP among cancer patients admitted to a CPC, and
2) The number of patients with NP who receive relevant treatment at the time of the first consultation in the CPC.

Methods: The study population is cancer patients with incurable metastatic or locally advanced disease (2014-2016). CPCs are centres that provide palliative care. Data are collected in first consultation with CPC. Patients are categorised as having NP if they:

1) Score ‘possible’ or ‘probable’ that a neuropathic component is present according to EPNS guidelines and at the same time
2) Score ≥ 4 or higher in the DN4 questionnaire. Patients with NP receiving tricyclic antidepressants or anticonvulsants are considered to receive relevant treatment.

Results: Three-hundred and three patients were admitted to CPC from June 2013 to October 2014. Fifty-two patients were excluded because they did not suffer any pain and 43 patients were excluded for other reasons. In total, 208 patients were enrolled in the study. According to the criteria, 72 patients (35%) were categorised as having neuropathic cancer pain. Of those, 14 patients (19%) received relevant treatment for NP.

Conclusion: NP is highly prevalent and pharmacologically inadequately treated among incurable cancer patients admitted to a CPC.

Abstract number: P1-013
Abstract type: Poster

The Effect of Lidocaine on the Abdominal Pain Caused by Peritoneal Dissemination

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Background: Abdominal pain due to peritoneal dissemination is often difficult to manage. We report eight cases where good analgesia was obtained with lidocaine.

Aims: To evaluate the effects of lidocaine on abdominal pain due to peritoneal dissemination.

Methods: Between February 2013 and August 2014, we investigated the dosage, efficacy, and side effects of lidocaine to treat abdominal pain associated with peritoneal dissemination. Lidocaine was administered to eight patients with gastric cancer (1), lung cancer (1), ovarian cancer (2), pancreatic cancer (1), malignant peripheral nerve sheath tumour (1), and ductal 1 cell leukaemia/lymphoma (1).

Results: All patients claimed to moderate to severe abdominal pain (5/10-10/10) on a Numeric Rating Scale (NRS). Opioids had previously been administered to five of the eight patients. After confirming the challenge test (intravenous infusion of 1 mg/kg lidocaine) that lidocaine was effective in all patients, we started continuous intravenous infusion of 500 mg/day lidocaine. The five patients who had used opioids obtained good pain relief within one day (NRS: 0/10-1/10). Three patients who received lidocaine alone obtained partial pain relief (NRS: 2/10-4/10). However, when lidocaine was used in combination with opioids, their pain almost completely resolved. The median duration of treatment was 25.5 days (range: 7-48). Typical side effects of lidocaine, such as neurological symptoms and bradycardia, were not observed in any of the patients.

Conclusion: In Japan, the sensation of abdominal pain induced by peritoneal dissemination was found to be accompanied by changes in the expression of substance P and µ-opioid receptors in the spinal cord of mice. In mice, the pain was not suppressed by morphine alone, but it was suppressed when morphine was used in combination with lidocaine. We suggest that clinically, lidocaine is very effective against abdominal pain due to peritoneal dissemination.

Abstract number: P1-014
Abstract type: Poster

Management of Cancer Related Neuropathic Pain. Answers to the “Burning” Questions

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Background: Neuropathic pain is common amongst patients with cancer. Treatment is often challenging particularly due to the limited evidence specific to the management of cancer related neuropathic pain.

Aims: (1) to perform a systematic review to evaluate the current evidence base regarding the management of cancer related neuropathic pain.

(2) to update the regional standards and guidelines for the management of cancer related neuropathic pain.

(3) to audit current regional practice in relation to the management of cancer related neuropathic pain.

Methods: A systematic review of the literature was performed. MEDLINE was the database that was searched. The regional standards and guidelines for the management of neuropathic pain were then reviewed.

During February 2014 an anonymous online questionnaire was completed by healthcare practitioners in the region managing patients with cancer related neuropathic pain.

Results: Screening tools have not been validated for the diagnosis of cancer-related neuropathic pain. There is no evidence to guide the radiation therapist in the treatment of pain associated with radiotherapy.

Conclusion: Cancer-related neuropathic pain is usually unresponsive or partially responsive to opioids. There is evidence for the use of adjuvant analgesics such as Antimyrtine, Gabapentin and Pregabalin. Evidence for the management of cancer related neuropathic pain is limited.
Effects of Acetaminophen at Different High Doses (2.4 g-4.0 g/Day) on Cancer Pain and Hepatic Toxicity

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Purpose: The Japanese Society for Palliative Medicine has published a Clinical Practice Guideline entitled ‘Clinical Practice Guideline for Cancer Pain Management’. In this guideline, high-dose acetaminophen (2.4g-4.0g/day) is recommended to treat cancer pain. However, the effect of acetaminophen at different high doses on cancer pain as well as the potential hepatic toxicity has not been reported in Japan so far.

Method: This study was conducted to retrospectively investigate the effects of different high doses of acetaminophen on the patients with persistent cancer pain who were treated from April 2008 to September 2014, as well as on the activities of serum alanine aminotransferase (ALT) and serum aspartate aminotransferase (AST). Patients were divided into three groups who received acetaminophen at 2.4g/day (2.4g group, n=45), 3.2g/day (3.2g group, n=46), and 4.0g/day (4.0g group, n=20), respectively. Pain was scored with the Brief Pain Inventory (BPI) and nausea/vomiting, sleepiness, and respiratory suppression appeared in both groups, but they all occurred infrequently and were mild.

Results: No significant differences were observed between the 2.4g group, 3.2g group and 4.0g group regarding the incidence of Grade 3/4 hepatic toxicity (2.2%, 4.3% vs 5.0%, respectively, p = 0.806). Although two cases stopped taking acetaminophen due to the increases in AST/ALT activities (one in the 2.4g group and another in the 4.0g group), acetaminophen-induced liver failure and death did not occur in this study. In contrast, significant differences in the NRS score were observed before and after acetaminophen administration in the 3.2g group (n=18) and 4.0g group (n=9), but not in the 2.4g group (n=16). The mean difference in the NRS score was 2.1 (95% CI, 1.4 to 2.8) in the 3.2g group, 1.6 (95% CI, 0.3 to 2.6, p = 0.019) in the 4.0g group, and 0.4 (95% CI, 0.4 to 1.3, p = 0.312) in the 2.4g group, respectively.

Conclusion: Our findings indicate that acetaminophen administration at the dose of 2.4-4.0g a day may be safe and effective for the treatment of cancer pain.

Abstract number: P1-016
Abstract type: Poster

Oxycodone/Naloxone Combination for the Management of Pain in Cancer Patients - Real-life Clinical Experience from Two Centres in UK and Malaysia

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Background: Opioid-induced constipation is a problem faced by cancer patients and combining Oxycodone with Naloxone (Targinact/Targin) is a way of addressing this. However, successes have been reported in the literature with regards to effective pain control, but not with regards to the effectiveness of this combination in terms of bowel movements. Patients using frequent rescue analgesia with oxycodone did not benefit much from the switch over compared to patients with stable analgesia. We observed much lower incidence of diarrhoea as compared to what was reported in clinical trials. Two patients had acetaminophen-induced liver failure and death did not occur in this study. In contrast, significant differences in the NRS score were observed before and after acetaminophen administration in the 3.2g group (n=18) and 4.0g group (n=9), but not in the 2.4g group (n=16). The mean difference in the NRS score was 2.1 (95% CI, 1.4 to 2.8) in the 3.2g group, 1.6 (95% CI, 0.3 to 2.6, p = 0.019) in the 4.0g group, and 0.4 (95% CI, 0.4 to 1.3, p = 0.312) in the 2.4g group, respectively.

Results: No significant differences were observed between the 2.4g group, 3.2g group and 4.0g group regarding the incidence of Grade 3/4 hepatic toxicity (2.2%, 4.3% vs 5.0%, respectively, p = 0.806). Although two cases stopped taking acetaminophen due to the increases in ALT/AST activities (one in the 2.4g group and another in the 4.0g group), acetaminophen-induced liver failure and death did not occur in this study. In contrast, significant differences in the NRS score were observed before and after acetaminophen administration in the 3.2g group (n=18) and 4.0g group (n=9), but not in the 2.4g group (n=16). The mean difference in the NRS score was 2.1 (95% CI, 1.4 to 2.8) in the 3.2g group, 1.6 (95% CI, 0.3 to 2.6, p = 0.019) in the 4.0g group, and 0.4 (95% CI, 0.4 to 1.3, p = 0.312) in the 2.4g group, respectively.

Conclusion: Our findings indicate that acetaminophen administration at the dose of 2.4-4.0g a day may be safe and effective for the treatment of cancer pain.

Abstract number: P1-016
Abstract type: Poster

Rapid Titration by Intravenous Administration of Oxycodone Injection in Cancer Patients with Severe Pain

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Purpose: Some cancer patients suddenly develop unbearable pain, and physicians must promptly cope with it. Rapid titration using morphine has been occasionally employed to control such severe pain. Oxycodone preparations have recently begun to be used instead of morphine as oral opioids for the management of cancer pain. The purpose of this study was to evaluate the effects of rapid titration using oxycodone injection in comparison with conventional titration using morphine injection.

Methods: The subjects were consecutive advanced cancer patients who consulted palliative care clinic or palliative care team due to severe pain (Numeric Rating Scale; NRS≥0 and/or Support Team Assessment Scale; STAS=3–4) and were judged to require prompt pain relief. Rapid titration was performed with the method previously reported. The evaluation items were: time needed until sufficient pain relief was obtained, pain relief success rate, and adverse effects. They were compared between the groups those treated with morphine injection (Morphine-group) and those treated with oxycodone injection (Oxycodone-group). ‘Successful pain relief’ was defined as alleviation of pain to NRS≤3 and/or STAS=0–1.

Results: 25 cases were used for rapid titration was morphine injection in 28cases (Morphine-group) and oxycodone injection in 15 cases (Oxycodone-group). The time needed until sufficient pain relief was obtained was 12 (4.2-28) minutes in Morphine-group and 10 (4-24) minutes in Oxycodone-group. The pain relief success rate was 36 and 40% within 6 hours, 64 and 80% within 24 hours in Morphine-group and Oxycodone-group, respectively, showing no significant difference. As for adverse effects, nausea and vomiting were more observed in Morphine-group, and patients treated with oxycodone showed respiratory suppression appeared in both groups, but they all occurred infrequently and were mild. Conclusion: Prompt and safe pain relief could be achieved by rapid titration using oxycodone injection in advanced cancer patients and is considered to be one of the useful choices.

Abstract number: P1-018
Abstract type: Poster

Hypnosis Can Reduce Pain in Hospitalized Older Patients: A Randomized Controlled Study

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Introduction and objective: Pain is a common and serious health problem in older patients. Treatment often includes non pharmacological approaches despite a relatively modest evidence base in this population. Hypnosis has been used in younger adults with positive results. The main objective of this study was to measure the feasibility and efficacy of hypnosis (including self hypnosis) in the management of chronic pain in older hospitalised patients.

Methods: A single centre randomised controlled trial using a two arm parallel group design (hypnosis versus massage). Inclusion criteria were chronic pain for more than 3 months with impact on daily life activities, intensity of > 4 adapted analgesie treatment, no cognitive impairment. Brief pain inventory was completed. Results: 33 patients were included (mean age: 80.6±8.2 - 14 men, 16 hypnosis, 27 massage. Pain intensity decreased significantly in both groups after each session. Pain intensity at baseline and pain intensity measured by the brief pain index sustained a greater decrease in the hypnosis group compared to the massage group during the hospitalisation. In this true, in the results section this is non significant). This was confirmed by the measure of intensity of the pain before each session that decreased only in the hypnosis group over time (P=0.008). Depression scores improved significantly over the time only in the hypnosis group (P=0.018). There was no effect in either group 3 months post hospital discharge.

Conclusion: Hypnosis represents a safe and valuable tool in chronic pain management of hospitalised older patients. In hospital interventions did not provide long term post discharge relief.

Abstract number: P1-019
Abstract type: Poster

Vertical Limits: High Dose Opioid Treatment in Cancer Pain Management

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Background: Pain in cancer patients is one of the most frequent and distressing symptoms. Opioids play a major role for managing cancer pain. To avoid overdosage in a general population it is important to know limits of a reference range for typical opioid doses - characterising high dose opioid therapy beyond these limits.

Aim: Systematic review to define these limits based on the published literature.

Methods: We searched the literature and identified the dose ranges of different opioids. Only randomised controlled trials (RCTs) with variable opioid dosing for cancer pain management and numerical rating scales (NRS) for pain relief were included, when data on mean doses of opioid (SD) were reported. Using the normal distribution theory according to Gauß, we calculated the 95% percentiles based on weighted mean and SD values. All mean and SD values were calculated after conversion to equi potent doses of oral morphine.

Results: Five studies matched our search criteria. We identified the following upper limits for a daily oral opioid dosage: morphine ~100 mg, hydromorphone ~ 40 mg, oxycodone ~150 mg.

Discussion and conclusion: We identified the upper limits of a reference range for a typical opioid pain therapy. Knowing these reference ranges may provide guidance for an adequate opioid regimen. Of course, opioids need to be titrated against pain focusing at side effects, and for selected patients high dose opioid treatment may be helpful and well tolerated.

Methodological challenges included different conversion rates for the calculation of equipotent opioid doses.

Abstract number: P1-019
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 1)
Breathlessness

Abstract number: P1-023

Abstract type: Poster

Effective Management of Breathlessness in Advanced Cancer Patient with a Program-based, Multi-disciplinary Approach: SOB Program in Hong Kong

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Breathlessness is common in advanced cancer patients. Because of its complex biopsychosocial etiology and manifestations, combination of both pharmacological interventions (PI) and non-pharmacological interventions (NPI) should be used. However, the intensive nature of NPI do limit the feasibility of implementation. To put theory into practice, the ‘SOB Program’ was started in our institution since April 2013.

Objectives:
1. Description of ‘SOB Program’
The Program is designed for all advanced cancer patients (both in-patient and out-patient) with dyspnea, to improve their symptom and functional level. It involves palliative care doctors, nurses, occupational therapists (OT) and physiotherapists (PT). After treating the reversible causes, patients with Medical Research Council (MRC) Scale >2 are given suitable interventions. Besides medications, various NPI including breathing and relaxation training, positioning, use of fan, walking aids etc are offered. All out-patients would receive a 4-week follow-up phone call. Those needed home oxygen are referred to OT to learn proper use.

2. Outcome
From April 2013 to August 2014, 216 patients entered into the program (in-patient: 127 (58.80%), out-patient: 89 (41.20%). 189 (87.50%) were offered PI and 193 (89.35%) were offered NPI. There was a significant increase in use of NPI (26.86% in Pre vs. 89.35% Post implementation). The three most commonly used NPI were use of fan (97.52%), breathing and relaxation training (94.91%), and use of walking aids (60.10%).

Specifically, we measured the subjective dyspnea relief in our out-patient group. 78 out of 82 patients (95%) who responded to phone follow-up had improvement (mean VAS percentage reduction: 31.66±10.93%, p<0.001; mean VAS absolute reduction: 1.91±0.7, p< 0.01).

Conclusion: Breathlessness could be effectively managed by a program-based, multidisciplinary approach. The success of our ‘SOB Program’ is encouraging. Similar program can be considered in other palliative centres.
Assessing Referrals for ‘Palliative’ Oxygen Therapy

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Background: It is not unusual for breathless non-palliative cancer patients to be prescribed oxygen despite a lack of evidence for this, other interventions being of proven benefit and the fact inappropriate oxygen therapy may be harmful.

Aim: 1. To assess the referral process for issuing domiciliary oxygen on discharge from hospital via a palliative indication, comparing against local guidelines. 2. To examine what assessments and interventions are used for breathlessness in these patients.

Methods: A retrospective case note review of adults discharged from a teaching hospital with domiciliary ‘palliative’ oxygen over a 6 month period.

Results: 26 patients were included (age range 32-89 years). The majority (22/26) had a malignancy, the commonest being lung cancer (11/22). The remainder (4/26) had chronic obstructive pulmonary disease or heart failure. The majority of cases the respiratory team (23/26) and palliative care team (23/26) were involved. Most patients (16/26) had a documented assessment of the severity of their breathlessness but in most cases (16/26) it wasn’t documented whether oxygen improved this. The majority of patients were prescribed opioids (24/26) and benzodiazepines (22/26) on discharge. 8/26 patients were visited with domiciliary oxygen despite not meeting the criteria. Documented reasons for this included: poor prognosis, patient anxiety, patient request, symptom benefit, previous commitment from other health care professional.

Conclusions: Our findings suggest there are significant numbers of non-hypoxaemic palliative care patients being issued with ‘palliative’ domiciliary oxygen despite a lack of supporting evidence. We suggest education and support for patients and healthcare professionals regarding breathlessness management may be helpful, in addition to further research exploring views of healthcare professionals regarding oxygen therapy in non hypoxaemic patients and assessment of the clinical and economic implications.

Abstract number: P1-025
Abstract type: Poster

What is the Feasibility of Evaluating the Impact of a Breathlessness Service on Hypothalamic-pituitary-adrenal (HPA) Axis Function in Breathless Patients with Advanced Disease? A Mixed-methods Feasibility Randomised Controlled Trial (RCT)

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Background: Breathlessness is a common, distressing symptom. Services have been developed to reduce its impact through the delivery of combined therapies. The efficacy of such services is challenging to evaluate, suggesting a need for biomarker exploration. As breathlessness is often perceived as a stressor, we hypothesise that the stress system, as regulated by the hypothalamic-pituitary-adrenal (HPA) axis, becomes dysregulated in chronic breathlessness and is restored to normal following treatment. Measurement of the diurnal cortisol rhythm in saliva provides a window into this system.

Aim: To evaluate the feasibility of conducting an RCT investigating whether a breathlessness service improves HPA axis function in comparison with ‘usual care’ in breathless patients with advanced disease. Aspects of feasibility of interest include recruitment, compliance, attrition and acceptability.

Methods: A mixed-methods feasibility RCT is currently underway. Participants are randomised to either a breathlessness service or an 8-week waiting list control. Salivary diurnal cortisol profile measurements (10 samples over 2 days) are obtained at baseline and 8 weeks. Sampling compliance is assessed using sleep actigraphy. Acceptability is assessed through semi-structured interviews. Recruitment and attrition patterns and interview transcripts have undergone preliminary analysis. Compliance data and hypothesis-testing pilot data are pending.

Results: The trial opened in June 2013 and will close in Dec 2014. Of the 365 patients screened, 122 (33%) have been eligible and 26 (23% of eligible patients) have been enrolled. Ineligibility is most commonly due to oral steroid use (25%) or inpatient status (29%). Five patients (18%) have been withdrawn, most often due to commencement of oral steroids. Patient attrition is currently 9%.

Conclusion: Recruitment has been slow and attrition high, but not prohibitively so. Overall, participants report a positive research experience.

Abstract number: P1-026
Abstract type: Poster

The Three Ps - Occupational Therapy Approaches to Fatigue Management in Cancer and Palliative Care

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Background: Fatigue has been identified as one of the most common, and limiting symptoms for cancer/palliative care patients (Stone and Minton, 2008). The type and level of occupational therapy intervention for fatigue management varies between healthcare settings, and there is not a widespread understanding of this area of practice (Purcell et al, 2010).

Aim: To identify the evidence for fatigue management with this patient group in order to implement evidence based OT fatigue management interventions within a hospice outpatient and in-patient setting.

Methods: A literature search using a range of databases was carried out with the assistance of the hospice library services, using a combination of search terms including ‘fatigue’, ‘cancer’ ‘oncology’ ‘palliative care’ ‘energy conservation’ and ‘occupational therapy’. The author and another occupational therapist reviewed the article abstracts and the full text versions of the most relevant articles.

Results: There was no consensus within the literature on the optimum method for delivering fatigue management. There was a mixture of individual face to face and telephone interventions, and group education programmes, with some promising evidence for an improvement in fatigue levels (Saark and Harlty, 2010). Typically patients participated in 3 or 4 sessions (Banerjee et al, 2004).

Conclusion: Occupational therapists have a key role to play in assessing and managing fatigue. Intervention typically includes education on energy conservation strategies such as prioritising, planning and positioning, with a focus on maximising engagement in meaningful activity. Individual and group approaches are both commonly used. Studies within this area are small and often not well described, therefore more research is needed. The author is implementing a review of the fatigue service provided within the hospice as a result of the evidence.
Cancer Cachexia, Body Image and Self-esteem
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Background: Distortions of body image that the individual designs for themselves are troubling and may reflect dissatisfaction with himself, changing their self-esteem.

Aim: To compare body image and self-esteem in patients with and without cachexia.

Methods: Cross-sectional study conducted between 2013-2014 with 378 adult patients with cancer of the digestive system and HP, 26%. Patients were classified into pre-cachexia (pre-CACS, n = 53), cachexia (ICACS, n = 122) and no-CACS (n = 203) groups, as proposed by Fearon (2011). The body image was assessed by the Stunkard’s Silhouettes Scale (domains distortion and satisfaction with body size) and self-esteem by the Rosenberg’s Self-Esteem Scale (low, moderate and high).

Results: The patients were men (55.3%), aged 52±10 (SD = 10), most had not metastasised and was not in an anticancer treatment. Tumors of the colon and rectum were prevalent in pre-CACS and no-CACS groups; tumors of the stomach and esophagus prevailed in CACS group.

Between 20% to 30% of patients in the 3 groups, the body image self-assessment corresponded to BMI. In pre-CACS and CACS groups, 93.7% and 64.8%, respectively, underestimated their body size. In the no-CACS, 38.4% (p<0.05) overestimated. The desire to increase body size occurred in 80.9% in CACS group and in 50.9% of pre-CACS group. Desire to decrease body size occurred in 44.3% of the group no-CACS. In the three groups, the majority of patients (88.7%, 82.0% and 78.8%) indicated high self-esteem.

Conclusion: A significant number of patients showed body image distorted and the reasons and the impact of this distortion will be investigated. The self-esteem observed in the 3 groups suggests little relationship between body image and self-esteem.

Multidisciplinary Programme for Intervention of Fatigue in Palliative Care Patients Using Biopsychospiritual Approach
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Background: Fatigue is a prevalent symptom in cancer palliative care, yet responds suboptimally to treatment. Physical fatigue is well recognised but difficult to ameliorate. The newer approach to fatigue causes is to manage fatigue as a system problem, using a biopsychospiritual approach to the patient and treatment planning.

Aims: To screen and identify all the underlying causes and evaluate the results of a multidisciplinary specialist-led programme in treating fatigue in palliative care patients. The programme utilises a structured biopsychospiritual approach, addressing the physical, psychological, social and spiritual needs.

Methods: A ‘Fatigue’ team is dedicated to review and manage patients’ fatigue. All cancer patients consecutively admitted with fatigue numerical rating scale of ≥ 2 were recruited. Fatigue was stratified into aetiological and deconditioning categories. An individualised treatment support plan was initiated. Outcome measures include Brief Fatigue Inventory, Fatigue NRS, Modified Functional Assessment Capacity, PPS and Hospital Anxiety and Depression Scale, and McGill Quality of Life Score. A pilot programme was commenced, and the baseline and 2 week results were compared.

Results: 11 consecutive cancer patients were recruited. 14 could not complete the 2 week programme due to early discharge or death. 17 patients completed two week programme. Mean age was 63. Commonest cancers were lung, breast and cervix. Commonest causes of fatigue were deconditioning, insomnia, pain, mood, chemo/RT side effects and sedatives. After 2 weeks intervention programme, the mean worst level of fatigue was successfully improved from 7.4 to 6.3 (p=0.018). As for impact of fatigue, improvement was seen in walking ability from 7.1 to 5.9 (p<0.005), and enjoyment of life from 7.5 to 6.1 (p<0.005).

Conclusions: A multidisciplinary structured palliative programme can reduce fatigue and impact of fatigue in palliative cancer patients within 2 weeks. Fatigue benefits from regular screening and intensive team support.

Poster Sessions (Poster Exhibition Set 1)

Other symptoms

Acotiamide Hydrochloride Hydrate Suppresses Anorexia Induced by Cancer Cachexia in Humans
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Background: Acotiamide (nonproprietary name: acotiamide hydrochloride hydrate) is a new chemical entity, which inhibits peripheral acetylcholinesterase activities. Acetylcholine is an important neurotransmitter to regulate gastrointestinal motility, and through the inhibition of degradation of acetylcholine, Acotiamide improves the impaired gastric motility and delayed gastric emptying, and consequently the subjective symptoms of functional dysphagia such as postprandial fullness, upper abdominal bloating, and early satiation. Anorexia is one of the most common symptoms of patients with advanced cancer and it presents as loss of appetite due to satiety. Acotiamide might improve cancer cachexia induced anorexia due to the same mechanism.

Aims: The aim of this study was to investigate the effects of Acotiamide on anorexia induced by cancer cachexia in humans.

Methods: The study was performed as a crossover design, ten cachectic patients with anorexia were randomly divided into two groups. Group A(n=5) received Acotiamide (100mg three times daily, orally) for two weeks followed by the control period without Acotiamide. Treatment with reversed order was performed for Group B(n=5). The amount of oral intake of each meal was measured and scored by 11 stages from 0 to 10 by nurses, and average oral intake during 14 days with or without Acotiamide was calculated and analysed. The results were expressed as the means: the standard error of the mean. The Student’s t-test was used to test for the significance of differences between groups. A P value < 0.05 was considered statistically significant.

Results: The average oral intake in the Acotiamide-on period was significantly larger than that in the Acotiamide-off period. This tendency was similarly seen in group A and group B, and neither an order effect nor a carry-over effect was seen.

Conclusion: Acotiamide appeared to prevent anorexia induced by cachexia, and have an effect on quality of life improvement and comfort in patients with advanced cancer.

Can Hospice Management of Anoxia Alter the Patient Journey?
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Background: Anoxia is a common problem for cancer patients often requiring paracentesis (P). Specialist palliative care units (SPCUs) offer an alternative to hospitals for this procedure. A comparable national cohort was studied by using data from the joint Office of National Statistics-Hospital Episode Statistics database. All people dying of cancer for the same 2 years were selected who had a treatment code for P within a year of death. Kaplan-Meier survival analyses were performed to calculate median life expectancies.

Results: SPCU-20 had a P and 27 died during follow-up 14-27 (52%) at home Median survival 42 days post-P National-12,452 had a P within a year of death-27% died at home (p=0.004) Median survival 39 days. Median survival days-ovarian 93, breast 32, lung 30, colorectal 38

Conclusion/discussion: P can be managed successfully in an SPCU as an outpatient. Those managed in an SPCU were more likely to die at home and less likely to die in hospital when compared with those who had P in hospital during the last year of life. Perhaps those willing to come to an SPCU would want to engage with palliative care and would be more likely to die at home. It might be that engagement with our service changes the disease journey for patients. The only way to answer the question about the better location for anoxia management for patients with palliative care needs is a trial where patients are randomised to hospital or SPCU. Any trial should assess health resource utilisation in addition to quality of life. The longer survival of ovarian cancer patients is of note. These patients may have more to gain from earlier consideration of semi-permanent drain placement.
Introduction: Death rattle is a term used to describe the noise produced in dying patients by the oscillatory movement of secretions in the upper airways. It is generally seen only in terminal patients with decreased consciousness. It is a frequent clinical sign occurring in 25-75% of dying patients. Evidence shows that antimuscarinic drugs can decrease the death rattle but there is no evidence whether aspiration of the secretions in the hypopharynx can decrease it. This is a reluctance to aspirate because it is thought to increase the secretions. For some relatives death rattle is hard to witness.

Aim: We aimed to assess the effectiveness of aspiration of hypopharynx to reduce the sound of death rattle in the dying patient.

Patients and methods: Over one year terminal ill patients submitted to Hospice were included, when death rattle of intensity score 1 or more developed within the last 48 hours of life using the Victoria Respiratory Congestion Scale. All patients were clinically scored by the VRCS before aspiration and after aspiration. The patients and the relatives reaction to the aspiration was noted. Due to ethical considerations repositioning and antimuscarinic (glycopyrronium) were used as well if it was considered to reduce suffering. We were aware that this might be bias and if using these other treatments, it was noted.

Results: From the data on the 18 patients, it seems that aspiration reduces death rattle when used alone and when combined with repositioning and glycopyrronium before aspiration. Death rattle decreased in 72% of the patients. Five of the 18 patients responded to the aspiration and some of these patients can have been bothered by being aspirated. All the relatives responded positively to the aspiration. Continuous aspiration can help to minimize death rattle in dying patients in the last 48 hours of life and it helps the family to be with the patient. Further research on the influence of repositioning is needed.

Abstract number: P1-034
Abstract type: Poster

Constitution in Specialised Palliative Care: Prevalence, Definition and Patient Perceived Symptom-distress

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Introduction: The prevalence of constipation in palliative care has varied in prior research, from 18-90%, measured with both a frequency-based and a patient-perceived definition. The aim of this study was to describe and explore the prevalence and symptom-distress of constipation, using different definitions of constipation, in patients admitted to specialised palliative care settings.

Methods: Data was collected in a cross-sectional survey from 453 patients in 38 palliative care units in Sweden. Variables associated with definition and definition were analysed using logistic regression and summarised as odds ratio (OR).

Result: The prevalence of constipation varied between 7-49%, depending on the definition used. Two constipation groups were found:
(i) Medical constipation - group (MCG; ≤ 3 defecations/week, n= 114; 23%);
(ii) Perceived constipation - group (PCG; Patients with a perception of being constipated the last two weeks, n= 171; 35%).

Three sub-groups emerged: patients with (a) only Medical constipation (7%), (b) only Perceived constipation (19%) and (c) with both Medical and Perceived constipation (16%).

There were no differences in symptom severity between groups, 71% of all constipated patients had severe symptom distress.

Conclusion: The prevalence of constipation may differ, depending on the definition used and how symptom distress is assessed. In this study we found two main groups and three sub-groups, analysed from different definitions of frequency of bowel movements and experience of being constipated. To be able to identify constipation, the patient definition has to be further explored and assessed.

Keywords: Palliative care, constipation, prevalence, definition, symptom-distress

Abstract number: P1-035
Abstract type: Poster

Is Gabapentin Effective for Uraemic Pruritus? A Systematic Review

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Objective: This systematic review aimed to assess the effectiveness of gabapentin in reducing pruritus in patients with chronic kidney disease (CKD).

Methods: A limited systematic literature review of randomised and controlled clinical trials was undertaken. Search engines were used to identify all relevant studies, but with no time limit. Relevant references were also screened.

Result: A total of 294 questionnaires responses were received (36% response rate). The majority of respondents were consultants practicing across hospital and/or hospice sites. 92% of respondents had prescribed AHEoL in the past 12 months. 56% reported that patients were routinely assessed for AHEoL. 73% had experience of being approached directly by patients and had all at some point been approached by family members or caregivers about the use of AHEoL. 89% agreed that decisions around AHEoL must be discussed with the patient if possible and 90% agreed that decisions must be discussed with family members. However only 56% regularly reported discussing AHEoL with patients and/or their families. When asked about whether AHEoL worsened symptoms at end of life, 78% responded ‘maybe’ rather than ‘yes’ or ‘no’, while 71% responded ‘maybe’ when asked if AHEoL improved symptoms. 46% felt that the religious or cultural beliefs of the patient/family had influenced their prescription of AHEoL. 14% reported that their own religious or cultural beliefs may influence their attitudes towards AHEoL. 21% felt recent media response to end of life care had influenced decision making around AHEoL. 61% agreed that a guideline for AHEoL could be a useful tool for end of life care planning.

Conclusion: This survey highlights the importance of an individualised plan of care, supported by guidance around the use of AHEoL, an area that holds so much clinical and ethical uncertainty.

Abstract number: P1-037
Abstract type: Poster

Posters Sessions (Poster Exhibition Set 1)
Abstract number: P1-038
Abstract type: Poster

O₂ or No₂ in Palliative Medicine?
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Background: Oxygen is frequently used in palliative care for dyspnoea. Traditionally oxygen may have been considered a benign therapy with few risks. However there are many potential side effects, not all of which are physical.

Objective: To evaluate the use of oxygen for symptom control in palliative care is supported by the evidence.

Method: A working group examined the evidence surrounding the use of oxygen in palliative care. A literature search was conducted in March 2013 using NHS Evidence, Healthcare Database. This searched AMED, EMBASE, HMIC, Medline, PsychINFO, BNI, CINAHL, Health Business ELITE. Terms ‘palliative’ end of life or ‘terminal’ were combined with ‘oxygen’ to search the title. The search was limited to full text and English language. All abstracts were analysed to exclude articles whose topic was not relevant to the literature review.

Results: There is no significant evidence that oxygen is more beneficial than air, although both give symptomatic relief of dyspnoea. Some studies show a small patient preference for oxygen, although this is not statistically significant.

Conclusion: The risk benefit ratio for the use of oxygen needs to be assessed on an individual patient basis including the risk of side effects of oxygen.

Abstract number: P1-039
Abstract type: Poster

Levetiracetam Use in Patients with Brain Tumours Towards the End of Life: A Feasibility Study Preparatory to a Pharmacokinetic Study
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Background: Levetiracetam is increasingly prescribed as a first line anticonvulsant therapy for patients with brain tumours. The use of subcutaneous (SC) levetiracetam to manage seizures in the terminal phase (although unlicensed) has been described in case reports. We are planning a pharmacokinetic study to determine the bioavailability of SC levetiracetam.

Objective: As part of the preparatory feasibility work we undertook a retrospective notes review.

Methods: To determine the frequency with which levetiracetam is used in patients with brain tumours approaching the end of life and the feasibility of undertaking a pharmacokinetic study.

Results: A retrospective notes review of hospice patients with brain tumours who had died. Data were extracted to determine the proportion of patients whom had been on oral levetiracetam prior to entering the terminal phase. Information about their subsequent seizure management was also recorded.

Results: The notes of 26 patients with brain tumours who had died over a 12 month period were reviewed. 12/26 (46%) patients were on oral levetiracetam as they approached the terminal stage of their disease. When patients were unable to swallow, the majority (11/12, 92%) required SC levetiracetam. Patients remained on SC anticonvulsant infusions for a median 5 days prior to death.

Conclusion: Levetiracetam is commonly used in patients with brain tumours. In our planned pharmacokinetic study we aim to recruit patients (n = 6) with brain tumours who are on regular oral levetiracetam. When patients lose the ability to swallow medication they will be switched to SC levetiracetam with testing of their serum levetiracetam level after 48 hours. Our retrospective notes review suggests that if we recruit 50% of eligible patients and allow for 50% follow up we can still expect to recruit the maximum sample size for our pharmacokinetic study in a single centre during a 12 month period.

Abstract number: P1-040
Abstract type: Poster

The Current Practice of Palliative Sedation in Austria - A Nationwide Multicentre Survey on Behalf of the AUPAC (Austrian Palliative Care) Study Group
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Background: Palliative Sedation (PS) is becoming an increasingly used practice in end-of-life care. In clinical practice and scientific publications indications and treatment decision making is still difficult to achieve. To date the practice of PS in Austria has not been properly investigated.

Methods: This multicentre study presents a retrospective analysis of sedation related data obtained at palliative care units and hospices from the Austrian Palliative Care (AUPAC) Study Group. Data on sedation were retrieved of all patients who died at an AUPAC unit between June 2012 and June 2013. Clinical characteristics and use of sedation or non-pharmacological interventions as well as the indication for the use of sedation or non-pharmacological interventions were documented. The main indications for PS were delirium (51%), existential suffering (32%), dyspnea (30%) and pain (20%). Drugs used were midazolam (79%), lorazepam (13%) and artificial hydration (p=0.03) and artificial hydration (p=0.01).

Results: This study allows the first insight into prevalence, and decision making of PS in patients in Austria. Indication and treatment decisions vary widely across AUPAC institutions. To enhance safety in clinical practice, implementation of a nation-wide guideline for the use of PS will be developed.

Abstract number: P1-041
Abstract type: Poster

Retrospective Study of Cases of Decerebrated Persons with Intellectual Disabilities: The Moment of Physicians’ Recognition of People Nearing End-of-Life
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Background: Physicians for people with intellectual disabilities (ID) are increasingly confronted with patients in need of palliative care. However, early identification of those patients is difficult. Research on this topic is scarce, despite the fact that early recognition of palliative care needs is essential for providing optimal and proactive palliative care. Little is known about when and how physicians recognize people with ID nearing end-of-life.

Aim: In the present study we aim to describe when physicians recognise patients with ID nearing end-of-life. Before this we aim to describe determinants, such as signals and symptoms, of the moment physicians recognise patients nearing end-of-life.

Methods: 97 ID physicians and General Practitioners filled in a comprehensive retrospective questionnaire about the process of palliative care provided to a deceased patient with ID. Hierarchical logistic regression analysis was used to examine determinants.

Results: Almost 25% of the physicians did not recognise patients with ID nearing end-of-life before the last week of life. Signals and symptoms of patients nearing end-of-life vary greatly. Most reported signals that led to this recognition were changes in typical behavior of the patient, a decline in functioning and not responding to treatment or medication. Most reported symptoms were fatigue, dizziness, decreased appetite and weight loss. Regression analysis show that the underlying illness is an important patient characteristic associated with the moment of recognition of people nearing end-of-life.

Conclusion / Discussion: The results show that in a significant amount of patients with ID recognition of people nearing death happened late in the end-of-life phase. The diversity of signals and symptoms on the moment of recognition of people nearing end-of-life is great. Insight in end-of-life signals and symptoms can contribute to early identification of people in need for palliative care.

Abstract number: P1-042
Abstract type: Poster

Pharmacological and Nonpharmaceutical Interventions for the Treatment of Chronic Cough in Patients with Intermittent Lung Disease: A Systematic Review
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Introduction: Chronic cough is cough lasting more than 8 weeks. It affects up to 80% of patients with Intermittent Lung Disease and is a major disruption in quality of life for patients due to the fact that it can cause loss of appetite, dizziness, vomiting, syncope, sweating, hoarseness and overall exhaustion. The cause of cough in patients with ILD may be due to a diagnosis other than the underlying condition in at least 50-54% of the cases. This review sought to find available evidence on the treatment of cough that is directly related to ILD.

Objective: To determine the effectiveness of pharmacological and non-pharmacological interventions for the treatment of cough in ILD.

Methods: This is a limited systematic review. Search was performed on the databases MEDLINE, EMBASE, Cochrane, Web of Knowledge for all types of studies in which an intervention was evaluated and changes in cough pattern and quality of life were one of their outcomes.

Results: A total of 1271 references were screened and 11 papers where finally obtained for this review, three systematic reviews, three open-label studies, 4 RCT (three double blind parallel, one crossover) and one N-1 of trial. Among the studied interventions were IFN, thalidomide, prednisolone, cotrimoxazole, fluticasone, tramadol, nabulized morphine, moxidazole, codeine, and levodropropizine. Even though the studies showed effectiveness for thalidomide, prednisolone, cotrimoxazole, fluticasone, tramadol and moxidazole and levodropropizine, sample size, selection bias and measurement bias diminish their possible effects on clinical practice.

Conclusions: A limited and heterogeneous amount of evidence is available. The results obtained offer limited but more promising information regarding treatment of cough in ILD but no evidence was found for treatment in end stage disease or on long term effects of these medications. Higher level of evidence is needed in order to be able to apply these results into our clinical practice.
Acute Bacterial Parotitis in the Dying Patient

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The clinical entity of acute bacterial parotitis (ABP), also known as acute suppurative parotitis, is an infection of rapid onset and is characterised by unilateral parotid gland swelling, localised erythema, intense pain and/or trismus. We describe two recent cases in adults in a specialist palliative care unit (SPCU). Prior to admission the patient's oral status was poor with extensive localised dental disease including calculus and caries. The patients were excluded from using the parotid gland as a feeding site due to the severe oral disease. Parotid swelling was unilateral and of short duration. Both patients presented with fever, malaise and severe pain in the parotid region. On examination both had tender, non-tender, fluctuant swellings of the skin and subcutaneous tissues of the parotid glands with no associated lymphadenopathy. Leukocytosis was present. Laboratory investigations showed signs of systemic sepsis and insulin resistance. Oral and nasogastric feeding were attempted but both patients were unable to tolerate these feeding routes. The presence of an additional feeding route was required to ensure adequate nutritional support. We describe the use of large volume paracentesis (LVP) to drain the infected parotid gland.

Methods:
Informed consent was obtained. The device was inserted under parotid gland skin incision using ultrasound to localize the gland. The gland was drained approximately 1–2 l of pus. The incision was left open to heal by second intention.

Results:
Both patients were maintained in the SPCU on opioid pain relief. There were no complications of the LVP procedure. A reduction in pain and improvement in feeding was seen in both patients.

Conclusion:
Parotid abscesses can be drained by LVP. This case series demonstrates the use of LVP to relieve symptoms of parotitis in palliative care patients. Further study is required to assess the benefits to patients and healthcare systems with regards to additional cost and resource utilization of this procedure. Future studies should focus on the development of a clinical guideline for parotid abscess management in palliative care patients.

Abstract number: P1-045
Abstract type: Poster

Cancer-related Insomnia: Wireless Monitoring of Sleep Metrics

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Abstract number: P1-046
Abstract type: Poster

Large Volume Paracentesis versus Tunnelled Drainage Catheters for the Management of Malignant Ascites in Adults: A Systematic Review of the Literature

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Abstract number: P1-047
Abstract type: Poster

Mood Stabilizers and Patients with Advanced Illness- A Forgotten Tool?

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Abstract number: P1-048
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 1)
Rating Delirium Severity Using the Nursing Delirium Screening Scale: A Prospective Study

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Background: Delirium is a frequent neuropsychiatric complication in palliative care (PC). The Nursing Delirium Screening Scale (Nu-DESC) is a brief, 5-item, observational tool. It has face validity, but has not been validated for use in PC settings.

Aim: To assess the validity of the Nu-DESC as a delirium severity rating tool for PC inpatients.

Methods: We conducted a prospective, observational study on a 3:1 bed, inpatient PC unit. Consecutive patients admitted to the PC unit were approached for pre-engagement informed consent. Patients were excluded if they had delirium on admission, were unable to converse in English, or had a Palliative Performance Score (PPS) of ≤ 10%. Nu-DESC scores were obtained at the end of each 8-hour nursing shift. Upon delirium diagnosis, as confirmed by the Confusion Assessment Method, the attending physician conducted a Clinician’s Global Rating (CGR) of delirium severity; and a study investigator (blinded to CGR and Nu-DESC scores) conducted a Memorial Delirium Assessment Scale (MDAS) rating. Pearson correlation coefficients were calculated for Nu-DESC and MDAS scores.

Results: Of 153 patients screened, 139 were eligible for study, and 46 developed incident delirium and remained eligible for primary analysis. Mean age was 73 years (range 36-96); 83% had cancer; and median PPS was 30%. Pearson correlations between MDAS and Nu-DESC average and maximum scores were 0.42 (p=0.005) and 0.41 (p=0.006), respectively. CGRs for delirium were mild (43%), moderate (48%), and severe (9%). Delirium subtypes per MDAS assessments were primary psychomotor activity (9%), hypnagogic (72%), hypnopompic (0%), and mixed (15%).

Conclusions: Based on moderate correlation with MDAS scores, our study demonstrated concurrent validity of the Nu-DESC as a delirium severity rating tool. When a precise measure of delirium severity is required, a more specific tool should be considered.

Abstract number: P1-049

Abstract type: Poster

Standard Operating Procedures in Palliative Care for Somatic and Psychiatric Symptom Management - A Pilot Assessment of Possible Application in Other Departments

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Background: Treatment of patients in a palliative care situation should be based on existing evidence and clinical experience. Many specialties have developed standards to improve therapy and create awareness in members of other specialties. For our department standard operating procedures for the symptom oriented treatment of dyspnea, pain, anorexia and nausea were defined and implemented in 2014. It is unknown, whether a transfer of the SOP established in our palliative care clinic into other specialties that care for patients in a palliative care situation is feasible and accepted by other disciplines.

Method: SOP were prepared and analysed by health care experts in other departments (residents and attending physicians, neurology and internal medicine, n=11) and asked to answer the questions: a. would the SOP be feasible, b. would they be effective, c. would you implement them, d. do you find them helpful. Answers were given on a Likert scale from 0=not at all to 3=fully and were dichotomised (0, 1 = negative reaction and 2, 3 = positive reaction).

Results: All of the health care specialists (n=11) in other departments expect the SOP’s both to be feasible as well as effective. Most of the health care specialists in other departments thought they would implement the SOP’s for palliative care patients (98.1%, n=10) and they would be helpful in their work with palliative patients (72.7%, n=8), reasons for negative reaction was: specific medication as in SOP not available on ward, n=2, no answer given, n=1.

Conclusions: The pilot assessment shows that the proposed SOP may be transferred into routine treatment of other specialists, thus (i) fostering better symptom oriented treatment of patients with palliative care needs in non-palliative departments, and (ii) establishing an awareness for palliative care needs and possible treatments and (iii) alleviating working with palliative patients for medical doctors of other specialties. More research is needed.

Abstract number: P1-050

Abstract type: Poster

A Protocol for the Control of Agitation in Palliative Care

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Background: Agitation occurs frequently in palliative care and is one of the most important reasons for sedation. Agitation can have many causes and can be reversible, but it occurs very easily to be distressing for all involved.

Aim: To study severe agitation, but had no development in our service for the control of agitation.

Methods: The protocol was activated in 18/06/2007, which was the date of the opening of our palliative care unit (PCU) and all patients were included in the study until 31/12/2013.

Protocol for the control of agitation:

- Haloperidol - 5 mg SC + Midazolam - 5 mg IM

30 minutes later, if the situation is not controlled:
- Haloperidol - 2 mg SC + Midazolam - 5 mg SC, up to 2 doses (30 minutes interval)
30 minutes later, if the situation is not controlled:
- Midazolam 5 mg SC every hour till the control of the situation if the agitation recurrers:
- Less than 2 hours after control, resume the protocol from the interruption point.
- More than 2 hours later: restart the protocol from the beginning.

Results: During the period in study 1554 was admitted and the protocol was used in 135 (9%): 102 (76%) were males and the mean age was 65.75 years (SD ± 12.08). The most frequent diagnosis was head and neck cancer, 37 (27%), followed by lung cancer, 27 (20%). The protocol was used correctly 584 times, from 1 to 3 times in each patient, median 3 times. The interval between the first dose and the control of agitation was from 1 to 105 minutes, median 14 minutes. 134 (9% of the administration) of the agitation episodes were controlled with only the first dose of the protocol. There were any treatment complications.

Conclusion: The protocol for the control of agitation developed in our PCU is very effective as demonstrated by the quick control of the situation, usually with only one dose, and the lack of complications.
Bowel Obstruction In Cancer Patients


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Background: The effects of single nucleotide polymorphisms (SNPs) in the cognitive function of opioid treated patients with cancer is unknown.

Aim: To identify associations between SNPs of candidate genes, high opioid dose and cognitive dysfunction.

Methods: Cross-sectional multicenter study (European Pharmacogenetic Opioid Study, 2008-2009). Genotyping revealed 5 SNPs in 4 different genes. The SNPs were analyzed in patients with a diagnosis of bowel obstruction during a 6 month period (January to June 2013).

Results: During the period under study 106 patients had a diagnosis of bowel obstruction. 67 (63%) were female and the median age was 66 years (22 to 100). The most frequent cancers were colorectal, 39 (37%); gynecological, 23 (22%); and gastric 16 (15%). The most frequent metastases were peritoneal, 48 (45%); hepatic, 34 (32%); and 26 (25%) were locally advanced. Previous treatments undergone by patients directed to cancer were: surgery 75 (71%); 72 of them were abdominal; chemotherapy 72 (68%); and radiotherapy 30 (28%). In 95 (90%) the bowel obstruction has resolved. In 40 (38%) there was an intervention: 7 (18%) with stent placement; and 33 (82%) surgery. 66 (62%) patients underwent conservative treatment. In all patients who had the placement the obstruction advanced in 31 (94%) out of 33 who have undergone surgery had the obstruction resolved vs. 57 (86%) out of 66 who had a conservative management (p = 0.327). 77 (73%) patients were discharged home and 29 (27%) died in hospital. 28 (26%) patients were referred to palliative care: 17 (59%) out of 29 who have died and 11 (14%) out of 77 who were discharged (< 0.001).

Conclusion: Bowel obstruction occurs more frequently in abdominal cancers such as the digestive and gynecological ones. Most of the patients treated in this study required conservative measures. When indicated the placement of a stent may be very effective. Only a minority of the patients were referred to palliative care mainly those with the poorest condition, as most of them died in the sequence of the episode of bowel obstruction.

Effect of Shitei-To, A Traditional Chinese Medicine Formulation, against Hiccups - Effect of Shitei Extract on Drug-induced Convulsions in Mice

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Introduction: Cancer patients sometimes have hiccups for the enforcement of chemotherapy. The tumor itself, or chemotherapy or the tumor itself. Hiccups, which are rhythmical, clonic contractions of the diaphragm, are considered as a form of convulsions. For a treatment of intractable hiccups, a number of major tranquillizers or anticonvulsant medications such as benzodiazepine or barbiturate have been used. The traditional Chinese medicine Shitei-To, which is a mixture of Zingiber officinale [L.] Merrill et. Perry) has long been used for the treatment of hiccups as natural herbal therapy in Japan and China. Shitei-To has anticonvulsant effects.

Methods: Significant associations (P< 0.05) between MMSE scores and SNPs in the genes HTR2A, HTR3A, HTR3B, HTR3E, and HTR4 were analysed regarding 86 SNPs in 43 genes. Inclusion criteria: cancer, age ≥18 years, regular opioid treatment for ≥3 days, and available genetic data. Cognitive function was assessed by Mini Mental State Examination (MMSE). Analyses: 1) SNPs were rejected if evidence of violation of Hardy-Weinberg equilibrium (P< 0.0005), or minor allele frequency < 5%.

2) patients were randomly divided into development sample (2/3 patients for initial SNPs selection) and validation sample (1/3 patients for confirmation). In the development sample, 3) a false discovery rate of 10% was used for determining associations (Benjamini-Hochberg method).

Krukal-Williss test (co-domain model) and the Mann-Whitney test (dominant and recessive models) were performed.

Results: Significant associations (P< 0.05) between MMSE scores and SNPs in the genes HTR2A, HTR3A, HTR3B, HTR3E, and HTR4 were analysed regarding 86 SNPs in 43 genes. Inclusion criteria: cancer, age ≥18 years, regular opioid treatment for ≥3 days, and available genetic data. Cognitive function was assessed by Mini Mental State Examination (MMSE). Analyses: 1) SNPs were rejected if evidence of violation of Hardy-Weinberg equilibrium (P< 0.0005), or minor allele frequency < 5%.

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Krukal-Williss test (co-domain model) and the Mann-Whitney test (dominant and recessive models) were performed.

Conclusion: The findings did not support influence of those SNPs analysed to explain cognitive dysfunction in this sample of patients.

Quality of Life Assessment of Subcutaneous Needle Drainage for Lymphoedema in Patients with Advanced Malignancy

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Patients with advanced malignancy commonly develop lymphoedema of the lower limbs. This can have a profound impact on quality of life (QOL). Standard therapy for lymphoedema includes massage, bandaging and compression hosiery, but this can be of limited effect at the end of life. Draining the fluid through the placement of needles under the skin is a technique mentioned sporadically in the literature. It has been shown, in small studies, to be of benefit for symptom control; however it is not clear how it affects QOL and if there are any negative outcomes.

The aim of this pilot study was to use objective tools to measure quality of life and function of patients with severe lymphoedema before and after subcutaneous needle drainage. It also captured data on complications. A protocol was developed locally for the procedure. The LymphQOL questionnaire was used before, immediately following and 3 weeks after the drain. It tested several domains including activities of daily living, appearance, and symptoms. A functional measure was utilised to capture changes in the patient's important activities.

The pilot included 10 patients. The volumes of lymphoedema drained ranged between 102mls and 12,679mls. One patient did not drain at all. Of the remaining nine participants, all but one showed improvement, with five having positive outcomes with their own mobility measures. Two of the patients developed cellulitis managed with oral antibiotics. This pilot showed promising results with patients with severe, refractory lower limb lymphoedema when standard therapy is no longer an option. It appears to be a safe intervention with positive results for the majority of patients. It is the first study using objective measures in the literature. It is a small study in one centre of New Zealand and warrants further research.

This study was funded by the Campbell Ballantine Fellowship.
Abstract number: P1-058
Abstract type: Poster

Gastrointestinal Adverse Events during Naloxegol Treatment for Opioid-Induced Constipation: Evidence from Double-Blind RCTs

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Background: Opioid induced constipation (OIC) is a serious and frequent adverse event. Naloxegol, a recently approved oral, peripherally acting μ-opioid receptor antagonist (PAMORA), has been shown to be effective in OIC treatment.

Aim: The objective was to analyse the incidence of naloxegol-related gastrointestinal (GI) adverse events (AEs) in adult OIC patients.

Methods: This analysis is part of a systematic review. Five databases including MEDLINE, PubMed, Cochrane (CENTRAL) and EMBASE were searched in August 2014. Studies were screened independently by two reviewers for randomised controlled trials (RCTs). Risk differences (RDs) with 95%-confidence intervals (95% CI) were calculated using RevMan 5.3 (Copenhagen: NNT-Health). Effect model.

Results: One phase II and two phase III RCTs were identified, studying a total of 985 patients treated with naloxegol and 540 with placebo. Abdominal pain, nausea and diarrhea were the most frequently observed AEs and their incidence tended to increase with higher doses (see Table). Daily doses of 1.25mg caused noticeably less abdominal pain than higher doses. RDs were highest for abdominal pain (RD 0.04 [0.00-0.08]) and comparable for nausea (0.00 [0.00-0.06]) and diarrhea (0.04 [0.02-0.07]).

Conclusion: The AEs seen during treatment with naloxegol are low; the most frequent AE is abdominal pain, which likely represents a pharmacological effect of the PAMORA. The data suggest that dose titration may be useful to achieve the optimal balance between efficacy and AEs.

Fundings: None

Naloxegol patients per group; dosing
Abdominal pain n (%), (RD 95% CI)
Nausea, n (%)
Diarrhea, n (%)
Study
PBO: 235; IG1: 235, 12.5 mg
PBO: 19 (8.0); IG1: 21 (8.7)
PBO: 18 (7.8); IG1: 22 (9.5); RD: 0.02 (0.00-0.05)
PBO: 10 (4.3); IG1: 11 (4.7); RD: 0.03 (0.00-0.06)
PBO: 10 (4.3); IG1: 9 (3.9); RD: 0.01 (0.00-0.03)
PBO: 7 (3.3); IG1: 8 (3.4); RD: 0.01 (0.00-0.03)
Chey et al. (2013)

PBO: 265, 25 mg; IG2: 285, 50 mg
PBO: 18 (7.8); IG2: 20 (8.6)
PBO: 18 (7.8); IG2: 19 (8.9); RD: 0.02 (0.00-0.04)
PBO: 10 (4.3); IG2: 14 (5.6); RD: 0.04 (0.00-0.09)
PBO: 10 (4.3); IG2: 11 (5.2); RD: 0.02 (0.00-0.06)
PBO: 8 (3.2); IG2: 9 (3.8); RD: 0.01 (0.00-0.04)
Chey et al. (2014)

PBO: 255, 50 mg; IG3: 355, 50 mg
PBO: 19 (7.6); IG3: 20 (7.1)
PBO: 19 (7.6); IG3: 21 (7.4); RD: 0.04 (0.00-0.08)
PBO: 11 (4.5); IG3: 17 (6.3); RD: 0.03 (0.00-0.06)
PBO: 10 (4.2); IG3: 11 (4.2); RD: 0.01 (0.00-0.03)
PBO: 8 (3.2); IG3: 8 (3.2); RD: 0.00 (0.00-0.01)
Chey et al. (2014)

Abstract number: P1-059
Abstract type: Poster

Symptom Prevalence, Palliative Care Needs and Quality of Life in Multiple Myeloma - A Multicentre, Cross-sectional Study

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Background: Multiple myeloma remains an incurable cancer with evidence that patients suffer more symptoms than in other haematological conditions. Palliative care services are rarely involved.

Aim: To assess symptom prevalence, symptom severity, quality of life and palliative care needs in patients with multiple myeloma and to determine which factors are associated with higher symptom burden and poor QOL.

Method: This multicentre, cross-sectional study included patients with multiple myeloma at all disease stages. The EORTC QLQ-C30, EORTC M14 and the Myeloma Patient Outcome Scale (MyPLOS) were used to quantify HRQOL and palliative care needs. Point prevalence of symptoms and concerns at time of the survey was determined. Hierarchical regression and path analysis were used.

Results: 555 patients with multiple myeloma with a median age of 69 years (range 34-92) and on average 2.5 years post-diagnosis participated. 18.2% were newly diagnosed, 47.9% had stable disease and 32.7% had relapsed disease or were in the advanced, palliative phase of life. Patients reported a mean of 5.1 symptoms. Over 70% had pain, 88.7% fatigue and 61.1% breathlessness. The most burdensome symptoms in the advanced stages were fatigue, poor mobility, pain, and tingling in the hand/feet. A positive correlation between disease severity and number of symptoms was found (r=0.21, p<0.001).

Performance status (0–1: 0.24–0.0001), disease type (Light chain disease versus immunoglobulins G or A) and type of treatments (stem cell transplant versus chemotherapy) had a significant direct relationship with HRQOL.

Conclusion: Burden of symptoms in multiple myeloma is high, especially in the advanced stages of disease. Those receiving more toxic treatments and with light chain disease are at increased risk for poor HRQOL and should be considered for early referral to palliative care services.

Funding: Myeloma UK, St Christopher’s Hospice, National Institute of Health Research

Poster Sessions (Poster Display Session 1)

Abstract number: P1-060
Abstract type: Poster

A Questionnaire Survey of Physicians and Nurses Regarding Constipation in Palliative Care Patients

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Introduction: The aim of the study was the assessment of the methods used for a diagnosis and treatment of constipation among surveyed physicians and nurses taking into account the efficacy of several drugs and respondents’ knowledge of constipation management guidelines of the Polish Association for Palliative Medicine.

Methods: A total of 217 respondents including 149 nurses and 68 physicians from home care services, palliative care units, out-patient palliative medicine clinics, mainly form two provinces (Wielkopolska and Kujawsko-Pomorskie) were administered a 20 questions survey regarding causes, diagnosis and treatment of constipation.

Results: The surveyed met in clinical practice on average 7 patients with constipation during 7 days. The majority of surveyed devoted on average 4h for the treatment of constipation. Both nurses and physicians for the diagnosis of constipation most frequently used the time since the last bowel movement (84% nurses, 76% physicians) and symptoms reported by patients (85% nurses, 93% physicians). Among constipation causes the surveyed listed mainly drugs (92% nurses, 96% physicians) and opioids were judged as drugs having the biggest impact on constipation appearance (96% for both groups). The treatment consisted mainly of oral laxatives (86% nurses, 95% physicians) usually in combination with rectal measures (85%) and diet recommendations (91% nurses, 91% physicians). For the question of the knowledge of recommendations of the Polish Association for Palliative Medicine regarding constipation management (elaborated in 2009) 208 surveyed responded. 143 (69%) positively and 65 (31%) negatively.

Conclusion: The responses obtained indicate for the necessity of a continuous staff education and call for GI group updated constipation management guidelines in palliative care patients. These guidelines were recently published by the Expert Group of the Polish Association for Palliative Medicine.
Factors Influencing Uptake of a Comprehensive, Evidence-based, Carer Support Needs Assessment Tool in Palliative Home Care

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Abstract number: P1-062
Abstract type: Poster

Background: The Carer Support Needs Assessment Tool (CSNAT) is an evidence-based tool for carer assessment and support. Successful implementation of the CSNAT requires a change from existing practitioner led approaches to carer assessment to one which is facilitated by the practitioner, but led by the carer.

Aims: To identify factors which facilitate or hinder uptake of the CSNAT into practice.

Methods: The CSNAT was implemented in 6 palliative home care services. Qualitative data were collected via interviews (9 practitioner ‘champions’; 6 managers), 2 focus groups and 3 workshops. All were recorded, transcribed and analysed thematically.

Results: Uptake of the CSNAT varied between services and practitioners and was influenced by the receptivity of the context into which it was introduced, in particular the: -Organisational preparedness (e.g. existing administration systems, working patterns, competing demands). 
-Individual preparedness’ (e.g. the extent to which practitioners understood the underlying tenets of the CSNAT and whether they felt they could bring about benefits). 
-Additionally, facilitation to support implementation of the CSNAT was key, this included: 
-Internal facilitation’ within the service (e.g. clear organisation steer, support for a CSNAT ‘champion’ discussed at meetings). 
-External facilitation’ from the research team (e.g. provision of training, reference materials, on-going support for champions).

Conclusions: The study identified two main factors which influence effective implementation of the CSNAT: a) receptivity of the context (both at organisational and individual level) and b) level of facilitation (within or outside the organisation). Findings correspond with 2 existing models of sustainable implementation of practice developments. Further work is underway to explore how organisations can best be supported during implementation CSNAT.

Funder: NHRI Research for Patient Benefit

Abstract number: P1-063
Abstract type: Poster

A Psychometric Approach to the Spanish Version of Bugen's Coping with Death Scale

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Background: Working in a death context on a regular basis can have adverse effects for palliative care professionals. As a professional competence, coping with death has been defined as professionals' abilities and skills to cope with death, and also his/her beliefs and attitudes towards these abilities. Among the instruments used to assess professionals' ability to cope with death, Bugen's Coping with Death Scale is one of the most employed.

Methods: As the first CFA showed bad psychometric behavior for 4 items of the scale. These items were removed and a second CFA was estimated and tested, with better results (c2=1305.41; df=84; p<.01; RMSEA = 0.09, 90% confidence interval 0.08 – 0.10). Based on this latest version of the scale, descriptive analyses for the palliative care professionals participants were offered.

Conclusions: The results for Bugen's Coping with Death Scale support previous exploratory studies. Some items behaving badly are identified. The short version shows clearly improved psychometric properties for the Spanish context. Descriptive analyses pointed appropriate levels of coping with death in Spanish palliative care professionals.

Main sources: This research was partially funded by the Spanish Association for Palliative Care (SECPAL).

Abstract number: P1-064
Abstract type: Poster

Pioneering Research on Demoralization in Spanish Palliative Care Units

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Background: Demoralisation is experienced when someone feels deprived of spirit, disheartened, and confused. Clarke and Kissane proposed a checklist for a demoralisation diagnosis (existential anguish/distress, pessimist cognitive attitudes, helplessness, absence of coping motivation, social isolation and emotional fluctuation). Literature reveals that, in some cases, depressive symptoms do not vanish after interventions, and conform a 'demoralisation syndrome'. No published research on demoralisation's measure in the...
Assessing Physical Performance in Non-small Cell Lung Cancer: Is the Short Physical Performance Battery Acceptable, Feasible and Able to Predict Fitness for Treatment?

David J. T. Collins, S. Clarke, D. T. Waves, L. J. L. Davidson, M. A. H. Johnson, G. A. F. J. Taylor, M. L. M. M. J. attention, and lung cancer. The Short Physical Performance Battery (SPPB) comprises three timed components: balance (side-by-side, tandem and tandem stands), 4-metre gait speed, and 5 chair rises. Results: Acceptability and feasibility of SPPB will be presented descriptively, as well as discussion of its practicality in a busy clinic. Correlations between total and component SPPB scores, PS and receipt of treatment will also be reported. Conclusion: Increasing evidence suggests that supportive interventions such as exercise may be beneficial, even for patients with advanced NSCLC. Measuring physical performance at baseline, in addition to the taxonomy, will help to define more value in defining individualised supportive care plans, and may allow more accurate prediction of fitness for treatment.

Building a Taxonomy of Integrated Palliative Care Initiatives

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Methods: The taxonomy was developed based on a systematic literature review, expert interviews and an online survey. The taxonomy was reviewed and consented in an expert workshop. The scope of the classification system to be invented was restricted both regionally (Europe) and in terms of its application (focusing on cancer, COPD and CHF). Results: The final taxonomy encompasses the process of IPC as well as structure and working modes. Hence, the classification system developed by InsuP-C consists of eight categories including two to four items each. For instance, the classification is divided into the items pathway, model and guideline. Likewise, the category collaboration and communication, aiming to classify the interaction between care givers involved in the provision of IPC, is differentiated into the items network, protocol, team and case management. As a measurement tool, the taxonomy allows to evaluate IPC as well as to compare respective initiatives.

Conclusion: Developing a classification system has been a crucial task of the InsuP-C project. The taxonomy will be applied to identify those initiatives of IPC that will be examined empirically in the continuation of the study. Thereby, it has to be tested whether the taxonomy is flexible and robust enough to cover IPC schemes in different health care contexts.

Assessing Physical Performance in Non-small Cell Lung Cancer: Is the Short Physical Performance Battery Acceptable, Feasible and Able to Predict Fitness for Treatment?

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Background: Physical performance is the observable ability to perform physical functions. Many non-small cell lung cancer (NSCLC) patients present with impaired functional status. The performance status (PS) score in current use is subjective, and low inter-clinician agreement is a consistent treatment planning problem. Objective performance tests, such as accelerometry, require days of compliance with monitoring and are not routine clinical use. The Short Physical Performance Battery (SPPB) is a valid, reliable and responsive clinical test of physical performance in older people. It assesses lower limb strength and endurance, and has been used in NSCLC patients in research settings. However, its value in the routine oncology clinic setting has not been tested.

Aims: We aim to assess: (i) acceptability and feasibility of the SPPB in patients attending a rapid access lung cancer clinic (RAALC); and (ii) whether it can predict fitness for treatment.

Methods: This is part of a prospective study of PS 0-2 NSCLC patients (target n=80, recruitment and analysis on schedule for completion in April 2013). SPPB and PS scores are collected at presentation to the RAALC; thereafter receipt of treatment is recorded longitudinally. SPPB comprises three timed components: balance (side-by-side, semi-tandem and tandem stands), 4-metre gait speed, and 5 chair rises.

Results: Acceptability and feasibility of SPPB will be presented descriptively, as well as discussion of its practicality in a busy clinic. Correlations between total and component SPPB scores, PS and receipt of treatment will also be reported.

Conclusion: Increasing evidence suggests that supportive interventions such as exercise may be beneficial, even for patients with advanced NSCLC. Measuring physical performance at baseline, in addition to the taxonomy, will help to define more value in defining individualised supportive care plans, and may allow more accurate prediction of fitness for treatment.

Prognostic Value of PPS in Patients Atended at Home: Is It Also Useful?

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Introduction: Performance status is traditionally associated with survival in cancer patients. Most of the studies consulted are in inpatients. Aim: We wonder if this variable, measured by the Palliative Performance Scale (PPS), is also a good prognostic tool in a home cohort. Methods: A longitudinal, retrospective, survival study, along 2013. Inclusion criteria: ≥18 years old with advanced cancer, attended at home, with PPS value registered. Variables: age, gender, primary location, PPS, survival from first visit, delirium and place of death. Description of island and Kaplan-Meier survival functions were performed, as well as concordance. Regression: Authorisation for reviewing records was requested to the Ethical Committee. Results: 473 patients were visited during 2013, 383 met inclusion criteria. The profile of our sample was 78 years old with one disease and 75% of last location being at home (53%), and a few with delirium at first visit (12%). Median PPS was 50% (interquartile range 25-75: 40-60%), with median survival of 30 days (IQR 25-75: 72-67 days). PPS showed a great association with survival, with statistically significative differences. Means and Medias... (Log Rank 258, P= 0,000), as well as delirium at first visit (p<0,000). Patients with a better performance status in our first visit died more frequently in the hospital than at home (pearson chi square 19,65; p<0,000). Younger than 60 years presented a better performance status than older (pearson chi-square 6,37; p<0,012). No association was found between primary location and PPS or survival. Cox regression was positive for PPS value and delirium, with a mortality risk of 3.1 for each 1% in PPS.

Conclusions: PPS is also a good tool for survival estimation in home care support teams. Effectiveness of competing PC interventions. However, there is a dearth of EEs of PC interventions which deprives decision makers of the basic information required to meet the needs of dying patients. The Quality Adjusted Life Year (QALY) is the most widely used measure in cost-utility analysis. In some medical fields (including PC), generic preference-based measures of health (PMBH) like the EQ-5D are currently used to derive QALYs that have been found to be inappropriate.

Aim: To assess the feasibility of deriving a PMBH from the Palliative Outcome Care Scale (POS), for use in economic evaluations of PC interventions.

Methods: The POS was used to derive a health state classification using a 5-stage approach. Stage 1 uses factor analysis to establish instrument dimensions. Stage 2 excludes items that do not meet the initial validation process and Stage 3 uses criteria based on Rasch analysis and other psychometric testing for the final health state classification. Stage 4, item levels are examined and Rasch analysis is used to reduce the number of item levels. Stage 5 repeats Stages 1-4 on alternative data sets to validate the health state classification. Results: A unidimensional health state description consisting of 7 items was derived from Rasch analysis. A sub-sample of 14 plausible health states which can be used to obtain preference values were identified from the Rasch item level map. Conclusion: Rasch analysis provides a useful means of developing plausible health states for valuation. This research will provide a basis for estimating QALYs to inform cost-effectiveness analysis of palliative care interventions.
Abstract number: P1-072
Abstract type: Poster
Using Confusion Assessment Method for Detection Delirium among Hospice Patients - Screening or a Diagnostic Instrument?
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Background: Delirium is a common condition, affecting up to 80% of terminally ill patients. Identification of delirium can be difficult, because the symptoms can be mistaken for other conditions like depression, dementia and so on. Our hypothesis is that patients with hyperactive delirium (heightened arousal, restlessness and agitation) are easier recognised than the hypoactive delirium (Patients withdrawn, quiet and sleepy). A Danish national guideline (2013) recommends systematic screening by the Confusion Assessment Method (CAM), which is validated as having high specificity and sensitivity.

Aims: The aim of this study was to evaluate the use of CAM, as a diagnostic tool, in our Hospice.

Methods: A retrospective study
From 1.4.2014, all patients admitted to our hospice were screened with CAM every evening as well as if the patient was suspected of having delirium. TOC patient notes of 114 patients admitted to Hospice from 1.4. until 20.7.2014 were examined. The results of the CAM score were recorded and compared with documents on psycho-social conditions.

Results: Of 61 patients, 2 were excluded because the CAM score wasn’t done. 59 patients included: 19 patients were in delirium according to the CAM score (32%).

Conclusions: The reproducibility of CAM was very high (Interclass Correlation Coefficient: CP group 77%, NCP group 93%). The reproducibility of EOC was good (Intraclass Correlation Coefficient: CP group 77%, NCP group 93%).

Results: The EOC tool allows assessing EoLP patients’ needs systematically and holistically. We believe that the scale improves the understanding of the psychosocial needs of EoLP and provides a more comprehensive palliative care approach, specific, individualised and effective.

Abstract number: P1-075
Abstract type: Poster
Case Finding for Advanced Chronic Patients in Need of Palliative Care Approach at High Risk of Death in the Next 12 Months: Development of a Predictive Model
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Background: 75% of deaths in high-income countries are caused by progressive advanced chronic conditions, identifying advanced chronic patients in need of palliative care (PC) at high risk of death can be crucial to provide intervention.

Aims: To determine factors associated with mortality and to develop a predictive model to identify advanced chronic patients in need of PC at high risk of death in the next 12 months.

Methods: 995 patients with advanced chronic conditions in need of PC as assessed by healthcare professionals using the NECPAL CCOMS-ICO© tool (NECPAL+) were included in an observational, analytic, prospective cohort study. Cox regression analysis was used to identify which NECPAL CCOMS-ICO© tool indicators were associated with mortality within 12 months after NECPAL+ identification. A predictive model was created based on selected factors. Sensitivity, specificity and the area under the Receiver Operating Characteristics (ROC) curve were calculated.

Results: Mortality rate at 12 months was 25.9%. Factors associated with 12-month mortality were: consideration by healthcare professionals that patient requires PC (Hazard ratio (HR)=2.62), cancer status (HR=2.20), request from patient’s main carer for PC or limitations of major therapeutic interventions (HR=1.67), functional dependency (HR=1.42), functional decline (HR=1.39), request from main carer for PC or limitations of major therapeutic interventions (HR=1.38), nutritional decline (HR=1.38), 22 admissions in previous year (HR=1.18) and Charlson score (HR=1.11). Under the ROC curve-0.77. A cut-off point of 0.08, 70.2% (sensitivity) of patients who died and 70.4% (specificity) who did not die were successfully predicted.

Conclusion: We present an acceptable predictive model that can be used to assess the mortality risk of individual patients in the next 12 months.


Abstract number: P1-076
Abstract type: Poster
A Cross-sectional Study of Self-reported Difficulty in Climbing Up and Down Stairs as a Predictor of Falls and Functional Status in Elderly Patients with Prostate Cancer
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Background: Falls in the elderly cancer patient cause a significant amount of morbidity and mortality. There is a simple tool for the oncologist to use in the clinical setting identifying elderly cancer patients with a high risk for falls. This study’s objective was to determine if a questionnaire of self-reported difficulty in climbing up in down stairs correlates with functional tests and self-reported history of falls.

Patients and methods: Older males (N=34, mean age 72.6y) with prostate cancer were assessed during a single oncology visit. They completed questionnaires evaluating difficulty climbing up and down stairs, history of falls and independence in activities of daily living and three objective tests of function (the Timed Get Up and Go Test [TUG], Unipedal Stance Test, and Grip Strength Analysis).

Results: Of 33 patients completed the assessments, 15 reported difficulty in climbing up and 10 in climbing down stairs (9 both). Difficulty in climbing up stairs was associated with significantly longer TUG test time and less grip strength. Difficulty climbing down stairs was associated with a significantly shorter TUG test time and less independence in activities of daily living. Both climbing up and down stairs were associated with number of falls in one year (sensitivity was 81% and specificity was 83%).

Conclusions: Self-reported difficulty in climbing up and down stairs closely correlates with objective functional testing and number of reported falls in one year. This questionnaire may be a useful clinical tool for screening high fall risk cancer patients.
Abstract number: P-077
Abstract type: Poster

Status of Prognosis Prediction in Terminal Cancer Patients at a Japanese General Hospital

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Background: Evaluating prognosis prediction in terminal cancer patients is very important in providing appropriate palliative care at the right time. At our hospital, we have used the Palliative Prognostic Score (PPS) to estimate prognosis since July 2011. Here, we describe the status of prognosis prediction in terminal cancer patients at a Japanese general hospital.

Method: We retrospectively analysed 149 patients in whom we predicted using the PPS Score at the time of admission between August 2011 and July 2014, after cancer treatment discontinuation.

Results: Patients were divided into groups according to their PPS Score: group A (0-5.5), group B (5.6-11.0), and group C (11.1-17.5). We compared the results of our survival analysis in these groups with the results of a previous study.

Conclusion: Next, we compared actual survival with clinical Prediction of Survival (CPS), a structural component of the PPS Score. Survival was analysed using the Kaplan-Meier method and compared among the groups.

Abstract number: P-078
Abstract type: Poster

The Patient’s View: 208 Advanced Cancer Patients’ Self-reported Prioritized Symptoms and which HCP Took Care of them

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Introduction: Advanced (adv) cancer patients (pts) face a variety of SY which are variably managed by different health care professionals (hcp).

Aims: To investigate the frequency of pt-prioritised SY, the intensity of pt-reported SY and the pt-perceived involvement of hcp in their management (mgmt).

Methods: The reported data is part of a larger study (268 adv cancer pts, defined palliative care (PC) needs, 74% ECOG ≤1-2), monthly collection of pt perceived needs/recalled delivery by hcp for 7 PC key interventions, demographics (adapted EACPC dataset), PC needs (IPOS), QoL (EPOS), and quality indicators (QI), inapposite anticancer treatment, aggressiveness of end-of-life care, quality of dying. For the current analysis pts were asked to prioritise their disturbing SY in the past 6 months and whether these were addressed by hcp.

Results: Pts prioritised SY were pain (185, 66% of pts, IPOS mean score 1.9), fatigue (149,56%).2, anxiety (103,38%), 2 nausea (82,31%), 10) breathlessness (34, 20%), 10) anorexia (61, 20%), 9) dyspnoea (20, 10) pain (20, 10). The actual median survival times were 26 (95% confidential interval [CI]: 23-29), 18 (95%CI: 15-21), and 10 (95%CI: 7-13) days in groups A, B, and C, respectively.

Conclusion: More SY needs to be managed for pts at our hospital.

Abstract number: P-079
Abstract type: Poster

Comparison of Symptom Control Effectiveness Provided by Two Health Care Teams to Patients with Advanced Cancer

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Introduction: The effectiveness of different strategies of palliative care provision is little known.

Objectives: To compare symptom control effectiveness provided by two health care teams: interconsultation palliative care (IP) and non-palliative care (NP).

Method: Pragmatic clinical trial carried on 138 consecutive adults with advanced cancer, admitted in oncology hospital (2012-2013), who presented pain intensity ≥4 (0-10) or at least others two symptoms with intensity ≥4 (0-10). 93 patients with an IP team and 45 by NP were attended by IP TEAM and by NP, respectively. All were interviewed at admission, after 24h and 48h from admission. SYs were measured by the Edmonton Symptom Assessment System (ESAS). The sum of ten symptom scores (ESAS with sleep) was defined as the symptom burden. The endpoints were 2 points reduction of the initial pain or other symptoms scores after 48h from admission and 20% reduction of the initial symptom burden score after 48h from admission. Multiple Poisson regression analysis adjusted for age, KPS and number of metastasis was used to analyze the occurrence of the endpoints. The significance level adopted was 5%.

Results: The symptoms burden average score at admission were 44 (SD=2.3) in IP group and 45 (SD=1.5) in NP group. After 48h from admission, symptom burden improved only in NP group (p < 0.001), Wilcoxon test). Poisson regression showed relative risk reduction of 2 points in IP team score (RR=1.209; 95%CI: 1.149-1.274 in IP group; and in pain score (RR=0.0595%; 95%CI: 0.38-0.96) for NP group.

Conclusion: Patients showed moderate symptom burden at admission in IP and NP groups, and after 48h from admission the symptoms controls were poor in both groups. Only constipation in IP group and pain in NP group showed minimum clinically important difference.

Abstract number: P-080
Abstract type: Poster

Interprofessional Team Use as a Measure of Complexity of Pain Management Needs

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Background: The Edmonton Classification System for Cancer Pain (ECS-CP) can be externally validated and can be identified as a feasible tool to measure the complexity of pain management needs. Future studies should consider other approaches for assessing the impact of IP team involvement.

Use of the VOICES-SF among Bereaved Carers in Denmark: Validation and Cultural Adaptation

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Background: Our main study aimed at assessing quality of care in the last three months of the patient’s life, as well as circumstances surrounding death, by questionnaires answered by the bereaved relatives. In Denmark, we could not find comparable studies.

Aims: To validate the VOICES-SF in a Danish setting and test the feasibility of using this questionnaire among bereaved carers.

Methods: The slightly modified Danish version of VOICES-SF was tested in cognitive interviews with 36 bereaved relatives of deceased cancer patients. Verbal probes (i.e. questions about the items) were prepared and supplemented with think aloud responses in telephone interviews covering a large geographic area.

Results: The mean duration of the interviews was 60 minutes (range 25 - 120). The VOICES-SF was found feasible and easy to answer. It was not regarded as unnecessarily upsetting and items were generally comprehended as intended. However, one item regarding the general practitioner was frequently misunderstood and was therefore changed in the final Danish version of the questionnaire.

Conclusion: The VOICES-SF worked well in Denmark after a slight cultural adaptation. Bereaved carers were positive towards the use of this questionnaire. One item was frequently misunderstood in the Danish sample, and its validity should also be tested in other countries.

Funding: Funded by TrygFonden, Danish Cancer Society, Aase and Ejnar Danielsen's Fund.
Background: Family satisfaction is a critical indicator of quality of care for patients with advanced illness that is commonly measured in palliative care research. Yet the systematic assessment of family satisfaction as a quality indicator is rarely practiced. This is in part due to an emphasis on the importance of family input and support for caregivers in advanced care for those with cancer and other serious illnesses. Measurement burden may be one barrier to widespread use of family satisfaction measures.

Methods: We used data from the Palliative Care for Cancer Patients study, a multisite observational study of the effect of inpatient palliative care on patient health outcomes and health services use among patients with advanced cancer. Using Item Response Theory, we developed a shortened 5-item version on the FAMCARE scale to measure family satisfaction with care. We used univariate regression analysis to detect significant differences across five treatment sites controlling for patient demographics, cancer type, family-related items, and end of life and use of inpatient palliative care.

Results: Family-related items were available on 1979 patients. The most common cancer type was GI (28%) followed by lung (13%). Mean FAMCARE-5 score across sites ranged from 5.54–6.89 out of 10 indicating highest level of satisfaction. Family members of patients at site 5 (n=783) were significantly (p<.01) less satisfied with their care than family members at other care sites.

Discussion: Variability in family satisfaction with advanced cancer care across sites can be detected using a brief 5-item questionnaire. The development of less lengthy and burdensome measures for monitoring family satisfaction among patients with serious illness can facilitate the routine assessment of family satisfaction to maintain and promote high quality care across care settings.

Funding: NCI Grant S05CA16227-05, NIA P30-AG028741

Abstract number: P-083
Abstract type: Poster

Development of a Questionnaire to Evaluate Quality of Palliative Care

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Background: In Sweden, palliative care is provided across a variety of care settings by a range of professions, supported by recently developed national guidelines. The quality of palliative care is evaluated with a national register focusing the last week of life. However, there is need for defining feasible measures of quality of palliative care.

Aim: To develop a questionnaire evaluating quality of palliative care from the perspective of health care professionals at different care settings.

Methods: The core issues in national clinical practice guidelines for palliative care were chosen to represent quality of care. To generate items, a brief inventory on existing measurement properties, this questionnaire can be used nationally to evaluate the quality of palliative care.

Development of a questionnaire to evaluate quality of palliative care:

Ostlund U.1, Henriksdottir A.1, Wennermark M.1, Åströdi K.1,2,3

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Aim: To develop a questionnaire evaluating quality of palliative care from the perspective of health care professionals at different care settings.

Methods: The core issues in national clinical practice guidelines for palliative care were chosen to represent quality of care. To generate items, a brief inventory on existing questionnaires was undertaken and items from three existing questionnaires were rewritten to represent staff perspectives. To check for relevance, coverage and face validity an expert group reviewed the items. A first version asking for comments was answered by 10 nurses in specialist palliative care, 4 nurse assistants in elderly care, one nurse and one social worker from paediatric oncology. The questionnaire was somewhat revised and completed by 99 professionals to explore response patterns. For further refinements, the questionnaire was critical reviewed by an expert on questionnaire construction. Finally, cognitive interviews with health care professionals were conducted.

Results: All items were considered relevant but some were unclear and revised to improve readability. Some relevant issues were experienced not covered, consequently new items were added. During validation process, the response alternatives were refined. At this point the questionnaire consists of 40 items covering the core dimensions: symptom management, dialogue and support, involvement, encounter and organisation of care.

Conclusion: The questionnaire seems to have content validity. After evaluating measurement properties, this questionnaire can be used nationally to evaluate the quality of palliative care.

Abstract number: P-084
Abstract type: Poster

Constructing Connection through a Shared Assessment Process

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Background: A global increase in demand for palliative care is driving capacity building for all nurses. The purpose of using validated assessment scales in nursing is to pursue holistic care. A number of scales are utilised by palliative care teams however these tools have not been extensively used by generalist nurses.

Aim: This study reports the findings of implementing a shared palliative care clinical assessment process on a general medical ward at a regional hospital.

Methods: Three-phased mixed method study. The awareness level of five validated assessment scales and the frequency nurses used and subsequently refined the questionnaire. Patients changes in status was recorded at the pre, midterm post study points in a short questionnaire. The assessment process was completed on a daily basis, audited mid and post study. Appearance was conducted using the SPSS version 21. Focus groups for the end of data collection and descriptive analysis was employed to identify emerging themes from semi structured open ended interview questions.

Results: Thirty one nurses participated, no nurses were extremely aware of the five validated scales with 54.28% having no awareness at all pre study. Post study, 28.88% of the nurses were extremely aware with 37.77% of nurses being very aware of the scales. Prior to the study commencing 59.08% of nurses experienced occasional difficulty in communicating patients change in status with 20.61% having difficulty post study. Eighty four to 97% of the scales had the data assessed as correctly recorded. Emerging themes included the process was relatively easy to complete, it assisted in holistic assessment and improved communication.

Conclusion: A structured clinical assessment process can improve the span of assessment skills of general nurses. Extending the use of this assessment process in other general hospitals would further capacity building in the provision of palliative care.

Nurses Memorial Foundation SA Inc.
Auditorium Improvement

Abstract number: P1-087
Abstract type: Poster

Translation of the Social Difficulties Inventory into German and Psychometric Analyses in Two Samples of Cancer Patients with and without Palliative Condition

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Background: Psychosocial support in palliative care of cancer patients should rely on patients’ individual requirements, thus good screening instruments are needed. The Social Difficulties Inventory (SDI, Wright et al., 2011) aims to identify patients who require further support.

Aims: Translation of the SDI into German and psychometric evaluation in two samples of cancer patients with and without palliative condition.

Methods: Following recommended guidelines for translation of questionnaires:
1. translation and back translation,
2. patients’ evaluation of cultural equivalence,
3. psychometric evaluation considering factor structure, internal consistency and construct validity.

For pretest two samples with a total of 27 patients were interviewed. Psychometric evaluation was carried out in 250 cancer patients who were recruited from an outpatient radiotherapy clinic (n=229) and replicated in a sample of palliative patients (n=166).

Confirmatory factor analysis was used and subscale reliability was evaluated using Cronbach’s α. Construct validity was examined via correlations with distress and symptom burden.

Results: Forward-backward translation resulted in minor amendments and cultural adaptations. The German SDI was rated as acceptable and clear by the majority of the interviewed patients. Factor analysis confirmed the 3-factor solution (money matters, everyday living, self and others) and could be replicated in the palliative sample. Floor effects were demonstrated in the money matters-subscale. Satisfactory internal consistency was demonstrated for all subscales (α=0.62 to 0.88) and construct validity was confirmed.

Conclusion: The German translation of SDI is culturally and linguistically acceptable and can be used for cancer patients with and without palliative condition. Patients’ factor scores can be verified in both samples inspected. The money matters-subscale should be handled with caution because of the floor effects.

Funding: German Cancer Aid

Poster Sessions (Poster Exhibition Set 1)
Impact of a Palliative Care Consultation Team on Medication Changes before Palliative Care Unit Admission in a Japanese Comprehensive Cancer Center

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Abstract number: P1-093
Abstract type: Poster

Aim: This study aimed to investigate changes in medication profiles among patients with advanced cancer before PCU referral (T1) and on admission to the palliative care unit (PCU) (T2).

Methods: We enrolled consecutive patients referred to the PCU and then transferred to a PCU from April 2013 to September 2014. Profiles of medications at T1 and T2 were recorded retrospectively. The Paediatric Index of Mortality (PIM) test and chi-square test were performed to analyse changes in opioid dosages and medication use, respectively.

Results: In total, 70 patients were analysed. Forty-five patients (64%) had advanced cancer, and 25 patients (36%) had advanced non-cancer. Median period from admission to the oncology ward to T1, and from T1 to T2 was 5 days (interquartile range, 1-12) and 15 days (interquartile range, 7-24), respectively. Medications for symptom control, including adjuvant analgesics, steroids, and neuroleptics were given more significantly (p = 0.03, χ2 = 0.02, p < 0.01). Opioid dosage in daily oral morphine equivalents was higher at T2 (median, 48 mg; interquartile range, 24-121) than at T1 (median, 39 mg; interquartile range, 13-100; p = 0.01). In this study, laxatives showed a tendency toward decreasing (p=0.09). Drugs for chronic illness were used by 13% and 7% of patients at T1 and T2, respectively (p = 0.28).

Conclusions: This revealed that:
1. The PCU appropriately increased medications for symptom control, and
2. Relatively few patients were still taking drugs for chronic illness at the time of PCU referral.

Background: Patients with advanced cancer suffer from various symptoms. Palliative care consultation team (PCT) have to immediately alleviate symptoms and also relieve suffering from unnecessary medications in such patients.

Aims: This research project was approved by the ethics board of the University of Hertfordshire.

Methods: The questionnaires which contained ‘tick box questions’ and a free text section. Data is collected and analysed using the software package IBM SPSS Statistics 24. Data was compared using Wilcoxon ranked sum test and chi-square test to perform analysis.

Results: 436 of 1294 questionnaires were returned in the first year of the survey. Care was described as ‘excellent’ or good in 72% of cases. 82% of respondents reported being treated sensitively. However, 0% did not recall any decision about an issue nor about the plan of care at the end of life. 16% described help with eating and drinking as ‘poor’ and 13% said that information about pain relief and sedation was ‘poor’. Only 46% strongly agreed or agreed with the statement that there had been ‘enough communication from ward staff’.

Conclusion: This project gives a voice to the bereaved and shows that professionals want to listen and learn. Pride can be taken when care is delivered to an excellent standard but this survey exposed the unacceptable standards of care. The PCT is suggested as a key point to improve. The WCT has agreed to improve care and continues to seek feedback from the bereaved on one measure of quality improvement.

Abstract number: P1-095
Abstract type: Poster

Patients’ Perception of Types of Errors in Palliative Care - Results from a Qualitative Interview Study

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Abstract number: P1-096
Abstract type: Poster

Development of a Conceptual Framework to Assess Quality in End of Life Care in Dementia: Contextual, Structural, Process and Outcome Variables

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Abstract number: P1-093
Abstract type: Poster

Aim: The Supporting Excellence in End of Life Care in Dementia (SEED) research programme (https://www.hee.nhs.uk/seeds) aims to support professionals, both care workers and providers, to deliver quality, community-based end of life care in dementia, through the development of a comprehensive approach to patient care delivery, known in the UK as an Integrated Care Pathway (ICP).

Methods: In order to identify indicators to measure the quality of this care, we developed a conceptual framework for assessing quality in end of life care in dementia, based on a review of existing palliative care literature, including the ICP’s White paper defining optimal care in older people with dementia. The framework provides a comprehensive overview of contextual, structural, process and outcome variables in patient care delivery, against which existing quality indicators for palliative care have been classified.

Results: The majority of existing quality indicators for palliative care measure processes of care (n=167, 76%), which include assessment and referral processes, shared decision-making and patient/family information and education. Within processes of care, only a quarter of indicators appear to measure quality of actual treatment, support and care provided (n=41). Results suggest that even fewer indicators measure outcomes of care (n=24, 15%), which include physical comfort and psychological/spiritual well-being.

Conclusion: Overall, results suggest a need to develop quality indicators of end of life care in dementia that measure individual level person centred outcomes, in addition to indicators that assess the structure and processes of care.

Background: The provision of end of life care in dementia is of increasing importance as the population ages. Various indicators of quality have been developed, however none of these are specific to dementia. We have planned a further study to investigate changes in patient-reported outcomes, and to reveal the burdens of polypharmacy and drug formula from a pharmacist-based perspective in the PCT.

Auditor of Clinician Screening for Depression and Anxiety in Patients Admitted to a Hospice Setting

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Abstract number: P1-096
Abstract type: Poster

Hospital End of Life Care: Lucky or Unlucky Dip?

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Abstract number: P1-094
Abstract type: Poster

Aim: To assess and improve the quality of end of life care (EOLC) across a large two hospital NHS organisation by using questionnaire feedback from bereaved relatives. The collection of both quantitative and qualitative data enables education and direct feedback to frontline staff. The questionnaire includes questions relating to the main findings of the UK Neuberger review of the Liverpool Care Pathway published July 2013.

Methods: Questionnaires are sent to relatives 6 weeks after the patient’s death in hospital. The questionnaire contains ‘tick box’ questions and a free text section. Data is collected and analysed to provide both an organisational overview and individual ward performance. Results are presented both to average leads, clinical teams and patient/user groups.

Results: 436 of 1294 questionnaires were returned in the first year of the survey. Care was described as ‘excellent’ or good in 72% of cases. 82% of respondents reported being treated sensitively. However, 14% did not recall any decision about an issue nor about the plan of care at the end of life. 16% described help with eating and drinking as ‘poor’ and 13% said that information about pain relief and sedation was ‘poor’. Only 46% strongly agreed or agreed with the
Do Hospitals Deliver ‘Good’ End of Life Care (EOLC) in the Absence of the Liverpool Care Pathway (LCP)? A Hospital Audit of the Documentation of EOLC for Dying Patients Following the Phasing out of the LCP and After the Introduction of a Locally Developed Tool

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The announcement in July 2013 of the phasing out of the Liverpool Care Pathway (LCP) caused anxiety within UK healthcare institutions. In part, the concern was that without a guidance document the principles of best care for patients in the last days of life would be forgotten. In our hospital, use of the LCP fell dramatically after July 2013. It led to rapid introduction in January 2014 of a Key Elements’ document (based on the principles of the LCP) on which clinicians could record prompted aspects of the care of dying patients. This paper presents an audit of documented care in our hospital before and after the introduction of the Key Elements document. The audit reviewed notes of deceased patients in December 2012 and in May 2015 respectively, for evidence of 7 ‘key’ aspects of end of life care (EOLC). The aspects of care reviewed were consistent with the later published ‘Principles of Care for the Dying Person’.

The December audit reviewed 18 case notes. It showed 88% of notes had 5 or more ‘key’ aspects of good EOLC recorded. The May audit reviewed 16 case notes. It showed documented standards had not dropped with 87.5% of notes recording 5 or more ‘key’ aspects of good EOLC. However, recording on the Key Elements document was minimal (1 set of notes). At both time points, care interventions least recorded were spiritual care and aspects of nursing care (e.g. mouth care).

Our results suggest that some key aspects of EOLC were still being delivered in our hospital after effective cessation of the LCP. There is no evidence however, that clinicians used the new Key Elements to record their practice (although they may have used it as guidance). Lack of use of the new document may reflect paucity of knowledge or a reluctance to engage in its use. The audit highlights the difficulty of new documentation into clinical practice and the possible problems with implementation. The audit is limited by small numbers and its retrospective nature.

Poster abstract: P1-098
Abstract type: Poster

Forensic Attention to Detail: Lessons Learned from a Clostridium Difficile Outbreak in a Hospice Setting

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Background: Three different patients tested positive for Clostridium Difficile over a 3 month period. Each had attended a different clinical department within the hospice for their care. Enhanced fingerprint testing demonstrated the strains were indistinguishable PCR-type 027 highly suggesting transmission within the hospice.

Method: An incident meeting was held, chaired by Public Health England, to examine the root cause analysis in detail, and action plan agreed. An external infection control audit previously undertaken by Department of Public Health was reviewed. Overall score was 94% against a compliance score of 84%. Environmental ATP swabbing was undertaken by the community infection control team, 17/18 swabs passed the criteria for cleanliness, 18th swab was border line fail.

Intervention: Hand washing training and infection control is mandatory annually for all staff, students and volunteers, and is included as part of the new starter induction programme. Additional in-service training about Clostridium Difficile continues. Infection control policies were updated and specific infection control information leaflets devised and are now distributed to families. Housekeepers receive specific infection control training. Housekeeping establishment hours have been increased and cleaning schedules reviewed. Disposable hoist slings and slide sheets were purchased. Monthly audits of hand hygiene, waste, environment and sharps bins continue. Results are circulated to staff with action plans if necessary. An audit of Proton Pump Inhibitor and antibiotic prescribing was undertaken and results presented to clinical staff. HPV fogging was recommended and undertaken at the cost of £5000.

Outcomes: A score of 99% was achieved in the final external Public Health audit. The incident highlighted the importance of collaborative working between Hospice, NHS partners and Public Health England. Everyone is aware that infection control is everybody’s business.

Poster abstract: P1-099
Abstract type: Poster

Measuring the Impact of Palliative Care Using the Priorities of Patients and Carers to Refine a Service Evaluation Questionnaire

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Background: The delivery of optimal palliative care requires understanding of the patient and carer perspective. A service evaluation questionnaire, comprising nine questions and a free text box, had been implemented across palliative care settings in Wales. The free text responses of 596 palliative care service evaluation questionnaires were analysed to examine the experience of patients and concerns of patients and carers. The emotional and oncological care was central to the delivery of quality palliative care for patients and carers. It constituted a core practice referring to a positive change in attitude, affect or ability to cope following palliative care admission. Information from the AFTER follow on study, testing and refining of the original questionnaire to reflect patient and carer priorities

Aims: To refine the questionnaire to incorporate patient and carer priorities with the aim of implementing the updated questionnaire.

Methods: Thematic analysis was used to explore free-text questionnaire responses from 596 patients and carers. The resulting themes were used to inform initial questionnaire refinement during an expert consensus day. In two further stages of refinement, semi-structured cognitive interviews were used with patients and carers (N=17) in receipt of palliative care to test the extent to which questions were relevant and understandable.

Results: A number of changes were suggested by patients and carers, regarding the layout, wording and format of the questionnaire. Suggested changes arising from interviews were used to inform the final questionnaire revisions.

Conclusions: This two stage study evidences the value of routinely collecting and analysing free-text data when measuring the quality of healthcare provision. The refined questionnaire provides a more efficient and pertinent route to feedback for patients and carers, and has been presented to the Palliative Care Implementation Board for their use.

Poster abstract: P1-100
Abstract type: Poster

Does Bereavement Support in Intensive Care Units Meet UK National Guidelines? A Critical Care Staff Survey

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Background: Average mortality in Intensive Care Units (ICUs) in the UK is around 18%. Evidence is growing that a considerable proportion of bereaved family members develop prolonged grief, complicated by serious social, psychological and medical consequences. In 1998 the Intensive Care Society (ICS) published guidelines for bereavement care in the ICU emphasising its clinical importance.

Aims: To investigate staff perceptions on bereavement care in a large UK tertiary referral ICU and to identify whether national recommendations are met.

Design: We circulated an online survey using SurveyMonkey® to all critical care staff. The questions were mapped against the ICS guideline, specifically looking at staff training, support, audit and policies.

Results: A total of 68 responses - 17 consultants(25%), 11 junior doctors(16%), 37 nurses(54%) and 3 allied healthcare professionals(4%) were collected. Table 1 shows the results highlighting lack of training, support and follow-up for relatives as major concerns for staff.

Table 1

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>Unsure (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel competent in speaking to children about bereavement?</td>
<td>19(28.8%)</td>
<td>42(62.6%)</td>
<td>6(12.31%)</td>
</tr>
<tr>
<td>Do you feel training about bereavement in the intensive care unit (ICU) is adequate?</td>
<td>62(95.8%)</td>
<td>1(1.56%)</td>
<td>3(4.88%)</td>
</tr>
<tr>
<td>Do your ICU training on bereavement care?</td>
<td>5(7.69%)</td>
<td>35(53.85%)</td>
<td>20(30.46%)</td>
</tr>
<tr>
<td>Do your ICU offer training on bereavement care?</td>
<td>15(25.86%)</td>
<td>42(72.41%)</td>
<td>1(1.72%)</td>
</tr>
<tr>
<td>Does your ICU have a written bereavement policy?</td>
<td>13(21.65%)</td>
<td>33(55.93%)</td>
<td>21(32.42%)</td>
</tr>
<tr>
<td>Do your ICU have a follow-up clinic for bereaved relatives?</td>
<td>15(25.42%)</td>
<td>81(71.56%)</td>
<td>3(3.03%)</td>
</tr>
</tbody>
</table>

Conclusions: We identified significant inadequacies in the management of bereavement care in our ICU, including failure to adhere to national guidelines. Staff highlighted the need for further training and support and a Palliative Care Social Worker has been appointed to develop a service in line with the national guidelines.

Poster abstract: P1-101
Abstract type: Poster

Implementing and Assessing a Caring for the Dying Care Bundle

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Background: Wide variations in the quality of care provided to people dying in acute hospitals exist. One potential solution is the implementation of care bundles. This work aims to investigate the effects of a care bundle for the dying on the quality of care delivered to dying people in acute hospitals, with quality referring to evidence-based, patient-centred, safe care.

Methods: Approvals by the local ethics committee, a quasi-experimental study was undertaken. The bundle was composed of an observation chart to monitor and respond to common symptoms, monitor family distress, facilitate prescribing. The primary outcome was whether pain score documentation improved as evidence-based recommendations. Secondary outcomes included whether the burdens of investigations were reduced after dying had been diagnosed and whether there was a difference in the opioid doses prescribed after dying was diagnosed in opioid-naïve people. Compliance with the care bundle was summarised.

Results: A baseline audit was conducted to document usual practice (n=96). The pre and post proportion of people who had pain scores after dying was diagnosed were compared revealing significant differences between baseline and intervention (p = 0.001). A significant difference in investigation numbers ordered after dying was diagnosed was observed (p = 0.05, p = 0.001). No statistical differences were seen in opioid doses prescribed to those previously opioid naïve and then commenced on opioids after dying was diagnosed. After the 6 months pilot, 76% (n=70) compliance with the bundle was noted, pain, breathlessness and family distress scores improving from 13%, 1% and 0% compliance respectively to >85% each.

Discussion: This work, although preliminary, highlights that systematically implementing and objectively assessing care bundles at the end of life can provide meaningful and measurable change.
Abstract number: P1-102
Abstract type: Poster

**Implementing a Patient, Family Caregiver and Public Involvement Model for Palliative Care Research in Order to Influence Clinical Care, Policy and Funding**

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**Background:** To achieve evidence-based, high-quality palliative care (PC), researchers need to collaborate with patients, family caregivers and the public (PPI) to plan, conduct and disseminate research that responds to patients' and relatives' needs.

**Aim:** To implement a PPI model in PC research to produce high-quality research with findings relevant to patients and families that influence clinical care, policy, and funding.

**Methods:** Patient and public advocates and researchers conducted nominal group technique research to establish how PPI in PC research should be delivered. Salient recommendations emerged and were used to develop a PPI implementation framework. The PPI implementation model was implemented through systematic, co-design and collaborative process with patients, family caregivers, and stakeholders. The implementation of the first two workshops was systematically reviewed in order to determine components essential to implementation.

**Results:** An overall structure for the PPI model was developed and three variants were reviewed in order to assess the model. The components of the model were: Aim, outcome, structure, costs, and resources. Implementation review revealed that PPI model implementation depends on: PPI operational and strategic leadership from research staff; consistent relationship-based work with participants, which involves acknowledging the value of their clinical care experiences; a blended means of implementation (e.g., face-to-face and virtual platforms); sufficient resources to support implementation.

**Conclusion:** Implementing PPI in PC research requires a continuous and a continuous professional relationship with all collaborators. These findings highlight the potential for optimising the value of clinical experiences within research settings in PC. Future research is needed to further implement, sustain and impact of the model.

On behalf of BuildCARE

**Abstract number:** P1-103
**Abstract type:** Poster

**The Safe Prescribing of Medicines in a Hospice Setting**

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**Background:** Within the hospice setting potentially harmful drugs are prescribed on a daily basis making it imperative that safe prescribing is a key aspect of palliative care.

**Aim:** To highlight the importance of the prescribing standards outlined in the hospice’s ‘Medicine Policy’ in addition to good prescribing practices identified by the hospice pharmacist.

**Method:** With a view to minimising prescribing errors an audit of all currently prescribed medications was conducted over a two week period at the hospice. The audit standards were divided into two parts, one completed by the medical student and the second by the hospice pharmacist. Any standards not met were recorded daily, the type of error made was recorded as a tally and collated at the end of the audit period.

**Results:** A total of 91 errors were recorded in part 1, and 24 in part 2. In part 1 41% (n=37) of the errors were due to a lack of instruction for priority of use when multiple medications were prescribed i.e. prescribed for managing one symptom. Within part 2, specific formulation details were also frequently missing from the prescription (67%, n=16). This was particularly problematic when polypharmacy or polytherapy was required. Other common problems included missing allergy status information, incorrect abbreviations of units, failure to complete the indication box and maximum medicine frequency not prescribed for prn medication.

**Conclusion:** The audit results were presented to hospice staff to highlight areas for improving prescribing thereby reducing errors and potential harm to patients. This audit tool was quick and easy to complete and is an effective way of raising the awareness of good prescribing practice.

**Abstract number:** P1-104
**Abstract type:** Poster

**Implementation of PaTz-groups in the Netherlands**

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**Aims:** PaTz (palliative care at home) is an intervention to improve palliative care provision and strengthen knowledge. PaTz-groups consist of GPs and district nurses who work in the same area. They meet six times a year with an expert in the field of palliative care to discuss palliative patients. With funding from ZonMW Foundation, PaTz and Netherlands Comprehensive Cancer Organisation (IKNL) initiated 10 groups. The experience with the implementation of these groups will be used to initiate more PaTz-groups.

**Approach taken:** We started with informing potential PaTz-groups. They had to meet the following requirements:
- consist of at least 5 GPs and 2 district nurses
- there had to be a chairperson
- groups were prepared to participate in a pre- and posttest

All groups received training for the chairperson. Furthermore they were supported in the first meeting.

**Results:**
- 16 interested parties came forward. 6 groups withdrew voluntarily. Main reason was lack of time.
- 10 groups began in the period between April and September 2014 with a total of 67 GPs and 35 district nurses. The results of the pre- and posttest will be available in autumn 2015.

**Lessons learned:** Contributing factors to the setting up of a group were:
- A doctor is the one who initiates the group
- The PaTz-meeting takes place during a regular meeting
- The group is already familiar with the expert in the field of palliative care.

**Abstract number:** P1-105
**Abstract type:** Poster

**Psychosocial Interventions’ Effectiveness at the Programme for the Comprehensive Care of Patients with Advanced Illnesses in Spain in 2013**

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**Background:** The programme for comprehensive care of patients with advanced illnesses starts in 2008, as an initiative and funding support of La Caixa Foundation, with the aim of adding quality and put in value the task of palliative care teams towards individuals (and their families) in end of life situation. The program has implemented 29 Psychosocial Care Teams (PSC/Ts) distributed among Spain, with a minimum of one team per region, and with 120 professionals, mainly psychologists and social workers. These teams aim at offering support to the existing palliative care services. They provide care to advanced patients and their families in regards to emotional, spiritual and social issues and contribute to their integral care.

**Aims:** To assess the psychosocial interventions’ effectiveness provided by PSC/Ts towards advanced patients and families.

**Methods:** Quasi-experimental, prospective, multi-centred, one group and pre-test/post-test study. The evaluation of patients and relatives (individuals) taken care by PSC/Ts from October 1st 2012 to September 30th 2013 was included. The assessment of psychosocial interventions’ effectiveness was performed after the basal visit and for 4 follow-up visits. The dimensions observed included: mood, anxiety, unease, adaptation and suffering, for patients; and, unease, anxiety, depression, and insomnia, for relatives.

**Results:** 10.471 advanced patients and 18.131 relatives have been assessed during the period of study. 32.674 and 44.106 visits, respectively, were performed. There is a significant improvement in the following areas:
- 1) evaluation performed during the 4 follow-up post basal visits;
- 2) all variables for patients;
- 3) anxiety and emotional unease variables for relatives.

**Conclusion/discussion:** The PSC/Ts provide effective interventions and contributes to improve the emotional symptoms and unease of patients and their families.

**Quality of Information from Acute Hospitals to a Hospice**

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**Background:** Recent experience in a hospice appears to show that discharge letters received from acute hospitals often lack a sufficient clinical summary and drug information to provide optimal continuity of care and good symptom control.

**Aim:** To assess the completeness and reliability of information supplied by acute hospitals.

**Methods:** A retrospective analysis of patients admitted to a hospice from acute hospital trusts was over 8 months was performed. The Royal College of Physicians Hospital Discharge Record Keeping Standards Audit Tool was adapted and used. The presence or absence of a discharge letter, drug information, including Patients Own Drugs (PODs) and indications and test results were audited and discrepancies between these were noted. The adequacy of clinical summaries and continued drug recommendations were also reviewed.

**Results:** Nineteen referrals were received (8 hospitals), 16% (3) did not have a discharge letter. In the 16 letters received, 4 clinical summaries were inadequate, 4 were missing relevant investigation results, and one did not have a list of drugs. In 12 cases, drugs were listed in the letter and a photocopy of the corresponding drug chart was supplied. However, only 4 of these matched and 28 discrepancies were found in the remaining 8. Of the 8 patients with PODs, 3 did not correspond with the discharge letter and/or drug chart.

**Conclusion** Indication for medications was not in 53% (4) patients.

**Patients:** Patients were frequently transferred to the hospice with inadequate information. Essential clinical information was missing or not supplied in 37% (7 patients).

**Drug discrepancies** were found and drug indications and test results were missing or not forwarded. The omission of such information impacts on continuity of care and is detrimental to optimising symptom control.  Our efforts are now focused on communicating these audit findings to the Palliative Care Teams in our referring hospitals to improve quality of information on transfer.

**Abstract number:** P1-106
**Abstract type:** Poster

Poster Sessions (Poster Exhibition Set 1)
Poster Sessions (Poster Exhibition Set 1)

Abstract number: P1-107
Abstract type: Poster

Are COPD Patients Receiving Adequate End of Life Care?

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Aim: To assess our current practice for patients with COPD (Chronic Obstructive Pulmonary Disease) against recent end of life care components in NICE guidelines.

Background: Half of the patients known to our hospice have chronic non-malignant disease COPD makes up a significant proportion of these patients. There has been an interest in developing our respiratory service further. However an audit of our current practice needed to be done first to allow the service to be appropriately developed.

Design and method: All patients on the case load in 2013 at our Hospice were identified. All notes were then reviewed.

Results: 65 patients were known to us in 2013. The majority were referred from the respiratory care team, the local hospital and local General Practitioners. Multiple criteria were noted as the reason for referral, most common reasons being symptom control and psychosocial support. Evidence from 2007 to 2014. Evidence of informal depression screening was sought in a baseline audit in 2007. Following this, the Hospital Anxiety and Depression Scale (HADS) was introduced into the clinical notes as the formal screening tool and completion of the HADS was assessed in subsequent audits.

Results: A total of 289 inpatient admissions have been audited between 2007 and 2014 with between 23 and 61 hospice inpatient admissions having been audited annually. In the initial audit only 40% (10/30) of patients had either formal depression screening or were documented as being unsuitable for screening. Only 1 patient, of those diagnosed with depression during admission, had a documented management plan. Introduction of the HADS has improved practice. In subsequent audits, between 70% and 90% of inpatients have either been screened using HADS or were documented as being unsuitable for screening and 100% of patients diagnosed with depression had a documented management plan.

Conclusions: The introduction of the HADS in clinical practice and annual audit of its use within a hospice IPU has been associated with improvement in the rate of depression screening and documentation of depression management. This more proactive approach should result in earlier diagnosis and treatment of depression which may impact on quality of life. Additionally, it is the experience of clinicians within this hospice IPU that the HADS promotes holistic care and can act as a ‘gateway’ to more open discussions with patients and families.

Abstract number: P1-108
Abstract type: Poster

An Audit of Depression Screening in a Hospice Inpatient Unit

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Background: Depression is common, often undiagnosed and untreated in palliative care patients. The aims of this rolling audit have been to assess if patients in a hospice Inpatient Unit (IPU) have documented depression screening and secondly, a documented management plan if diagnosed with depression, according to locally agreed standards.

Methods: A retrospective audit of consecutive admissions to a 10 bedded adult hospice IPU has been undertaken from 2005 to 2014. Evidence of informal depression screening was sought in a baseline audit in 2007. Following this, the Hospital Anxiety and Depression Assessment Scale (HADS) was introduced into the clinical notes as the formal screening tool and completion of the HADS was assessed in subsequent audits.

Results: A total of 289 inpatient admissions have been audited between 2007 and 2014 with between 23 and 61 hospice inpatient admissions having been audited annually. In the initial audit only 40% (10/30) of patients had either informal depression screening or were deemed unsuitable for screening. Only 1 patient, of those diagnosed with depression during admission, had a documented management plan. Introduction of the HADS has improved practice. In subsequent audits, between 70% and 90% of inpatients have either been screened using HADS or were documented as being unsuitable for screening and 100% of patients diagnosed with depression had a documented management plan.

Conclusions: The introduction of the HADS in clinical practice and annual audit of its use within a hospice IPU has been associated with improvement in the rate of depression screening and documentation of depression management. This more proactive approach should result in earlier diagnosis and treatment of depression which may impact on quality of life. Additionally, it is the experience of clinicians within this hospice IPU that the HADS promotes holistic care and can act as a ‘gateway’ to more open discussions with patients and families.

Abstract number: P1-109
Abstract type: Poster

TACT: What Impact Does Research Partner Involvement Have on the Working Practices of a Clinical Trial Unit and Academic Research Centre?

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Background: From 2005 a clinical trials unit has involved lay representatives (‘Research Partners’ RPs) as members of trial management groups (TMGs), reviewing documents and chairing and presenting at sub-committees. However, the impact of their work has not been routinely examined. The TACT study was conducted to investigate the input and impact of RPs to ensure the best possible working partnership between the trials unit and the public is achieved.

Method: Semi-structured interviews were conducted with 10 RPs and eight staff members to explore RPs’ views and expectations about the role of RPs as members of trial management groups and the impact their involvement had on the conduct of the trials unit. Interviews were audio-recorded and transcribed and relevant outputs were analysed using a Framework approach to analyse the impact of their work.

Results: RPs and members of staff understood the RP role to be an advocacy role for patients. RPs spoke of feeling welcomed into the trials unit and most were happy with their level of involvement; however others made more negative points reflecting a perceived bias in the unit’s tendency to use more experienced RPs, the RP role being a funding requirement that is taken seriously and is mandatory. A number of RPs were unclear about the degree to which RPs should be involved in their work. While there was a general recognition that greater commitment was required in the RP initiative, it was evident that time pressures and stresses were constant barriers to achieving this.

Conclusions: RP impact led to generally unfavourable results. Evidence of RP Input in TMGs did not equate with subsequent actions and contributions in the centre’s outputs appeared to be minimal.

Recommendations: Members of staff require further training to fully understand how RPs should be incorporated into the units work. They also need greater support to enable them the time to fully engage with the initiative. Regular auditing of the RP role needs to be developed to ensure that RPs are being involved as fully as possible in appropriate stages of the units work.

Abstract number: P1-110
Abstract type: Poster

Evaluation of Hospice Care Service in Malignant and Non-malignant Terminal Patients in a Hospice Care Unit in Taiwan

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Background: Hospice care had been in practice for 30 years in Taiwan. However, it was not until 5 years ago that non-malignant terminal patients were included. Thus, not only the general public need to be made aware of this change, but medical staff members also need more experience in caring for terminal patients with non-malignant disease.

Aims: To investigate if current care provides benefit to both malignant and non-malignant patient.

Methods: This study consisted of 299 terminal cancer patients who were admitted to the hospice ward during August of 2013 to June of 2014. We evaluated clinical outcomes of patients one week after admission and then weekly until patient’s death by using Support Team Assessment Schedule (STAS). For each category, the intensity of the problem was scored on a 5 point scale (0,8). Higher score indicating increased severity.

Results: Comparing to patients with non-malignant disease, cancer patients had significant higher level of pain, sleep disturbance, lymphoedema, depression, and anxiety (p<0.05) at the first STAS assessment. However, non-malignant patients had higher level of dyspnoea (p<0.03) and poorer insight on his/her prognosis (p<0.001) as compared to cancer patients. On day 14 after admission, there was no significant difference between the scores of cancer and non-cancer patients. ECOG score and length of admission were not significantly different between these two groups.

Conclusion / Discussion: Non-malignant patients were less prepared and had poorer insights on his/her prognosis in the hospice care unit. The term ‘terminal’ in non-malignant disease may be hard to define. In addition, ‘advance care planning’ is not popular in Taiwan, hence life-and-death issue is usually not discussed in time. Medical staff members should be obligated to fully inform non-malignant terminal patients of their disease course and prognosis, allowing patients enough time to cope with their condition and make important decisions.

Abstract number: P1-111
Abstract type: Poster

Differences in Medication Prescription between Hospitals, Hospices and Home in the Last Week of Life: Results from the MEDILAST Project

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Background: Medication management in the last phase of life is often challenging. Little is known in this context about the differences in medication prescription between care settings.

Aims: To compare medication prescription between patients dying in hospitals, hospices and home care in the last week of life.

Methods: Multi-center retrospective study of clinical records from patients with chronic conditions who died in the wards of geriatrics, oncology, neurology, cardiology and respiratory medicine of 3 academic centers and 7 peripheral hospitals, 3 high care hospices and 32 primary care practices in the Netherlands.

Results: Records from 178 patients were reviewed, of whom 84 (47%) were men. Mean (SD) age at the time of death was 74 (13) years. No differences were found between settings for gender and age. The mean (SD) number of medications prescribed in hospitals, hospices and home care were 14 (5), 11 (4) and 10 (5), respectively (p< 0.001). The three most prescribed types of drugs varied per setting. In the hospital 77% of patients received opioids, 68% antidepressive agents and 63% antacids; in hospices 80% sedatives, 77% opioids and 62% laxatives; and in home care 72% opioids, 61% sedatives and 52% antacids. Decision-making around the use of antidepressive agents in hospitals revealed the use of antidepressive protocols.

Conclusion: Medication prescription seems to focus on symptom control in the three settings. However, medication with preventive purposes like antithrombotic agents, antacids and laxatives frequently add to the medication burden of dying patients, especially in hospitals. Clinicians could reduce this burden by a continuous reassessment of prognosis. Research is needed to assess the harm/benefit of preventive medication prescription in this population.

Source of funding: This study was carried out within the framework of the MEDILAST project (Medication Management at the End of Life), funded by a grant of the Dutch government (ZonMW 1131.0036).
The Quality of Palliative Care in the Netherlands

Fröhlich B.1, Jansen-Segers M.1, Onwuteaka-Philipsen B.2, Middelburg-Hebly M.1, van Trigt L.1
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Abstract type: Poster

Abstract number: P1-112

Performance Measure and Quality Improvement in Palliative Care: Towards a Minimum Data Set for a Region in Ontario, Canada

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Abstract type: Poster

Abstract number: P1-114

Performance Measurement and Quality Improvement in Palliative Care: Toward a Minimum Data Set for a Region in Ontario, Canada

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Abstract type: Poster

Abstract number: P1-116

Poster Sessions (Poster Exhibition Set 1)
Measuring the Quality of End of Life Care for Patients with Advanced Cancer on the Intensive Care Unit

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Background: Outcomes for critically ill cancer patients have improved; hence intensivists are increasingly willing to initiate a trial of Intensive Care Unit (ICU) therapy. Yet ICU mortality remains high. Quality indicators for end of life care (EOLC) on ICU were proposed by the American College of Critical Care Medicine (ACCCM). Aim: To explore EOLC provision for patients with cancer who transitioned to EOLC on ICU.

Methods: Retrospective note review of medical patients admitted to a cancer ICU over six months. Patients who transitioned from active ICU to EOLC were identified. Quantitative and qualitative data analyses were undertaken, with respect to ACCCM quality domains for EOLC. Admission characteristics were compared between patients who actively transitioned to EOLC and active treatment groups to identify factors predictive of EOLC transition. Results: 28/85 (44.7%) patients transitioned to EOLC on ICU. Of the EOLC group: 56.2% saw the palliative care team, and symptom control was achieved in 79%. When deciding to transition regarding target to EOLC, and reusability were made, 51.4% and 40.5% patients respectively were too unwell to discuss these. EOLC transition was discussed with 97.3% relatives. 76.3% of the EOLC group died on ICU, with preferred place of death known in 70%. Psychological, welfare or spiritual support was offered to 29%, 21% and 37% respectively. Qualitative analysis identified themes: 1. Achieving consensus to initiate EOLC discussions; 2. Concomitant prognosticating and managing uncertainty; 3. Shared oncology and ICU decision making; 4. Integrative palliative care; 5. Family-centred versus patient-centred care. Baseline performance status and prognosis were potential predictive factors for EOLC transition (p = 0.01 and p < 0.001 respectively).

Conclusion: Tools and guidance to support delivery and documentation of high standards of EOLC are needed. Earlier advance care planning whilst patients are well enough may enhance individualised EOLC on ICU.

Managing Paraparesis in Hospice Inpatients: Does Having a Structured Protocol Improve Patient Safety and Length of Stay?

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Methods: Examine the use, choice, dosage and route of medications used to manage the dying phase in Palliative Patients in Community, Hospice and Hospital Settings. Outcomes for critically ill cancer patients have improved; hence intensivists are increasingly willing to initiate a trial of Intensive Care Unit (ICU) therapy. Yet ICU mortality remains high. Quality indicators for end of life care (EOLC) on ICU were proposed by the American College of Critical Care Medicine (ACCCM). Aim: To explore EOLC provision for patients with cancer who transitioned to EOLC on ICU.

Methods: Retrospective note review of medical patients admitted to a cancer ICU over six months. Patients who transitioned from active ICU to EOLC were identified. Quantitative and qualitative data analyses were undertaken, with respect to ACCCM quality domains for EOLC. Admission characteristics were compared between patients who actively transitioned to EOLC and active treatment groups to identify factors predictive of EOLC transition. Results: 28/85 (44.7%) patients transitioned to EOLC on ICU. Of the EOLC group: 56.2% saw the palliative care team, and symptom control was achieved in 79%. When deciding to transition regarding target to EOLC, and reusability were made, 51.4% and 40.5% patients respectively were too unwell to discuss these. EOLC transition was discussed with 97.3% relatives. 76.3% of the EOLC group died on ICU, with preferred place of death known in 70%. Psychological, welfare or spiritual support was offered to 29%, 21% and 37% respectively. Qualitative analysis identified themes: 1. Achieving consensus to initiate EOLC discussions; 2. Concomitant prognosticating and managing uncertainty; 3. Shared oncology and ICU decision making; 4. Integrative palliative care; 5. Family-centred versus patient-centred care. Baseline performance status and prognosis were potential predictive factors for EOLC transition (p = 0.01 and p < 0.001 respectively).

Conclusion: Tools and guidance to support delivery and documentation of high standards of EOLC are needed. Earlier advance care planning whilst patients are well enough may enhance individualised EOLC on ICU.

Method: Retrospective note review of 12 paracentesis episodes in the year prior to protocol implementation and 11 episodes in the year post-protocol implementation. Written free-text survey to nursing staff. Results: Average length of hospital stay decreased after protocol implementation (9.2 days pre-protocol compared to 5.4 days post). Average length of drainage time decreased after protocol implementation (5.26 hours pre-protocol compared to 2.30 hours post). The frequency of hypertensive episodes was unaltered. Frequency of blood pressure measurement during drainage, and staff management of hypotension, became more consistent. The surveyed nursing staff found the protocol acceptable, identifying both positive (safety, accountability) and negative (paperwork, time) implications. Conclusions: A research to support the development of a structured approach to paraparesis in a hospice setting. Implementation of a protocol does appear to reduce average duration of drainage and length of stay in uncomplicated patients, with no adverse effect on safety. Further research on larger sample sizes is warranted.

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Medications for Symptom Control in the Dying Patient: An Analysis of the Use, Choice, Dosage and Route of Drugs Used to Manage the Dying Phase in Palliative Patients in Community, Hospice and Hospital Settings

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Background: Appropriate use of medications is essential to ensure adequate symptom control for the dying. This may vary across different settings due to a variety of factors. Clinical practice generally favours the subcutaneous route for medication delivery in the dying; however, the prevalence, and use, of alternative available routes has not previously been reported.

Aim: To analyse the use, dosage, choice and route of medications used to manage symptoms in the dying.

Method: A prospective and retrospective, multi-professional case note analysis of deaths in community, hospice and hospital settings over a two month period in 2014. Results: Data for 277 deaths were recorded. Most were female (n=147, 53.1%), aged 71-80 (n=176, 62.7%) with cancer (n=205, 74.6%). Most were hospitalised by the end of life (n=86, 31%) and community settings (n=17, 6.1%). Specialist Palliative Care (SPC) was involved in the majority (n=245, 88.4%). Common subcutaneous infusion (SCI) symptoms driven medications were used in 207 (74.2%). In those receiving SCI medications, opioids were used in most (n=187, 90.3%), morphine was used most commonly (n=59, 29.2%). The median equal oral morphine dose at death was 60mg/24hr (IQR: 30-180mg/24hr). Common SSCI medications were midazolam (n=162, 78.3%), glycopyrronium (n=62, 30%) and levomepromazine (n=60, 29%). Median doses were higher compared to the UK National Care of the Dying Audit Hospitals (NCDAH) 2014. Thirty four (12.4%) patients had an alternative intravenous (IV) route, e.g. intravenous (IV) access, percutaneous endoscopic gastrostomy (PEG) tube in situ at death.

Conclusion: This analysis provides quantitative data about medication use in the dying across a variety of setting settings. The prevalence of SCI is high (74.2%). While SCI may reflect the complexity in SCI). Further guidance on the use of other medication delivery routes in the dying is required, as several patients had IV and PEG access at death.

Poster Sessions (Poster Exhibition Set 1)
Abstract number: P1-122
Abstract type: Poster

Developing Palliative Care Knowledge and Skills in a Heart Failure Team: Does it Improve Quality of Care Delivery?

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Background: Over the past few years, the local Heart Failure (HF) team has improved their palliative care knowledge and skills, particularly developing confidence with prognostication: this process started with joint working between the specialist palliative care (SPC) and HF teams on a Principles of good palliative care project in 2010. Prior to the project, the HF team undertook a documentation audit to review their management of the palliative care needs of their patients. Teaching sessions followed, with subsequent time imbedded into practice, principles of good palliative care guidance, including optimising communication with primary care regarding needs and likely prognosis.

Aims: We set out to understand better whether the HF team’s journey resulted in good quality palliative care delivery to their patients.

Methods: We first closed the audit loop to ascertain whether the clinical records evidence any change in practice, and then set up a sequential focus group study with the HF team to understand in what ways their practice has changed and how this impacts on quality of care delivery.

Results and discussion: Qualitative analysis is ongoing but seems to suggest significant changes in how the team now approaches and coordinates patient care, and provides insight into how this translates into quality of care.

We will present the findings of the audits (pre- and post-intervention) as well as the final analysis of the focus group study. We will specifically consider how team culture influences quality of care delivery.

Abstract number: P1-123
Abstract type: Poster

A Swedish National Palliative Care Plan (Swe-NPC): A Pilot Study

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Background: A Swedish national palliative care plan has been developed evolving from The Swedish Register of Palliative Care, National Guidelines for good palliative care at the end of life. National Palliative Care and the Liverpool Care Pathway for the dying patient. Parallel to the contribution of a multi-professional national reference group the plan can be tested in clinical practice.

Aims: To test the feasibility, reliability and validity of Swe-NPC in different clinical settings.

Methods: Two municipalities volunteered to pilot test the care plan for three month in four long term care facilities including a home for people with dementia and a county palliative care hospital setting. Employees (n=146) received a two-day training session, and face to face support from the project leader once a week during the trial. Data consisted of field notes from every contact, three taped-recorded focus group interviews with staff (n=18) from the settings, and a summary of the review of Medical records of patients on the Swe-NPC. Data were analysed using both quantitative and qualitative content analyses.

Results: In total 50 patients had been on Swe NPC. It was found to be a concrete and structured approach in planning care for patients along the palliative trajectory, even though it requires adjustment for the very old patients. Also the pilot study raised questions about which information staff was required to give to patient and family, and the kind of knowledge, education and procedures needed to make Swe-NPC sustainable in everyday practice.

Conclusion: Swe-NPC is a promising tool for improving the care of patients along the palliative trajectory. It does however need further testing in for example, acute care, and a stronger inclusion of variety of patients’ and families’ perspectives.

Abstract number: P1-124
Abstract type: Poster

Systematic Use of a Quality Registry for Palliative Care Development

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Background: Systematic quality improvement of care at the end of life is still scarce. The regional palliative care (PC) service is organised as one department with eight services that comprises 80 hospice beds and 300 sites for advanced home care covering a population of 1.2 million inhabitants.

Aims: To systematically compile and report quality indicators through the Swedish Palliative Care Register (SPCR) for the eight PC services and to visualise and communicate the results to all units and staff in order to increase quality of care for both the units and the department overall.

Design: Data were retrieved from registrations in the SPCR. The quality reports covered twelve indicators including aspects of medical information to the patient and relatives, patients’ wishes of place of death, symptom assessment and control and pressure sores. Since February 2014 all units have been presented with theirs and the others quality scores in the form of spider charts once a month.

Results: 98% of the patients were registered at death after inclusion in the SPCR. Average quality scores from January to September 2014 were compared with average scores for 2013 in the department overall. The compliance rate of 10/12 indicators showed some increase. The average quality scores for all 12 indicators showed a slight increase, 72.6% to 75.9%.

However, for individual units major improvements occurred while no decrease was found. Possible improvement strategies behind the positive changes will be further analysed and a conclusive analysis including the full-year results for 2014 will be presented.

Conclusion: Our experience is that a structured use of SPCR provides support the development of care and provides opportunities for internal and external benchmarking. As such quality improvement initiatives have seen better quality of reporting. Low quality scores helped to prioritising topics for teaching and training. The observed follow-up time is short and the positive trends must be interpreted with caution.
Audit of Record of Recording and Pulse of Atrial Fibrillation in a Hospice Setting

Sperrin G., Subramaniam S.

Abstract type: Poster

Methods: A retrospective audit was undertaken of 20 sets of DN records from two DN teams against 33 standards set - stable phase: 12 standards, unstable/deteriorating phase: 6, last 24 hours: 4. All charts were immediately and one later in bereavement phase. The results revealed that 12/24 standards were met 100% of the time, 12/24 standards met in 60-80% and 6 were met in 55-39%, with 9 standards never met. For an individual patient 61-100% of standards were met.

Discussion: It is clear that a consistent model of care with agreed standards owned by DN teams, make a significant difference to the organisation of DN support in those approaching end of life, and the families who care for them. The Community of Practice of Band 6 DNs responsible for end of life care in the community is embarking on a baseline audit prior to implementing the same plans.

Low Molecular Weight Heparin (LMWH) - Prescription Audit for Prevention of Vascular Thromboembolism (VTE) In Inpatient Hospices

Subramaniam S., Duhamel V., Daid P.

Poster Session (Poster Exhibition Set 1)

Methods: Sperrin G.

Abstract type: Poster

Aim: To undertake a baseline audit against standards based on the GSF model of care.

Method: A retrospective audit was undertaken of 20 sets of DN records from two DN teams against 33 standards set - stable phase: 12 standards, unstable/deteriorating phase: 6, last 24 hours: 4. All charts were immediately and one later in bereavement phase. The resulting intervention, the development of a DN GSF Care Plan and a Care’s Care Plan based on these standards, which were documented before the audit was repeated.

Results: In the first cycle, 10 standards were met in over 80% sets of clinical records with only one standard met 100% of the time, 8 standards met in 60-80% and 12 were met in 55-39%, with 4 standards never met. For an individual patient 33-77% of standards were met. Following the intervention, in the second cycle, 24 standards were met in over 80% sets of clinical records with 16 of these standards met 100% of the time, 2 standards met in 60-80% and 6 were met in 55-39% or less, with no standards never met. For an individual patient 61-100% of standards were met.

Conclusion: It is clear that a consistent model of care with agreed standards owned by DN teams, make a significant difference to the organisation of DN support in those approaching end of life, and the families who care for them. The Community of Practice of Band 6 DNs responsible for end of life care in the community is embarking on a baseline audit prior to implementing the same plans.

Audit of Drug Chart Documentation and Usage to Re-design Drug Chart in a Hospice

Subramaniam S.

Poster Session (Poster Exhibition Set 1)

Methods: Review of all medications documented in drug charts for 2 months before and after redesign.

Results: 6/7 had weight recorded in their notes and drug chart. Renal function was recorded in only 2/32 (12 N/A), Indication recorded in 13/36 (N/A:8), Renal function recorded but only 7 (1.8%) had rate recorded. 32 (78%) of patients had recent electrolytes documented.

Conclusion: It is clear that a consistent model of care with agreed standards owned by DN teams, make a significant difference to the organisation of DN support in those approaching end of life, and the families who care for them. The Community of Practice of Band 6 DNs responsible for end of life care in the community is embarking on a baseline audit prior to implementing the same plans.

Evaluation of End of Life Care at a Regional Cancer Centre: Results of a Study Using the VOICES Questionnaire

Sperrin G., Finnch M., Groves K.E., Fanneg C.

Abstract type: Poster

Methods: VOICES authors gave consent to condense the questionnaire to 35 focussed questions.

Conclusion: This audit gave a snap shot insight of the documentation of drug charts. There are some areas in need of improvement as recording of allergies (need to be 100%), usage of steroid box in case of steroid prescription. We also noticed that recording of reason for drug chart being redesigned and further audits planned.

Audit of Drug Chart Documentation and Usage to Re-design Drug Chart in a Hospice

Subramaniam S.

Poster Session (Poster Exhibition Set 1)

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Conclusion: It is clear that a consistent model of care with agreed standards owned by DN teams, make a significant difference to the organisation of DN support in those approaching end of life, and the families who care for them. The Community of Practice of Band 6 DNs responsible for end of life care in the community is embarking on a baseline audit prior to implementing the same plans.
Palliative Team Groningen, founded in 2013, aims to provide an advance care plan (ACP) for all patients with a life expectancy of less than three months.

In this pilot study, palliative patients in three Dutch hospitals who were given an ACP upon discharge. This document, which remained with the patient throughout, covered four themes: end-of-life decisions, medication, a tailored plan regarding policy towards anticipated problems and possible interventions, and an overview of current problems in the four palliative dimensions.

Ninety-eight plans were filled out from April 2013 to September 2014. Policy regarding readmission and CPR was recorded in 96% of ACPs. 79% stated whether euthanasia or palliative sedation had been discussed. Medication was often recorded in a separate document. The average number of anticipated problems was 3.2; a solution was provided in 90% of cases, 52% of which followed national guidelines. Expected problems were mostly physical in nature. Of the current problems, physical problems were reported in 81%, socio-economic issues in 16%, psychological or spiritual issues in 43% and care-related problems in 68% of the ACPs.

The high documentation rate of advance directives with respect to readmission and cardiopulmonary resuscitation on ACPs is a favourable outcome, although no baseline is known. In the ACPs, fewer problems were anticipated based on expected baseline on previous studies. This may be due to underrecognition. National guidelines were not followed for palliative treatment suggestions in half the cases, possibly due to a lack of expertise. In the four problem domains, psycho-spiritual and at death were underreported, perhaps because they are not traditional medical domains. We therefore conclude that education regarding palliative guidelines, ACPs and their role in optimal palliative care is required in hospitals.

Using Pain and Breathlessness Symptoms as Quality Indicators: Experience of a Brazilian Palliative Care Service at a Private Hospital

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Background: Patient reported outcomes are useful if we need interventions alleviate palliative needs and burdensome symptoms perceived as such by patients, and therefore to be used as indicators of the quality of the care provided.

Aim: To describe the experience of using pain and breathlessness symptoms scores as quality indicators.

Methods: Prospective longitudinal study. Pain and breathlessness were assessed using the Palliative Care Outcome Scale-Symptoms (POS-S) at admission (D0) and at day 3 (D3). We aimed to improve symptoms severity POS-S scores for at least 75% of patients. We used Wilcoxon signed-rank test to compare POS-S scores before and after medical intervention.

Results: 414 patients were followed from January 2013 to July 2014. Median age was 76 (±16) years, 213 (51%) were female and 362 (87%) were white. Malignancy was the main diagnosis in 213 (56%) patients, dementia in 51 (12%), organ failure in 44 (11%), frailty in 28 (7%), stroke in 28 (7%) and other diagnoses in 28 (7%). Pain was present at admission in 161 (39%) cases and most of them (67%) were suffering from moderate to severe pain (scores of 4 or 3 or 2). Breathlessness was present at admission in 162 (39%) and most of these patients (62%) were suffering from breathlessness, scored as moderate to severe. Only 118/161 (73%) and 111/162 (69%) of patients with pain and breathlessness, respectively, completed POS-S at D0 and D1. Improvement of symptom scores occurred in 94 (82%) and 82 (75%) patients for pain and breathlessness, respectively.

Conclusion / lessons learned: By recording symptom severity at admission and by day three (after medical intervention) the palliative care team was assured that their intervention improved symptom control for most patients and was assured of the quality of their care in treating those symptoms.

Abstract number: P1-133

Abstract type: Poster

Unplanned Palliation – Auditing the Effect of Abrupt Removal of the UK Standard Liverpool Care Pathway (LCP) on the Quality of Documented Plans for Patients Having Active Treatment Withdrawn

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The LCP was abruptly removed from use by hospital policy resulting to our recommendation of its withdrawal. This audit aimed to determine the subsequent effect on the documentation of the LCP categories, particularly from improved documentation but also increased prescribing activity. The exceptions to this were nutrition and hydration, which had an increase in the proportion of patients for whom these were documented. A coordinator is selected to lead and sustain the process. Every palliative department and their role in developing and implementing national evidence based clinical guidelines in palliative care.

Method: The Danish Multidisciplinary Cancer Group of Palliation (DMCG-PAL) aims to develop national evidence based clinical guidelines since 2010. Participants are from hospices, palliative departments and teams all over Denmark. The groups consists of participants with both clinical and academic skills. Participants receive education in preparation of focused questions, literature search and analysis, assessment of the literature and evidence-determination. Employees with academic skills make the research and analysis of the literature, and decide together with employees with clinical skills, which literature is useful for recommendations. A coordinator is selected to lead and sustain the process. Every palliative department and hospice in Denmark is expected to participate in the process.

Results: 51 nurses, 17 physicians, 2 psychologists, 6 physiotherapists, 1 social worker, 1 music therapist and 2 chaplains cooperate on developing of 22 clinical guidelines within 12 palliative symptoms (dyspnoea, pain, cognitive disturbance, lymphedema, death, rattle, obesity, fatigue, fluid therapy, young carers and palliative sedation). Eight guidelines have been accepted by The Danish Clearinghouse for Guidelines. Tree guidelines are published as systematic literature searched area. Four guidelines have been sent to Clearinghouse for judgement in autumn of 2014, and seven guidelines will be ready for judgement in 2015.

Conclusion: Throughout the four years DMCG-PAL has been established, it has proved that it is possible to develop national, multidisciplinary evidence-based clinical guidelines. The presence of managerial, academic and clinical skills is a prerequisite to develop clinical guidelines. Participants gain skills in systematic methodology and are responsible for implementing the guidelines in their own department.

Abstract number: P1-136

Abstract type: Poster

Audit of Intravenous Infusions of Bisphosphonates Carried Out in the Community over a Twelve Month Period

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Background: Intravenous bisphosphonates are routinely administered in hospital. This community service aims to provide interventions at home.

Method: The electronic notes of all patients who had an intravenous infusion of a bisphosphonate in 2012 were reviewed. Clinical and demographic data extracted included diagnosis, assessment prior to infusion, number of infusions given, documentation of discussions about side effects and risks of treatment, and ongoing treatment plan.

Results: Over this 12 month period 36 infusions were administered, to 10 patients. The number of treatments ranged between 1 and 9. In 7 cases zoledronic acid was administered and in 3 cases pamidronate. The infusions were either started by the patient's oncologist in hospital and then were transfer over to the care of the MMT for future treatments, or in 2 cases were started by the MMT after discussion with their oncologist.

There were 4 male, 3 prostate cancer, 1 renal cell carcinoma and 6 female, 5 breast cancer and 1 colon cancer, all patients had bone metastases. For 5 of the patient bisphosphonate infusions were administered to help in the management of their pain. None of these patient received bisphosphonates to treat oncological guidelines. Their ages ranged from 60-85 y.o (73).

The infusion was prescribed in accordance with recommend treatment guidelines. In only 2 cases was there documentation that the possible side effects and risks of treatment had been discussed with the patient.

Discussion and conclusion: Patients expressed their appreciation of the service as it avoided attendance at hospital. The infusions were anticipated on majority of cases in their homes.

Four patients infusions given at the Pearson Unit when the MMT is based. Following this audit it was found improved monitoring of side effects and risks of treatment. That nurses ask about side effect particularly dental issues, and if indicated examine the patients mouths.
Abstract number: P1-137
Abstract type: Poster

Initiating Opioids in Patients with Advanced Disease: How Well Are We Doing?

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Background: Pain is common and prevalent in patients with advanced, disease. Advice on prescribing strong opioids has previously been varied. In the UK, NICE published opioid prescribing guideline in palliative care. It is not known how well prescribers are adhering to these guidelines.

Aims: To assess how compliant medical and non-medical prescribers in an NHS trust are with standards on opioid initiation and providing patient information

Methods: 1) Retrospective analysis of inpatient ward initiation of opioids from 2 acute hospitals and 2) Prospective analysis of community and outpatient opioid initiation was undertaken at a joint UK acute and community trust.

The retrospective arm assessed completion of pro formas for patients started on strong opioids who were either referred to the palliative care teams or known to have been started on opioids by other teams. Pharmacy lists of opioid prescriptions in hospital were also made available. Prospective arm: Prescribers completed pro formas at time of initiation of strong opioids. Data collected included demographics, opioid prescription information, and information given to patients. Summary statistics used to describe data.

Results: 110 patients were included (92% retrospective, 8% prospective). 75% of patients had cancer. Less than half of patients were started on oral morphine first line. 61% of patients were started on a daily dose of 20-30mg of oral morphine. Laxatives were co-prescribed in 60%. Oral morphine was prescribed as maintenance therapy in 35% of patients. In only one third of cases patients were asked about concerns of treatment. Written information was given to only 6% of patients. Patients didn't have advice on constipation or nausea in 60% of cases.

Conclusions: There were areas that did not meet NICE guidance in terms of opioid prescribing and provision of written information. Future strategies include specific prescriber education and development of comprehensive written information on opioids.

Abstract number: P1-138
Abstract type: Poster

Responding to Demand and Finding Ways to Work Smarter. An Audit into Increased Numbers of Referrals to a Hospital Palliative Care Team

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Aims: A significant increase in the number of inpatient referrals to the Palliative Care team at the Royal Free Hospital, London was noted in the first 3 months of 2014. A retrospective review of referrals received was undertaken to investigate the possible causes of this. Design: All referrals taken between the 1st January and the 31st March 2014 were identified using the palliative care database. Data was recorded on the number of referrals taken each day, level of urgency, teams making referrals, aim of referral, appropriateness of referral and patient outcomes.

Results: 251 sets of notes were reviewed; 2 sets of notes were missing. The number of referrals each day ranged from one to nine and there were significantly more referrals on Mondays and Thursdays. 139 referrals (55.4%) were non-urgent and 81 (32.2%) were prioritised as urgent. Over half (53.2%) of all referrals were made by the Oncology and Geriatrics teams. 69 referrals (27.5%) were from medical specialties. Patients were mainly referred for symptom control (62%). Only 19 referrals (7.6%) were considered inappropriate. Patients remained under the palliative care team for an average of 9.5 days (range 1-55). 119 patients (47.4%) were discharged to home, hospice or nursing home and 86 patients (34.2%) died.

Conclusions: The increase in total number and urgency of referrals in combination with an increased length of time of required palliative care input may reflect an increasingly complex patient case load with multiple co-morbidities. The majority of referrals were for symptom control and an increase in non-malignant referrals was noted. The significantly increased number of referrals on certain days seems related to the timing of referring Consultants' ward rounds. As a result of this work, we have proposed cross-specialty ward rounds and further education for hospital multi-disciplinary teams regarding the role of the Palliative Care team.

Abstract number: P1-139
Abstract type: Poster

Early Screening for Palliative Care Needs in the ICU: A Multihospital Replication

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Background: An initial study in 4 hospital ICUs in Detroit demonstrated good predictive value of a palliative care (PC) screen for hospital and ICU LOS, mortality, and hospice referral (BMU Supportive and Palliative Care – 4/2014).

Aims: The goal of this study was to replicate these results in an independent sample.

Methods: The screen was applied to MICU patients in 4 different ICUs in a Mid West and Southern City in the US over a 16 week period. Outcomes included percent of patients screened for and received a PC consult, and association of screen with hospital LOS; metastatic cancer, and post arrest with neurological compromise. Perceived need for palliative care was associated with death or hospice discharge.

Results: A total of 497 patients were screened. Mean age was 63.0 years (SD 16.4); 206 patients were positive (67.0 years:SD 14.8) and 291 were negative (60.1 years:SD 16.5, p< 0.001). Positive vs. negative screened patients were not different by race or gender. One third (35.3%) were screened positive, and 33.6% of positive screens received a PC consult compared to only 4% who screened negative. Positive screens were associated with statistically significant increases in hospital and ICU LOS, and inpatient hospital mortality and hospice discharge. The items 'admit from Skilled Nursing Facility' and 'Readmission to ICU' were associated with increased hospital LOS; metastatic cancer, and post arrest with neurological compromise. Perceived need for palliative care was associated with death or hospice discharge.

Conclusions: Study of the ICU screening instrument in an independent population again found 5 factors positive associated with patient outcomes, but again demonstrated no predictive value of end-stage dementia or intracranial hemorrhage. PC screening in the ICU with 5 validated predictors is recommended for the detection of patients for PC who will experience a high percentage of adverse outcomes.

Abstract number: P1-140
Abstract type: Poster

Multi-hospital Replication of a ICU-screen for Palliative Care

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Background: An initial published study of four hospital ICUs in Detroit demonstrated that a seven-item palliative care (PC) screen good predictive value for hospital and ICU LOS, mortality, and hospice referral. Our goal was to replicate these results in an independent sample.

Aims: To assess the relationship between each of the individual screening factors and the outcomes.

Methods: The same screen was applied to MICU patients upon admission in three different ICUs in two US-cities over a 16-week period. Outcomes included percent patients screened, consulted PC, and association with LOS, inpatient mortality, and hospice referrals.

Individual factors were regressed against a composite variable of inpatient mortality or hospice referral.

Results: A total of 497 patients were screened. Mean age was 63.0 years (SD 16.4). Positive vs. negative screened patients were different by age (67.0 years positive patients vs. 60.1 years (SD 14.8) and 291 negative patients were 60.1 years (SD 16.5, p< 0.001) but not by race or gender. Of the 206 positive screened, 33.6% received a positive PC consult compared to only 4% of screened negative. Positive screens were associated with statistically significant increases in hospital and ICU LOS, and inpatient hospital mortality and hospice discharge. The items 'admit from Skilled Nursing Facility' and 'Readmission to ICU' were associated with increased hospital LOS; metastatic cancer, and post arrest with neurological compromise. Perceived need for palliative care was associated with death or hospice discharge.

Conclusions: Study of the ICU screening instrument in an independent population found the same five factors were positively associated with patient outcomes, but again demonstrated no predictive value of end-stage dementia or intracranial hemorrhage. PC screening in the ICU with the five validated predictors is recommended.
Bereavement

Abstract number: P1-145

Abstract type: Poster

Bereavement Outcomes of Family Caregivers: Do Spousal and Adult Child Caregivers Experience Grief Differently, and what Factors Influence this?

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Background: Family caregivers (FCs) are at higher risk of complicated grief (CG) than the general bereaved population. The understanding of risk factors (RFs) for CG in FCs is incomplete, in particular, whether some RFs are particularly relevant to certain FCs.

Objectives: Describe and compare bereavement outcomes of spousal and adult-child FCs; and determine the relative importance of certain RFs for CG for different FCs.

Methods: Secondary analysis of data from the Qualycare study, which examined care provided to people in the last stages of life. Data analysis: independent samples t-tests, correlation, c² tests, multiple regression analysis.

Results: 246 adult-child and 238 spousal FCs were included. Spousal FCs experienced higher grief intensity (GI) and more prolonged grief (p < 0.001), and sought formal support more frequently than adult-child FCs (p < 0.001). Female gender of FC and younger patient age predicted 24.2% of variance in GI for adult-child FCs; 8.3% for spousal FCs. Patients with adult-child FCs were significantly more likely to die in a nursing or residential home (p < 0.001). This was associated with lower GI for adult-child but not spousal FCs. Intensity of caregiving was similar in both FC groups, but predicted 11.6% of variance in GI for adult-child FCs, compared to 0.5% of variance for spousal FCs. Higher patient severity of psychological and physical symptoms, and FC anxiety, were associated with higher GI (p < 0.001).

Conclusions: Effective risk assessment for CG allows targeting of interventions shown to improve outcomes. Results showed that female FCs caring for younger patients, and spouses, are at risk of CG, and should be targeted for secondary intervention. Intensity of caregiving was an important risk factor for adult-child FCs, highlighting role strain, and the importance of the ‘relief model’ of bereavement for this group. Clinical recommendations, methodological challenges, and implications for future research are discussed.
Abstract number: P1-147
Abstract type: Poster

Identifying Risk Factors and Coping Style of Complicated Bereavement
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Background: The well being of family and others close to a dying patient with cancer is part of the medical team's responsibility in terminal illness. Health providers have a continuous responsibility to assist the bereaved and to recognise the individuals at risk of developing abnormal grief reactions to the loss of the loved one.

Aims: The assessment of the vulnerability and coping factors will assist in identifying those family at risk of adverse effects of bereavement and will allow early therapeutic interventions.

Methods: The primary caregivers of cancer patients with end-stage disease who presented for the first time in our department were screen, shortly after using, Bereavement Risk Assessment Tool. The inventory was conducted during interviews and personal observations. The risk and protective factors were identified and compared with those in the literature.

Results: Of the 252 patients admitted to our department in a period of 2 weeks, 81 patients presented for the first time to palliative care unit and 70 caregivers agreed to respond to the interview. At 23.85% (56) caregivers was identified at least one risk factor positive in more than four groups of factors: comorbidities, concurrent stressors, circumstances around the death, lack of supports, relationships. 37.14% (26) caregivers reported self-expressed concerns regarding own coping or abuse/dependency in relationship with the patient. 42.85% (30) caregivers reported lack of social support.

More than three protective factors were identified in 37.14% caregivers. 20% (14) caregivers could be considered at risk of complicated grief.

Conclusion / Discussion: The diagnosis of cancer, by its specific progression and progression, may be considered an adaptive factor to bereavement. Most caregivers find the internalised belief in own ability to cope effective with the death of their loved one.

Abstract number: P1-148
Abstract type: Poster

‘Rising from the Mist’: Systematic Review of Grief Reactions in Family Caregivers of Advanced Cancer Patients
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Background: The question remains whether we know enough about family care’s grief in cancer end of life care and how this affects their preparedness for caregiving, care delivered and how their well-being is impacted.

Aim: We systematically reviewed the literature on anticipatory and post-death grief in families with advanced cancer patients guided by the questions: what are the prevalence, characteristics, predictors, and experience of grief reactions?

Method: Searches were conducted May-September 2014. Sources included data bases (PsycINFO, MEDLINE, CINAHL, EMBASE), hand searches of journals’ contents and reference lists, existing systematic reviews and conference abstracts.

The studies were included if describing grief in family care’s of advanced cancer patients. We excluded studies that were non-grief or non-cancer specific. Qualitative and quantitative studies were assessed. Two reviewers assessed abstracts and methodological quality.

Progression of research over time, findings on subjective experience, prevalence, parallels, and predictors of grief are presented.

Results: We found 33 studies, 4 qualitative. More than half of studies presented are part of a larger study, with grief not being one of the primary outcomes. Carers experience anticipatory and post-death grief as multiple losses for themselves and the person with cancer. Care subjective features are ambiguity, dual roles and lossing balance. A multifaceted profile of risk factors was found. Prevalence rates were up to 40%. Links between anticipatory and post-death grief seem to be non-consistent.

Conclusion: Grief in caregivers of cancer patients can be expected in anticipation of imminent death. Secondary stressors in predicting grief reaction post-death are important. The continuum of grief might be more complex phenomena than identified in present research. There is a lack of longitudinal and prospective studies needed to embrace the grief’s processual nature.

Abstract number: P1-149
Abstract type: Poster

Linguistics and the Burden of ‘Guilt’ in Bereaved Relatives
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Background: At a conference on ‘Ethics of Choice: Implications of a National Choice Offer in End of Life Care in End of life Care’. Bereaved carers described their care experiences in the context of trying to fulfill a dying patient’s choices. They described how they were left with feelings of guilt: ‘When I explored feeling of guilt focused on the role they have done better. As the debate opened to include audience participants the word guilt became a recurrent theme, especially in relation to relative feelings for, for example, their loved one’s preferred place of death could not be achieved.

Aim: To explore the linguistic use of guilt in bereavement considering implications for the psychological and spiritual wellbeing of bereaved relatives and the role of language and policy of choice.

Methods: Review of the literature on guilt and bereavement. A linguistics based analysis of synonyms and antonyms of guilt and was conducted with the feedback of guilt with a Public Health Practitioner, Ethicist and Theologian. Exploration of meanings of guilt in a bereaved relatives focus group.

Results: Feelings of ‘guilt’ are a recognised feature of bereavement. The word is widely used in common language representing a range of synonyms: regret, shame, contrition, fault, culpability and doubt. The key theme was the high expectations created by medical professionals, albeit with the best intentions, about a good death, particularly preferred place of death for the loved one.

Conclusions: Guilt is a term commonly used by bereaved relatives. There appears to be a ‘taught/professionalised’ or ‘learned’ element in common parlance to sum up a range of concerns. This has important implications for the psychological and spiritual wellbeing of bereaved relatives as ‘guilt’ implies guilt and a lack of expertise health professionals should communicate realistic expectations around caring of the dying with more emphasis on unpredictability of dying and explore the bereaved’s interpretation of guilt in giving advice.

Abstract number: P1-150
Abstract type: Poster

Creating Memories for Children and Young Adults within the Acute Hospital Trust
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Background: BHRUT hospitals charity Treasured Memories Appeal was set up in 2006 following an audit that highlighted that there was an unmet need for patients that had children and wanted to create memories.

Aim: To provide ongoing support to a bereaved child or young person whose parent has a life-limiting illness.

Method: The appeal team researched the available resources and embarked on fund raising events to gain finance to purchase the aids. These consisted of a range of aids from Memory Boxes to purchasing presents for future life events. The resources have grown since the set up and in conjunction with the expertise of the health care professionals have helped to facilitate conversations and activities.

Results: In the last two years since the project gained momentum, staff have become confident in facilitating these types of conversations. 104 memory boxes have been created. 2 computers have been purchased with wifi access in order for patients to link up with events that they are not able to attend. The following have been recorded by patients and their children. ‘To see their faces when they open their presents was wonderful. You allowed my children to have a great Christmas to remember me by’. ‘I was able to take photos of Mummy on our special days out, which helped me to remember her’. An 8 year old boy was able to cut a piece of his mum’s hair to place in his memory box and named his teddy bear the same nickname his mother had called him.

Conclusion: Treasured Memories are now at the forefront of the team and have enriched the knowledge in facilitating these types of conversations. The feedback from patients and families has been positive, which highlighted the difference it makes to patients and families in creating memories.

Abstract number: P1-151
Abstract type: Poster

Symptoms and Suffering Perceptions at the End of Life of Cancer Children and the Impacts on the Caregivers
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Background and aims: Little is known about the symptoms and suffering at the end of life in children with cancer. Facing this, we assessed the perception that parents have of the symptoms and suffering that the children underwent at the end of life, and the presence of mood disorders and grief reactions in the parents and their correlation.

Methods: In 2012, 250 families of child that had lost a child between the years of 2000 and 2010, in a specialised, public hospital in Brazil, were contacted. A survey was carried out through self-applied questionnaires sent by mail (Hospitalarian Anxiety Depression Scale - HADS and Texas Revised Inventory of Grief - TRIG).

Results: 60 caregivers with time of mourning ranging between 14 and 80 months reported, on average, 12 symptoms that affected the well-being of their children on their last week of life. The presence of a symptom during the last week of life of the child showed no association with complicated grief.

Conclusion: These parents present with high levels of anxiety and depression (74.0% and 81.0%, respectively), as well as complicated grief (38.0% absent/ low grief, 12.0% delayed grief and 34.0% prolonged grief).

These variables related to present grief were analysed, there was strong positive correlation with past grief, showing anxiety and depression, and negative correlation with palliative care. As predictor factors in the multiple regression analysis, past grief and depression were evident.

Conclusion: Parents related great suffering of their children in the end of life. There was strong positive correlation between present and past grief with anxiety and depression, and with burden of symptoms referred by doctors, and negative correlation with palliative care time.
The disclosure of the diagnosis of a life-threatening disease is a matter which varies geographically depending on various aspects being the most important the cultural one. Aim: To study the opinions and difficulties of general practitioners concerning this important aspect of care.

Methods: A questionnaire specifically developed for this survey was sent to about 10% of the general practitioners in the Northern region of Portugal.

Results: 135 (85%) doctors consider that breaking bad news is a difficult task. Many doctors think that diagnosis and prognosis disclosure may be psychologically deleterious and may have a detrimental effect on patients’ hope. On the other hand, 135 (85%) doctors feel they need training in breaking bad news, but only 56 (35%) actually have attended training actions. However, only 42 (26%) doctors think that those training actions had a positive influence on their practice. When questioned about what they would want if they had a life-threatening disease, such as cancer: 144 (93%) answered they want to know the diagnosis, 10 (6%) had no opinion and only 1 answered she did not want to know it; about the prognosis, 129 (83%) would want to know it, 11 (7%) would not and 15 (10%) had no opinion.

Conclusion: To break bad news is still a difficult task for family physicians. Their attitude on this duty is different from what they wish if they had an advanced life threatening disease. Most recognize they need training, but only a minority has attended training actions. Those actions seem to be largely ineffective, an aspect which should be urgently corrected.
Poster Sessions (Poster Exhibition Set 1)

perceived usefulness and usability of the aid were examined.

Results: Although somewhat confronting, most phase 1 participants believed the aid to be useful. Further analyses will categorise the reasons participants mentioned. Participants provided valuable suggestions to enhance the content and usability of the aid. Data collection for phase 2 is ongoing (until Jan 2015).

Conclusion: This mixed method design was conceptualised to test the hypothesis that the PDQ intervention could be used to enhance a more person-centred climate for people with palliative care needs in the acute hospital setting, and provide evidence regarding its acceptability. Outcome measures will be used and post interventions. Primary outcome: Person-centred Climate Questionnaire patient version (PCQ-P), Secondary outcome: Consultation and Relational Empathy (CARE) measure; PDQ feedback questionnaires were used in all participants post intervention in addition and post.

Results: 30 patients, 17 HCPs, and 4 family members participated. Results showed a positive correlation between higher PCQ-P scores and higher CARE scores, indicating that the PDQ can make improvements to a person-centred environment and levels of empathy perceived by patients. The PDQ supported disclosure of information previously unknown to HCPs, which has implications for improving person-centred care. Positive results from PDQ feedback questionnaires were received from all participants.

Conclusion: The PDQ has potential to improve patients’ perceptions of care, and HCP attitudes. Furthermore, it was well received by participants. The PDQ could be incorporated into clinical practice for the care of palliative care patients in the acute setting to the benefit of personalised and dignified care.

Further research using the PDQ across wider geographical areas, and more diverse settings, is indicated and planned.

Abstract number: P1-161

Abstract type: Poster

‘It is Difficult to Talk about, but I think It can Help me’ – A Qualitative Study about Advance Care Planning for Patients with Life-threatening Pulmonary Disease

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Background and aim: Advance care planning (ACP) is a tool for communication and mapping of patients’ wishes, priorities and preferences for end-of-life care. So far, ACP is not used in any hospital in Norway. In order to prepare for the introduction of this tool, we wanted to explore the views of Norwegian pulmonary patients on ACP.

Methods: We conducted three focus group interviews at the Department of Thoracic Medicine in a Norwegian teaching hospital, with a purposive sample of ten patients (52-80 years), five of them women. The participants suffered from end-stage COPD, lung cancer or lung fibrosis. Our aim was to talk about end-of-life issues and preferences regarding these. Analysis was performed using system text condensation.

Results: The participants’ primary need facing end-of-life communication was the relieving of suffering. They thus discussed themes contributed to the safety. (i) Give me what I need. Difficulties in communicating about important matters could give a feeling of loneliness and sadness. There was a common agreement that healthcare workers should ask all patients about their needs for communication and planning ahead. (ii) Seize the turning point: The participants in this study preferred the discussions to take place at the point of decision-making. (iii) The conjoint matter. Transparency was important, but difficult to balance. The participants also stressed the importance of using the medical record as a means of communication.

Conclusions: Establishing ACP for patients with life-threatening pulmonary disease should rest upon relationship building and increased awareness of dramatic turning points during disease progression. Health care professionals can support these patients by emphasizing individually tailored communication.

Abstract number: P1-159

Abstract type: Poster

Patients’ Understanding of Terminology Used in Palliative Care Services

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Background: Good communication stipulates that we avoid using jargon. However patients’ understanding of terms such as ‘Specialist Palliative Care Nurse’ – Macmillan Nurse – seems variable. Patients who are already known to a Palliative Care Specialist Nurse often ask whether they could see a Macmillan nurse. As palliative care evolves and the role of nurses has changed to include complex symptom control, the subsequent name change to ‘Specialist Palliative Care Unit’ seems logical.

Aim: To establish the understanding patients have of the terms commonly used in palliative care and ascertain whether the terms we take for granted cause any confusion.

Methods: Qualitative study using semi-structured interviews with 20 participants attending palliative care outpatient clinics. Participants had a range of life limiting conditions and prognoses. Patients new to the service and those already known were sampled to identify any differences in their understanding. Interviews were recorded and transcripts were analysed using the principles of thematic analysis.

Results: Only 4 patients were able to identify that the roles of Specialist Palliative Care Nurses (SPCN) and Macmillan Nurses were similar. 4 patients felt that the SPCN was the same as the cancer specialist nurse. 5 patients specifically mentioned the Macmillan Nurse being available to provide hands on basic nursing and overnight care. All participants identified end of life care with the term hospice. More than half did not know what a Specialist Palliative Care Unit entailed. Almost a third thought it was the same as the acute oncology ward or chemo/radiotherapy unit. Only 3 patients expressed their understanding of this understanding of this terminology.

Conclusion: There seems to be a real discrepancy between what is meant by these terms used commonly in practice and what is actually understood by patients. This raises serious issues which would need to be addressed from further study.

Abstract number: P1-160

Abstract type: Poster

Testing and Evaluating a Complex Intervention in Relation to Dignity and Person Centred Care in the Acute Hospital Setting

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Background: Providing person-centred, dignity-conserving care for hospitalised patients is central to many international healthcare policy. The Patient Dignity Question (PDQ) What do I need to know about you as a person to take the best care of you that I can?: is a question designed from empirical research on patients’ perceptions of their dignity at end of life to help healthcare professionals understand the patient as a person.

Methods: This mixed method design was conceptualised to test the hypothesis that the PDQ intervention could be used to enhance a more person-centred climate for people with palliative care needs in the acute hospital setting, and provide evidence regarding its acceptability. Outcome measures will be used and post interventions. Primary outcome: Person-centred Climate Questionnaire patient version (PCQ-P), Secondary outcome: Consultation and Relational Empathy (CARE) measure; PDQ feedback questionnaires were used in all participants post intervention in addition and post.

Results: 30 patients, 17 HCPs, and 4 family members participated. Results showed a positive correlation between higher PCQ-P scores and higher CARE scores, indicating that the PDQ can make improvements to a person-centred environment and levels of empathy perceived by patients. The PDQ supported disclosure of information previously unknown to HCPs, which has implications for improving person-centred care. Positive results from PDQ feedback questionnaires were received from all participants.

Conclusion: The PDQ has potential to improve patients’ perceptions of care, and HCP attitudes. Furthermore, it was well received by participants. The PDQ could be incorporated into clinical practice for the care of palliative care patients in the acute setting to the benefit of personalised and dignified care.

Further research using the PDQ across wider geographical areas, and more diverse settings, is indicated and planned.

Abstract number: P1-161

Abstract type: Poster

‘To Just Ask them Is the Easiest Way to Find out…’ – Ways of Communication in the Process of Integrating Specialized Outpatient Palliative Care. A Qualitative Pilot Study

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Background: Specialised outpatient palliative care (SOPC) needs sensitive and intelligible communication between all participants. To date only little is known about how communication is accomplished in daily practice between general practitioners (GP), patients, relatives and palliative care team (PCT).

Aim: This study’s aim is to investigate structures of communication that are established within the process of integration of SOPC. The focus is on personal experiences of actors within SOPC, like barriers and difficulties at the point of integration.

Methods: Qualitative study design using purposely sampling. Focused group discussions (≥ 5 participants) with palliative care professionals (n=3 groups), analysis using formulation interpretation (Bohusch et al. 2013), analysis using content analysis (Mayring).

Results: Healthcare professionals (HCP) define communication as a basis of their work and a process of openness and empathy which succeeds if everyone feels involved. Common problems are seen in a difficult communication in hospitals, prescription without communication and barriers like lack of time and sealing off from communication. PCTs experience communication with GPs as deficient concerning exchange of information and agreements about tasks and functions, which causes feelings of isolation. GPs regard PCT as an important addition to their work, but clarifications of the sphere of activities and assignment of tasks in their cooperation is required. A lack of defining roles and meaning for each other causes dissatisfaction of PCTs regarding communication with GPs.

Conclusion: Communication in the process of integrating specialised PC in the outpatient setting needs to be improved when it comes to the process of integrating specialised PC in primary care setting; especially information regarding activities, assignment of tasks and goal definition needs improvement.

Abstract number: P1-162

Abstract type: Poster

Communication, Key for an Excellent Palliative Care (PC) Practice

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The goals of this presentation are: To highlight the importance of communication in PC team, between the team and patient/family members throughout the end of life process. To identify the factors which influence communication in PC units and in breaking bad news. To identify the barriers that impact directly the effective communication.

Background: Communication is the most important component in providing PC especially during the last days of life. Communication plays a very important role in PC especially between staff members (within the multidisciplinary team), between doctor and patient/family members and between the patient and family members.

Factors which can affect negatively the communication process: Being not aware of the diagnoses and prognosis make communication difficult because it affects directly to achieve the goal of PC. Quality of life are until the end of life. The absence of a law on the communication of the diagnosis. Deficiency of health culture in the community. Lack of information on PC. Not accepting the truth of the diagnosis until the end of life. Staff burnout, overload. Stress and negative emotions of the patients and his family members. Factors which affect communication positively: Team work, where the support provided to one another is essential to prevent burnout and offer the service with professionalism. Awareness of the patient/family members and on the diagnosis and prognosis of the disease allows an open communication, a quality service and quality of life. acquaintance of PC from patients, family members, healthcare professionals or community, also affects the mitigation of barriers to provide PC with quality.

Conclusions: Communication is key to providing excellent PC and being successful in its provision. Communication in the end of life takes a special meaning. Communication is a complex process and it becomes a difficult challenge in terms of an advanced disease. PC requires verbal communication skills, good listening and a being present.

Abstract number: P1-163

Abstract type: Poster
Abstract number: P1-164
Abstract type: Poster

Preferences toward the Disclosure of Life-threatening Illness and Place of Care and of Death among Patients in a University Hospital in the Philippines

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Background: Issues on who to tell the diagnosis first, the patient or the family, the timing of disclosing the diagnosis, whether gradual or immediate; and who should be tasked to disclose, the doctor or the significant family member of the patient, has long been a point of discussion among health care providers.

Aims: The study aims to determine the preferences of the Filipino patients as to full disclosure of their current state of illness, preference of disclosure, person in charge for disclosure, (the doctor or significant family member), preference for place of care and death.

Methods: This is a cross sectional analytical study done in a private tertiary university hospital among a total of 80 respondents to a validated questionnaire using Square test. With level of significance set at α=0.05 was done using SPSS.

Results: 30 terminally-ill patients and 50 acutely ill outpatients took part in the interview. Most patients, regardless of whether they have terminal or acute illnesses, have preference for disclosure, for the doctor to perform the disclosure, for immediate disclosure, and for home as the preferred place of care and the preferred place of death. Majority of the patients opted for disclosure as they believe that patients have the right to know the truth about their own condition, that disclosure enables the patients to resolve unfinished business, that being informed of their actual medical condition would enable them to cooperate closely with the health care professionals attending to them, that disclosure relieves them and their family of the burden of unnecessary treatments, and that the patients will eventually learn about the situation anyway.

Discussion: Doctors need to be knowledgeable and skilled in communication as most patients, regardless of state of health and nature of illness, prefer disclosure. Physician should solicit patients’ and families’ participation in decision-making as to treatment options and preferences for place of care and death.

Abstract number: P1-165
Abstract type: Poster

Can we Talk to Dying People?

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Background: About 75% of dying people in the Czech Republic are dying in hospitals. While physical ailments can be solved by medication quite easily, there is no pill to solve patient’s questions, sadness, loneliness and fear.

Perhaps this is the reason why we are afraid of talking to dying people and to their next of kin. We are not able to talk of pain so easily.

Aims: The main aim of this study was to identify satisfaction in the end of life of patients or their family members (if there was no possibility to speak directly with the patient) about communication with attending physician.

Methods: Semi-structured qualitative interviews about embarrassing in communication in the end of life were conducted with patients or next of kin from 2010 to 2012. Interviews were recorded, transcribed and analyzed using framework analysis.

Results: 19 participants were recruited in total. Interviews were conducted in 11 cases with patients and in 8 cases with next of kin. Statements of patients and family members were surprisingly similar. Most groups were not properly informed about on-going death. Physicians communication was usually limited to test results and current health condition. Doctors spoke only about curative therapy, they did not offer possibility of palliation. In many cases was said, physicians showed no emotional or spiritual support. In some cases was emotional or spiritual support very poor. All patients reached a verdict that doctors were short of time to communicate with them, although for all patients communication was essential to gain confidence.

Discussions: About the reason why patients were not properly informed, they did not have opportunity to prepare for death and to part with family.

About the reason next of kins were not properly informed about on-going death, they were not prepared for bereavement and made a complaint. Consequently, health workers are losing credibility.

Abstract number: P1-168
Abstract type: Poster

Decisions Findings Process Near the End of Life: A Survey in German Paediatric Oncology and Intensive Care Units (ICUs)

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Background: Decision findings near the end of life is always ethically challenging for a medical team, especially in case of children and adolescents. We designed a survey to discover how these decisions are made in Germany, how the process is structured and which impact it has on the team, particularly how much these decisions burdens the team members and if they arouse conflicts.

Methods: An anonymous online survey was sent to physicians, nurses and psychologists both of oncology units and PICUs from 32 different German hospitals.

Results: A total of 77 responses was obtained (response rate 26,10%) and 2/3 of them from oncology units (68%). The most common procedure by far (80,52%) was to find a position within the meeting according to the parents. Working with a clinical ethic commission occasionally or often was stated by 35,6 %. We detected a significant positive effect on the communication structure when ethic commissions or neutral observers were included in the decisions. However, medical profession is leading in communication, medical profession is leading in decision making. On the question how often conflicts during the decision making communication strained the team, one third answered often or always. We found conflicts in all ranks: middle professional categories, between hierarchical levels and between individuals.

Conclusions: Decision making near the end of life in paediatrics are streaning and full of conflict potentials and our findings could be helpful and respectful inclusion of all professions represents an important part of this.

Abstract number: P1-167
Abstract type: Poster

On the Way to Advance Care Planning? The Practice of Consultation for Advance Directives in a German Region

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Background: Although advance directives (ADs) are legally binding in Germany, their prevalence and quality is often insufficient. Comprehensive Advance Care Planning (ACP) programs are, apart from the pilot project beizen begeiten, still not widely implemented in Germany. There is, however, an increasing number of organisations and individuals offering consultation for ADs. So far, there is hardly any knowledge about their consulting profile and thereby the quality of ACP in Germany.

Aims: To assess the current status of organisation, actual practice and possible improvement of AD consultations by different professional groups compared to international ACP programs as best practise model.

Methods: A pilot study using an electronic questionnaire (Likert-Scale) completed by 198 consultants (notaries, hospice nurses, nurses and general practitioners) in the region of Munich.

Results: The structure and content of AD-consultations differed between and even within the professional groups. Due to within-group variability, it was not possible to describe clear consulting profiles for each group. Nevertheless, some focuses could be detected in the groups: A typical consultation is initiated by a healthy (62-70%), 61-80 years old (57-90%) and 20-60 years old (57-90%) consulted individual herself (61-100%). A consultation takes up to 30 minutes (43-57%) and includes 1-2 meetings (48-60%). 48-97% of the consultants inform about hydration, terminal illness, irreversible unconsciousness. 33-85% suggest to invite the future legal representative, 53-91% report positive experiences of such an involvement. Emergency plans are created only by 0-24% of the consultants.

Discussion: These results show that the AD consultation does not yet fully meet the quality criteria of international ACP-programs (e.g. initiate conversations, ACP process with several meetings, participation of future legal representative, planning for emergency).

Conclusions: It underlines the need for more comprehensive ACP-programs.
Poster Sessions (Poster Exhibition Set 1)

Abstract number: P1-169
Abstract type: Poster

Differences in Preferred Place of Care and Place of Death Between Cancer and Non-cancer Patients in Palliative Trajectories
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Background: Congruence between preferred and actual place of care (POC) and place of death (POD) is considered an essential component in end-of-life care. Existing literature on this subject is limited and based mainly on cancer patients. As a result, there may be a tendency to apply knowledge from cancer to non-cancer settings. Hence, knowledge needed to clarify if patients with non-cancer diagnoses have different preferences than cancer patients regarding POC/POD.

Aim: To investigate possible differences in preferred POC and POD between cancer and non-cancer patients in palliative care trajectories.

Methods: To identify possible differences in preferred POC/POD, three groups of patients are included in this study. Patients with heart failure, lung disease or cancer respectively participate in a prospective randomised controlled trial testing feasibility and possible advantages of Advance Care Planning (ACP) in a Danish context. Participating patients are asked about preferred POC/POD in the baseline questionnaire of the ACP study. Eligible patients with an estimated lifetime of 6-12 months are included. The first 40 consecutive patients from each of the three diagnostic groups will be included in the present study. The inclusion of patients began November 2013 and ends May 2015. Until now 78 patients have been included in all relevant regression models will be used to compare the preferences, allowing adjustment for age and gender. The project is founded by The Danish Cancer Society and TrygFonden.

Results: Data of patients’ preferences regarding preferred POC/POD will be presented.

Conclusion: Knowledge of preferences regarding POC and POD may differ between patients with different diagnoses and thus may help target future research appropriately.

Abstract number: P1-170
Abstract type: Poster

Communication with Cancer Patients
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Background: Effective patient-physician communication is at the core of health care, especially for cancer patients. The importance of education of communication skills to medical students has been recently acknowledged in medical universities in Iran.

Aim: To identify what cancer patients expect from communication with their oncologists.

Methods: Non-structured and experimental medical interview with more than 2000 patients with advanced stage of cancer who were referred to palliative care clinic from 2011 to 2014.

Results: The following list of recommendation for physicians has been generated based on the most frequent points mentioned by the patients.

1. In presence of patients, it is preferred to directly address them rather than their relatives
2. Let the patients talk about themselves, physical problems, emotional feelings, spiritual suffering and even economic problems. The physicians cannot solve all these problems but by being heard makes the patients comfortable.
3. If the patients need and want to know about their diseases the physician should completely explain for them.
4. The patient should be informed in each visit even if the physician thinks that it is not required.
5. Although the whole truth about the disease or its outcome might not be revealed to the patients, any lie should be avoided.
6. The physician should avoid telling something to the patient which makes him/her feel more secure
7. The physician should avoid telling something to the patient which makes him/her feel more prepared.
8. The physician should avoid telling something to the patient which makes him/her feel more involved.
9. Use of humor in communication with the patients is recommended.

Conclusion: Education of communication skills should be part of curriculum of medical students and residents of all specialties.

Abstract number: P1-171
Abstract type: Poster

Sharing the Diagnosis of Dementia: Breaking Bad News to People with Intellectual Disabilities
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Background: Following previous research findings that existing models for breaking bad news to patients who have a life-limiting illness are inadequate in meeting the needs of people with intellectual disabilities (ID). A 2 year study into breaking bad news to this group of patients/relatives resulted in the development of a new model for breaking bad news to people with ID, which was presented at the EAPC Conference 2011 in Lisbon. The model is based on the finding that bad news situations are usually complex and are made up of lots of different chunks of knowledge and information; the acquisition of these chunks is a non-linear process that can be unpredictable. Building someone’s foundation of knowledge and understanding is central to the model. It has been used successfully in practice; however, it is unclear how this can be applied to people with ID and dementia. UK and European dementia strategies specify that everyone is entitled that everyone is entitled to know of their diagnosis.

Aim: To explore whether the new model for breaking bad news can be used effectively in sharing a diagnosis of dementia with people with ID.

Methods: The model was applied to people with dementia and ID as follows:

1. The literature on dementia and breaking bad news was analysed;
2. Theoretical assumptions were made based on the model itself;
3. The model was applied in real-life situations.

Results: Through a case study, we will present how the model for breaking bad news was used successfully in breaking bad news to a man with ID and dementia.

Conclusion: Initial exploration of the use of the model has promising results, but a study is now underway to investigate further how people with ID and dementia can be best supported in their need for understanding.

Development and organisation of services

Abstract number: P1-172
Abstract type: Poster

CASA Study: Care and Support Access - Implementation of a Palliative Approach for HIV-+ Young Men Who Have Sex with Men to Improve Engagement and Outcomes - Preliminary Results
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Background: Early implementation of a palliative approach (EIPA) can improve chronic disease management. We target a subset of people living with human immunodeficiency virus (HIV) to demonstrate how EIPA can be introduced for non-palliative specialists. HIV positive young men who have sex with men (YMSM) remain at risk for poor outcomes facing myriad impediments to achieving disease control.

Methods: EIPA, facilitated by an educational intervention combining iterative teaching and on-site coaching, patient representatives and emphasis on self-care for staff used to introduce key elements of PC into the management of HIV disease. The interdisciplinary team guided by patient-family needs, focuses upon goal-setting, symptom management, and communications skills. We intend to:

1. determine the impact of EIPA to improve patient-centered care;
2. describe the impact of EIPA upon YMSM related to decreasing viral suppression, impact on mental health and quality of life (QOL); and
3. describe the impact of EIPA upon staff with regard to reducing stress of providing care.

Mixed methods and a quasi-experimental design are used to compare outcomes in a longitudinal sample of 204 YMSM from two outpatient clinics in one urban U.S. city.

Results: In the era of HIV disease control preliminary data shows a co-morbid population. Of 57 YMSM currently enrolled 66% are under 30. The majority self-identify as African-American (75%), Hispanic (11%), and mixed (11%). Thirty-two percent have a high school education, 17% have less. Thirty-two percent are employed, 16% are disabled. Despite the young age, 30% have been incarcerated. 74% report skipping medication, a third have missed at least half of their scheduled appointments. Drug use/abuse history: marijuana (80%), cocaine (26%), amphetamines (11%), alcohol dependence (23%).

Conclusions: EIPA is being tested to improve outcomes in patients known to be non- adherent. Staff are evaluated for stress related care to delivery.

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015
The Impact of Dragos Nurses on the Quality of Life of Pediatric Patients

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Context: In Romania, annually, approximately 5,000 children and young adults are diagnosed with cancer. 80% of those patients are coming from all over the country to receive curative treatment in 5 different public hospitals. Project idea came as a response to a need identified in a few hospitals in Bucharest, Romania, by the team Dragos Nurses. The role of Dragos nurses will be to meet the needs of children and young people with advanced cancer, together with support and guidance for their families and caregivers.

Aim: Dragos nurses team represents the pediatric hospital team created with the purpose of delivering high quality Palliative Care to pediatric patients and their families, while receiving oncologic curative treatments. This paper aims to present the impact of the Dragos nurses team on the symptom control of beneficiaries.

Method: quantitative retrospective study, conducted between October 1st 2012 and September 30th 2014, on 174 patients. The data collection is based on the patients’ charts and the nurses reports.

Results: Number of patients: 174; number of nurses intervention: 2565; number of doctors intervention: 736; number of social worker interventions: 455. The SAV scores dropped from an average 6 to 0. (From 174 patients, 90 had pain and for 85 of them the pain dropped to zero).

90% of the most frequent symptoms (oral lesions, anaemia, anorexia and nausea) had been controlled.

Conclusions: Dragos Project had been a great challenge for every team practitioner involved, because of the rigid mentality in the Romanian health system, lack of resources and time, number of patients, the lack of palliative care understanding.

The presence of Dragos Nurses in the hospital, involved controlling the prevalence symptoms in a very high percent and the improvement of the quality of life for the patients and their family members, the team being a real support for them.

Integration of Palliative Care into Comprehensive Cancer Centers in Germany - Where Do We Stand?

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Background: The extent of integration of palliative care (PC) in German Comprehensive Cancer Centers (CCC) funded by the German Cancer Aid (DKH) is unknown.

Aims: The purpose of this study was to investigate clinical, research and teaching similarities and differences of PC in CCC structures in Germany.

Methods: Structured quantitative and qualitative interviews were performed with the heads all PC departments. Additionally an external perspective was described by 11 persons who were not directly involved in PC, but represented inpatient and outpatient care. Interview questions were generated after a comprehensive literature search and discussion with PC experts. The interviews were conducted from May to August 2014.

Results: At the time of the survey 13 CCC with 14 different sites in Germany (1 CCC had 2 university hospitals) were funded by the DKH. Of these, 12 sites had a palliative care unit (PCU). In 36% (PC) consulting services were provided in all 11 CCC. Palliative care outcome measures were routinely used in 11 (79%) sites. Tumor board participation of PC specialists was not provided in 3 (21%) institutions. The majority of centers described participation problems due to staffing shortage. In 7 (50%) centers, integration of PC into CCCs were available; in 10 (71%) standard operating procedures (SOP) exist. In the last five years 5 PC departments (36%) were invited to participate in research projects of other departments of the CCC, 10 sites (71%) had started own PC research projects. Professships in PC were available in 5 CCCs (36%). PC training courses were provided in all PC departments.

Conclusions: The extent and depth of PC integration in the 14 CCC is sites is rather heterogeneous. The gained data will foster the development of a ‘Best Practice Model for Palliative Care Integration into the German CCC’.
What Do We Know about Different Models of Specialist Palliative Care? Findings from a Review of Reviews

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Poster: What Do We Know about Different Models of Specialist Palliative Care? Findings from a Review of Reviews

Abstract number: P1-177
Abstract type: Poster

Background: Expansion of palliative care services internationally means robust evidence is required to support policy and service commissioning decisions. The advantages and disadvantages of different models of palliative care need to be identified. Exploration of the most effective components of these models is also needed.

Aims: This review of reviews identifies the potential strengths and weaknesses of different models of palliative care and their relative appropriateness for various populations and patient groups.

Methods: A comprehensive search of 7 databases from 2000-2014 for English language systematic and narrative review level evidence was undertaken. Reference lists of included reviews were scrutinised to identify further reviews. Reviewers independently screened titles and abstracts for relevance using pre-determined inclusion criteria. Two reviewers independently extracted data for each included study. Methodological quality was assessed using the AMSTAR tool. Narrative synthesis was undertaken.

Results: From 16141 papers identified, 8 medium - high quality reviews of specialist palliative care were included. Most evidence related to models of palliative care delivered in the home. Heterogeneity in descriptions of models of palliative care and lack of detailed description of individual models made appraisal and comparison difficult. However, evidence suggested different models may be appropriate depending on local priorities, population need and existing services. Limited evidence exists about the cost-effectiveness of each model. Many methodological limitations, it was not possible to identify the best and worst performing models or potential beneficial components of models.

Conclusion: Better reporting of models of palliative care and further primary research is needed to identify beneficial models/components of models and their cost-effectiveness.

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Abstract number: P1-178
Abstract type: Poster

Healthcare Professionals’ Perspectives of the Role of Specialist Palliative Care in a Major Trauma Ward: A Qualitative Study

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Background: Major trauma centres are regional centres of excellence, improving survival and outcomes for patients across England. However, 27% of major trauma patients will not survive their injuries and a significant proportion will survive, but with permanent disabilities. A literature review found a few studies on palliative care and the Trauma Intensive Care Unit, in a US setting, but this is the first study to examine the role of specialist palliative care in major trauma in the UK. Palliative Care is known for its focus on impeccable assessment, relief of suffering, and support for the dying and their carers. Currently, little is known about the best model for providing this type of care in a major trauma centre.

Aim: To explore the perspectives of doctors, nurses and allied health professionals on a major trauma ward regarding the potential contribution of specialist palliative care.

Methods: Semi-structured face-to-face interviews were conducted among a purposive sample of healthcare professionals working on a major trauma ward in an inner London teaching hospital. Data was analysed using the framework approach.

Results: Nine healthcare professionals were interviewed. Participants reported instances where end-of-life was felt to be sub-optimal. Moreover, they stated they did not feel confident or comfortable for care in the dying. Participants reported they had little experience working with the specialist palliative care team and described common barriers to referral. Other themes emerging from the interviews included prognostic uncertainty, decision-making at the end of life and concerns about communication with patients and families.

Conclusion: Major trauma professionals recognise the importance of caring for the dying and the place of palliative care. Specialist palliative care has the potential to enhance care experiences and reduce staff stress, but the best model and resource implications for this need further research.

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Abstract number: P1-179
Abstract type: Poster

Ten Principles of the Economic Case for Specialist Palliative Care

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Aim: Numerous studies have documented the impact of specialist palliative care (SPC) on costs, yet no one has completely articulated the economic imperative for SPC, and how it could be aligned with the clinical-moral imperative. A ‘business case’ is needed in which the indirect benefits for institutions are linked to the direct clinical benefits for patients, especially in the US and other capitalistic or mixed healthcare economies.

Approach: We reviewed published studies of healthcare financing and SPC impact. We incorporated insights from our hands-on work on program financing with hundreds of SPC programs in US over the past 15 years.

Results: We identify, articulate and provide evidence for ten principles which together form a business model for SPC. The first and foundational principle is SPC has a demonstrable positive impact on patient-centered outcomes. The second is that hospital utilization tends to dramatically increase toward the end of life. The third and fourth principles describe the implicit and explicit financial disincentives for over-utilization of hospital care. The fifth and sixth principles describe the impact of inpatient and community-based palliative care on utilisation and costs. The seventh principle is that SPC teams are often inadately staffed and poorly resourced. Principles 8 and 9 demonstrate the ‘return on investment’ for institutions adequately staffing inpatient and community-based programs. And the final principle is that all SPC programs can use published and internal data to demonstrate these principles within their own institutions and communities. We point out methods and analytic tools that are available to help.

Conclusions: With this framework, SPC program leaders can articulate and demonstrate the benefits that would accrue to patients and payers. With most relevant to the hyper-fragmented, capitalistic US health care system, most of these principles also apply in other countries.

Abstract number: P1-180
Abstract type: Poster

Barriers to the Development of Palliative Care in Europe. Data from the EAPC Atlas of Palliative Care in Europe 2013

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Background: We define barriers to the development of Palliative Care (PC) as those factors which prevent proper and comprehensive provision of PC in a country.

Aim: To identify barriers reported by PC experts in the EAPC Atlas of Palliative Care in Europe 2013.

Method: A specific question was developed for the survey. Please, list in order of importance the three main barriers to the development of palliative care in your country at the present time. The questionnaire was submitted to PC leaders of 53 European countries, previously identified through National Associations, with a response rate reaching over 80%. Responses were subjected to a comparative content analysis and categorised by three different referees.

Results: 153 barriers were reported: 92 were governmental, 41 to the professional world and 20 to socio cultural factors. Amongst the varied barriers identified within the governmental category, the report highlights ‘importance to policy’ (n=19), ‘funding’ (n=27), ‘legislative’ (n=11), ‘opioids’ (n=9) and ‘lack of certification in PM’ (n=6). In the professional domain, ‘lack of education’ (n=23), ‘lack of integration’ (n=10) and ‘work capacity’ (n=4) were identified. Socio-cultural barriers include lack of awareness (n=14), ‘cultural obstacles’ (n=5) and ‘opiophobia’ (n=1).

Conclusion: Despite the continuous efforts and claims to put PC into political agendas, still professional report a great number of barriers related to health policy, funding and legislation.

Abstract number: P1-181
Abstract type: Poster

Bridge over Troubled Waters: Co-ordination of SPCS across Boundaries

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Background: Patients known to specialist palliative care services (SPCS) can be admitted to hospital without hospital palliative care nurse specialist (HPCNS) knowing they are there. If not formally referred their support is not readily available.

Aim: To identify patients with SPC needs, admitted to hospital without notification or referral to HPCNS. All patients known to SPCS should be notified to HPCNS on admission to enable SPC’s input and support.

Method: Lists of A&E and attendances, inpatient GSF alerts and informal notifications to admin staff, were scrutinised for patients known to SPCS in community, care home or hospice. Key enablers (GSF registration, Advance Care Planning (ACP)) already in place; the date last seen or spoken to or outcome and discharge method recorded.

Results: 21 admissions, already known to SPCS elsewhere, were identified by this method. 50% were notified to HPCNS by SPCS elsewhere. Admission method: 10 (48%) via A&E, 6 (29%) by GP via Emergency Admissions Unit, remainder unknown. 9 (43%) were referred by ward staff to HPCNS, 4 (19%) notified to from other sources, 8 (38%) present in hospital without HPCNS being aware. If notified or referred: 3 (23%) on day of admission; 8 (62%) within 24 hrs, one within 72hrs and one after this. All 21 (100%) were GSF registered, one had an ACP and 15 (71%) had recorded preferred place of care.

Conclusion: Where SPCS had notified and admitted admission then patient received support during stay. Scutary of GSF alerts would enable HPCNS to be aware of those SPCS patients admitted to hospital, where admission was unknown, providing all were GSF registered. This highlights the importance of cooperation between health services, where appropriate. An admission flowchart was developed to streamline the process of notification of admissions to hospital where these are known and the creation of a new TRANSFORM Team is increasing identification of those known to be GSF registered and also those requiring SPC input.
“Can you Come Right Now?” Development of a Palliative Rapid Response Ambulatory Service in a Comprehensive Cancer Centre

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Introduction and background: Innovations in cancer care have resulted in patients with metastatic cancer having greater access to life-prolonging treatment. Increasingly oncology treatment is provided in ambulatory care settings. Many of these patients suffer severe symptom distress requiring specialist palliative care. Health promotion models advocate early assessment and introduction to specialist palliative care services for patients with metastatic disease. The Department of Pain and Palliative Care (DPCC) at Peter MacCallum has developed a Palliative Care Rapid Response Team (RRT) in ambulatory care.

Objectives: To provide timely access to palliative care within ambulatory care settings integrated into the acute oncology model To improve follow up for patients and families by facilitating coordination and maximising continuity of care for patients with complex needs

Method: The DPCC at Peter MacCallum developed a palliative care rapid response team staffed by physicians and a nurse practitioner.

Results: Within a 12 month period there was a 40% increase in the number of referrals received. Patients were referred earlier in their disease trajectory. More than 75% patients referred to RRT reported pain moderate (4 to 7) to severe (8 to 10) pain scores using the Numerical Rating Scale at time of first presentation. Patients assessed by the RRT were more likely to have their next of kin present at time of initial presentation compared with patients referred from inpatient areas. The RRT also reviewed patient who required admission to hospital before they arrived in inpatient areas. This facilitated direct collaboration with treating oncologists and implementation of palliative management plan prior to formal admission procedure.

Conclusion: The introduction of the RRT increased access to specialist palliative care to patients with metastatic disease undergoing cancer treatment.

Abstract number: P1-183
Abstract type: Poster

Delivering a Multi-stranded Information and Support Service in the Community

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In 2008 following a multi-disciplinary discussion about reaching out to the community, the Hospice was the first in the UK to launch its innovative Information and Support service the Hospice Outreach Project HOP® utilising a custom truck. The premise was to develop a multi-stranded service which would offer drop-in information, support and advice for people that were ill, bereaved or worried about someone who was...

Aims: Widen access and increase referrals Provide high quality health and wellbeing information To offer drop in information, support and advice in the heart of the community via a alternative model Break down some of the taboos surrounding death and dying Design: Develop mobile and static strands operating 5 days a week

Staffed by full time Team Leader, part time Information Support Specialist (registered nurse and and registered Health Visitor and 15 trained Information Service Volunteers - this skill mix provided a high quality, low cost model of operation Working collaboratively with other organisations sharing resources to access harder to reach groups

Results:

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The contact figures for the Information Service demonstrate that the public want to engage with the hospice and utilise the services provided. Analysis of the data indicates that elements of the service are providing a service to different groups of people than those who have previously accessed the hospices services.

Conclusion: The Information Service is recognised as a valuable model that widens access to services for local community The mobile and static mix offers optimum flexibility and accessibility Volunteers are vital to the continued existence and development of the service Future developments include 7 day working, further collaborative working. Sharing innovative practice not only builds bridges it develops services for those who need them the most.

Abstract number: P1-186
Abstract type: Poster

Making the Best of Clumsy Co-ordination: Improving the Co-ordination of Care for End of Life Patients

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Background: An area in the North of England (pop 235,000) already supports identification and co-ordination of patients approaching End of Life through Gold Standard Framework (GSF) in primary care and acute hospital. However attempts to unite these processes are hampered by the lack of an appropriate IT co-ordination system. Aims: To facilitate co-ordination of care by compiling a central cross-boundary register of patients recognised to be approaching end of life. Sharing Advance Care Planning and smooth transition for patients changing care settings

Method: The integrated Specialist Palliative Care Services (SPCS) complies a locality wide end of life care register by collecting information from the hospices, GP surgery and care homes. With consent all patients are flagged on the hospital patient administration system for identification and tracking on admission to hospital allowing SPCS to identify the patients needs, wishes and preferences and to develop individualised care plans. Community team are informed when patients are identified in hospital. Gold Standard Framework Care Plans have been introduced in hospital
and community to ensure patients’ needs are assessed consistently and that assessments follow the patient reducing the need for replication of work.

Results: The SPCS now holds a cross-boundary list of all patients thought to be approaching end of life (891). For those who die, 94% have a documented Preferred Place of Care at the time of death, and 85% of those achieve it.

Conclusion: Multicentric central cross-boundary end-of-life care register improves communication between different health care providers enabling patients to be cared for and die in their place of choice. Work is on going to make this available on a fully accessible IT system.

Abstract number: P1-187
Abstract type: Poster

Improving Clinical Palliative Cancer Pathways

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Background: Spring 2014 we started a project to evaluate and improve quality of the palliative cancer pathway in the hospital. Aims or goal of the work: Develop a standardised, evidenced-based patient care pathway, Ensure good quality of services to patients and their families where treatment and care meets physical, psychosocial and existential needs, Patients and users contribute actively in the design and improvement.

Design, methods and approach taken: Redesign method was used to develop a coherent palliative cancer pathway based on national guidelines, together with patient representatives, multidisciplinary clinical team, general practitioners, staff and cooperating municipalities. Data was collected from hospital registers about readmission and procedures made, next to data from the Norwegian Cause of Death Registry. Baseline measurements were also performed including audits of patient journals based on a defined set of criteria. A Cancer Patient Experiences Questionnaire was performed on 30 patients, together with 4 in-depth interviews with patients and relatives.

Results: 20 areas of improvement were identified during the redesign process and by analysing the data. Main areas to improve are: Patients receive different level of quality of treatment and care depending on cancer type / diagnosis. The organisation and treatment in the acute care department. Professional communication skills. To strengthen the offer and systematic information about support treatment integrated in the pathway. Unclear responsibility of follow-up in pain treatment. Assertive community team. Strengthen the follow-up program of relatives.

Conclusion/lessons learned: In palliative treatment and care it is important to develop a standardised patient centered pathway were shared decision making and individual needs are taken into account, as this patient group will have different individual needs along their patient journey.

Abstract number: P1-188
Abstract type: Poster

Strengthening Patient Voices in Quality Improvement of Palliative Care Pathway in a Norwegian Hospital

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Background: Improvements of clinical pathways are usually not focused on user-knowledge and experience, and are often developed by healthcare personnel. The objective in this project was to actively use patients’ and users’ experiences in design and improvement of a clinical palliative care pathway in a public hospital.

Aims or goal of the work: Develop a standardised, evidenced-based patient care pathway

• Ensure good quality of services to patients and their families where treatment and care meets physical, psychosocial and existential needs

• Implement common recommended palliative tools for measuring patient reported outcome measures.

• Patients and users contribute actively in design and improvement

Design, methods and approach taken: The Cancer Patient Experiences Questionnaire developed by The Norwegian Knowledge Centre for Health Services was used. 300 patients answered the survey electronically by touch-technology during their hospital visit. Additionally 4-in-depth interviews were performed to better understand patients and their relatives’ needs, resulting in a move to strengthen their voice.

Results: Patient response indicates patient satisfaction with the current service and important areas of improvement.

Conclusions/lessons learned: Ethical aspects should be taken into account when involving palliative patients in improvement projects. Still, their contribution to improve treatment and care is very important. Valuable insights are provided about the content and structure of the service, and how it is delivered. Information technology can facilitate participation in questionnaire surveys. People may have multiple roles over a lifespan, and we may all be service users at some time. By using different methods and techniques to capture users’ needs and experiences the patient voice is strengthened in quality improvement.

Abstract number: P1-189
Abstract type: Poster

Living and Dying at Home... Not Alone: The Empowering Hold of Technology

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Context: Domiciliary care workers play an important but often unrecognised role in supporting people to remain at home as they reach the end of life. Despite this, few receive specific training in end of life care. Focussed training enables home care workers to improve the quality of care for such people working with primary care, and contribute to better co-ordinated cross boundary care.

Aim: Evaluating progress since the introduction of GSP training to Domiciliary Home Care Teams in end of life care.

Method: The GSP Domiciliary Care training programme in End of Life Care was introduced to Agents across the country. The Teams were trained in a series of face to face training sessions with pre and post test and induction period when tablets were offered to clinical staff for getting familiar with the equipment and the potential data base.

Results: 107 clinical staff members out of 111, completed the survey. Based on the identified needs and barriers in using the new technology, a course with the following modules was developed.

M1. Concepts of computer operation (135 minutes);
M2. Skills of test editing (170 minutes);
M3. Presentation skills (145 minutes);
M4. Excel skills (240 minutes).
M5. Browsing and e mail (90 min).
M6. Using Mobile technologies (120 minutes).

Conclusion: The process of educating the clinical staff in order to implement electronic patients’ records was based mainly on self assessment training needs. The gradual development of knowledge and skills to work at a more advanced level with tablets and complex applications is facilitating transition toward a new digital phase of PC services management.

Abstract number: P1-190
Abstract type: Poster

A Cinderella Service-Improving End of Life Care Provided by Domiciliary Home Care Teams in Peoples’ Homes and Boosting Confidence and Competence of Staff

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Context: Domiciliary care workers play an important but often unrecognised role in supporting people to remain at home as they reach the end of life. Despite this, few receive specific training in end of life care. Focussed training enables home care workers to improve the quality of care for such people working with primary care, and contribute to better co-ordinated cross boundary care.

Aim: Evaluating progress since the introduction of GSP training to Domiciliary Home Care Teams in end of life care.

Method: The GSP Domiciliary Care training programme in End of Life Care was introduced to Agents across the country. The Teams were trained in a series of face to face training sessions with pre and post test and interactive learning and reflective practice in 6 modules, with virtual learning Zone/DVD, and resources. Comparative before and after qualitative and quantitative evaluation is intrinsic evaluation.

Results:

1. Improved communication, working relationships and collaboration with District Nurses and GPs.
2. Increased Advance Care Planning discussions, now part of the initial assessment plan, with information shared with others to improve coordination of care.

Poster Sessions (Poster Exhibition Set 1)
Better together: A Seamless Service in A Seaside Town - 15 years on

Hermann M.1,2, Aedo N.1, Aikli R.1, Cavani L.1, Ermonni K.1, Fodseyh K.1, Jacobsen K.1, Kurto R.1, Laeth C.1, Pardon K.1, Aspis A.1, Kivio S.1, European Palliative Care Cancer Symptom Study

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Background: Palliative care (PC) is organised differently across countries. This may indicate suboptimal PC organisation, may harbour generalisable secondary results, and calls for high quality research to identify who the PC patients are in relation to organisational and medical variables.

Aims: To describe the organisation of PC at participating sites including characterisation of PC patients on sociodemographic and medical data.

Methods: A web-based centre survey on organisation, economic and academic resources was completed by 35/52 local PC teams at initiation of, or during PC treatment. Symptoms were self-reported at inclusion and every 4 weeks for 3 months/until death (up to 11 months at some sites). Medical data were registered by medical staff concurrently, on web paper.

Results: 30 centres; 19 hospitals, 1 nursing home, 3 hospices, 1 home service in 12 countries took part. 73% had PC hospital teams and in-and outpatient services; offering chemo/radiotherapy. 12 PC patients ranged from 113-279. 85% had cancer. Mean length of patient stay ranged from 7-73 days. Physicians/nurses were present 24/7 in 49% and 63% of centres respectively. 14 centres had <1 medical professions, 3 had 1 profession in nursing. 12 centres had full/part-time research staff. State and/or community funding was predominant (86%). 1379 (9-150 per site) patients were included; M/F: 50/50, median age 66 (21-97), median Karnofsky score 70 (10-100). Lung and GI cancers were common (50%), had metastases, 38% had weight loss. 1066 patients died during follow-up; mean survival was 157 days (SD 152) from inclusion.

Conclusion: Variations in PC organisation, resources, delivery, treatment and patient mix were observed. Lack of registration of PC and survival varied. Thus, studies in PC must employ strict inclusion criteria to ensure a uniform characterisation of patients that permits generalisability of results.

Abstract number: P1-193

Abstract type: Poster

A Scoping Review to Explore the Feasibility of Establishing a Care Home Centre of Excellence, Innovation, Training and Research in Scotland, UK

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Background: The increasing demographics of the oldest old in European societies and the demand for quality care towards the end of life is putting pressure on health/social care policies and long-term care institutions to think strategically. In the UK, the majority of residents admitted to a nursing home die within a year of admission. There are three times the number of care home beds than in the NHS; however, little undergraduate training and education is undertaken in these institutions. Rarely do professionals seek a career in the care of frail older people in care homes.

Aim: To undertake a scoping review of teaching nursing homes (TNHs) and to work with local universities, health and social care to establish plans for a care home centre of excellence, innovation, training and research.

Methods: A scoping review methodology was adopted because of the lack of research literature to undertake a formal systematic review. Available academic literature, grey literature and websites were examined using the term teaching nursing home (TNH). Telephone interviews and meetings were held with key stakeholders in Scotland, Norway and Holland. Data were selected, sorted and categorised in relation to funding, training, innovation and research.

Results: An initial report on 26 studies was written. Despite TNHs serving frail older people, there was no reference to end-of-life care or palliative care training. Benefits and challenges associated with TNHs were highlighted and resources required to establish such an innovation. The systematic process of developing a TNH enabled health and social care, and, genetics and palliative care and funders to work together.

Conclusion: The education of care home staff in the care of frail older people in the last year of life alongside undergraduate education and training at a TNH has the potential to raise the profile of aged care workforce and promote recruitment into this neglected area of care.

Abstract number: P1-195

Abstract type: Poster

Talking Integrated Palliative Care: What Should We Be Talking about?

Hodkinson F.1, van der Eerden M.1, Payne S.1, Hughes S.1, van Wijngaarden J.1, Linge-Dahl L.1, Hardcastle C.1, Lukin J.1, On behalf of the IPC-Talking Integrated Palliative Care (IPC-TIC) Group.
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Objective: The FP7 project inSUG-C aims to determine the best way to deliver integrated care to people who have advanced cancer, heart or lung failure at the end of life. The wide range of services available leads to questions about which organisational requirements an integrated palliative care service should have. IPC-TIC has been established to answer this question.

Methods: An online questionnaire was sent to 10,848 EAPC contacts. 665 responses were received and statistically analysed with SPSS.

Results: An IPC approach should include at least two different organisations (63%) and cover both homecare and inpatient settings. Most participants chose a network approach based on familiarity with, and approachability of, palliative care specialists (70%) over a

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Integrated Palliative Care in Cancer, COPD and Heart Failure: What is the Optimal Timing?

Hodkenson E.1, van der Eerden M.1, Haswell J.1, Vijnagarden J.1, Hughes S.2, Line-Dahll E.2, Payne S.2, Lukes R.2 (on behalf of InSup-C)

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International Observatory on End of Life Care, Division of Health Research, Lancaster, United Kingdom

Objective: Early integration of palliative care (PC) is a contentious topic, as is the integration of PC in different disease trajectories. Developing patient centred integrated PC (IPC) approaches in cancer, chronic obstructive pulmonary disease (COPD) and heart failure (HF) demands more information on PC treatment in disease specific requirements.

Methods: An online questionnaire was sent to 10,848 EAPC contacts. 665 responses were received and statistically analysed with SPSS.

Results: According to the participants information on PC should be given later in COPD/HF (Gold Standard 3: 43.3%/NY HFC: 34.8%) than in cancer (time of diagnosis: 61.3%). The same disease stages are suggested by a majority (>50%) as the starting point of PC consultation in COPD/HF. In cancer there was no majority in favour as to when PC consultation should start. In all disease groups respondents suggested that treatment should be taken over by PC teams at a later stage in advanced cancer: 54.7%; Gold Standard 4: 48%; NY HFC: 50.3%. The majority chose the GP as primary contact person for COPD/HF patients (43%) and in cancer (35%). In cancer the significance of the PC specialist (14.9%) is considered higher than in COPD/HF (8%/7.5%). Responsibility for PC treatment in all disease groups is seen as that of the PC specialist (cancer: 58%, COPD: 46,1%, HF: 46,2%). Most respondents favoured PC specialists as the lead palliative care clinician in cancer (homecare 22%, inpatient 33.5%) than in COPD/HF (homecare 13.6%/14.3%, inpatient 23.9%/24.6%).

Conclusion: Respondents suggest similar requirements for IPC in COPD and HF, but that these differ from those in cancer. Different requirements in terms of timing of the introduction of PC and with whom key responsibilities lie, need to be considered in the development of guideline in different conditions.

The research leading to these results has received funding from the European Union’s Seventh Framework Programme (FP7/2007-2013) under grant agreement n° 335555

Abstract type: Poster

Abstract number: P1-198

Research Active Hospice-moving Forward

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Aim/Goal: The Hospices report ‘Research in palliative care: can hospices afford not to be involved?’ highlights the need for hospices to strengthen their contribution to research and the evidence behind the interventions they offer. A Hospice in Scotland was inspired by the report and has adapted the 3 level research framework to become a ‘Research Active Hospice’.

Method: Multidisciplinary steering committee for research was established within the Hospice to take this work forward. Three level framework was used to map out current research activities, identify gaps and inform research strategy.

Senior staff with background in research have dedicated time for research

Frontline staff being encouraged to enhance their research skills through the provision of a series of short workshops addressing general skills

Regular meetings, open to all clinical staff, providing a forum to discuss new ideas, new proposals and ongoing work

A writing group meeting weekly to support those writing for publication, presentation or degree thesis

Results: Adapting the framework in the Hospice has increased the research capacity and enabled more focused approach for research activities

The collaboration established with research teams in Universities allows for a more rigorous approach to investigating and developing practice, sharing of ideas and developing research together.

Conclusion: The report from Help the Hospices has supported the Hospice to move forward in making research more established, accepted and expected within the Hospice.

Abstract type: Poster

Abstract number: P1-199

Poster Sessions (Poster Exhibition Set 1)

Do We Need a Network Coordinator for Liverpool Care Pathway in Norway? An Evaluation Study

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Background: Liverpool Care Pathway (LCP) was introduced in Norway in 2007 and has since been implemented at 339 (Oct 2014) sites across the country. The increasing number of user sites created a demand for coordination and quality assurance. In 2012 we set up a position for a network coordinator for LCP as a two year project. The coordinator is available for advice, audit, and teaching.

Aim: To evaluate the function of the network coordinator and the need for this position.

Methods: A web-based survey was developed using SurveyMonkey and sent to all LCP main contacts in Norway in September 2014 (n=233), with two reminders. (We also performed qualitative interviews in a representative sample, but results from the interviews will not be presented here.)

Results: We received at total of 154 (66.1%) responses: 111 nursing homes, 38 municipal home care services, 15 hospitals and 9 other. 33% had been using the LCP less than one year, 46% 1-3 years, and 14% more than 3 years. The rest were in the process of implementing the care pathway. The majority considered all the start kit ‘very useful’ or ‘useful’, especially the algorithms (91.9%), information leaflet (91.5%), and guidance for local LCP (89.3%). 57.7% had attended a regional LCP conference. 86.4% were aware of the network coordinator and 71.7% had been in contact with her; mostly by e-mail, 79.8% rated her availability as very good. The most common reasons for contacting the coordinator were questions regarding registration, implementation, education, and practical use. The respondents clearly saw a need to continue the position of network coordinator (57.7% ‘high’ and 33.7% ‘moderate need’). Many respondents gave free comments describing the usefulness of having a national coordinator.

Conclusion: The results of the survey show a positive evaluation of the LCP network coordinator function and a continued need for this position.

Main source of funding: The Norwegian Directorate of Health

Abstract type: Poster

Abstract number: P1-200

Realist Evaluation of a UK Specialist Care at Home Innovation

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The Macmillan Specialist Care at Home service is designed to bring together teams of professionals who work in an integrated way to improve palliative and end of life care for people affected by cancer and other chronic conditions, in the community. Some of the outcomes it is designed to deliver are associated with less frequent Accident and Emergency admissions, reduced stays in hospital and a majority of people being cared for and dying in their preferred place. The proposal evaluation utilising a realist evaluation approach aimed at understanding the mechanisms that lead to different outcomes. A realist evaluation commenced May 2014, of six innovation sites is designed to build capacity with regard to self-evaluation to integrate and embed sustainable evaluative processes into the Innovation Centres from the start. The research will involve the development and evaluation tools to be refined and shared with the Centres. A key aspect of the evaluation will be to develop good communication channels with the Innovation Centres to facilitate and support building capacity for robust but pragmatic evaluation practice at different levels. The realist evaluation will answer the questions: ‘What works, for whom, in what respects, to what extent, in what contexts, and how?’ The underlying generative mechanisms that explain ‘how the outcomes were caused and the influence of context will be identified. Data will therefore be collected using a mixed methods longitudinal approach involving three main elements: Evaluation participatory training workshops, Case studies of the six Innovation Centres, National stakeholder enquiry. Data will be collected on context, process and outcomes utilising a specifically developed service data tool as well as reliable and valid outcome measures and qualitative observation and interviews.

Abstract type: Poster

Abstract number: P1-201

Straight to the Point: A Week in the Life of Point of Care Ultrasound

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Background: The literature shows increasing use of ultrasound within the hospice setting. Our hospice has been using point of care portable ultrasound scanner (US) to enhance patient care, by answering a specific clinical question, since 2010. We feel USU has transformed the patient experience since its introduction to the service. Previously presented data from Dec 2010 to Mar 2014 shows that 158 patients had 286 scanning episodes resulting in 164 scans and the perception is towards a positive impact on patients and family experience.

Aim: To ensure that the use of USU within hospice is to answer specific clinical questions and to assess frequency of use within a single week.

Methods: Retrospective point of care audit of one week of point of care ultrasound in a ten bedded hospice setting. Patients and scanning episodes identified by a search of memory on ultrasound machine and corresponding entry on electronic clinical record. Results: During this week there were 2 separate scanning sessions in a total of 9 patients and 4 outpatients) by 3 doctors resulting in 8 procedures. Each answered a clinical question - Is urinary retention present? (2 patients: 1 procedure); Is there a drainable pleural effusion? (2 patients: 2 procedures); Is there a drainable ascites? (3 patients: 2 procedures); Peripherals for nerve for nerve block (1 patient: 3 procedures).

Conclusion: This snapshot audit confirms that point of care USU is being used extensively within the hospice as part of the clinical examination alongside the stethoscope. It is being used appropriately to answer specific clinical questions, leading to decreased admission to intervention time and hence faster symptom relief with less upheaval for patients. USU enables the hospice to provide a definitive service, to arrange planned and increasingly symptomatic patients allowing for necessary blood tests and investigations prior to admission. Data for the year 2014/15 will be available for the conference presentation.

Abstract type: Poster

Abstract number: P1-197

Poster Sessions (Poster Exhibition Set 1)

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015
The State of Social Palliation in Denmark

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EAPC has published White Papers in 2013 on education for the care of palliative patients and established a task force of social workers. In Denmark, a group of social workers in specialised palliative care is building on this to upgrade psychosocial support and intervention. Social Palliation focuses on legal options and psychosocial support during terminal illness and in the aftermath of death. It draws from International Theories and methods in Social Work, Legal aspects, Psycho-social issues, Social Science and Environmental Health.

We have conducted a study in two specialised palliative teams in larger Copenhagen, covering 286 patients over a period of 14 months. The study focuses on patients’ social need of support and reveals the relevance of addressing social aspects of terminal illness, as the majority express such needs.

Standardised curriculums for palliative care professionals are prepared by the Danish Multidisciplinary Cancer Group in Palliation. Within this framework, we have developed national competences for Social Workers in Palliative Care, as prior no qualifying curriculum existed for social palliation.

Achievements

· Completion of a quantitative and qualitative study demonstrating the need for support in psycho-social-legal matters in palliative care
· Development of a training program for social workers
· Established liaison to educational institutes and municipalities
· Published article on the need for social palliation, Omsorg 3/2014

Our work provides a framework for expanding the knowledge of social work in specialised Palliative Care. It gives options for screening, optimising the focus of work and calls for the coordinating and bridging role between the specialised level and the basic level in primary care. Social palliation works towards relieving family distress and securing their rights.

Poster

Abstract number: P1-203
Abstract type: Poster

Development of Palliative Care Nursing Specialization in Poland

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Nursing in Poland has changed over the years, as well as regulations and conditions of nursing profession. The first law regulating the legal status of nurses and rules of the profession comes from 1935. Further legislation expanded competences and independence of professional nurses. On the basis of the regulation of the Minister of Health and Social Welfare of 17 December 1998, in the course of two-year post-graduate studies ending with a state exam nurses can obtain the title of specialist in the field of palliative care nursing. However, the draft of a new list of specialisation in 2011 did not include palliative care nursing. On 12 December 2013 the Minister of Health signed a decree on the list of fields of nursing activities, in which specialisation and qualification courses can be carried on. This list, among thirteen areas, palliative care nursing have been included. Implementation of certain benefits by a nurse without a doctor’s order is subject to the having of a specialist course or obtaining a nursing specialist title. On 12 August the President of the Republic of Poland signed an amendment to the Act on professions of nurse and midwives and midwivesower to ‘ordinar medicins and to issue prescription for medication’. Since 2006, Polish Society of Palliative Care Nursing associates more than three hundred active professional nurses. Currently in Poland, almost 4000 nurses implement the provision of palliative and hospice care. 649 of those nurses obtained specialisation in the field of palliative care nursing. A particularly important element in the maintenance of the specialisation was the decision of the Minister of Health of 20 December 2011 on the appointment of the National Consultant in the field of palliative care nursing.

Poster

Abstract number: P1-204
Abstract type: Poster

Cancer Patients Dying in Intensive Care Unit (ICU) is it Avoidable?

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The ICU doesn’t seem to be the best place for dying patients with cancer, but in a previous study we found out that 42 (16) patients out of 536 cancer patients died in ICU in our university hospital in 2010.

Goal: We would like to explore the characteristics of the patients and to find out if the referral to the ICU could be avoidable.

Methodology: We reviewed the patients’ charts for the demographic data, the cancer site and metastatic status, chemotherapy undergone, and the main cause of the referral. We also studied the access to Palliative care service, and the patient preference about the end of life issues.

Results: 42 cancer patients died in ICU in 2010. 62% were male, age 68 (16); the most frequent cancer types were hematologic (21%), gastrointestinal (21%) and head and neck (21%); 36% had metastatic disease. The mean length of stay was 14 days (SD 13) in ICU. Only one patient had access to a palliative care service (45% in cancer patients population who died in other departments, p=0.001), and that was during the last day. 24% of the patients received two chemotherapy lines or more and 19% during the last month of life, two of them during the ICU stay.

The main cause for referral in ICU was septic shock (143%) and acute respiratory distress (12 (29%); 74% of ICU referral are linked with the cancer disease.

Conclusion: The collaboration with the oncologist and hematologist should start earlier. We assume that opening a discussion with the patient and his family about the end of life issues could avoid the unnecessary referral in ICU.

Poster

Abstract number: P1-205
Abstract type: Poster

Reducing the GP Out-of-Hours (OOH) Palliative Care Handover Form

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Background: A project commenced in 2012 with an OOH service to develop a palliative care information transfer process. A GP a OOH Palliative Care handover form was developed and pre- piloted in 2013. After the pre- pilot phase the form was redesigned and condensed from 3 pages to 1 page. A guidance document and information leaflet was developed to support implementation of the form in one geographical area.

Aims: This work aims to report on an evaluation of the implementation and use of the form and identify necessity and relevance of the tool within other healthcare settings.

Methods: A mixed methods approach was used. Quantitative data from forms received was gathered and a series of qualitative interviews were carried out with GPs and nurses who used the form and with healthcare workers in residential centres and members of the specialist palliative care community who hadn’t used the form. Interviews were recorded and data analysed for key themes.

Results: Early findings indicate that:
1. Those that had used the form identified that it supports the transfer of relevant information from GPs to OOH services to assist in the care of patients with palliative care needs.
2. Within other healthcare settings the forms adds to existing paperwork.
3. Use of such a form has the potential to enhance information transfer and service delivery within other healthcare settings.
4. The use of a shorter form appears to increase the likelihood of form field completion.

Conclusion: Accurate transfer of information to OOH services enhances delivery of care and assists in the decision making process of practitioners. Use of such a form has the potential to enhance residential and specialist palliative care services and integration of key fields where existing paper work exists.

Poster

Abstract number: P1-206
Abstract type: Poster

Burden of Emergency Medical Service with Palliative Home Visits in Slovenia

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Introduction: Palliative care (PC) in Slovenia is a developing medical profession. Today, the majority of PC patients in Slovenia are under medical treatment by family doctors. Out of their working hours PC patients with an acute deterioration of symptoms are taken care by the emergency medical service (EMS), which represents additional workload to the PC professionals in hospitals and hospices.

Aim: To determine the burden of EMS with PC home visits in different region of Slovenia. The analysis included three units of EMS, which differ in composition.

Methods: Data were collected through a questionnaire during a 3-month period. Data were analysed with methods of descriptive and analytic statistic.

Results: The results are shown by regions respectively by units of EMS. In pre hospital unit Ljubljana 20% of all house visits (HV) were due to PC calls. Emergency interventions were recorded in 28.3%. The most common problem was dyspnea (27%). Out of all, 15% of patients had been transferred to hospital. In the Unit 1A ZD Vrhnika 14% of all HV were palliative. Dyspnea was the most common cause for the call (32%). 19% of patients had been sent to the hospital.

Conclusion: Load of emergency home visits due to PC acute complications has ranged from 14% to 30%. In some regions there were less palliative HV, which can be explained by the fact that emergency doctor in rural areas are more familiar with PC patients. In two EMS units the most common cause of palliative HV was dyspnea, following by pain. In rural areas percentage of referrals to hospital was higher, most probably due to smaller set of investigations, which are available at home setting in those EMS. In a future, PC in Slovenia could be improved with the formation of mobile palliative teams that could intervene in such palliative crisis.
Aim: This study aims to describe GPs' perceived roles toward the MOC, the GPs' expectations and barriers for participation in the MOC.

Methods: Semi-structured interviews with 16 GPs throughout the country, all having MOC experience, were conducted. Thematic analysis principles were used to analyse the data.

Results: GPs consider MOC participation as a part of their job and are willing to make efforts to attend the MOC meetings. Their perceived roles at the MOC depend on the complexity of the patient's case, the quality of the interactions with other participants and task participation is minimal. Little is known about what the perceived barriers for participation are and how Belgian GPs perceive their role toward MOC participation.

Discussion and conclusion: An important motivator to participate is the GP's perceived educational aspect of the MOC. An important motivator to participate is the GP's perceived educational aspect of the MOC. An important motivator to participate is the GP's perceived educational aspect of the MOC. An important motivator to participate is the GP's perceived educational aspect of the MOC.
Adapting the Dignity Care Intervention to a Swedish Context

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Aims: The Dignity Care Intervention (DCI) was developed in Scotland to be used by community nurses caring for patients with palliative care needs, with an aim to conserve patients’ sense of dignity. The DCI includes the Patient Dignity Inventory (PDI) that is used to identify dignity related concerns with the patient, the nurse-discuss identified concerns and ways to address them by using reflective questions and evidence based care actions provided in the DCI. The DCI is now translated and adapted for implementation in Swedish palliative care.

Design, method, and approach: DCI is based on Choochinos model of dignity and the PDI is one key component. Two researchers independently translated the model and the inventory from English to Swedish and the research group examined the translations together with the original versions. An expert review focusing on items and response alternatives was accomplished followed by cognitive interviews with patients answering the preliminary Swedish version of the PDI. Evidence based care actions were updated with Swedish publications such as these, clinical guidelines and governmental publications.

Results: Swedish versions of the model of dignity and the PDI were produced, the process of translation and adaptation added clarity and consistency. From the review of Swedish publications, care actions were adapted and updated.

Conclusions: The focus has been on achieving cultural relevance which might have affected equivalence to the original model of dignity and the PDI. To get local context evidence for care actions, focus group interviews will be conducted with nurses, physicians, patients and family members. In adapting the DCI it will be implemented and evaluated in clinical settings. Two clinical settings have agreed to collaborate in this phase. Implementing the culturally adapted DCI will be a way for nurses to provide evidence based and person centred palliative care.

Abstract number: P1-213
Abstract type: Poster

Profiles of Palliative Care Services and Teams Composition in Brazil: First Steps to the Brazilian Atlas of Palliative Care

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The population ageing and health professionals growing interest culminated in the revision of several Brazilian regulations, improving population access to Palliative Care services since the years 2000. To have a better understanding of practices and integrate the services, two encounters were organised (2012/2014) by a company called MAIS Group, which is developing the Brazilian Atlas of Palliative Care. Aims: To characterise the profile of palliative care services in Brazil.

Methods: Services were added on the electronic mailing lists from the National Academy of Palliative Care and the MAIS Group, were invited to participate of a free of charge online survey. State; funding structure; type of service; team composition; palliative care training; dedication and teamwork functioning were asked.

Results: 68 services (from 16 Brazilian states) answered; 35 are located in São Paulo State. The most prevalent model is ambulatory (33%/55); mixed model (54%/79); assistance to adults (88%/60) and elderly (84%/75) prevail, and public funding (50%/34) prevail. Services reported team composition: physicians (88%/97), nurses (98%/97), psychologists (92%/63), social workers (92%/63), physiotherapists (89%/59), speech therapists (74%/62), occupational therapists (51%/41), nurses (66%/42), pharmacist (64%/42), nursing aides (64%/42), occupational therapists (33%/36), dentists (51%/35), and volunteers (40%/6). The majority were reported as part time work with a specific composition. 89% (60) have clinical meetings and 68% (46) of those indicated weekly meetings.

Conclusions: It’s worrisome that there is a marked concentration of services in only one State, that the majority of them assist adult/elderly with no trained professionals in Palliative Care. This study is not without limitations; there is a possibility that sample does not include all palliative care services in the country; however this study provides useful insight regarding the development of Palliative Care in Brazil.

Abstract number: P1-214
Abstract type: Poster

Specialized Outpatient Palliative Care - Results from a Representative Survey among Physicians in Germany

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Background: Specialised outpatient palliative care (SAPV) since 2007 allows patients (pts) with incurable diseases and limited life expectancy to be cared for until death in their familiar surrounding. Little is known about structure, organisation and work pattern within SAPV teams.

Methods: An online survey was carried out from 9/2013 to 3/2014 with 124 physicians with a dedicated role to referral, networks and palliative care teams. Aim of survey was to evaluate the status quo of SAPV from the viewpoint of physicians.

Results: 120 respondents (96.77%) were enrolled in SAPV; 18.33% of them (n=22) were on a direct contract with a health insurance provider. A non-parametric qualitative for palliative medicine and for pain therapy was reported by 96.69% and 21.49% of the physicians, respectively. In average, 11.62% are organised in a network. The networks comprise GPs (in 81% of the cases), nurses (in 79.39%), pharmacists (in 70.6%/48), spiritual assistants (61.8%/42), pharmacists (64.7%/44), occupational therapists (66.7%/46), social workers (66.7%/46), physiotherapists (66.7%/46), nurses (66.7%/46) and volunteers (40.6%/26). The major part were reported as part time work with a specific composition.

Conclusions: In general, physicians are enthusiastic about his incorporation into therapeutic team than those who have no experience in working with a pharmacist.

Abstract number: P1-215
Abstract type: Poster

The Cooperation between Physicians and Pharmacists at Polish Residential Hospices

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Background: In hospice and palliative care pharmacists together with the other medical staff are involved in supporting patients in dealing with pain and other symptoms related to life-threatening illness.

Aims: The aim of the study was to evaluate the physician-pharmacist cooperation at Polish residential hospices.

Methods: A cross selectional survey was applied. Two types of anonymous questionnaires were addressed to physicians and pharmacists from all Polish residential hospices (n=93). The questionnaires were consisted of 2 types of questions: closed ended with a tick box and open ended. Statistical analysis were calculated using STATISTICA Version 10.

Results: 16 pharmacists and 30 physicians from 32 hospices responded to the survey (response rate 34%). 19 out of 32 residential hospices cooperate with the pharmacists. Both pharmacists and physicians stated that the pharmacist is not a member of palliative care therapeutic team, however he should be. The study indicated that pharmacists more often cooperate with nurses than with physicians. Nevertheless, physicians reported that cooperation with the pharmacists involve: advising them in pharmacotherapy (27%), monitoring of adverse drug reactions (20%), compounding (19%) and others (clinical trials, ordering drugs, pharmacoeconomics). According to the pharmacists the major benefits of pharmacists employment at the hospice are as follows: decrease in costs of the pharmacotherapy (53%), proper drug storage (50%) and improvement in the access to drugs (47%).

Conclusions: Generally, the cooperation between pharmacists and physicians at Polish residential hospices considers administrative and organisational activities rather than the clinical ones. Physicians who actually cooperate with a pharmacist are more enthusiastic about his incorporation into therapeutic team than those who have no experience in working with a pharmacist.

Abstract number: P1-216
Abstract type: Poster

Out of Hour Palliative Care Consultation Service for Patients in Brazov County Romania

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Background: The national palliative care strategy is describing 3 levels of delivering care according to complexity of cases: 1-support for self care; 2-general palliative care; 3-specialised palliative care.

Specialised services apart of delivering direct care to patients with complex needs have the role to offer support for the first 2 levels. Our specialised palliative care service is caring for around 1200 new adult patients yearly in home care, outpatients, inpatient, and day center. It has piloted since February 2014 a consult telephone service (CTS) for out of hours available from 4 pm to 7 am and weekends. It is staffed with highly trained palliative care nurses, who can access if needed the on call palliative care doctor.

Aim: To analyse the activity of the CTS in the first 7 months of existence.

Method: Retrospective study done by reviewing entries in the CTS database and documentation included in files of patients who received a CTS intervention between February 1st to August 30, 2014.

Results: We identified 1853 interventions grouped in 2 main categories: monitoring calls (62.17%) – initiated by hospice staff for follow up of patients in the community and patients/family member calls in 37.83% (694 cases). Reasons for calls in the second category: uncontrolled symptoms 38% (pain 66.5%, neurological problems 49,38%, nausea and vomiting 26,53%, need for information about terminally ill patients, need for information about other services), problems with medication 11,15%, nursing needs 9,98% terminal care 9,84%. The average duration of a call was 10 minutes. The nurses needed doctor backup in 3% of cases. Solution to patients and family. Private number was used night 74% of cases, family requested to come to the hospice 9% home visit of the team the following day 12%, advice to call 112-5%. Conclusion: The CTS proved to be effective and needed. Staffing with nurses of CTS is an adequate choice. Symptom control was main reasons for calls.

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Abstract number: P1-217
Abstract type: Poster

Ethical Issues within the Nursing Home: A Systems Approach

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Aim: The aim of this review is to illustrate the organisational factors associated with ethical issues experienced within the nursing home from the care-providers point of view. This was achieved as part of a larger review which considered four factors associated with ethical issues in the nursing home.

Method: Avedon's (2014) recommendations for systematically conducting a literature review in health and social care were adhered to. Four search strategies were implemented which aided the retrieval of research papers based within nursing homes, involving nursing staff and focusing on ethical aspects of care. A total of 37 papers were retrieved.

Results: Four themes emerged: individual, group, organisational and societal factors, which were linked to ethical issues. Focusing on the organisational issues, the overall structure of care was viewed as unsupportive of person centred care. Nursing homes consisted of low doctor: resident ratio, limited guidelines for communication with residents and relatives, a communal set up which overlooked individual needs, and a culture of missing or overusing restraint. Lack of resources and limits to the care available left care providers experiencing ethical issues regarding the best way to provide the standard of care they felt was essential for older adults. No papers were retrieved which specifically covered ethical issues experienced by nursing staff during palliative care provision within the nursing home, revealing a gap in the literature.

Conclusion: Organisational issues are often difficult to resolve; however, further research could explore what ethical issues care-providers deal with most frequently and develop recommendations for a redistribution of resources in nursing home care. Further research may also be conducted quantitatively on palliative care within the nursing home. This study is funded by the Queen’s University Belfast (School of Nursing and Midwifery).

Abstract number: P1-218
Abstract type: Poster

Rehabilitation in Palliative Care: Improving Quality of Life?

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Background: Advances in treatment techniques have been associated with increases in cancer patient survival rates. For many patients, cancer is now seen as a long term condition involving multiple treatments that may at times be very disabling. Physical disability affects most aspects of life and leads to depression, increased caregiver needs, poor quality of life and health care resource utilisation. Rehabilitation aims to improve the quality of survival, helping people adapt and lead fulfilling lives with minimum dependency regarding expectation. Rehabilitation strategies contribute to palliative care by maintaining and, if possible, promoting functional independence during a period of expected physiological decline. At the Marie Curie Hospice West Midlands a 12 week rehabilitation programme has been developed for post palliative chemotherapy cancer patients.

Aims: The programme aims to improve patients’ quality of life. It uses a patient centred multidisciplinary approach to maximise physical and psychological function through a tailored prescription. All patients attending are assessed by both a medico and a physiotherapist at weeks 0, 6 and 12.

Methods: Patients who commence the programme complete the Palliative Care Outcome Scale (POS), The Brief Fatigue Inventory (BFI), and if appropriate a breathlessness scale and/or GAD-7 at weeks 0, 6 and 12. Comparison of questionnaire scores for each patient at weeks 0, 6 and 12 will be recorded and evaluated.

Results: Early results show that patients participating in this programme are showing improvements in their POS scores and their BFI score as they progress through the 12 weeks. Conclusion: As far as we can present this programme is only available to patients who have recently completed palliative chemotherapy. However, the next step will be to offer this programme to patients with a palliative cancer diagnosis regardless of the oncological treatment they have received.

Abstract number: P1-219
Abstract type: Poster

Coordinate My Care - Intelligent Data Informs Intelligent Clinical Practice and Service Provision

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Aims: Coordinate My Care (CMC) is a clinical service underpinned by an electronic solution. The aim is to provide patient information about those at end of life or with specific care needs. Information is stored on a record which can be shared by clinicians. CMC is a platform to facilitate change in how care is delivered to patients with complex needs. Successful outcomes of CMC rely upon accurate and intelligent data collection and analysis. For optimum clinical practice and service provision, data must be viewed and utilised as both a driver and result of change.

Methods: The team regularly analyses data about all aspects of CMC numbers of clinicians trained to create records and use the system, 7010 numbers of records created across London-17919; specialty creating records: community 20%, GPs 26%, Hospice 33% Acute 21%. This is correlated with the economic, health and social data associated with each borough. In areas where fewer records are being created, education and training may be provided as a solution. The data are therefore closely monitored for exponential growth.

Results: Needs peculiar to each demographic locality are being addressed and responded to appropriately. Patient care and clinician performance is fully auditable. Areas of strong practice are highlighted and areas of weak practice are noted and responded to by CMC. Data are shared throughout different localities to share good practice for learning and development purposes.

Conclusions: Data must be analysed regularly to ensure that any service is providing evidenced, clinically sound patient care. Data are an intrinsic part of any service provision, to be used from conception and throughout delivery to measure success. Changes in data must be analysed and responded to appropriately. Data are both a driver for and a result of change. Some aspects of clinical practice can be measured by data analysis.

Abstract number: P1-220
Abstract type: Poster

Migrant Dying - Challenges for Service Providers and Needs of the Migrant Population

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Background: In the course of emerging Palliative Care (PC) policies in Switzerland, there is a growing interest in the needs of migrants. The authors recently conducted two studies addressing this. A, first, a needs assessment was done in 2014, mandated by the Swiss Federal Office for Public Health. Second, a research project (2012-14), funded within the National Research Program 67 'End-of-life' (Eol), is exploring how the old age nursing home is dealing with migrant dying. Both projects focus on how migrant patients might be challenged by and challenge PC and Eol services.

Aims: 1) Exploring main challenges to equal access to PC and Eol services, and challenges for services to offer equitable high-quality services. 2) Recommendations for policy and practice measures.

Methods: The needs assessment included: a) an international literature research, b) a rapid ethnographic appraisal (interviews and focus groups with migrants) c) and telephone interviews with 10 specialist PC services. The study on nursing homes is based on extensive participant observation of interational co-constructions of 'doing death' and 'doing diversity'. Analysis followed the principles of Grounded Theory.

Results: Main challenges for patients and services are: a) differing views of adequate communication (direct/indirect), of ,good death' and of proxy decision-making, b) high confidence of migrant patients in professional services, but focus on curative care, c) need of providers for institutionalised transcultural support and need of patients for advocacy, d) only weak and informal networks between services and migrant organisations.

Conclusion: Measures to improve PC services should mainly focus on: training professionals in communication skills and in reflecting their own values, raising awareness of Eol, issues and knowledge on PC services in the migrant population, developing local networks between PC providers and migrant communities (religious specialists, social workers, interpreters).

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Abstract number: P1-221
Abstract type: Poster

How Is Ascites Managed in UK Hospices?

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Background: Ascites is a cause of distressing symptoms for patients and in 2012-13 there were almost 37,000 finished consultant episodes (over 207,000 bed days) for patients admitted for paracentesis in English hospitals. Hospices can manage this problem too, but there is perceived variability in how hospices support these patients.

Aims: To survey the current management of ascites in adult hospice inpatient units within the United Kingdom.

Methods: An electronic questionnaire created using Survey Monkey® was distributed to 197 UK hospices with inpatient units identified via the Help the Hospices’ directory and weekly newsletter. Consent was implied by response to the questionnaire. Results: 78 units responded to the survey (41% response rate). 57/78 had performed a paracentesis in the last year and 21/78 answered that they had an ultrasound scanner. Of those that had not performed a paracentesis the main reasons were: lack of ultrasound scanning, belief that patients got a good service in hospital, and lack of expertise. Only 7 units never used ultrasound before paracentesis.

Just 3 units always provided an information leaflet prior to paracentesis, and 21 said they would always ask a patient to sign a consent form. 57/78 said that they prescribed diuretics, with 21/78 using an oral diuretic. Only 7 units always provided an information leaflet prior to paracentesis. Of those that had not performed a paracentesis the main reasons were: lack of ultrasound scanning, belief that patients got a good service in hospital, and lack of expertise. Only 7 units never used ultrasound before paracentesis. Just 3 units always provided an information leaflet prior to paracentesis, and 21 said they would always ask a patient to sign a consent form. 57/78 said that they prescribed diuretics, with 21/78 using an oral diuretic. Only 7 units never used ultrasound before paracentesis.
Specialist Palliative Care Involvement in a Cross Sector Multi Professional Approach in the Care of Frailty Patients with Complex Long Term Conditions in a North London Borough

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Background: With an increasingly aging population there are more frail patients than ever with multiple physical and mental health co-morbidities. Frailty refers to a patient’s vulnerability when dealing with such stressors. A north London borough has developed an innovative cross-sector multi-professional approach to manage the most complex of these frail patients focused around a weekly Integrated Care Hub meeting. Specialist palliative care was invited to contribute to this frailty work.

Aim: The aim of the project was to provide earlier access to specialist palliative care for patients with long term physical and mental health conditions; to guide patients, families and carers with the goal of advancing and planning care promoting patient choice in place of care and death. To work alongside primary and secondary care, social care and voluntary organisations supporting colleagues in decision making in complex care management.

Design: Two networks exist – one for non-specialists who were funded from the Clinical Commissioning Group Integrated Care budget for 2 years. Results: Halfway through the project 34% of all referrals to palliative care were identified as ‘frailty’ patients in the north sector. 19% of these had a cancer diagnosis, 43% of these patients that died on our care load. Of these 96% died in their or their families preferred place of care. These patients previously had a high chance of dying in hospital. 34% of the frailty patients had a short to medium palliative care intervention and were then discharged. 22% remain on the care load. The palliative care teams have had an increase in collaborative working practices with other professionals.

Conclusions: Specialist palliative care services have an important role to play in the management of frail patients with complex needs. The evidence presented here shows that our involvement does help maximise patient and family choice at the end of life thus reducing hospital deaths.

Abstract number: P1-223
Abstract type: Poster

The Gold Standards Framework Acute Hospital Programme to Support End of Life Care in hospitals

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Background: GSF is a well-established UK service improvement/training programme in end of life care for generalist frontline staff UK to improve care for people in the final years of life. Since 2008 the GSF Acute Hospitals Programme has been used by over 40 acute hospitals with several progressing to accreditation. Research confirms that 30% of hospital deaths are in their final year of life, yet few previously identified this many patients to begin proactive care.

Aims: The programme aims to improve the quality of care, cross-boundary coordination and collaboration and to decrease hospitalisations, enabling more to live and die at home. It includes teaching and assessing against the three GSF steps of identify, assess and plan and provides workshops, resources, coaching and independent evaluation.

Method: A comparative evaluation is undertaken in each hospital ward including key outcome ratios, audits of patients (After Death/Discharge Analysis), staff confidence, organisational change and qualitative data. The programme is independently evaluated and hospitals are benchmarked.

Results: The key results included:

- Improvements in staff knowledge and confidence in most areas of end of life care.
- Reduced length of hospital stay.
- Earlier identification of patients in the final year of life - about 30% and appropriate specialist referrals.
- More advance care planning discussions.
- Improved communication with primary care.
- More rapid discharge processes and care planning for the last days of life.

Conclusion: GSF4H enables hospitals to improve their quality of end-of-life care at grass roots level delivered by generalist frontline teams, with better referrals to specialists, offering better advance care planning and improved communication. Use of GSF in acute hospitals is a major factor in developing the model of integrated cross boundary care. Accreditation enables wards to receive the Quality Hallmark Award and to be recognised by the regulator CQC.

Abstract number: P1-224
Abstract type: Poster

Long Term Sustainability of Best Practice in Care Homes - Using the Gold Standards Framework Care Homes (GSFCH) Training and Accreditation Programme

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Context: With over 25,000 care homes in UK caring for some of the most vulnerable people, and about 20% people dying in care homes, can we develop a national momentum of best practice that is effective and sustainable? Can we develop care with high hospital admission rates at the end of life. About 50% hospital admissions are thought to be preventable with better proactive care.

Aim: The GSFCH quality improvement programme aims to effect organisational and cultural change leading to sustained improvements in care for all residents, to ensure quality assurance and quality recognition so that ‘gold standard’ becomes standard care for all.

Method: Involves training the end staff. ACCREDITATION: Accreditation assesses the care home against 20 quality standards ensuring the standards are embedded and sustained, evidenced by portfolio, ACP audit and a robust assessment visit.

Results: Evidence from over 2,500 care homes trained, almost 500 accredited and over 100 reaccredited after 3 years reveals sustained improvements in EOLC and ACP showing a positive impact on the quality of care received toward the end of life. Portfolio content, feedback from relatives and residents, and whole team involvement show that staff identify, code and anticipate the needs of residents, demonstrate continued practice improvements through audit and reflective practice, research and evidence, and are more proactive in their care, thereby reducing crises, hospital admissions and enabling more to die at home.

Conclusion: The GSFCH reaccredited homes have maintained and improved their standards of care and ACP uptake- not just standard practice but enhanced practice- ensuring consistency, continuity and sustainability. We can now be confident that residents in GSF accredited care homes receive gold standard care that this is sustained. Working with the regulator CQC, GSF is becoming part of the industry standard across the UK as a national model of best practice.

Abstract number: P1-225
Abstract type: Poster

GSF Improving End of Life Care in Primary Care

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Background: Most UK GP practices adopted the principles of Foundation Level GSF (bronze) i.e. a GSF/Palliative Care Register and a meeting to discuss them. The 2010 National Primary Care Audit confirmed that only 25% of people who died were included on the register. Most were cancer patients but importantly, those on the register received better coordinated care. Therefore Next Stage GSF was developed with ‘Silver’ and ‘Gold’ quality improvement programmes, plus Accreditation and the RCGP endorsed Quality Hallmark Award.

Aims: To improve the early identification of patients to ensure equity of access, improve assessment both clinical and personal through Advance Care Planning (ACP) discussions and improve collaboration and coordination of care reducing unnecessary hospital admissions and the associated costs.

Method: The GSF ‘Going for Gold’ quality improvement programme is a 6-module practice-based training programme with a robust evaluation process. Evaluation includes:

- Key outcome ratios - evidence of measurable change before and after training intervention
- Audit: Patient level - After Death Analysis sample
- Staff confidence
- Organisational changes
- Quality Patient/care/staff feedback

Practices can then progress to accreditation with a portfolio of evidence and assessment visit/ phone call.

Results: The results following accreditation of the first 10 practices showed significant improvements including more identified early and included on the register, from care homes and with non-cancer having advance care planning and DNACPR discussions care assessment and support reducing hospitalisation.

Conclusion: Significant improvements were seen in all accredited practices. Particular improvements included earlier identification for the register leading to better systematic care of patients. Additional benefits were improved confidence of staff and pride in this area of work and cultural change in care, especially for the frail elderly.

Abstract number: P1-226
Abstract type: Poster

Hospices in Denmark - A Common Program for Research, Development and Documentation (RDD)

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Background: The first Danish hospice was established in 1992 and now there are about 18 hospices with 9 - 24 beds each and 250 beds in all. While the first hospices were private institutions, all the hospices are now defined as specialised palliative care institutions and part of the public health care system. This development holds certain challenges. The one to be addressed here is the demand for research, development and documentation (RDD).

How do we combine the general and growing demand for documentation and evidence with a research-based understanding of what is assumed to be the special role and content of hospices?

Aim: To develop and promote a program for research, development and documentation (RDD), that can fill the gap, the essence and the quality of palliative care in Danish hospices.

Methods: The project is organised as a cooperation between the association of leaders at Danish hospices and researchers from P&V, Knowledge Centre for Rehabilitation and Palliative Care. Since 2012 we have been discussing the challenges of RDD in Danish hospices - and the possibilities for further development. In 2014 the hospices decided to work on a common research program (2015 - 2020) designed as:

- A network between leaders and researchers
- A background study (international literature study, national study of RDD in Danish hospices)
- A strategy for RDD, including a theoretical and methodological framework
- A plan for studies to be made across hospices

Results: At the EAPC conference 2015 we will present the program.

Conclusion: To develop evidence-based practice in the Danish hospices, leaders, professionals and researchers have to work together on the basis of a common strategy of RDD, and the framework of RDD must be able to contain multiple designs and methods.
Out of Hours Nurse-led Telephone Service in a Greek Home Palliative Care Unit: Preliminary Results

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Background: Out of hours (OOH) telephone support to cancer patients, and their caregivers, is an essential element of quality service.

Aim: To assess the needs of cancer patients, receiving home palliative care (HPC), during OOH and subsequent interventions.

Methods: Prospective data from an OOH, nurse-led, call service of a HPC program, for cancer patients, was collected from November 2013 to June 2014. Epidemiological data of callers, characteristics of requests, and interventions were recorded. The calls were split or merged according to callers’ request on a 24-hour basis, thus comprising the study sample.

Results: Fifty six out of 98 (57.1%) patients cared for during the study period used the OOH service (n=96 calls). There were 322 requests, mostly by patients’ children (32.0%). Most callers (89.4%) had one request, of 4.3 min mean duration, usually in the afternoons on weekdays (45.5%). Symptom Problem (54.7%) were more prevalent, followed by information needs (18.9%) and pharmacological issues (15.2%). Physical symptoms (69.6%), mostly pain (21.3%) and end of life issues (13.6%) were more frequent in the Symptom/Problem category. Information Needs category included practical matters (33.9%), death (21.9%) or exam results’ announcement (16.4%). Nurses characterised 52.8% requests as emergencies, more often the Symptom/Problem category (66.2%) and among them physical symptoms and end of life issues (n=64, 44.7, p<0.001). Advising and supporting callers was the most frequent intervention 41.6%, along with pharmacological modifications in 37.9%, or practical issues (13.3%). Nurses were able to effectively address 69.3% of requests by phone, while a palliative care team was needed in 22.7%. Hospital admission was advised in 2.5% and there were also 3 home visits.

Conclusion: Telephone consultations by palliative care nurses, can address patients’ and caregivers’ needs during OOH effectively, without a home visit, or inappropriate hospital admission.

Abstract number: P1-228
Abstract type: Poster

Dementia Friendly Palliative Care: Are We Confident?

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Palliative care has not traditionally been involved in supporting people with dementia but, as a specialty, is recognising the need to do so, particularly in the context of David Cameron’s Dementia Challenge. At least 50% of the UK nursing home population have dementia as a primary or co-morbidity or primary reason for needing care, given the ageing population, this places a need to develop a local service to support people with dementia. Therefore our hospice staff need to be competent to provide palliative and end of life care (EOLC) in this context. Anecdotally our hospice staff feel under pressure for this, so we disseminated a survey to guide education initiatives and support service development.

Between February and March 2014 we opened an online survey to all clinical and non-clinical staff including line managers and volunteers, to gather organisation wide data as a baseline. The questions we devised were based on the Department of Health document ‘Common Care Principles for Supporting People with Dementia’ generating quantitative and qualitative data as well as feedback to service development. Given the ageing population, we decided to disseminate a survey to get a deeper insight in good practice in order to explore support factors that enhance self-determination and participation of people with ID in end-of-life decisions.

Abstract number: P1-229
Abstract type: Poster

Integration of Haematology-oncology and Palliative Care Services and Staff Perceptions to Referral

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Background: Integration of palliative care services (PCS) with haematology-oncology (HO) patients is a quality standard in Britain. Healthcare professionals face difficult management decisions in defining the point at which further chemotherapy is appropriate and when a change to a more palliative approach should be pursued.

Aims: To characterise referrals to PCS in patients with HO malignancies and barriers to early and appropriate referral.

Method: We reviewed notes for adult inpatients dying of HO disease in a large teaching hospital between 2009-14. Information regarding PCS referral and discussions around dying was collected. A survey was completed by staff regarding PCS input.

Results: There were 49 patient deaths available for analysis. Of 33 patients who received curative therapy, 30% were referred to PCS. Of 11 patients receiving treatment without curative intent, 73% had PCS referral. 4 of 5 patients receiving no further curative therapy were referred. 15 of the 49 deaths occurred in ICU, none of which had had PCS input. Documentation of discussions around death took place in 34 cases (69%). Preferred place of therapy were referred. 15 of the 49 deaths occurred in ICU, none of which had PCS input.

Conclusions: The majority of patients had a documented discussion about death. Referral rates to PCS were generally high, however none of the 15 ICU patients had PCS input despite frequent documented recognition of deterioration. This poses the question of whether there is a role for PCS in ICU patients in an ICU setting. Documentation of PCS input in ICU meetings was poor, possibly due to subsequent progression of disease being unexpected. Early integration with PCS and HO is a quality standard and the MDM setting provides an opportunity for this. The survey of healthcare professionals confirmed the value of PCS input and that in some cases referral is made too late.

Abstract number: P1-230
Abstract type: Poster

Palliative Care in Residential Homes for People with Disabilities

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Background: Due to the increasing longevity, people with disabilities are likely to die over a prolonged period of time because incurable, chronic illnesses occur more frequently with old age. Many people die of conditions which are seen as the typical concerns of palliative care.

Aim: The aim of the study was to analyse the situation on aspects of palliative and end-of-life care in residential homes for people with disabilities.

Methods: A representative mail survey in residential homes for people with disabilities in Switzerland has been conducted to examine availability of written end-of-life care policies, staff training, as well as the place of dying, the provision of palliative care and the involvement of residents in end-of-life decisions. Topic-guided problem-centred group interviews with care, nurses and staff of palliative care services have been conducted to get a deeper insight in good practice in order to explore support factors that enhance self-determination and participation of people with ID in end-of-life decisions.

Results: As the average age at death in the study population was 25 years lower than the general population, most residential homes are challenged. Furthermore people with disabilities experience a high percentage of end-of-life decisions, but written policies on end-of-life care are only available in one of four residential homes and little training on end-of-life care is conducted.

Conclusion: It is important to systematically provide training on end-of-life care within the residential homes for adults with disabilities in Switzerland. Instruments to assess pain and physical symptom as well as the decisional capacity are needed. Advanced planning, for example by means of issuing a greater number of do-not-resuscitate orders, is therefore needed in order to improve the degree of involvement in the end-of-life decisions of people with ID. Furthermore international comparable data should be generated.

Abstract number: P1-231
Abstract type: Poster

How Does Palliative Care in the European Region Develop? Identification of Indicators Monitoring the Development of Palliative Care: A Systematic Literature Search

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Background: So far the World Health Organization (WHO) Public Health Model presents dimensions of palliative care (PC) development. However, the rapid progress of PC services in Europe suggests generating a web-based version of such a tool with additional domains for comparison, monitoring and identification of improvement areas.

Aims: To identify and organise indicators to monitor the development of PC in the WHO Public Health Model and beyond.

Methods: A systematic search was conducted in Embase, Medline, Cochrane Database, and CINAHL during June/July 2014. Keywords and MeSH terms describing PC, indicators and development were combined.

The selection criteria were: language (English, Spanish and German), year of publication (past 10 years), human nature, available abstract and full text. Screening was performed through two reviewers and discrepancies resolved by consensus.

Results: In total 3590 studies were identified, of which 130 were included in analysis. Publications originated from America (40%), Europe (22%) and Asia (15%). The years 2005 and 2013 presented the greatest extent of papers covering indicators.

Journals of health/palliative care/cancer, management and nursing focus were outstanding. Literature search led to 9125 papers covering indicators. The identified and already established indicators, e.g. mortality rate (per 100.000), are utilised frequently, future research concerning the new ones in relation to validity and feasibility should be performed.

Conclusion: How does PC develop in the European region? Identification of indicators and their development needs to be performed, to be eligible for reorganising the WHO Public Health Model.

Abstract number: P1-232
Abstract type: Poster

Benchmarking the Provision of Palliative Rehabilitation within the UK Hospice Setting

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Background: Rehabilitation is an important part of a holistic palliative care approach. Evidence for palliative rehabilitation is limited leading to large variation in practice and uncertainty about how best to deliver care.

Aims: To benchmark the provision of palliative rehabilitation, exploring the level and range of allied health professional (AHP) staffing, interventions, settings and service evaluation.

Methods: National survey of rehabilitation practice within the adult voluntary hospice sector
using a 68 item online questionnaire. Most questions were closed with multiple, non-ranked options. Ordinal data were summarised by median (inter-quartile range, IQR). Frequency counts and percentages with 95% confidence intervals (95% CI) were calculated for overall responses to items. Results: Forty-one hospices across the United Kingdom participated, serving populations ranging from <5,000 up to >1,000. A wide range of education in palliative care for patients at hospital discharge have been observed. Additionally, SYMPAQ clinic has improved care continuity, as increases in new consults per quarter. Patient visits doubled again by 2011 to 512 and increased to 681 visits by 2013 reflecting an 1. Growth: The outpatient palliative care clinic (named SYMPAQ: Symptom Management, Pain and Quality of Life) at Mayo Clinic in Rochester, MN was established in 2008 and had 89 patient visits in its first year. By 2009, the number of patient visits more than doubled to 219. Patient visits doubled again by 2011 to 512 and increased to 681 visits by 2013 reflecting an average yearly increase in patient visits of 60% per year since its inception. This growth has spurred significant staffing and outcome tracking changes. Patterns of expansion: Cancer, predominantly, was the most common diagnosis in patients referred to SYMPAQ clinic in the first two years. However, substantial increases in patients with cardiovascular disease and end-stage renal disease as the primary life-threatening diagnosis have been observed in subsequent years. Similarly, referring clinicians reflect a wide range of disciplines with increasing referrals from primary care providers (up 40%) and pulmonologists (up 3-fold increase) in the last two years. Additionally, SYMPAQ clinic has increased care continuity, as increases in new consultations were observed. Implications: Changing clinician referral patterns and a diversification of primary palliative care diagnoses willfrequency changes as well as tracking of patient outcome metrics and referring provider satisfaction.
Supporting Family Carers in Home-based End of Life Care: Using Participatory Action Research to Develop a Training Programme for Carer Support Workers

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Background: Family carers provide much of the care for relatives who are dying. They often face great difficulty in doing this, not least as this is a new experience for them.

Aim: To develop and pilot a training programme (TP) for volunteers and paid workers who support carers in providing end of life care at home.

Methods: An action research approach was used. Workshops were attended by key stakeholders from carer support agencies, palliative care and bereaved carers. These explored the learning needs of and challenges faced by carer support workers in both paid and volunteer roles. A programme was developed to address identified learning needs, using the domains of an evidence based carer support needs assessment tool (CASNAT) as a framework. The TP was drafted and then piloted with developers acting as facilitators. A second pilot took place with independent facilitators. Individuals (n=24) from different organisations took part in the pilots. Evaluation of the TP included by an independent evaluator, completion of participant feedback forms on the day (n=22) and interviews (n=8).

The TP was modified iteratively, based upon feedback.

Results: An innovative, introductory TP for those who support lay carers providing home-based end of life care. Learning materials include activities and discussion topics, case studies, film of bereaved carers talking of their experiences, and taught elements. The programme has been well evaluated, comments include well explained; interesting; informative discussions; very practical! The programme will be free at point of use and published online. It is designed as a one day programme, with ideas for further activities to allow facilitators to tailor to their local needs.

Conclusion: Participatory methods enabled the development of a training programme that is acceptable to a large number of key stakeholders and evaluated well by carer support workers. Further research is needed to assess the impact of the programme on practice.

Abstract number: P1-237
Abstract type: Poster

Optimising Care of the Dying in the Australian Acute Care Setting

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Background: More than 50% of Australians die in acute hospitals. Despite this, there is no accepted minimum standard of care and significant variations exist. Reports continue to identify that the care provided to such people at this stage of life may be less than ideal and that care of people dying in hospitals need improve. A care bundle was developed to improve the quality of care delivered to dying people in acute hospitals and a pilot of this was undertaken in a regional teaching hospital in New South Wales. Implementing such a bundle requires the provision of structured education to medical and nursing staff.

Aim and design: In order to facilitate the delivery of necessary education to support the bundle, a space for education was developed. This was based on information extracted from best available evidence to inform care of the dying. Two distinct components to the package were developed: 1) General education regarding palliation; 2) discipline specific components for medical and nursing staff.

Points for discussion: Online education is popular in Australia given the difficulties in providing face-to-face education to remote locations. Given the need to upskill all health staff in palliation, education may improve end of life care provision in acute hospitals. Online learning addresses the challenges of educating large numbers of staff at separate locations in a short funding environment. Spaced education has been proven by RCT to be effective in clinical settings and to prolong information retention. The challenges of providing education for staff at various levels and of filling a basic knowledge void with regards palliative care itself are significant.

Abstract number: P1-238
Abstract type: Poster

Developing a Palliative Care Competence Framework - Lessons from Ireland

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Background: The National Clinical Programme for Palliative Care in Ireland identified the development of a Palliative Care Competence Framework as a key objective and convened a Project Steering Group to support, guide and oversee this development.

Aims and objectives: The aim of the project was to develop a Palliative Care Competence Framework for healthcare and social care professionals working across a range of care settings.

Description of innovation: The Project Steering Group undertook an initial analysis and evaluation of existing competence frameworks, from the UK, US, Canada, Australia, and Northern Ireland, in order to agree an approach to the framework development in light of this analysis.

Six Domains of Competence: The domains of the Palliative Care Competence Framework provide for core competences for health and social care professionals whilst also detailing discipline specific competences up to specialist level. The framework will inform academic curricula and professional development programs for health and social care professionals. The framework will also enhance the care of people with life limiting illness, and foster greater inter-professional and inter-organisational collaboration in palliative care provision. The outcome of the project is a clear framework to support evidence-based, safe and effective palliative care for generalist and specialist practitioners irrespective of place of practice.

Abstract number: P1-239
Abstract type: Poster

Dignity Care Intervention Ireland (DCI Ireland): Pre and Post Education Evaluation for Nurses Working in the Community Setting

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Background: Maintaining the dignity of the individual being cared for is key to the provision of palliative care. Nurses working in the community setting require knowledge and skills to meet the needs of service users and their families in need of a palliative care. DCI Ireland is a community based pilot project implementing a dignity care intervention for individuals, with life-limiting illness.

Aim: To evaluate the impact of a targeted education programme regarding Palliative Care and the DCI Ireland for nurses working in the community setting in Ireland this junior.

Methods: An educational programme was developed for nurses working in the community in four pilot sites (n=54). The education programme consisted on two elements: 1. An on-line programme incorporating an introduction to the Principles of Palliative Care and their application in clinical practice and the DCI Ireland. 2. Two facilitated workshops for further elaboration of the DCI Ireland.

Conclusion: Participatory methods enabled the development of a training programme that is acceptable to a large number of key stakeholders and evaluated well by carer support workers. Further research is needed to assess the impact of the programme on practice.

Abstract number: P1-240
Abstract type: Poster

Junior Doctors Caring for the Dying: What Do They See, Do and Need to Perform this Role?

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Background: In their first year of work, newly qualified doctors care for patients who are dying, but many feel unprepared for this role. The Liverpool Care Pathway (LCP) for the dying was designed to facilitate guidance of this care, but a recent national review has led to it being phased out from acute hospital trusts in the UK.

Aim: to explore the experiences and learning for the dying to develop an understanding of their perceived abilities and attitudes around this role; what they do, what they observe others doing and what they perceive they need to perform this role following the use of the LCP.

Methods: Electronic questionnaire to all new junior doctors working within one Deanery in the UK.

Results: Ninety-four junior doctors responded (45% response rate). Junior doctors perceive that for the majority of patients, consultants were involved in the decision making process of recognizing when someone is dying. Many, but not all (60%) observe their consultants caring for the dying. Junior doctors perceive anticipatory medications are prescribed for patients and appropriate discussions are had with patients and family members about nutrition, hydration and why the patient is now thought to be dying. Despite this, junior doctors perceive only 50% of patients are ‘optimally’ cared for on acute hospital wards.

Conclusion: The importance of education about palliative care and the provision of dignity preserving care cannot be underestimated. Ensuring nurses have the requisite knowledge will contribute to the future development of practice and subsequent improved care for patients approaching the end of life.
Demonstrating Medical Student Competency in Palliative Care: Development and Evaluation of a New ‘OSCE’ Station

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Background: Primary palliative care skills are important for most physicians but an authentic assessment tool using standardised patients has not been reported for medical students.

Aims: To develop, implement, and assess the characteristics of a palliative care observed structured clinical examination (OSCE) for 4th year medical students. In its second year, we modified the case to prepare it for future use as an evaluation tool.

Methods: Incorporating palliative care and education expert input, we created a representative case and a checklist of 16 history items in three palliative care domains. In its second year, based on review of the first year analysis and further expert input, we revised the checklist to 14 history items in three palliative care domains. We also trained a new standardised patient with an acting background because the first SP found the daily emotional toll too hard. Each of one hundred rising 4th year medical students completed this case and 7 others in a single day as part of a required evaluation. We performed standard item analyses on the history items and determined inter-rater reliability.

Results: The one hundred students scored an average of 75% (SD 13) on the 14 history items up from 64% (SD 12) on 16 items the previous year. There was 95% (from 94%) agreement in ratings on the history items between the SP and a remote observer. Of note, the students performed better on the MRS communication skills questions on the palliative care case than on any other case. The students reported that the case seemed adequate.

Conclusions: A palliative care OSCE is feasible to implement with high inter-rater reliability. We found that using a professional actor as the standardised patient is an improvement for this emotional case. Our analysis of the OSCE demonstrates successful uses in assessing student competencies in primary palliative care.

Abstract number: P1-241
Abstract type: Poster

Stepping Forward: Sustaining Quality End of Life in Care Comes Following on the Six Steps to Success Programme

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Background: In an area (pop 235,000) with 112 care homes (3400 beds), the Six Steps to Success Programme supports delivery of high quality End of Life (EoL) Care. 45 homes achieved accreditation and a further 12 in next cohort. As a result, care homes have systems in place to identify residents approaching EoL, provide care and support families. Completing the programme and sustaining the changes made, is demanding yet rewarding.

Aim: To support care homes to continue delivering high quality EoL following completion of 6 programme, reduce unnecessary hospital admissions and enable residents to be cared for and die in preferred place of care.

Methods: Support initiatives include: delivery of cross boundary EoL education and support from local Specialist Palliative Care (SPC) and TRANSFORM Team; monthly visits to homes; regular telephone calls; collection and collation of data from homes; those approaching end of life are included on cross-boundary register; flags on admission to hospital TRANSFORM to support admission and facilitate smooth transfer between care settings; quarterly link meetings (hosted by hospice) to share experiences and receive updates; syringe driver loan scheme in place for homes who attend competency based training.

Results: Locally agreed criteria for care and end of life accreditation have been set in 30% with the majority meeting the requirements (33/35). The TRANSFORM Team has built excellent relationships enabling timely support, prompt best practice, and identifying and meeting the educational needs of staff. Quarter of collected helps demonstrates the good work they have done, identify challenges and share good practice, whilst qualitative feedback demonstrates the value, to them, of the support they receive.

Conclusion: Through collaborative working with SPCs, acute trust and primary care, Care Home staff feel valued in EoL Care. Ideas and enthusiasm are generated by ongoing support for homes dealing with the challenges such as high staff turnover.

Abstract number: P1-244
Abstract type: Poster

Core Skills Survey and the T RAN SFORM Education and Support Team

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Background: A well circumscribed area in the North of England already had an integrated specialist palliative care service consisting of NHS community and hospital teams and a voluntary hospice providing ingenting, day, outpatient and patient at home services; was in the second national wave of the Transforming Acute Hospitals programme and has started to implement the Six Steps Programme in care homes.

Aim: To provide a team that works 7 days a week across hospital, community and care home settings to educate and support staff in caring for those patients recognised to be in the last year of life, especially those without specialist palliative care needs, and to proactively seek out and support their families.

Method: The TRANSFORM team was created, merging TRANSFORM Hospital Clinical Lead and life facilitator, Six Steps Care Home Facilitators and new posts to embed AMBER care bundle and Advance Care Planning.

Consistent education is delivered by the team across all areas with practical support scaffolding learning.

Patients likely to be in the last year of life are identified on admission to hospital and support given to ensure a co-ordinated approach to care and smooth transition between settings, whilst respecting patients choices and preferences.

Strong clinical relationships developed between all services with regular contact with hospital and community teams and care homes.

The team supports geographical boundary data collection highlighting areas of strength and opportunities for improvement.

Results: Although only in existence since May 2014, figures already show an increase in numbers of staff receiving training and an increase in numbers of life care education the a 30% increase in numbers of dying patients whose wishes to be at home are respected and met.

Conclusion: A corporate team approach has enabled the development of a trusted and reliable service. The TRANSFORM team empowers and supports all health care professionals to confidently deliver high quality end of life care.

Abstract number: P1-245
Abstract type: Poster

The Leadership Development Initiative: Improving Physician Leadership Skills

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Aims: The Leadership Development Initiative (LDI) was created with the goal of increasing leadership skills in international palliative care physicians and enhancing palliative care globally. This study summarises findings from the Cohort 2 Core Skills Survey and the Post-LDI program evaluation, with the aim of understanding the physician’s self-perceived leadership skills and the physicians valued within throughout their LDI leadership journey.

Study design and methods: Physicians were asked to complete a Core Skills Survey and rank their self-perceived leadership skills before beginning LLI and again after each LLI course. When completing the second survey, physicians were asked to ‘retroactively’ rate their core skills, looking back to before they started the program. Physicians also completed a Post-LDI evaluation which included 16 questions in which they ranked each of the skills presented across the LLI courses and provided comments noting the impact of their experiences in the LLI program.

Results: Results showed that leadership core skills increased significantly with each training (p < 0.01). In addition, physicians felt that in their role (in rank order) that their greatest resources for success were 1) LDI experience and courses (29%), 2) networking (21%), 3) mentorship advice (27%), and 4) leadership (21%).

Abstract number: P1-243
Abstract type: Poster

11th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015
The aim of this paper is to compare existing palliative care curricula and to analyse actual improvements for remote learners and those with resource constraints. Additionally, provide evidence of efficacy or impact. However, such programmes were reported to offer discussion boards or elements of face to face tuition. Un-moderated programmes did not receive literature and where evident, was often compromised by other factors more associated with narrative review. A bibliometric analysis was carried out to determine trends in published duplicates. Following examination of titles and abstracts 26 papers were selected for complete databases was conducted. This yielded 1441 results reduced to 1084 on removing duplicates. Key areas for workforce development in palliative and end of life care have been identified in the UK National End of Life Care Programme. Multiprofessional education for health and social care workers is recommended to improve quality of care across different settings. However, challenges exist with wide variances in knowledge and practice. Educational aims were to facilitate joint learning of core principles of palliative and end of life care, enhance awareness of roles and responsibilities, identify commonalities, critique current practices and identify areas for change. A 3 day programme of reflective practice was undertaken using a social constructivist approach to learning. Managers and junior staff members were separated for part of the programme to enhance articulation of concerns, learning needs and perceived status of current practice. Feedback to whole group was anonymised. 89 participants from 40 diverse health and social care organisations attended. 92%(n=85) evaluated improvements in knowledge in key areas to also include the perceived power of reflective practice, recognition of the importance of professional liaison and ethics, promotion of dignity and choice, looking after self and valuing other staff members. 96%(n=80) of participants strongly agreed that reflective activities had facilitated examination of current practices. 172 individual and organisational proposals of practice change were recorded. Themes related to individual and multiprofessional communication, collaboration, education and training, feedback, attitude change, teamwork and focused planning. A total of 966 questionnaires were sent out. Response rate was 76.2%. Two-thirds of the responders were aged 20-29 years, and more than half (54.5%) had < 4 years work experience. Most of the nurses surveyed were working in the inpatient setting (98.9%), followed by the outpatient setting (7.6%), and in the community (2.6%). More than half of the nurses (52.3%) stated self-perceived inadequacies in EOL care. More than half the nurses (50.3%) felt that the end of life is a time of great suffering. More than a third of the nurses interviewed agreed that little can be done to help someone achieve a sense of peace at the end of life (42.9%), that they were uncomfortable talking to families about death (40.9%), that feeding tubes should be used to prevent starvation at the life (39.4%) and that the use of strong pain medicines can cause the patients to stop breathing (37.9%).

Conclusion: This study highlights knowledge gaps, misconceptions, and self-perceived inadequacies about death and dying amongst nurses. Education and administrators need to recognise the importance of strengthening EOL care education in nursing schools and as part of ongoing educational programs if quality EOL care is to be provided to our patients.

Six Steps to Success Programme: Improving End of Life Care for Care Home Residents
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Background: Over 425,000 elderly and disabled people live in residential care homes in the UK. Despite regarding the care home as their ‘home’ a majority of residents are admitted to hospital at the end of their lives. Inappropriate admissions to hospital from care homes at the end of life (EoLC) identified within the End of Life Care (EoLC) Strategy resulted in the call for improved education surrounding EoLC for care home staff. Responding to this, three cancer/end of life networks in Northwest England, with endorsement from the National EoLC Programme, developed the Six Steps to Success programme for care home staff. It aims to ensure all residents receive high quality EoLC enshrined in the philosophy of palliative care. Care home staff are supported by an EoLC Facilitator from the local area.

Method: Mixed method evaluation in 3 phases, 1) examination of audit data (quality markers and measures; post death information; knowledge, skills and confidence audits); 2) questionnaires and interviews with Six Steps Facilitators and 3) case studies with 6 care homes.

Analysis involved descriptive statistical comparisons and frequencies, qualitative data were subject to content analysis to identify themes.

Results: All care homes demonstrated improvements in the use of Advance Care Planning (ACP); the number of residents who died with an ACP in place increased from 45% to 56%. Knowledge and confidence regarding EoLC increased markedly amongst care home staff; there was 92% improvement for Spirituality skills and 79% improvement for ACP knowledge. The number of residents dying in their preferred place of death increased from 81.3% to 83.1%.

Conclusion: The evaluation has shown that this flexible and adaptable model of training for care home staff has had undeniably positive results in care homes. The Six Steps to Success programme has empowered care home staff to deliver better care for their residents ensuring their wishes and preferences at end-of-life are met.
The King's College London MSc in Palliative Care at 16 Years: Quantifying the Contribution of Former Students in Advancing the Palliative Care Evidence Base

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Background: The EAPC states inter-professional education is critical to promote the specialty of palliative care. In 1998, King's College London developed an inter-professional MSc in Palliative Care that aims to provide students with skills to appraise research and conduct methodologically robust studies, and to advance knowledge and understand the principles and practice of palliative care.

Aim: To quantify the contribution of former students in advancing the palliative care evidence base.

Methods: Database of MSc students from 1998-2013 was analysed to describe former students’ characteristics. PubMed, Google Scholar and Scopus databases were used to identify published papers and academic texts first, or co-authored, subsequent to students’ graduation.

Results: 248 students graduated from the course since its inception. Of these, 85% (n=213) were female. The geographical origin of students varied: 68.8% (n=181) were from the UK, 20.5% (n=181) were from other European countries and 10.5% (n=28) were from elsewhere in the world. More than half (52.5%, n=138) of the students were doctors, 42.2% (n=111) were nurses and 4.9% (13) were allied health and social care professionals. 109 (41.6%) former students were identified as having published research in scientific journals and/or contributed to academic texts. The total number of outputs published was 741 (median 6.81, range 1-91) and included those in the British Medical Journal, Lancet Infectious Diseases, Journal of Pain and Symptom Control, Palliative Medicine and Social Science & Medicine, among others. The most heavily cited paper on factors influencing death at home was cited 332 times. Contributions to textbooks included those in the Oxford Textbook of Palliative Medicine and the Textbook of Palliative Medicine.

Conclusion: Students who participated in the MSc in Palliative Care have made a global impact on the volume of high quality research used to inform clinical care and palliative care policy.

Abstract number: P1-252
Abstract type: Poster

Review of the First Romanian Palliative Care Online Course

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Background: The online palliative care program (OPCP) was developed in partnership between the local hospice and the Medical Faculty on a free platform-Schoology on the level 8 of EAPC curriculum for physicians. Launched in October 2011, it contains 10 online modules (palliative care introduction, pain, communication, ethics, terminal care, depression, delirium, insomnia, nausea/vomiting, dyspnoea) including theory, exercises, case studies, protocols, additional reading. Each module is credited with CME points.

Aim: This study aims to detect weaknesses and strengths of the OPCP with regard to pedagogic and technological aspects.

Method: Retrospective study, based on the content analysis of the all the application forms and final module assessment.

Results: 206 participants enrolled in the program; 103 finalised the chosen module, 25 failed the examination, 15 did not access the material at all, 63 are in the training, GPs were the largest group (45.6%) enrolled. The most requested module was the pain module (45.6%), followed by depression module (16.5%). Utilisation of the video content was moderate: exercises and case studies, referrals to specialised literature, clinical protocols and legal aspects. Informational content was appreciated as very good (100%) and new (99%), methods and materials excellent (51%) and very good (36%). Suggestions for the improvement of the program were: more practical examples, case studies related to patients’ ages, the final evaluation test to allow participants to check the correctness of the answers, application available on mobile phone.

Conclusion: There was raised interest from GPs and for pain management training. The program requires an improvement regarding the software and evaluation method. The quality of information, material and methods, was appreciated as very good and excellent and interactive methods build in the modules were appreciated.

Abstract number: P1-253
Abstract type: Poster

A Bridge to the Community

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Aim: The aim of the project is to provide state-wide access to two collaborative education programs on New South Wales.

Design: Vocational training for care workers: To meet the care needs of people near the end of life a programme has been developed and implemented by HammondCare through the HammondCare Registered Training Organisation and will be available in all participating Local Health Districts. This includes training in care principles and ethics of palliative care; pain and symptom management both in end-stage cancer and end-stage chronic/chronic/terminal/ decompensated/ disease; communication; understanding loss and grief; and self-care for the palliative care worker.

Palliative care training for health professionals: Continuing professional interactive education in palliative care is available throughout New South Wales using real-time videoconferencing, recorded materials (including podcasts and podcasts), and printed material/publishers in recognition of time spent in registrable activities. The material for this education has been developed by HammondCare's Learning and Research Centre in Palliative Care in consultation with consortium members, Sacred Heart and Calvary.

Results: A series of educational opportunities has been created to meet the needs of all practitioners in end of life care throughout the state.

Conclusion: We have created a successful and interactive education programme that meets the needs of health professionals across the state which will continue to grow and offer opportunities as the programme develops.

Abstract number: P1-254
Abstract type: Poster

e-Learning, We-Learning, I-Learning: A National Forum for Palliative Medicine Undergraduate Medical Education

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Background: In the UK, newly qualified doctors will look after forty dying people in their first year after qualification. How can medical students be prepared to provide the best possible care for dying people and those in the last year of life? Undergraduate Medical Education is one of three Special Interest Forums (SIF) of The Association for Palliative Medicine. Its mandate was renewed in 2012. The SIF has a coordinating forum executive which lobbies and supports the membership through annual conferences with biennial themes of research and practice and an on-line resource.

Aims: To describe and disseminate the methodology of a national SIF for Palliative Medicine Undergraduate Medical Education practice and research

To quantitatively and qualitatively describe the impact of a national forum in distilling and implementing excellence in Palliative Medicine undergraduate medical education practice and research

Methods: Delegates at the second annual conference completed a pre-post evaluation which included self-rating statements about knowledge of undergraduate curriculum and research methods in educational assessment. Open comments on the impact of the conference were sought. Numerical ratings were analysed descriptively, submitted comments thematically analysed.

Results: 30 of 52 delegates (response rate 58%) submitted evaluations. There was positive shift in delegates self-rating in all five statements. Key themes included appreciation of shared practice, benefit of multiple teaching methodologies and future collaboration.

Conclusion: The SIF has run two national conferences, developed a website of teaching methods and updated a national curriculum influenced by the EAPC curriculum and supporting national medical guidance. The SIF has shown a sustained collaborative approach to developing resources and networks to support improvement in undergraduate medical education. Future aims include further synergy between teaching research and education programme delivery.

Abstract number: P1-255
Abstract type: Poster

Palliative Care at a Danish University Hospital, a Network for Nurses in Palliative Care

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Background: In Denmark, 55 % die at hospital. It is necessary for professionals at the basic level to have adequate knowledge of and education in palliative care. Knowledge is lacking on whether a network for nurses within the field of palliation can ensure implementation and optimisation of palliative care.

Purpose: To investigate if a formally established network of nurses at Aarhus University Hospital in Denmark consisting of key persons in palliative care across departments and in collaboration with a specialist team can increase perceptions among professionals and departments of own competences within palliative care.

Method: A questionnaire study was conducted among all department managements, immediately superiors and key persons. The questionnaire to department managements included questions on framework for and content of palliative care; questionnaires to immediate superiors and key persons included evaluation questions on continued competence development and effect.

Results: A total of 94 % of the department managements acknowledged that palliative care is an important task for the department. It was considered beneficial to have a key person in palliation at the department. The evaluation showed a positive effect on continuous development of professional competences in key persons, on involvement of interdisciplinary and cross-sectorial collaboration as well as on the overall knowledge of palliative care at the department.

Conclusion: A formally established network supported by the management has strengthened the role of key persons and the ability of departments to manage palliative challenges.

Conclusion: Collaboration between professionals at the basic and specialised level is considered important in the professional development of palliative care in individuals and in the organisation. Further development of palliation as an interdisciplinary area at the basic level is needed.
People with Intellectual Disabilities: Promoting Quality End of Life Care

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Abstract type: Poster

Background: Internationally concerns have been highlighted about the quality of palliative care that people with intellectual disabilities receive. It has also been evidenced that people with intellectual disabilities are seldom referred to hospice and palliative care services.

Aim: This study aimed to explore the experience of health and social care professionals in providing palliative care to people with intellectual disabilities.

Methods: An exploratory, qualitative design was used. A purposive sample of thirty health and social care professionals, working in intellectual and palliative care services, who had provided end of life care to adults with intellectual disabilities, were recruited to the study. Following informed consent, they were asked to reflect on a case scenario of a person with intellectual disability to whom they had provided end of life care. A semi-structured interview technique, detailed in the literature with open questions and prompts, was used to explore their experiences and insights. The narratives from the case scenarios were content analysed using a recognised framework.

Results: Three themes emerged from the data within the case scenarios: identifying end of life care needs, meeting support needs and empowerment in partnership. Examples of good practice and issues in practice were apparent.

Funder: HSC Research and Development Doctoral Fellowship Scheme

Conclusion / Discussion: This study contributes to the developing international evidence base to enhance end of life care for people with intellectual disabilities and provides further insights into this area of practice.

Abstract number: P1-257

Palliative Care Module at Undergraduate Level of Education - Evaluation of Implementing the Unitary Curricula in One Nursing Technical College in Bucharest, Romania

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Abstract type: Poster

Context: In 2007 it has become mandatory the inclusion of the Palliative Care (PC) module in the basic training for nurses at the public and private Nursing Technical Colleges in Romania. After the publishing in 2010 of ‘The Trainers’ Manual in Palliative Care at basic level of education for nurses’, the manual was voluntarily adopted at national level as training courses: 5 common modules and 1 module at the choice of the participant from pediatrics, weekly working group meetings of nursing PC trainers for one year; internal and external training for trainers, through the design of the specialised program in PC nursing based on the EAPC’s standards. Competencies development by an international expert panel, followed by the testing of the teaching methods used, 81% the length of the module as being interactive the teaching methods used, 81% the length of the module as being interactive.

Conclusion: This is a first initiative in evaluating the implementation of the PC unitary curricula in nursing schools in Romania. It has been demonstrated the effectiveness of the implementation of the module in regard to enhancing the students knowledge in PC and the structure of the module.

Abstract number: P1-258

Palliative Care - On Becoming a Specialty for Nurses in Romania

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Abstract type: Poster

Background: Since the beginning of Palliative Care (PC) services in Romania in 1992, the pioneering organisation has in the mission to educate the interdisciplinary team members at specialist level. In 1999, PC was recognised as a specialty for physicians and multiple attempts were made to recognise PC specialty for nurses.

Context: The development of the PC nursing specialty program in Romania started with the competencies development by an international expert panel, following the testing of the competencies among nurses in PC services.

Aim: To ensure the competence and quality training in PC for nurses in Romania through the design of the specialised program in PC nursing based on the EAPC’s standards.

Method: Research, translation and adaptation to national legal context of relevant resources; weekly working group meetings of nurses of PC module for one year; internal and external training for trainers, through the design of the specialized program in PC nursing, based on the EAPC’s standards; the development of the PC nursing specialty program in Romania started with the competencies development by an international expert panel, following the testing of the competencies among nurses in PC services.

Results: EAPC nursing curricula for specialised level was chosen as base for developing the curriculum and adapted to the national legal framework for running specialised programs for nurses. A total number of 850 hours are covered in: 210 hours (25%) of theory (6 residential courses) - 5 common modules and 604 hours (75%) of clinical practice, 4 out of the total 16 weeks being mandatory displayed in the pioneering PC service. The

Abstract number: P1-261

Compassion Awareness Education - A Collaborative Venture

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Abstract type: Poster

Context: Nursing education in Palliative Care (PC) in Romania became a matter of high interest over the past few years, both at undergraduate and postgraduate level. Nurses are confronted in their practice with palliative and end-of-life care issues: communicating with patients and families, educating patients and families regarding diet and disease progression, stoma care and lymph edema, specific nursing techniques, administering the opioid medications, preventing and managing of pressure sores, caring for fragile wounds. Aim: To address gaps in the current care of cancer patients in advanced and terminal stages, particularly of those living in remote or isolated communities, by empowering community nurses with the basic and intermediate palliative care knowledge.

Method: EAPC nursing curriculum for introductory (A) and advanced (B) level, together with the ELNEC International Curriculum were chosen as base for developing the curriculum and adapting corresponding Palliative Nursing (PN) professional competencies. A quantitative prospective study was conducted between October 1st, 2012 and September 30th, 2014 to monitor knowledge acquisition during the training by using a pre and post tests.

Results: In 24 months of the project a total number of 2752 professionals have been trained in the field: 219 specialised care givers, 1064 nurses (A), 1163 nursing students (A) and 306 nurses (B). The courses have been held in 30 different location in the country, 20% from rural areas and 80% from urban areas. The knowledge gained at the courses enhanced from an average of 6.06 to 8.87 points. Correlations with different variables show a medium of 3 points in between the tests.

Conclusion: This project ensured provision of Palliative Care training and support of nurses towards gaining the abilities and knowledge specific to basic palliative care knowledge. It also encouraged others to take a hands-on approach to the development of the Palliative Care Nursing specialty in the country.
teach compassion awareness education over a year long project. Identical half-day sessions using evidence-based theories, included experiential learning and introduced action planning to embed learning in practice.

The participants worked in a range of roles in health and social care, and will disseminate their learning to colleagues. The half day programme includes guidance on sustaining compassionate practice in the workplace. A customised three-point evaluation process is integral to the project.

**Results:** In the first two months of the project, 325 staff from a range of professions employed in December 2012 attended. Participants reported increased levels of confidence in delivering compassionate care following the education sessions. Post session surveys indicate that many participants used their action plans in practice. This project has enabled local practitioners to establish and strengthen relationships with local hospices and primary care organisations. The use of an action plan within the education sessions supported participants to engage more deeply with the concepts of compassionate care and how to foster it in themselves and others.

**Abstract number:** P1-262

**Abstract type:** Poster

**The Training Evaluations of the End-of-Life Care Facilitators (EO LF) Educational Program for Nurses that Practice Advance Care Planning (ACP) in Japan**

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**Background:** The need for Advance Care Planning (ACP) in Japan is attributed to the increase in elderly people who wish to live independently as long as possible. ACP is the process in which patients, their families and medical experts collaborate towards common goals of treatment care. Not only does ACP improve end-of-care, it also enables elderly people to live an active and dignified life in accordance with their wishes. Therefore ACP is implemented for terminal-stage patients as well as healthy elderly people.

**Aims and methods:** To promote their involvement in end-of-life care, we need to clarify difficulties they identify. Experience. Further, ACP should be facilitated by nurses for it to be effective.

**Aims:** This study aims to understand the concept of ACP and create a training program for nurses in facilitating ACP for elderly people with chronic illness. This paper describes participants' evaluation of the program by pre- and post-test, and participant's reflection sheets.

**Methods:** The subject comprised nurses interested in implementing ACP. The training program combining a lecture and group discussion was a one-day course held in four times between December 2013 and January 2014. Evaluation of the course was conducted by questionnaire after completion of the course.

**Results:** The 40 nurses who participated the course. The course was effective with 94% of the participants answered that 'the training is meaningful' and 92% that they 'would like to apply the training.' The desire to implement ACP was described in the free comments section with 'I hope to keep the sense of values and life history of the elderly in mind when communicating'.

**Conclusion:** We have created such a program that incorporates both the opinions of health care workers and information from the published literature, and then we evaluated its utility.

**Abstract number:** P1-265

**Abstract type:** Poster

**Evaluation of a Mental Health Program for Palliative Care Health Care Workers**

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**Background:** Health care workers who are engaged in palliative care face the patient’s death and the grief of the family on a daily basis. Because they are constantly in a stressful situation, mental care for them as well as for the patients and family is important. They likely need some kind of support from a mental health program.

**Aims:** We have created such a program that incorporates both the opinions of health care workers and information from the published literature.

**Methods:** The workshop using our program involved the participation of 15 nurses. The program was well received. Then, we modified the program incorporating the opinions of both participants and facilitators.

**Results:** The program contains three parts, and each part is configured to last approximately one hour. The three parts also can be scheduled together requiring about three hours. The program is flexible and can be modified according to the workplace situation. In the first part, the significant event analysis is performed in groups of four to five people. The second part, to work as a facilitator to reduce the mental problems and the third part, to use the program in the workplace environment.

**Conclusion:** Mental health programs should be easy to access, easy to use, and adaptable to each workplace environment. In the opinion of the participants of this study, our program is easy to use. It will be necessary to revise repeatedly and continue to improve the program in the future by incorporating the opinions of both the participants and facilitators.

**Abstract number:** P1-266

**Abstract type:** Poster

**EAPC Enquiry on Spiritual Care Education**

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**Background:** The White Paper on Palliative Care Education states that in order to benefit patients and their families, all palliative care professionals should be able to open dialogue about meaning, purpose and change - central points in any discussion of spirituality and spiritual needs. The confidence to assess these issues and meet appropriate outcomes will only be achieved through relevant training programs.

**Aims and methods:** In October 2013, an online enquiry was launched by the Education sub-group of the EAPC Spiritual Care Taskforce among EAPC members. The enquiry was designed to capture all those courses running presently, or planned for the near future, which would interest professionals and volunteers to develop skills and improve practice. Results: We received 36 responses from which 78% (n=28) derive from Europe. The enquiry revealed that 81% (n=29) of training programmes use the EAPC working definition of spirituality. 64% (n=21) of training is provided to all health care professionals, profession-specific training is less common. 89% (n=26) of training is provided inface-to-face in a classroom setting. The highest priorities within training are: reflective listening and communication (69%, n=31), individual awareness and self-handling (78%, n=28), and
Abstract number: P1-267
Abstract type: Poster

Dying in Social Media: Effectiveness of Social Media versus Classroom Based Education in Palliative and End-of-Life Care Topics among Undergraduate Nursing Students

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Background: Online social networks act as a mode of communication that helps to share information and resources and collaborate with peers through engaging in social media based digital dialogues. Yet, little evidence exists on the use of social media in healthcare professionals' education, particularly in palliative and end of life care education.

Aim: To explore the effectiveness of social media and classroom based education among undergraduate nursing students in one UK Higher Education setting.

Methods: A qualitative participatory approach was adopted. In total of 196 first year undergraduate nursing students were invited. 157 students joined Facebook based teaching and 34 students attended classroom-based end-of-life care teaching that delivered similar learning objectives. Multiple data were collected: student run two focus groups (n=12 students), feedback from Facebook discussion forum (n=2803) and email feedback responses (n=8). Using NVivo11®, a thematic analysis was undertaken.

Results: A comparative analysis between social media versus classroom based education resulted in five themes (a) /^Facebook^ explored its effectiveness in teaching care ethics; (b) of more help is needed in care topics among nursing students: speaking out, looking at real life situations, technology lessens interest, emotional teaching, and re-learning.

Conclusion: Our data is explored that using social media in social death dying education enhances students' learning experiences both in emotional as well as knowledge acquisition similar to classroom teaching. However, Facebook teaching provided more flexibility and increased interest yet attained similar learning outcomes.

Abstract number: P1-268
Abstract type: Poster

Using Collaboration and Innovation Across Continents to Provide Palliative Care Education

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Introduction: Delivering effective palliative care to patients and families requires education for all healthcare workers. Accessing education is challenging in terms of time, cost and manpower, particularly in resource poor settings. Using technology for education is not a universal concept: the most usual concern is lack of internet availability. Technology and massive open online courses (MOOC’s) continue to develop however. We report on a project successfully using collaboration between organisations in Africa and UK to produce 20 open access e-learning modules on palliative care topics.

Methodology: Each module comprises interactive quizzes, reflective practice, facts presented as film clips and slides and ends with future learning prompts, resources and evaluation. The focus of the interviews and teaching in UK and Africa. An evaluation form seeks satisfaction scores and free text comments on expected change in professional practice.

Results: Out of 256 participants, 38 (15%) requested a text version. All modules have been completed a course in 2003-2013 (n=150). Questions covered demographic information (n=4), pre-course information on medical education, specialty and working place (n=3) and post-course information regarding current work and activities to promote PM (n=12).

Conclusion: The Nordic Specialist Course in Palliative Medicine has a profound impact on participants' post-course career and most are now working within PM as leaders, teachers and activists. PM will be approved as a formal competence field in all the Nordic countries during 2015. The Nordic course, or a comparable course, will be required for the theoretical part.

Abstract number: P1-270
Abstract type: Poster

Impact of the Nordic Specialist Course on the Development of Palliative Medicine in the Nordic Countries. A Survey among 150 Participants from Five Courses during 2003-2013

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Background: The five nordic associations for Palliative Medicine (PM) have since 2003 organized a theoretical specialist training course consisting of 6 week-long modules over 2 years. All major topics in PM are covered. Participants must attend the modules, compile a limited research project, hand in a written assignment, enter each module and pass the final exam in order to receive the diploma. Up to now 150 physicians have participated in five courses.

Aim: To examine what impact this educational program has on participants and the field of PM.

Methods: An ad hoc electronic questionnaire was sent out to the physicians who had completed a course in 2003-2013 (n=150). Questions covered demographic information (n=4), pre-course information on medical education, specialty and working place (n=3) and post-course information regarding current work and activities to promote PM (n=12).

Conclusion: The Nordic Specialist Course in Palliative Medicine has a profound impact on participants’ post-course career and most are now working within PM as leaders, teachers and activists. PM will be approved as a formal competence field in all the Nordic countries during 2015. The Nordic course, or a comparable course, will be required for the theoretical part.
Abstract number: P1-272

Abstract type: Poster

Does Medical School Prepare for Strong Opioid Prescribing in the Real World?: The Experience of Junior Doctors at a District General Hospital in the United Kingdom

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Background: Opioid prescribing is a fundamental competence of doctors. Confusion and uncertainty, however, regarding initiation, titration and side effects are not uncommon. Undergraduate medical education should lay the foundations for safe and effective prescribing of opioids including accurate assessment of dosage and likely side effects.

Methods: A written questionnaire exploring the knowledge and attitudes toward opioid prescribing was distributed to cohorts of junior doctors from foundation year one (FY1), foundation year two (FY2) and core medical training (CMT), working at a district general hospital in the UK. Questions were taken from the implementation tool accompanying national guidance on opioid prescribing. Correct answers were scored one point and the maximum score was 20.

Results: 10 FY1, 10 FY2 and 10 CMT doctors responded. Mean scores from each cohort were 13.30, 14.95, and 13.15 respectively. Five FY1 doctors cited sedation, addiction/dependence, and quicker death among fears of opioid prescribing. Only four FY1 doctors attempted to perform a simple drug calculation and none of their answers were correct.

Conclusion: Lack of knowledge of correct opioid prescribing produces a risk of unsafe practice. However, prior formal education on this subject was perhaps brief and largely at undergraduate level. There was a theme of misconception regarding the safety profile of appropriately prescribed opioids; this may have arisen from a focus on rare but important safety issues. While all cohorts did not score highly on average FY1 doctors answered most questions incorrectly. This is concerning and could lead to patient harm.

Conclusions: We suggest undergraduate medical education may not be preparing doctors for safe opioid prescribing, titration and monitoring of strong opioids. Undergraduate education needs to address basic controlled drug prescribing in order to produce doctors who are able to safely and effectively prescribe opioid medication.

Abstract number: P1-273

Abstract type: Poster

Development, Implementation, and Assessment of a Palliative and Hospice Care Online Module and Clinical Experience for Second-year Medical Students

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Background: In order to prepare medical students for bedside learning in the care of patients with terminal and advanced illness, education in the principles and practices of palliative and hospice care is best initiated in the pre-clinical years. Online tools have been shown to increase student engagement, retention and understanding. The purpose of this project was to assess the feasibility of e-learning modules for medical students. Students from both groups then completed a knowledge- and attitude-assessing questionnaire.

Methods: The online module was piloted with 112 second-year medical students in 2012 and 2013. Students were randomly assigned to the complete the online module or not (control group). Assessment was undertaken using the required half-day hospice clinical experience. Students in both groups then completed a knowledge- and attitude-assessing questionnaire.

Results: Students who completed the online module prior to the hospice experience scored higher on multiple choice questions pertaining to hospice and palliative care (p < 0.05, two-way ANOVA) but their attitudes were similar to those who did not complete the online module. Overall, the students felt somewhat uncomfortable caring for dying patients even though they regarded it as a physician’s duty, and that palliative/hospice care education is important in medical school.

Discussion: When combined with a mentored clinical hospice experience, an online module needs to address basic controlled drug prescribing in order to produce doctors who are able to safely and effectively prescribe opioid medication.

Abstract number: P1-274

Abstract type: Poster

A Survey of Cancer Pain Management Knowledge and Attitudes of Northwest Bulgarian Physicians

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Introduction: A survey amongst physicians from Northwest Bulgaria was conducted as a part of a bigger project on epidemiology of cancer pain, its control and potential barriers to its management. The main target was to reveal their knowledge and attitudes towards cancer pain management, the use of opioids for control and effects of opioid regulation on their prescribing practices.

Methods: A questionnaire survey based on the similar survey from Canada was delivered to physicians from Northwest Bulgaria. We assessed their basic knowledge and attitudes towards cancer pain management and opioids prescribing and also collected demographic data.

Results: Using the Regional office of Bulgarian Medical Association database 250 practicing physicians were contacted by email. 149 questionnaires were returned (60% response rate). Oncologists and ED physicians achieved highest knowledge score and had less concern about regulation restrictions. On the other side were surgeons and GPs from small towns. Most concerned about opioid regulations were those from small towns and rural area and those with > 30 years of practice. Most don’t know answers were given to the questions about equianalgesic dosing (35%) and breakthrough pain dosing (30%). The highest percentages of wrong answers were given to questions about addiction - the risk of addiction in any patient on opioid is 25% higher’ - 51% ’physical dependence is a sign for addiction’ - 62% and ’Patients who complain of disproportionate pain are drug abusers’ - 56%

The most confusing answer given by almost 60% (77) was that ‘placebo is a useful test to determine the reality of patient’s pain’.

Conclusion: The results of the survey reveal insufficient knowledge of the physicians of Northwest Bulgaria about cancer pain and its treatment. There are also concerns about regulation especially among older physicians and those practicing in smaller settlements, which is a big barrier to adequate cancer pain control.

Abstract number: P1-275

Abstract type: Poster

Identifying Palliative Care Domains relevant to Emergency Medicine

Resident Training: Literature Review and Expert Consensus

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Aims: Hospice and Palliative Medicine is a subspecialty of Emergency Medicine (EM). EM trainers routinely care for patients with serious life-limiting illness. However, no defined palliative care (PC) curricula for EM resident training exist. The objective was to identify PC domains and topics that are relevant to EM training through literature review and expert consensus. The ultimate goal is to design a EM-PC resident curriculum for the US.

Methods: Clinical practice guidelines review and a comprehensive search of MEDLINE, CINAHL, ERIC, PsychINFO, and SCOPUS was completed for published studies using the terms: palliative care, hospice, palliative care, emergency medicine, topics, education, and training. Citation search and abstract review by 2 independent reviewers yielded 4 studies from 47. Manuscript analysis revealed recurring topics for EM-PC in 3 domains: palliative care, hospice, and consultation.

Results: Topics relevant to EM-PC training in 3 main domains (with 23 sub-topics) were identified:

1) Provider skill set (e.g., management of chronic pain/distressing symptoms, difficult communication, goals of care),
2) Clinical recognition (e.g., rapid PC assessment, prognostication),
3) Logistical understanding (transitions across care settings, multidisciplinary team/support systems).

Conclusion: Key PC topics and domains relevant to EM resident training were identified. These are being mapped to develop competencies and milestones for the EM-PC resident education curriculum. Next steps include using the Delphi method to validate and develop a final topic list.
Abstract number: P1-276
Abstract type: Poster

**GPs and EoL Care - Views and Experiences**

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Methods: A national validated survey was mailed to all GPs of the country.

Results: The response rate was 44%. 28% of GPs received no formal training in palliative medicine and had been practicing for 23.7% of their years. 3.3% of respondents declared that their religion was important in EoL care. 43.3% (23.3% disagreed, 31.4% neutral) agreed with the right of a patient to decide whether or not to hasten the end of life. 31.4% agreed (30.1% disagreed, 18.1% neutral) that high quality palliative care nearly removes all requests for euthanasia. 70.5% agreed (17.7% disagreed, 11.9% neutral) that physicians should aim to preserve life. On average, in the previous 12 months, they cared for 4.44 EoL patients (95% CI: 3.67-5.21). 15% of GPs withdrew or withheld treatment in the care of these patients. Of the remaining 85%, 24.4% agreed with such practices. 41.1% had intensified analgesia at EoL with the possibility of hastening death whilst in the remaining 58.9%, 28.5% agreed with such practices. 7.5% had sedated patients at EoL. Lastly, 89.1% GPs would never consider euthanasia.

Significant correlations (p<0.05) were observed between considering euthanasia, previous practice of sedation, importance of religion in decision making and patients’ rights in EoL. A thematic analysis of comments highlighted the importance of the topic, feeling uncomfortable in EoL care, the religious aspect of care, lack of legal framework and the challenge of symptom control.

Conclusions: For many GPs, religion guides choices in EoL care. There needs to be more training in palliative care. A huge majority of GPs oppose euthanasia but a good number of GPs are in favour of rationalising treatment at EoL whilst addressing the often conflicting issues of patient rights at EoL and the need to preserve life.

Abstract number: P1-277
Abstract type: Poster

**Flemish Physicians’ Labeling of Palliative or Terminal Sedation: Broader than Guideline Descriptions**

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Methods: Attending physicians were approached by means of a postal questionnaire about end-of-life sedation. The paid care staff considered themselves to be at the centre of the communication. They did feel responsible for the end-of-life care, but not for the end-of-life decisions. They were confident about their own opinion as they felt familiar with the patient’s needs and preferences. Paid care staff and representatives both reported being unclear about who had the responsibility for the end-of-life decisions.

Conclusions: The roles and responsibilities turned out not to be quite clear, with uncertainty and conflicts arising particularly as regards evaluating the quality of life. Advance care planning and shared decision making could be useful tools to improve the process.

Abstract number: P1-278
Abstract type: Poster

**Palliative Sedation (PS) at the End of Life - Revision of the Norwegian Medical Association’s Guidance**

Background: In 1998, a palliative care physician accused a colleague of having performed illegal euthanasia on eleven patients. He denied all allegations, insisting that it was a matter of symptom control according to a procedure then called terminal sedation. After police investigation, the case resulted in emission of prosecution due to insufficient evidence. Subsequently, the Norwegian Medical Association (NMA) mandated an expert panel that worked out a guideline on ‘palliative sedation’. Published in 2001, it was the first of its kind in Europe.

Aim: To revise the 2001 NMA guideline on palliative sedation (PS) for the dying.

Methods: In 2013, the central board of the NMA appointed a new working group. Taking into account follow-up data, released in 2006, on the practice of PS in line with the 2001 guideline, the group came up with a considerably shorter document than the one of 2001.

Result: The new guideline consists of a brief introduction and 12 items. The amendments and the new items are as follows:

1) In rare instances, isolated psychiatric symptoms may be an indication for PS (No. 2)
2) PS may be given to patients whose life-expectancy is beyond a few days (No. 3)
3) PS may be applied within primary health service, provided the required competence and resources are in place (No. 4)
4) Intensifying analgesia at EoL with the possibility of hastening death whilst in the remaining 58.9%, 28.5% agreed with such practices.
5) When the patient takes just sips of water, there is usually no indication for parenteral fluids (No. 11)

Conclusion: The revised and, in 2014, approved NMA guideline on PS represents a somewhat more liberal stance on the practice. We believe it will prove a helpful tool to clinicians, enabling them to deliver the best possible care to patients with refractory symptoms. It provides a framework for treatment that is well within both ethics and law. We will present the new guideline.

Abstract number: P1-279
Abstract type: Poster

**The Process of End-of-Life Decisions Regarding People with Intellectual Disabilities**

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Background: End-of-life decisions are made as often for people with intellectual disabilities (ID) as for the general population. Representatives, physicians and paid care staff are involved in the process of decision-making.

Aims: To study the process of end-of-life decisions and the roles and considerations which are important in the decision-making process.

Methods: This qualitative study, carried out in the Netherlands, involved semi-structured interviews with ID physicians, representatives of people with IDs and paid care staff. Interviews were made after the deaths of ten patients with IDs that had involved end-of-life decisions. The interviews were recorded digitally, transcribed verbatim and analysed using Grounded Theory procedures.

Results: Physicians involved representatives and paid care staff in the decision-making process. Physicians based their decisions on the needs, preferences and the medical life story of patients who are not (or not fully) able to decide. Physicians allocated to the representatives the capability of evaluating the quality of life of their loved one. The representatives felt highly responsible for the decisions and took into account ideas about quality of life, prevention of suffering and the ability of their loved one to understand the burden of possible interventions. The paid care staff considered themselves to be at the centre of the communication. They did feel responsible for the end-of-life care, but not for the end-of-life decisions. They were confident about their own opinion as they felt familiar with the patient’s needs and preferences. Paid care staff and representatives both reported being unclear about who had the responsibility for the end-of-life decisions.

Conclusion: The roles and responsibilities turned out not to be quite clear, with uncertainty and conflicts arising particularly as regards evaluating the quality of life. Advance care planning and shared decision making could be useful tools to improve the process.

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Norms and Valuation of Medication Management in the Last Phase of Life: A Qualitative Research

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Abstract number: P1-280
Abstract type: Poster

A Systematic Review of Ethical Issues in the Clinical Practice of Palliative Care

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Abstract number: P1-281
Abstract type: Poster

A Qualitative Research

Palliative Care

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Abstract number: P1-282
Abstract type: Poster

Abstract number: P1-283
Abstract type: Poster

Patients' Understanding of their Dying Trajectory and their Wish to Die

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Abstract number: P1-284
Abstract type: Poster

Living Wills Requesting Euthanasia in Flanders, Belgium

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Abstract number: P1-285
Abstract type: Poster

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015

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Results: Of people who died following a medical end-of-life decision (N=1733), 4% had a living will requesting euthanasia. Of these people, 37% did not receive euthanasia. Of those who did not receive euthanasia, 62% did not have a living will requesting it. People whose underlying cause of death was cancer (OR=6.8; 95%CI [2.6-17.38]) or a neurological disease (OR=10.6; 95%CI [3.1-36.40]) were more likely to have a living will compared to people who died of other conditions. Having a living will requesting euthanasia was less likely for people of 65 year and older (OR=4.9; 95%CI [1.4-17.30]) and for those dying in hospitals (OR=3.9; 95%CI [1.4-9.9]) or nursing homes (OR=3.9; 95%CI [0.9-16.6]) compared to those dying at home.

Conclusions: Having a living will requesting euthanasia will relate to the patient's gender, age and place of death. The preferences regarding euthanasia documented in a living will did not correspond to end-of-life decisions in more than one third of cases. More research is needed into the reasons and circumstances in which a living will requesting euthanasia is not followed.

Abstract number: P1-285
Abstract type: Poster

Advance Care Planning (ACP) - For Me or for you? An Expression of Egoism or Duty to Others?

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Background: Advance Care Planning is promulgated to promote patient's autonomy with respect to their physical wellbeing (for example Do Not Attempt Resuscitation orders) and protect against medical paternalism especially in the case of future loss of mental capacity. The concept of ACP as solely an egotistical approach to try to control physical death has been challenged. (1) Autonomy enables a patient to be a moral agent and many feel reciprocal duty to their family.

Aim: To revisit the concept of ACP to consider whose interests (patient, family, doctors, or care establishments) are taken into account. Specifically does ACP purely support a liberal autonomy concept related to patients' personal physical wellbeing or wider concepts of autonomy such as duty to others?

Methods: A literature review was conducted using terms: Advance Care Planning, autonomy, duty, responsibility, patients, family, caregivers. UK Policy Documents were examined.

Results: Domain themes in literature review is promotion of liberal autonomy but there is a medical model focussing on treatment or rather not treatment of physical conditions in case of future loss of mental capacity. Most emphasis is on negative autonomy i.e. treatment refusals. Many patients do not want to be a burden. Notable exceptions show that patients use ACP to try to reduce the burden on relatives of decision making and/or preparation for death (1). UK policy documents focus on patient autonomy and physical wellbeing and clear medical decision making.

Conclusions: Patients may reflect privately on how ACP decisions could impact on family. ACP in the UK focusses narrowly on patient autonomy and physical issues like DNAR. Widening the context to discuss impact of ACP decisions with family could promote the autonomy of the patient as a moral agent and enhance the benefits of ACP for patient 'me' and others 'you'.

(1) Singer PA et al Reconceptualising Advance Care Planning From the Patient's Perspective Arch Intern Med 199:158 879- 88

Abstract number: P1-286
Abstract type: Poster

What's in a Name? That which we Call Palliative Sedation - A Qualitative Study among Swedish Palliative Care Physicians and Nurses

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Background: Palliative sedation (PS) is an intervention aimed at relieving unbearable suffering at the end of life. There is scarce knowledge about this intervention in the Swedish palliative care context. Aim: The aim of this study was to examine perspectives on palliative sedation among Swedish palliative care physicians and nurses.

Methods: Thirty-three in-depth interviews with palliative care physicians (n=10) and nurses (n=23) were conducted. The interviews were analysed with qualitative content analysis.

Results: Palliative sedation was, in general, regarded as an accepted intervention in palliative care at the end of life. Several different definitions of the concept were used by the informants: PS (i) as a treatment to relieve anxiety by intermittent lowering of the patient's consciousness, (ii) as an unintended side effect of medication for symptom control or (iii) as intended continuous sedation to relieve refractory severe symptoms. Intended continuous sedation seemed more acceptable to participants. The informants stressed that palliative sedation can only be justified ethically by the presence of distressing symptoms in need of alleviation, and that PS also needs to be accepted by the patient. Therefore, the decision-making of PS should be shared between the physician and the patient. PS can never be justified solely by the patient's autonomous will, in case the physician finds no medical indication. Physical, and in a sense, psychological suffering were considered appropriate indications for PS, while physical suffering was not, and there were different opinions concerning existential suffering.

Conclusion: There seems to be a need for distinct definitions of PS, as well as more explicit guidelines for this intervention for health care staff working with patients in need of advanced palliative care.

Abstract number: P1-287
Abstract type: Poster

The Impact of the Carer Support Needs Assessment Tool (CSNAT) in Community Palliative Care Using a Stepped Wedge Cluster Trial

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Background: Family caregiving towards the end-of-life entails considerable emotional, social, financial and physical costs for carers. Evidence suggests that good support can improve carer psychological outcomes.

Aims: To investigate the extent to which the carer support needs assessment tool (CSNAT) used in end of life home care improves carers' carer strain and distress and mental and physical wellbeing.

Methods: A stepped wedge design was used to trial the CSNAT intervention in three bases of Silver Chain Hospice Care in Western Australia, 2012-14. The intervention consisted of at least two visits from nurses (2-3 weeks apart) to identify and review carers' needs. The outcome measures for the intervention and control groups were the carer strain and distress as measured by the Family Appraisal of Caregiving Questionnaire (FACQ-PC), the carer mental and physical wellbeing as measured by SF-12v2, and carer workload as measured by extent of assistance with activities of daily living, and at baseline and follow up.

Results: Total recruitment was 620. There was 49% attrition for both groups between baseline and follow-up mainly due to patient deaths resulting in 322 carers completing the study (233 in the intervention group and 89 in the control group). At follow-up, the intervention group showed significant reduction in Carer Strain relative to controls, p=0.018, d=0.348. Decrease in Carer Distress was also observed for the intervention group, while a greater increase in carer workload was observed for controls, although both results were not statistically significant after controlling for covariates.

Conclusions: The CSNAT implementation led to an improvement in carer outcomes. Effective implementation of an evidence-informed tool represents a necessary step towards helping palliative care providers better assess and address carer needs, ensuring adequate family carer support and reduction in carer strain and distress throughout the caring journey. (Funded by ARC)

Abstract number: P1-288
Abstract type: Poster

Family Caregivers of Frail Elderly at the End of Life: Predicting Overburdening

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Current literature shows that health interventions and healthy life habits contribute to increase life expectancy while maintaining functional independency (Fries, 2000). However, certain pathologies are still more frequent among elderly. It is calculated that, in year 2020, approximately 6.2% of the Spanish population will be 80 or more years old (INE, 2011). The present study focuses in family main caregivers of frail elderly at the end of life. We follow the definition that Stñoj et al. (1998) make of frail elderly: a person that presents advanced age; some degree of disability; multiple chronic diseases; polypharmacy; geriatric symptoms; and high risk of hospitalisation, institutionalisation, acute disease or death. Recent research point out that a high proportion of family caregivers of elderly patients at the end of life feels overburdened (Soto et al., 2014).

The present study aims to analyse the elements that might relate to overburden in family caregivers of frail elderly patients at the end of life, taking into account variables of the patient and the family caregiver.

It is a cross-sectional study, in which participated forty hospitalised frail elderly at the end of life, and their family main caregivers. Barthel Index, Hospital Anxiety and Depression Scale, and Zar Burt Interview were used.

Linear regression's analyses were carried out. The model that best predicted the variance of outcome measures for the intervention and control groups were the carer strain and distress, while social suffering was considered appropriate indications for PS, while high risk of hospitalisation, institutionalisation, acute disease or death.

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Recent research point out that a high proportion of family caregivers of elderly patients at the end of life feels overburdened (Soto et al., 2014).
Informal Caregivers in Critical End of Life Situations

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Background: Terminally ill persons often voice a desire to die at home, spending their final days in familiar surroundings and being cared for by those closest to them. Informal caregivers who are committed to fulfilling this wish face a number of burdens when caring for a person at the end of life. Aims: The study aims at identifying burdens, challenges and critical situations from the point of view of informal caregivers, and it explores their coping strategies helping them to overcome the encountered difficulties.

Method: In two different regions of Switzerland 25 interviews with informal caregivers caring or having cared for a person at the end of life at home have been conducted. For analysis, a grounded-theory approach has been applied. Results: The various stresses encountered by informal caregivers lead them to experience five different categories of straining emotions. It is less the stressors themselves, but more the emotions which influence how the caregiving situation is experienced. The different emotions are: (1) feeling tired and overburdened due to the strain of caring, the lack of sleep and the variety of tasks, (2) feeling alone and abandoned due to a lack of support and the difficulty to find someone to talk to, (3) experiencing grief and fear due to the confrontation with illness and death, (4) feeling helpless because of the lack of knowledge about the illness, possible symptoms and best practices in caring for a person at the end of life, and last but not least, (5) feeling having lost control over their own life.

Conclusion: The study contributes to a better understanding of end of life situations when informal caregivers are providing care at home. The results will lead to the development of instruments and workshops that reinforce and support informal caregivers, helping them to overcome the emotional and practical caring emotions associated with informal caregiving.

The study has been funded by the Swiss National Science Foundation.

Informal Caregivers at the End of Life: Modelling of a Complex Situation

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Background: How informal caregiving for a person at the end of life at home is experienced by informal caregivers is determined by a number of different factors. Aims: In the context of Swiss national research program, an integrated model has been elaborated with the aim of a better understanding of the diverse interactions and effects influencing caregiving situations at the end of life. Method: The basis for the model are 25 narrative interviews with informal caregivers having cared for a person at the end of life at home. The interviews which have been conducted in German and French give different regions in Switzerland have been audiotaped, transcoded and analysed with a grounded-theory approach.

Results: The model shows how stresses and available resources originate at different levels of the care system (e.g., micro-, meso-, and macro-system) and that therefore, not only the caregivers but also the patient must be considered, but politics, institutions and professionals as well. Conclusion: In order to ensure a satisfactory experience for all actors concerned, and to adequately support caregivers, it is important to get involved at all levels of the system. The study has been funded by the Swiss National Science Foundation as part of the national research programm NRP 67 ‘end of life’.

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Poster Number: P1-297

A Critical Review of Carers’ Perceptions of Palliative Patients’ Symptom Distress

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As palliative care is being increasingly provided by family caregivers in the community, the quality of life of those patients is very important. The aim of this review was to analyse and explore the various perceptions of informal and formal carers of adults receiving palliative care. A focused search of the literature was conducted using online databases, limited to articles published in English, systematic reviews, meta-analysis and critical reviews. The pertinent data was then filtered in accordance to the set inclusion criteria and analysed using the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) checklist.

The number of research articles eligible for the review was twenty-four, twenty-three of which were primary research studies and one systematic review. These were held across various countries and sections of the community, mostly during the patients’ illness and among patients with various diseases most of which were advanced cancer or advanced metastatic cancer. In all of the studies, the proxy was never chosen by the patient. There is no consensus about whether proxy and patients agree about their perception of distress. This is possibly dependent on symptom consciousness and visibility. General practitioners and district nurses differ greatly in ratings of difficulty of symptom control mainly due to their levels of confidence and training at treating certain symptoms. It is argued that family care givers are reliable at rating the level of symptom distress especially if the complaint is physical as opposed to psychological. However, it is contended that informal carers are not always in concordance with the patient and usually over-estimate symptom burden, and accuracy does not progress over time.

Abstract number: P1-298
Abstract type: Poster

Little Things Mean a Lot: Improving the Support of the ‘Families’ of Patients Approaching the End of Life

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Aim: To improve the experience of ‘families’ of all patients approaching the end of life.

Methods: Several initiatives including carers of patients approaching the end of life, the district nursing caseload, and the development of a cross-boundary carers care plan ensures the needs of carers are not forgotten. In addition, genograms and a care’s care-plan has been included in our local Individual plan for care of patients thought likely to be dying. The acute trust has created an ‘oasis’ room, which alongside ‘comfort’ packs, identified showering and catering facilities enables families to have much needed time away from the ward. Free parking and open visiting allow unhindered access for distressed families. Refurbishments to the hospital prayer room and growth of the chaplaincy team provide quiet space for reflection and a listening ear. The hospital mortuary has been refurbished. Communication skills training for mortuary staff, the use of ‘last thoughts and wishes’ cards, seeded memorial cards and assistance with hand-printing has led to the development of a compassionate and caring bereavement service.

Results: Use of carer’s care plans has contributed to meeting the 36 standards set for End of Life care in the community. The Oasis room is documented as being used every day and hands made comfort packs are appreciated by families. We have seen an increased use of the prayer room (and prayer requests left) and chaplaincy services. Feedback from families is collated by specialist palliative care who trouble-shoot in real time and feedback successes to teams.

Conclusion: A number of little changes have improved the support given to families at a difficult time.

Abstract number: P1-299
Abstract type: Poster

When Is the Decision Made to Place a Family Member with Dementia in a Care Home?

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Background: This qualitative study is based on interviews with informal carers of people with advanced dementia. It is part of a UK-wide mixed methods program to develop and evaluate a complex intervention to improve the end-of-life care for patients with advanced dementia and their carers. Aims: (1) Derive determinants of informal carers’ decision to place a family member in a residential care home.

Methods: Using a topic guide we interviewed 14 carers, 3 male, 9 female. Eleven were caring for mothers, one a father and two for their husbands. At the time of interviews all except one family member were already living in care homes. Interviews lasted approximately one hour, were audiotaped, transcribed verbatim and analysed for thematic content by two
researchers. We used a rigorous approach working to the quality framework recommended by Spencer et al (2003).

Results: Most of the informal carers had been caring for their relative for several years prior to care home admission. In this group, care home admission was mostly not pre-planned but a direct consequence of an unexpected and sometimes fast deterioration in their family member's health. In some cases, as a result of being hospitalised. These deteriorations caused numerous problems including incontinence, inability to walk, wandering, getting lost and aggression. It was these changes which led to the carers being unable to continue to cope with their relative and needed support.

Conclusion: Informal carers need better access to information about the nature and course of dementia. Many are unprepared for acute changes in their family member and make the decision for care home admission when they can no longer cope with the challenging demands of the caring role e.g. maintaining their family member in their own homes, looking after their own family and working full time. This could help with future planning at an earlier stage and may help reduce the stresses involved placing a family member in a care home.

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Abstract number: P1-300
Abstract type: Poster
Delivering and Participating in a Psycho-educational Intervention for Family Carers during Palliative Home Care: A Qualitative Study from the Perspectives of Health Professionals and Family Carers

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Background: Family carers in palliative care have a need for knowledge and practical support from health care professionals, resulting in the need for interventions.

Aim: To explore the perspectives of health care professionals and family carers of delivering and participating in a psycho-educational intervention in specialised palliative home care.

Methods: A psycho-educational intervention was designed for family carers based on a theoretical framework. The intervention was delivered over three sessions based on an intervention manual. An interpretative descriptive design was chosen. Data were collected through focus group discussions with health care professionals and individual interviews with family carers, and analysed using framework analysis.

Results: In the perspectives of both health care professionals and family carers, the delivering and participating in the intervention was described as a positive experience. Although the content was not always adjusted to the family carers' individual situation, it was perceived as valuable. Consistently, the intervention was regarded as something that could make family carers better prepared for caregiving. Health care professionals found that the work with the intervention demanded time and engagement and that the manual needed to be adjusted to suit each group's characteristics. The experience of delivering the intervention was something that gave satisfaction and contributed to insights into their work.

Conclusions: In the perspectives of health care professionals and family carers, the psycho-educational intervention had important benefits and there was congruence between the two groups in that it provided reward and support. In order for health care professionals to carry out psycho-educational interventions, they may be in need of support as well as securing appropriate time and resources in their everyday work.

Abstract number: P1-301
Abstract type: Poster
"You Are 24 Hours under Pressure" - Interaction of physical and Social Burden with Psychological Effects in Informal Caregivers of Brain Tumor Patients

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Background: Informal caregivers (IC) of dying cancer patients are confronted with many burdening situations, e.g. care at home. It is unknown whether this burden is associated with the underlying disease, in particular in case of brain tumor. The aim of this study was to analyse whether the perceived physical, psychological and social burden of IC of patients with a brain tumor, experienced during the time of home care, is related to psychological effects at a later date in comparison to the IC of the non-brain tumor group.

Methods: A mixed, quantitative and qualitative study was used. The qualitative part is presented here. IC were interviewed after the death of the patient (M=27.32, SD=7.7 months) and completed three questionnaires: (PHQ) short, BSFC-short, SeiQoL. The sample was categorised according to the diagnosis of the patient and matched by age, time since death and relationship to the patient. Correlations were calculated using SPSS.

Results: IC of 17 patients with brain tumors (Glioblastoma Grade IV) and 11 patients with non-brain tumors were interviewed. IC of mostly female (75%) and on average 58.3 years old (SD=7.2). In our sample patients with brain tumors mostly died at home or in a hospice, while the patients of the other group died mostly at the hospital. We found a significant correlation between home admission in the first phase of the interview and ex post rated perceived burden of home care, especially physical exhaustion (r=-0.492, p=0.013), loss of strength (r=-0.459, p=0.021), and impact on relationships (r=-0.469, p=0.019). Physical symptoms were influenced by the place of death of the patient and the prognosis of the disease.

Conclusions: Since brain tumors, especially Glioblastoma Grade IV, have a very poor prognosis, they need to be adjusted in the intervention more than IC of non-brain tumor patients. IC of Glioblastoma patients should thus be offered more support for the conservation of social resources.

Abstract number: P1-302
Abstract type: Poster
The Troubled Water under the Bridge: Lack of Palliative Care Referrals for Heart Failure

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Background: End-of-life (EOL) services, such as hospice and palliative care, are often lacking even for the sickest heart failure (HF) patients. Use of these services is hampered by lack of availability and limited referrals due to the unpredictable disease course. Patients and caregivers often refuse services because of a misunderstanding of HF’s terminality.

Aims: To determine whether caregivers of HF patients with a predicted survival of < 2 years experienced disease terminality prior to and after the patient’s death.

Methods: As part of a longitudinal study of 100 patient-caregivers dyads, caregivers were interviewed monthly until the patient’s death and then post-death. Interviews immediately preceding and post-patient death were analysed to determine caregivers’ perceptions of the terminality of HF.

Results: Of the 50 caregivers of patients who died, most did not understand the severity of the case and 66% viewed the death as unexpected. When caregivers retrospectively reflected on the patient’s illness, they recounted downward trends, but were not aware of its terminality. Caregivers who understood illness severity prior to death came to this realisation late in the disease trajectory. At the point of recognition, treatments were limited or withdrawn and the short-term use of EOL services was instituted.

Conclusions: The lack of perceived illness terminality has profound implications for patients and caregivers. Those who do not recognise the seriousness of the illness are less likely to accept EOL services. Clinicians also need to understand the HF EOL trajectory and that EOL discussions help patients and caregivers make informed choices; allowing them to receive quality care at EOL. Healthcare providers require education about the importance of discussions early in the disease trajectory so palliative care becomes a philosophy of care not merely a referral service for HF patients immediately preceding death.

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Abstract number: P1-303
Abstract type: Poster
The Influence of Psychosocial Situation of Terminality Ill Patients on Distress of their Families

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Background: Families of terminal ill cancer patients are faced with significant demands that can seriously impact their physical and mental health. It is important for healthcare professionals to be aware of caregivers’ support needs in order for these to be adequately addressed.

Aims: The purpose of the study was:
1) to assess physical and psychological condition of patients with metastatic cancer
2) to establish the influence of the patient’s psychosocial condition on: the overall quality of life, the intensity of anxiety, depression and anger and the degree of distress in families of patients with advanced cancer.

Methods: The study involved 70 subjects, aged between 28 and 92 (37 women). The studied persons were classified into two groups: the first group (I) consisted of hospice patients with advanced cancer (n=35); the second group (II) involved the family members of cancer patients (n=35). We used:
1) Questionnaire for patient, Hospital Anxiety and Depression Scale, Multidimensional Fatigue Inventory, EQ5D QLC-C15-PAL, Cantril Ladder (QoL), VAS1(pain), VAS2 (fatigue);
2) Questionnaire for family, Cantril Ladder (QoL), Hospital Anxiety and Depression Scale, Distress Thermometer, VAS3 (relationship).

The correlation level between variables was determined by the Pearson’s coefficient. The influence of independent variables on the dependent variables were determined by means of variance analysis and multiple regression analysis.

Results: Analysis of the results showed that:
1) the patients revealed high levels of pain and fatigue, poor quality of life;
2) worse mental and physical condition of the patient was associated with higher level of distress of the family;
3) there was a correlation between psychosocial condition of patient and level of anxiety and depression of his family

Conclusion: The study shows that malignant disease associated with psychosocial symptoms significantly influences the distress and emotions of patients’ family members.

Abstract number: P1-304
Abstract type: Poster
Building Bridges within Families. Helping Parents Communicate with their Children about Illness and Death

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Background: Every year, 10% of all patients dying in this organisation have children. (2012: 10 parents, 25 children, 2013: 11 parents, 26 children). Research indicates that children often experience being overlooked and ignored during their parent’s illness. Parents and their children often share how difficult it is to talk with each other about the illness, the children’s fear of mom or dad dying, and that they need help to do this.

Not all children and teenagers know what palliative care means.

Methods: In order to find the most relevant questions, a group of children who had ill parents was invited to the organisation. They toured the facilities and were encouraged to ask any

Abstract number: P1-305
Abstract type: Poster
Poster Sessions (Poster Exhibition Set 1)
question they considered important. These questions became the basis for the material in the book. An interest group, working specifically with caring for children and young relatives, used the book to develop the explanations and answers presented in the book. Often, the book is handed out to the families before they arrive, so that their children may be better prepared for the visit.

Results: Adults let us know that the book offers them the opportunity to talk with the children about how they feel and what is going to happen with mom, dad, grandmother or grandfather. Many parents tell us that the book is helpful in their communication about the illness and approaching death.

Conclusion: Recently the third edition of the book was published. The book is up-to-date with photos of staff members and surroundings, as well as updates to the text. The book is never presented without an explanation or discussion with the family about how to use it.

Group: Four staff members in the organisation.

Abstract number: P1-305
Abstract type: Poster

Sleep Disturbance and Related Factors among Family Caregivers of Advanced Cancer Patients

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Objective: Sleep disturbance of family caregivers (FCs) are common in the context of advanced cancer. The comprehensive factors for sleep disturbance among the FCs of oncology patients have not yet been investigated in Taiwan. The purposes of this study were to investigate potential predictors of sleep disturbance for family caregiver of advanced cancer.

Methods: A descriptive, cross-sectional study was conducted among 172 FCs. Data were collected using the Pittsburgh Sleep Quality Index (PSQI) and wrist actigraphy. A linear regression model was set up as the main statistical method to identify the predictive factors for sleep quality among FCs.

Results: Seventy-six percent of the FCs of advanced cancer patients experienced some sleep disturbance. Higher fatigue, greater depression, more caregiving burden, and spending over 16 hours on caregiving tasks each day were risk factors for sleep disturbances in female caregivers.

Conclusions: Sleep disturbance is common among Taiwanese FCs who have managed advanced cancer patients. FCs with risk factors for sleep disturbance should be identified and introduced to resources for assistance.

Abstract number: P1-306
Abstract type: Poster

Administering of Palliative Care through Family Members under Rural Setting in India

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Aim: Our goal is to give a pain free good quality of life in these advanced stage cancer patients. Objective of this study is to identify the main difficulties in achieving the above goal in a rural village setting in India.

Methods: The initial plan is to create a nodal centre at District Head Quarter, Tamluk for the management of advanced cancer patients. Then we create different leaflets for each of the problems mentioned above in vernacular (Bengali). One on Constipation, one on Pain, one on Fever; one on Haematuria and so on with necessary advice on medications with their doses and procedure for administering them with the help of palliative care specialists and palliative care volunteers. All leaflets are to be given to the caretaking family members, who would be required to follow the written instructions.

Results: This allows the family members to give the needed care to the terminally ill cancer patients without the presence of a medical professional or repeated visits to a medical centre saving their time and energy for giving care.

Conclusions: There is a wide gap of trained manpower in the field of palliative care in rural areas of West Bengal, India. Dedicated groups from rural areas and the family members of the terminally ill patients need encouragement, education and proper training for tackling difficulties at home itself. The leaflets can be a valuable input in that direction.

Abstract number: P1-307
Abstract type: Poster

The Palliative Care Patient’s Role in the Formal Family Meeting Practice

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Introduction: Formal family meetings (FFMs) are frequently used as a means of communicating with patients and families in the palliative care setting. Previous studies examining participants’ experiences of FFMs have focused on family members. Little is known about the patient’s role in the meeting. This study seeks to examine the palliative care patients’ experience in meetings, and experience of FFMs in an inpatient hospice.

Methods: Mixed methods are used, using a variant of the triangulation design (the convergence model). Data collected comprises quantitative (retrospective chart review, analysed using SPSS 22 descriptive statistics and Chi-squares) and qualitative (patient interviews after the FFM, analysed using thematic analysis).

Results: 82/227 (36%) admissions during the 6 month study period involved a FFM, with younger patients (χ² = 10.92, p = 0.001) and patients who were subsequently discharged being more likely to have had a meeting than those who died in the hospice (χ² = 8.304, p = 0.004). The patient was present at 34% of meetings, with patients closer to death less likely to attend (χ² = 16.96, p = 0.000). To accommodate the patients’ reasons for non-attendance and their level of participation when present. Given that patients closer to death are less likely to attend, early FFMs may provide an opportunity for patients to be actively involved in the process.

Abstract number: P1-308
Abstract type: Poster

Family Satisfaction with the Zone Palliative Care Program (ZPCP) - What Can We Learn from Implementing FAMCARE and FAMCARE-2?

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Background: The multiple assessments used in the Zone Palliative Care Program (ZPCP) help improve clinical care, and are valuable in research and administrative reporting. In response to Accreditation Canada’s recommendation, the ZPCP has adopted FAMCARE/FAMCARE-2 as a measure of family caregiver satisfaction of palliative care services. Items range from 1 (very dissatisfied) to 5 (very satisfied).

Aim: The aim of this study was to evaluate family caregiver satisfaction in the ZPCP (three hospices and a tertiary palliative care unit) between November 2010 and March 2014.

Methods: The FAMCARE or FAMCARE-2 was mailed to the identified closest relative of the patient approximately 2 to 8 weeks after the patient’s death. During the study time period, there were 2,663 deaths across all 4 sites. The total number of forms returned was 565, resulting in an estimated response rate of 21%.

Results: Overall, the results were very positive. For the FAMCARE, all items were rated as satisfied (5) or very satisfied (4) by over 75% of participants across all sites, with the exception of 4 items (Q9, Q12, Q17). For the FAMCARE-2, the frequencies of S and VS responses for 17 items were higher than for the FAMCARE. All items were rated as 5 or VS by over 75% of participants. The average subscales scores (FAMCARE-2) were very similar, ranging from 3.1 (physical symptoms and comfort, family support, patient psychological care) to 1.5 ( provision of information). There was greater variability for individual sites.

Conclusion: Despite the high level of patient symptom burden, and recognising that the FAMCARE/FAMCARE-2 tool may be capturing health care experiences prior to patient being admitted to a palliative care service, the reported level of family satisfaction was gratifying. The FAMCARE-2 questions are generally more applicable than the FAMCARE. The results also point towards recommendations for standardising administration of the tool throughout the ZPCP.

Abstract number: P1-309
Abstract type: Poster

The Impact of Guidelines and a Documentation Form on Formal Family Meeting Practice

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Introduction: Formal Family Meetings (FFM) are a vital tool in effective communication with patients and families. Audits in 2 specialist palliative care units (SPCU) revealed a number of practice deficits. A complete audit cycle is presented here, comparing data before and after the implementation of staff guidelines and a standard form for documentation of FFMs.

Methods: All FFMs that took place from 1st Jan to 31st March 2009 were audited against quality standards developed by a multi-disciplinary working group. A number of practice deficits were identified, particularly regarding pre-meeting planning and post-meeting follow-up. Guidelines and a standard form containing checklist reminders were developed and implemented. Re-audit took place on FFMs from 1st Oct to 31st Dec 2013 and compared with 2009 data using Fisher’s exact test.

Results: FFM practice had improved across a number of domains between 2009 and 2013. Patients were more likely to be offered the option of attending the meeting (76% in 2013, 56% in 2009, p = 0.006), as well as being consulted regarding which family members should attend (83% in 2013, 57% in 2009, p = 0.031). Staff preparation also improved, with a decision being made and documented as which staff members to attend in all cases in 2013 (p = 0.008). A staff discussion took place immediately before all meetings in 2013 compared with only 10% of meetings in 2009 (p = 0.005). Staff debriefing took place after 96% of meetings in 2013 compared with 15% in 2009 (p = 0.005).

Conclusions: There were significant improvements in FFM practices following the implementation of staff guidelines and standard documentation form, particularly regarding pre-meeting planning, post-meeting follow up and patient involvement.

Abstract number: P1-310
Abstract type: Poster

Acceptability of a Home-based Physical Activity Intervention for Caregivers of People with Advanced Cancer

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Background: Family caregivers (FC) of people with advanced cancer experience a wide range of difficult emotions, extreme fatigue, and decreased health. Finding ways to help FCs cope is needed. Physical activity (PA) may be one such mechanism as the physical and psychological benefits of PA have been well documented. Also, PA programs can be individually tailored to address self-care needs. Using Pender’s Health Promotion Model as a theoretical guide, an evidence-based PA intervention was developed.

Aims: Evaluate the clinical impact of this intervention. The ZPCP has adopted refinement and refine it, as necessary, to be acceptable to FCs.

Methods: A formative evaluation was conducted. FCs (n=18) providing care at home for
individuals with stage 3 or 4 cancer received the PA intervention for 6 weeks. Qualitative feedback about the content, structure, and process of the PA intervention was collected during a baseline home visit, weekly telephone calls, and follow-up interview. Data were analysed using content analysis. This was an iterative process with modifications made, as necessary, until the intervention was optimal and acceptable to FCs.

Results: The PA intervention was deemed acceptable to FCs. Caregivers reported that the flexibility of a home-based, individualised, lifestyle PA package, made it feasible for adherence. A collaborative approach, setting goals, using a simple PA log for self-monitoring, and receiving a weekly telephone call for coaching and support were perceived as helpful strategies that provided motivation to adhere to the PA plan. No modifications to the PA intervention were necessary.

Discussion: Rigorous development of a novel, evidence-based intervention provides an empirical foundation from which to proceed to pilot testing and efficacy studies with the aim to keep FCs healthier, potentially enabling them to provide care at a longer period and preventing them from becoming patients themselves.

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Abstract number: P1-311
Abstract type: Poster

Carers and Healthcare Professionals’ Views on Caring for Dying Patients in their Own Homes in North Wales

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Aim(s):
- To explore the experience of caring for someone who wished to die at home in North Wales.
- To explore the contribution of the home environment to the overall quality of a good death.
- To identify factors that influenced the quality of the experience of dying at home.

Method:
- Focus groups with carers and healthcare professionals, living at home who had experience of a dying relative.

Results:
- Carers reported that the quality of the experience of dying at home varied widely. Factors identified included the support available, the relationship between the carer and the dying relative, and the quality of care received.

Conclusion:
- An understanding of the impact on carers’ lives. Many people, particularly the elderly and those living alone will not wish to die at home. Clarify what outcomes are positive for home environment may be able to be shared with other places of death.

Abstract number: P1-312
Abstract type: Poster

Empowerment of Family Care Givers Living with People with Dementia

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Background: Dementia is acknowledged to be an incurable disease in the need of a broad understanding of palliative care. Most people with dementia are living with and cared for by their relatives. A training course based on validation® following Naomi Feil invited family care givers and their relatives with dementia to share experiences and improve their everyday living situation.

Aim: The aim of the presented study is to discuss empowering effects of the training course and aspects of early palliative care for family care givers living in the community.

Methods: Within a participatory approach a qualitative study and a literature research were conducted. Three expert interviews with the trainers, one focus group with care giving relatives and three narrative interviews with families living with a person with dementia were performed. Typical situations of the audio transcript taken during the training course were identified and analysed. Content analysis was organized individually and within the interdisciplinary research team.

Results: The training course based on validation® had empowering effects in different dimensions:
1) practical and theoretical support
2) exchange of experiences
3) creating an attitude and communicative behavior
4) trust in careful frame conditions
5) grief and bereavement accompanying the living with dementia from the very beginning of the disease.

Conclusion: Empowerment of family care givers can be observed after attending the training course based on validation®. Breaking the silence that often is associated with dementia and talking about difficult and challenging experiences strengthens coping strategies. This can be interpreted within the palliative care approach as an early and helpful intervention and support in painful situations in every day life.

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Abstract number: P1-313
Abstract type: Poster

Identifying Good Practice in Relation to Palliative Care for People with Intellectual Disabilities: Examples from 12 European Countries. Report from the EAPC Taskforce on Intellectual Disabilities

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Background: An estimated 5 to 15 million EU citizens have intellectual disabilities (ID). The EAPC approved a 2-year taskforce on palliative care for people with ID (2012-2014). Aim: To improve the quality of palliative care for people with ID and to develop consensus norms for palliative care of people with intellectual disabilities. This presentation focuses on (a) methods; (b) results; and (c) recommendations.

Methods: In order to address the needs of people with ID, the Group of Experts was identified through the networks of the 12 members of the Taskforce (itself representing 9 countries). The Group of Experts consisted of 35 professionals in 18 countries who had expertise in the field of palliative care, ID or both. They were asked to provide written examples of palliative care provision for people with ID. Analysis of the examples focused on their congruence with the 13 categories of the consensus norms, simultaneously developed by the Taskforce. Results: 65 Examples were received from 12 European countries. Among them, practice illustrations were found for most of the 13 norms. However, the following was noted: (1) respondents answered more to what is called ID good practice; (2) the availability and nature of services for people with ID and palliative care provision varied greatly between countries, affecting the possibility of providing good palliative care to people with ID; and (3) good practice was often due to the passion of dedicated staff, rather than to supportive social and health care systems and structures.

Conclusion: It was beyond the scope of this project to assess the effect of national/regional differences in service provision on the availability and quality of palliative care for people with ID. This needs further study. More work is also needed to educate and support staff in what constitutes good practice, not only in countries, but also in EU regions, providing European consensus norms for palliative care and ID, is an important first step.

Abstract number: P1-314
Abstract type: Poster

A Systematic Mapping Review of the International Palliative Care Research Literature

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Background: Globally, the need for palliative care services continues to outstrip supply. In order to attract greater global attention from policymakers, it has been argued that an international approach to research and advocacy is required. However, the extent to which an international approach to research is being taken is unknown.

Aim: This systematic mapping review presents a thematic analysis of all published international palliative care research. International research is characterised as studies focusing upon 2 or more countries, or global level organisational endeavours.

Methods: Five bibliographic databases (CINAHL, Cochrane Library, ASSIA, Web of Knowledge, Psychinfo) were searched for journal articles relevant to international and global palliative care/palliative medicine and end of life care. Inclusion/exclusion criteria were applied and data were extracted using a piloted extraction form.

Results: 811 relevant studies were included in the review. The first international palliative care research article appeared in 1980 and international literature has been published in 119 different academic journals. Research emanates from and focusses upon all world regions as well as an emerging body of work at global level. In total, 170 studies collected primary data and 441 were secondary analyses of existing data. Thematically, the most researched areas were: policy (n=87), evaluation (n=74) and stakeholder groups (n=49). The review revealed a predominantly observational research approach and few interventional studies were identified.

Conclusion: International palliative care research is a relatively new, but growing field.

However, many gaps in the evidence base remain in terms of thematic focus and the quality of evidence being produced. The relative absence of interventional research demonstrating the effectiveness and cost-effectiveness of palliative care risks limiting the tools with which advocates can engage with international policymakers on this topic.
Abstract number: P1-315
Abstract type: Poster

**Development of Palliative Care Services in the Republic of Serbia**

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**Background:** In 2009, the Ministry of Health in Serbia published a national strategy for palliative care, which acknowledged the need for palliative care services to be integrated into the government health system and provided throughout Serbia. An EU funded project supported the Ministry of Health to operationalise the strategy within the current health care system, between March 2011-November 2014.

**Aim:** To assist the Serbian Ministry of Health in the implementation of a strategy that will ensure high quality and sustainable palliative care services across the country.

**Method:** A team of national and international palliative care experts worked together in developing and implementing a comprehensive model of palliative care service delivery. Developing and implementing a comprehensive education strategy for health and social care professionals including continuing education and academic programmes.

**Reviewing existing legislation that has an influence on quality of palliative care and providing recommendations for its improvement**

**Results:** A model of palliative care service delivery developed along with supporting resources e.g. indicators and standards. Currently there are 15 palliative care sites, across Serbia e.g. PC Units, with others under development. More than 1,200 health care professionals have undergone continuing education and palliative care has been incorporated into the academic curriculum for medical, nursing and social work students.

**Changes** have been made to legislation in relation to the essential medicines list and the law on health care provision.

Four publications have been printed in Serbian on palliative care e.g. best practice guidelines.

**Conclusion:** Over the life-time of the project palliative care service delivery in Serbia has been strengthened considerably. Future development needs to be based around sustaining current services and ensuring further development of services at all levels of care in Serbia.

Abstract number: P1-316
Abstract type: Poster

**Appraisal of the Impact on Palliative Care Development of the EU Funded Project ‘Development of Palliative Care Services in the Republic of Serbia’**

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**Background:** The EU-funded project ‘Development of Palliative Care Services in the Republic of Serbia’ was implemented between March 2011 and November 2014. The project aimed to support the Ministry of Health (MoH) to develop a comprehensive and modern system of palliative care, accessible to all who require such care.

**Method:** A team of national and international palliative care experts worked together in developing and implementing a comprehensive model of palliative care service delivery. Developing and implementing a comprehensive education strategy for health and social care professionals including continuing education and academic programmes.

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Abstract number: P1-317
Abstract type: Poster

**How Do Professionals in Specialised Palliative Care Respond to a Wish to Hasten Death?**

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**Objective:** Health professionals in specialised palliative care (HP-SPC) are often confronted with wishes to hasten death (WTHD). Studies show that for this situation oncology nurses or general practitioners are often in a difficult position. While it is often assumed that WTHD may be altered by effective palliative care (PC), it is unknown how HP-SPC respond when they encounter such cases. This study aimed to identify HP-SPC responses to WTHD in daily practice.

**Method:** At four University hospitals in Germany HP-SPC with at least one year’s experience in PC were selected. Narrative interviews were conducted with 19 HP-SPC. Transcripts were analysed using the documentary method. Subsequently, an inventory of responses to WTHD was compiled, and their corresponding functions in the interactional context between patient and HP-SPC were reconstructed.

**Results:** On the patient level the reasons for categories proposed from the sociological study was symptom control, exploration, reorientation, and hope to ease patients’ burden. On the interactional level, the interactional context was established and maintained the relationship was of key relevance. Various methods served the functions self-protection and showing professional expertise on the professional level.

**Conclusions:** Both personal and professional development is necessary in order to respond to the inherent challenges presented by WTHD. HP-SPC should enhance their skills in establishing and maintaining trusting relationships as well as their awareness about their own resilience. Future guidelines should be amended by these issues and integrated into palliative care training programs. Encouraging professionals’ cooperation within and beyond the palliative care team can contribute to successfully delivering much needed support for patients with WTHD.

Abstract number: P1-318
Abstract type: Poster

**From “Sociological Study of Toboyo-ki” to “Clinical Application of Caring through Writing”**

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**Background:** What can sociology contribute to clinical medicine? Sociologists are generally not considered suitable specialists and therefore not considered essential in hospitals. In Japan, there is a social phenomenon. Writing is publishing true stories about the experiences of patients. This is called Toboyo-ki, and since the latter half of the 1990s, the number of such publications has remarkably increased along with the importance of patients’ feelings. Most such books are written by cancer patients. The first author, a sociologist examined them from various viewpoints. Toboyo-ki has seldom been regarded as a worthwhile study subject in any field. However, focusing on the independent experience of living with cancer from the viewpoint of patients is very important.

**Aims:** The study aimed to clarify the significance of writing Toboyo-ki for authors by using a sociological approach to create a practical and effective program useful in clinical medicine.

**Methods:** The approach involved a qualitative study. While many 500 books of cancer WTHD have been published between 1964 and 2009. The approach comprised several interviews with the book authors. Analysis was based on narrative approach.

**Results:** The action of writing was found to create oneself anew, considering oneself, changing one’s own interpretation, accepting the situation, and finding the meaning of oneself. Moreover, a specific quality, “passive-activity,” was suggested to be revealed in writing Toboyo-ki.

**Conclusion:** Now that the significance of Toboyo-ki writing has been demonstrated, the authors have prepared for the clinical application of caring for patients with breast cancer through writing. Our interdisciplinary research developed from the sociological study received a Grant-in-Aid for Scientific Research, and ethical judgments have been completed. We are now starting the six-90-minute sessions. We plan to discuss the outcome of these sessions in our presentation scheduled for May 2015.

Abstract number: P1-319
Abstract type: Poster

**Do Health Careers Know where their Patients Wish to Die?**

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**Aims:** Checking if a wish of place of death (PDoD) is known by professionals; if yes, is it respected; if no, why not.
Background: PC mobile team witnessed a lot of last days emergency hospitalisations and wondered if it occurred because no one asked the patient where they wanted to pass away.

Design: Retrospective quantitative study by questionnaire sent to health professionals (HP) incl. all adults living in a 167442 inhabitants area, deceased during the 1st semester of 2013 from natural cause.

Results: 475 died, 241 have exploitable data. Women: 52.2%, mean 82y old. PD: home 11.2%, nursing homes 28.6%, hospitals 58.9%. 42% lived alone at home, 4% were completely isolated. 63.4% HP (acute care facilities, home care, nursing homes) did not know where their patients wanted to die. For 46.1% at least 2 persons could have known. Spontaneous reasons for not knowing where a person wished to die, were mainly the difficulty of talking about end of life and impaired communication. For those whose wish was known, in 46.2% family 41.5%, general practitioner 4.1%. 32.2% died where they wanted. Among the others, they mainly died in hospital because family carers were exhausted and/or symptoms management was impossible at home.

Conclusion: Patient wish of his own PD is insufficiently known. Not enough HP are interested in a asking where their patients prefer to die because of difficulties of dealing with the subject. In consequence, too many people died in hospitals whereas political determination wants to promote free choice as far as PD is concerned. Level of awareness should be raised among professionals dealing with patient with life-threatening prognosis. Support for spouses should be a priority.

Funding: Reise aux Santé La Côte/VD Switzerland.

Abstract number: P1-320
Abstract type: Poster

Treatment Seeking Pathways for Romanian Cancer Patients - A Qualitative Study with Cancer Hospice Patients and their Relatives

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Background: In Romania cancer is the second cause for death with a mortality rate of 179.7 deaths in 100000 inhabitants. It has been recognised that due to proliferation technologic advances, medical specialisation, increased scientific knowledge base, that there is a need of someone from within the health care system to deliver guidance to patients in access to care.

Aim: To identify the cancer patients’ institutional trajectory and the barriers in seeking effective diagnosis and treatment modalities in the Romanian health system.

Method Qualitative study, data were collecting using in-depth interviews, observation and field notes, photo voice. Purposive sampling with participants, from rural and urban area, both genders, and a large age group. Study population was represented by palliative care patients with good performance status (ECOG up to 3), no cognitive problems and by their appointed family member. Parallel coding done by 2 researchers (sociologist), results reviewed by clinical researcher. Ethics approval was given by local board.

Results: 46 subjects were enrolled in the study: 25 patients (17 from urban area, 20 women, age from 20-84y old). There was not a standardised trajectory for the patients, but in most of them played a marginal role in the trajectory, public oncology hospitals and outpatients clinic in district hospital were usually just a temporary station till patients moved to a regional cancer centre or a private hospital. Family had the role of patient navigator Challenges were represented by overcrowded hospitals with overworked and less compassionate healthcare staff, lack of information on the disease, available treatments and planning of care, communication that does not foster hope, cost of medication, treatment, investigations, informal payments, travel to big cancer centres, bureaucratic system, complicated paper work to access some care packages, long queues. Financial aspects were a major theme for family members and rural patients.

Abstract number: P1-321
Abstract type: Poster

Health services research

Transition from Children’s to Adult Services for Young People with Life-limiting Conditions: Findings from Realist Evaluation Research in Belfast and Dublin

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Background: Improvements in care and treatment have led to more young people with life-limiting conditions living beyond childhood, which means they must make the transition to adult services. The loss of long-standing relationships with children’s services combines with poor co-ordination of services to make this a daunting prospect for young people and their families. Moreover, there is little evidence on transition into in-patient palliative care, with few models of good practice.

Aims: To describe service provision for the transition to adult services for young people with life-limiting conditions in Dublin and, to identify organisational factors that promote or inhibit effective transition.

Methods: A realist evaluation using mixed methods. A questionnaire survey was forwarded to 60 health, social, educational and charitable organisations to identify current transition practices. Semi-structured interviews with young people with life-limiting conditions are currently being conducted. Focus groups with carers will be undertaken in November 2014.

Results: There are 581 patients.

Findings highlight five context mechanism outcome (CMO) configurations that appear to facilitate the transition process: early commencement, a transition plan, development of self-management skills in the young person, collaborative interagency and interdisciplinary working, and the presence of a key worker. Interviews with young people and focus groups with families will allow refined configurations to be identified.

Conclusions: We identify key facilitators that can contribute to the transition process from the perspectives of organisations, young people and parents/carers. These insights could help to minimise gaps in the continuity of care and associated morbidity for young people transferring to adult services.

Source of funding: The All Ireland Institute of Hospice and Palliative Care and HSC R&D Division, Public Health Agency.

Abstract number: P1-322
Abstract withdrawn

Abstract number: P1-323
Abstract type: Poster

Palliative Doc Mobile - Access to an Electronic Palliative Care Patient Record Choosing the ‘Right’ Data - Results from a Focus Group

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Aim: PaDoMo aims to provide access to an electronic patient record using a defined data set in a palliative care network in Germany. By means of a mock-up data set a group of palliative care experts should judge completeness of data, intelligibility of data array, and data set’s value for field of work.

Method: 6 experts from different sectors of palliative care provision were identified and invited. Each expert received a cover letter, a paper copy of a mock-up data set based on the German ‘Innovations system Palliative Care (ISPC)’ which resulted from a previous project and additional information on the project. Participants were encouraged in terms of open reasoning to write up any comments on the mock-up data set. On a second assessment date each expert received access to an online survey. The questionnaire was compiled with SurveyMonkey® consisting of 5 questions on completeness, intelligibility of data array and everyday practicality on a five level scale (strongly agree, agree, neither agree or disagree, disagree, strongly disagree). Additionally, for each question a field for comments was generated. Demographic data of each participant were raised.

Results: Of 6 participants invited to the study n=4 participants did respond. Mean of age was 49.5 years (range 47-51 years). All of them were females. Professions were nurse manager, hospice nurse, physician and social worker. Data set was rate as good (weighted average 2.6). All data fields were valued as relevant for everyday practicality in palliative care provision.

Conclusion: The ISPC data set complies with requirements of palliative care provision. Comparing the responses reveals that completeness and mapping of palliative care patients (question 1-3) get slightly better rating than the reference to own work question (4-5). This may be grounded in nurses or social worker missing professional group-specific data. This study is funded by Fördernprogramm ik und Gender Med. NRW

Abstract number: P1-324
Abstract type: Poster

Monitoring and Nursing Care for Patients Receiving Palliative Sedation at Home

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Background: In the Netherlands, nurses have a prominent role in monitoring and care for patients receiving palliative sedation at home. However, little is known about the nature of monitoring by nurses and differences between the ideal and actual care for these patients.

Aims: To explore ideal and actual aspects of monitoring and nursing care for patients receiving palliative sedation at home.

Methods: Qualitative study using 2 focus group interviews with 12 nurse specialists working in palliative care and individual interviews with 7 community care nurses. Nurse specialists were asked how monitoring en care ideally should be performed. Community nurses were asked how they actually perform monitoring and care in daily practice. The interviews were fully transcribed and analysed using the interview topics.

Results: We identified five themes: comfort; monitoring; patient care; family support; cooperation with general practitioners (GP). The nurse specialists found it difficult to define comfort; they indicated comfort as a state of peace, relaxation and relieving suffering. They stressed the importance of monitoring and observation, using observation scales as indicated in the Dutch guideline Palliative Sedation. In contrast to this, almost all community nurses found it hard to use and experience a hospice standard observation scales. The nurse specialists as well as the community nurses all agreed that care and support for patients and their family should match the needs of these persons. However, nurse specialists emphasised the importance of a systematic approach. The majority of all nurses experience difficulties in communication and cooperation with GPs.

Conclusions: Nurses’ involvement in monitoring and care for patients receiving palliative sedation is beyond childhood and essential. However, nurses should act on a more systematic bases. Ongoing education, focused on using standards, observation scales and on cooperation with GPs, remains of utmost importance.

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015

Poster Sessions (Poster Exhibition Set 1)
Getting Research Active! Where Are We Now & Where Do We Want to Be? Developing Research Infrastructure within Specialist Palliative Care Units (SPCUs) in a Strategic Palliative Care Network (PCN) in England

Maylard CR.1, Hyyle C.1, Tiwari K.1, Hurheit C.1, Messiah S.2, Slocumme C.3, Newiss A.1, Dawson J.1, Cockley A.2. Research Workstream of the PCN: Caring and Meso-bio-Specialist Palliative Care Advisory Group.

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Aims: Research within SPCUs has not received the same focus as other core elements of the modern hospice movement - pain and symptom control, compassionate care and teaching. Research in palliative care: can hospices afford not to be involved? Highlights research is required to ensure evidence-based care is provided, create a culture of enquiry, and provide evidence of cost-effectiveness. Within a regional strategic PCN in England, the aims were to: Describe the research position regarding SPCUs' research activity Develop a more collaborative regional SPCU infra-structure, promote greater awareness of current research activity, and provide further information about research governance.

Methods: A 10-item 'Survey Monkey' questionnaire, themed from the 'Research in Palliative Care', was disseminated in April 2014 to all Consultants, Associate Specialists, Chief Executives, and specific Senior Managerial Staff working within regional SPCUs (n=46). Two reminders were sent.

Results: Thirty-two participants responded (response rate of 80%). Four participants only completed the demographic information - leaving 28/40 (70.0%) respondents. All respondents reported they were active in collecting routine data for audit purposes with just under half (48.7%) currently undertaking ethically-approved research studies. The main issues hindering engagement were: limited funding, time and capacity, lack of infra-structure, and limited understanding about research governance.

Conclusion: To facilitate a more research-active environment, we are now aiming to develop a more collaborative regional SPCU infra-structure, promote greater awareness of current research activity, and provide further information about research governance.

Abstract number: P1-326
Abstract type: Poster

Cancer Patients’ Needs for Palliative Care Estimated on Inpatient Services in the Last Year of Life

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The aim of the study was to investigate the scope and place of inpatient medical care provision for cancer patients in the last year of life to determine the need for PMC based on the actual use of inpatient health services in the region.

Materials and methods: We analysed the medical histories of cancer patients who were admitted to hospitals of all levels due to the deterioration of their illness and in need for palliative care in the last year of life.

Results: Patients who died from cancer in the last year of life received inpatient care at different levels (69.5 admissions per 100 patients per year). The admissions were mainly to the regional medical organisations (79.77±3.0% of all hospital admissions) and 20.23±3.0% to the regional specialised cancer hospital.

Conclusion: 220 beds used for providing medical care to cancer patients in the last year of life can be calculated as the minimum number of PMC beds including those based in a specialist cancer hospital (33.6 beds) facing the current levels of cancer morbidity and mortality in the region as well as the effectiveness of the primarily outpatient care. The number of PMC beds used by cancer patients in the last year of life was 80.12% of the total number of beds for PMC provision calculated according to the standard recommended by the State Program on Health Development in the Russian Federation until 2020. So we have to keep in mind that up to 80% of the total number of PMC beds established should be allocated for cancer patients and only 20% left for specialist PMC provision for patients with other progressive diseases. This emphasises the importance of developing and using the criteria for identifying patients with chronic progressive non-cancer diseases who really need specialist PMC.

Abstract number: P1-327
Abstract type: Poster

Living at Home with Advanced Cancer: What People Do and How They Manage their Activities of Daily Living in the Home Environment

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Background: Globally the number of people living with advanced cancer for extended periods of time is growing. Evidence shows that these people spend a significant part of their time in the home environment and up to 30% have problems with daily activities. Yet, little is known about what they do during the day and how they manage their everyday activities in the home environment.

Aim: To describe the everyday life of people with advanced cancer in the home environment including the speed of activities that occupy their time and their perceived ability to manage and perform daily activities.

Methods: Based on a cross-sectional design a consecutive sample of 164 participants with different cancer diagnoses were involved and a WHO functional performance score of 1-3 were included in the study. Participant reported their daily activities in structured self-completed time-geographic diaries and were interviewed by trained occupational therapists using the ADL-interview (ADL-I) combined with open-ended qualitative interview questions. Analysis of the data from diaries was conducted by use of descriptive Time-Geographical analysis program. Rasch measurement methods were applied to generate linear ADL-I ability measures, and the qualitative data were thematically analysed.

The results indicate that daily life of people with advanced cancer is dominated by activities in the home environment. They report most problems with physically demanding household activities and express frustrations in not being able to maintain prior activities.

Conclusion: The study contributes significant knowledge on the specific daily activity problems and challenges people with advanced cancer experience in regard to managing at home. Researchers and clinicians can draw on this knowledge as a prerequisite for developing and implementing home-based goal-directed interventions.

Abstract number: P1-328
Abstract type: Poster

Early Integration of General Palliative Care in Hospitals - An Organisational Intervention on a Surgical Ward

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Aim: Staff-related and organizational barriers need to be overcome in order to develop palliative care and its supporting infrastructure in daily clinical practice. We aimed to test and describe the use of a nurse-staffed phone line, with a focus on early identification and alleviation of patients' physical and psychosocial problems at home, patients' sense of security during their illness trajectory and advance care planning.

Methods: The intervention is targeted to patients with advanced gastrointestinal cancer and their relatives, who are offered at diagnosis telephone contact with a nurse with a specialism experience and expertise in the field of palliative care - the contact is lifelong. The phone line is open daily from 08:00-15:00. A proactive holistic approach is taken, including individual needs assessment, guidance, regulation of medication and follow-up in consultation with the patient's personal doctor. The nurse also acts as a sparring partner for colleagues and facilitates complex situations, provides complex information and guides. Contacts are described qualitatively in a log that is evaluated using descriptive statistic.

Results: Over 9 months 111 patients and 427 consultations were registered. Outgoing telephone calls to patients and caregivers (32%) and professionals (8%). Incoming phone calls (31%), and in-person meetings with patients and families during hospitalization or outpatient visits (29%). Of the percentage incoming calls, 10% were from patients, 7% from relatives, 11% from professionals (colleagues, specialist palliative care, oncology ward) and 3% from municipal care units.

Conclusion: The telephone service, staffed by one qualified nurse, is an interface that supports continuity and cooperation and could underpin more effective palliative care. The model provides options that support patients' and caregivers' quality of life by optimising symptom management at home and in hospital and by allowing for appropriate courses of action without inadvertent disruption.

Abstract number: P1-329
Abstract type: Poster

Anticipatory Care Planning: "What is the ACP Package?" Challenges regarding Understanding, Purpose and Definition

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Advance Care Planning (ACP) is deemed increasingly important in terms of improving care for people nearing the End of Life (EOL). A 2 stage study (based on MRC phase 1 development of a complex intervention) was conducted in the care home setting in one UK region to:

1. Map, refine and implement a process for ACP.
2. Evaluate the process with residents, relatives/friends and Health and Social Care Staff (HSCS).
3. Stage 1 findings: Mapping showed ACP to be complex and varied. An 'expert group' agreed a new process for Anticipatory Care Planning (ACP) for those with and without mental capacity (see EIPC 211(4):193-5).
4. Aim: Phenomenological study of residents, relatives/friends and HSCS engaged in ACP to explore their understanding.

Method: Interpretive phenomenological research in 5 care homes; in-depth semi-structured interviews conducted around individual resident cases, involving - Initial interview after first ACP discussion. - Follow up interview(s) - 3 monthly intervals.

Results: 9 resident cases (participants, considering mental capacity) 21 participants (15 relatives; 6 HSCS); 28 interviews completed. Language use: terminology, abbreviations and definitions used resulted in varied understanding across HSCS and caused anxiety for some relatives. Best well prepared for engaging in ACP discussions resulted in better experiences. Understanding the purpose of the meeting (eg level of decision making) and the 'role' of all participants in the discussions was sometimes lacking or confused.

Conclusion: For residents to be involved in ACP earlier initiation of discussions is required. The ACP process was valued by relatives and HSCS, however preparation, information, lack of jargon, abbreviations, and having clarity of role and purpose are important to ensure positive experiences and outcomes for residents and their families. The role of education and training to facilitate the ACP process and ensure clear and open communication is paramount to its success.
Health Care Utilization for Patients with Dementia near the End of Life: A Nationwide Study in Asia

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Background: End of life care in dementia has been studied increasingly, however, little was known in Asian population.

Methods: A nationwide, claim-based National Health Insurance Research Database in Taiwan was employed for study. We enrolled patients with dementia (Dementia+) and patients with cancer (Cancer+) who aged 18 years and above and deceased during 2007-2011, and surveyed the last one year of life. Care services used during 2009-2011 were checked for their use of hospice additionally, because the palliative care program in Taiwan had just covered patients with dementia since 2009.

Results: 683 Dementia+ were significantly older and had more comorbidities than Cancer+. In the last one year of life, there was no difference of the frequency of ED visit per patient between two groups. Median days of hospital stay of Dementia+ were significantly shorter (13.8 days vs. 17.0), acute respiratory failure (11.6%), and sepsis (5.1%). The percentage of patients who received aggressive interventions among Dementia+ and Cancer+ were as following: nasogastric tube insertion (74.7% vs. 51.9%), endotracheal tube insertion (55.2% vs. 22.6%), tracheostomy (8.6% vs. 3.5%), invasive mechanical ventilation (58.6% vs. 36.9%), hemodialysis (17.6% vs. 5.5%), defibrillation shock (7.9% vs. 2.3%), cardiopulmonary resuscitation (31.3% vs. 9.8%). Among 443 Dementia+ and 4,872 Cancer+, the hospital stay of Dementia+ was longer than that of Cancer+ (46 vs. 37). The majority of physicians (45.20%) were nephrologists. The top three causes of hospital admissions and ED visits among Dementia+ and Cancer+ were as following: nasogastric tube insertion (74.7% vs. 51.9%), endotracheal tube insertion (55.2% vs. 22.6%), tracheostomy (8.6% vs. 3.5%), invasive mechanical ventilation (58.6% vs. 36.9%), hemodialysis (17.6% vs. 5.5%), defibrillation shock (7.9% vs. 2.3%), cardiopulmonary resuscitation (31.3% vs. 9.8%). Among 443 Dementia+ and 4,872 Cancer+, the deceased during 2009-2011, only one Dementia+ and 893 Cancer+ received hospice care. Conclusions: Comfort-oriented concept and skill of end-of-life care for patients with dementia should be strongly introduced to general population and medical professionals.

Abstract number: P1-331
Abstract type: Poster

Exploring the Concept of Palliative Rehabilitation: The Active Palliative Rehabilitation in Lung Cancer (APRIL) Study

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Background: Evidence underpinning palliative rehabilitation is needed. APRIL was a six week home based intervention comprising physical activity (walking and muscle strengthening) and nutritional advice supported by weekly phone review and personalised goal setting. This intervention aimed to enhance quality of life, promote and maintain physical function and relieve dietary symptoms.

Aim: To develop and explore a novel rehabilitation intervention of physical activity and nutritional guidance for people with advanced inoperable non-small cell lung cancer (NSCLC) receiving palliative systemic treatment.

Methods: The MRC Framework for Developing and Evaluating Complex Interventions was used to design this multi-phase mixed methods cohort study. APRIL was developed based on consensus agreement. EQ-5D-5L, EQ-VAS, EORTC QLQ-C30, MFI-20, PGASA, QLQ-C15-PAL, and body measurements (6MWWT, ST560) were undertaken at baseline, intervention end and six weeks post completion. Semi structured interviews with patients and healthcare professionals (HCPs) explored experiences of the intervention.

Results: Forty nine patients receiving palliative systemic therapy for NSCLC were screened February to December 2013. Of the 19 eligible patients, seven declined and one became ineligible pre consent. Two patients withdrew before week six and one before week 12 leaving a final cohort of eight. Qualitative findings are presented under the themes Living with and beyond an advanced cancer diagnosis: experiences of the APRIL Programme for patients/patients and Palliative Care: exploring the intervention. Future Research should focus on early timing of palliative care consultations and the attention given to existential and social issues by HCPs.

Conclusion: The palliative rehabilitation approach of APRIL was valued by participants involved in the feasibility cohort study and the APRIL intervention was well received and acceptable. Robust evaluation studies within this population are being conducted by the researchers to assess rates of completion and whether the intervention is sufficiently generalisable and applicable to other palliative care settings. Further research is needed to examine the barriers and facilitators in the delivery of palliative care to people with PD. In addition, we intend to examine the impact of the intervention and these results are representative for a larger group of professional caregivers of people with PD. In particular, to see if there are differences between caregivers with a medical background and caregivers with a background in social work.

Abstract number: P1-333
Abstract type: Poster

Perceptions of Professional Caregivers of People with Intellectual Disabilities on Palliative Care Services

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Background: General practitioners, physicians and daily caregivers for people with intellectual disabilities (ID) are increasingly confronted with clients in need of palliative care. Previous studies have found that professionals in ID care services lack knowledge and experience concerning living with and end-of-life care. It is not known however, how professional caregivers see and experience the concept of palliative care.

Aims: The purpose of this study is to gain insight in the perceptions that professional caregivers of people with ID have regarding palliative care.

Methods: A semi-structured interview study was conducted among 18 physicians and 15 daily caregivers, who provide care to people with ID in the Netherlands. Topics included introduction of definition of palliative care and (and barriers and facilitators for) early identification of the need for palliative care.

Results: All the aspects of the WHO-definition on palliative care are referred to by the respondents. However, the respondents focus on symptomatic/somatic care, psychosocial and spiritual care are less mentioned. In addition, palliative care is mostly associated with the diagnosis of an incurable disease and less to a gradual decline in health.

Conclusion / Discussion: This study shows that professional caregivers have a complete, but somewhat distorted, understanding of the concept of palliative care. However, in practice recognition of the need for palliative care in people with ID is often only in the end-of-life phase. These findings are important for the practice developments and education.

Further research is needed to examine the barriers and facilitators in the delivery of palliative care to people with ID. In addition, it is interesting to examine to which extent these results are representative for a larger group of professional caregivers of people with ID. In particular, to see if there are differences between caregivers with a medical background and caregivers with a background in social work.

Abstract number: P1-334
Abstract type: Poster

Sessions (Poster Exhibition Set 1)
Cultural Awareness - Gaps and Views of Palliative Care Providers

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Background: Russian-speaking migrants (RSM) are one of the biggest migrant groups in Germany. Despite the numbers they rarely turn to palliative care services. This issue requires more systematic efforts of studies to identify the existing barriers for this group. This study analyses the palliative care service utilisation by RSM in Germany and depicts their subjective demands to quality of life.

Aims: The main aim is to identify RSM needs and problems in their access to palliative care. Providers’ views on culture-bound facets in the decision-making process and needs concerning quality of life shall be identified in order to reveal existing interculturally sensitive palliative care and barriers against using it.

Methods: The study analyses the perspectives of palliative care providers (35 semi-structured expert interviews), patients and relatives (around 30 semi-structured episodic interviews) on the conditions of palliative care service utilisation and reasons of non-utilisation mentioned by each group. Data analysis focuses on determinants of utilisation behavior and on developing group specific typologies.

Results: Three practice patterns of experts become evident:
1) emphasizing individuality independent from cultural background,
2) accepting cultural differences and using different ways of dealing with them and
3) reacting on cultural diversity only when it becomes a problem.
Different objectives of providers are evident: on one hand, to prioritise the equal treatment with better information about the concept of ‘palliative care’; on the other hand for (complementary) culture-specific offers, enabling further transfer of patients.

Conclusion / Discussion: Intercultural concepts dealing with the aforementioned challenges are underdeveloped in Germany. It is important to raise the awareness for these problems as well as develop an integrative design concept enabling RSM to benefit from hospice and palliative services.

Abstract number: P1-336
Abstract type: Poster

Assessing Albania Regional Hospitals Capacities Getting Started Palliative Care Service

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Background: Palliative Care (PC) is missing in health care sector (HCS) in Albania, meanwhile the demand for the service is growing up. There are estimated about 12,000 patients in need of PC per year. The government is aware to start the PC service, but has limited financial conditions. The budget of health sector has 29% of the GNP. Thus, the Government has recognised the effective strategy to integrate PC in public (HCS), is through regional hospitals (RH) (because their low level of the bed occupancy average 30%).

Aims: The main aim of the study was to assess the human resource (HR), medications availability, infrastructure flexibility, equipments and capacities of RH to get started PC service.

Methods: Quantitative data on perception and attitude of health care professionals (HCP) on PC services were gathered by a questionnaire delivered to 267 doctors and nurses in RH. Also, a semi-structured interview with hospital administrators was used to collect secondary data/desk research. Steps undertaken to get start PC service are, establishment the PC service in five pilot regions, theory and practical training of the pilot teams (PT), design the PC guidelines and protocols to be used in RH. The PC guidelines and protocols are in accordance to the guidelines developed by World Health Organization (WHO) and the guidelines developed by Albanian health authorities.

Results: Main findings show that only 10.5% of HCP agree to provide PC in RH, 50% of hospitals provide only medical care; only 1.59% of HCP have participated in any kind of PC training; 18 from 34 medications of the essential list for PC are lacking in all RH; there is extremely low level of opioid availability and usage in all RH as well as a lack of basic PC equipments and materials. Most RH in Albania have amount of space and medical HR needed for PC, but significant barriers exist concerning trained HR, medications, opioids, and equipments availability as well as organisational flexibility.

Conclusion: Intercultural methods used in the process of decision on and communication of a person’s future healthcare preferences. PC encourages dialogue between a patient, her/his family, and the healthcare team that can guide medical decision even when a person becomes incapable of making decisions or no longer wishes to be included. All PC programs and guidelines that are being implemented across healthcare systems around the world including in Alberta, Canada.

Alberta Health Services (AHS) is the major publicly funded comprehensive health care organization for the four million residents of the province of Alberta. ‘Goals of Care Designation’ is made in Alberta medical order used by healthcare providers to describe and communicate the general aim or focus of care. This paper highlights the results of the AHS implemented a multi-sector, provincial policy for ACP/GCP across all AHS facilities. ACP CRIO is a bold, innovative knowledge translation research program that has partnered with AHS to prospectively study the system-wide impact of implementing a formalized ACP framework across a large population and throughout a complex, multi-sector healthcare system. We have applied the knowledge-to-action cycle to support in-depth use of ACP/GCP across Alberta, through four research activities designed to identify:
1) Local barriers and facilitators to uptake of ACP/GCP;
2) Effective tools for education and engagement of stakeholder groups in ACP/GCP, adapted to the local environment;
3) Informative indicators to monitor uptake of ACP across the healthcare system, and how they can guide continuous improvement of the ACP implementation strategy;
4) Economic consequences of ACP implementation. Preliminary outcomes from this program of research will be presented.

Abstract number: P1-338
Abstract type: Poster

Factors Associated with Increasing Public Participation in Advance Care Planning in Alberta, Canada

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Background: Advance Care Planning (ACP) encompasses both verbal and written communications expressing preferences for future health and personal care and helps prepare people for healthcare decision-making in times of medical crisis. Governments and healthcare systems are increasingly promoting ACP as a way to inform medical decision-making but it is not known whether public engagement in ACP activities is changing over time.

Aims: To understand the gaps and barriers in the clinical, educational, legal-organizational and financial domain that would hinder the implementation of basic palliative care in the community through GPS.

Methods: Qualitative study using case studies (CS) and focus groups (FG) as data collection tools. Regional meetings were conducted in 4 pilot areas in Romania with GPs and nurses in RH. Also, a semi-structured interview with hospital administrators was used to collect secondary data/desk research. Steps undertaken to get start PC service are, establishment the PC service in five pilot regions, theory and practical training of the pilot teams (PT), design the PC guidelines and protocols to be used in RH. The PC guidelines and protocols are in accordance to the guidelines developed by World Health Organization (WHO) and the guidelines developed by Albanian health authorities.

Results: Main findings shows that only 10.5% of HCP agree to provide PC in RH; 50% of hospitals provide only medical care; only 1.59% of HCP have participated in any kind of PC training; 18 from 34 medications of the essential list for PC are lacking in all RH; there is extremely low level of opioid availability and usage in all RH as well as a lack of basic PC equipments and materials. Most RH in Albania have amount of space and medical HR needed for PC, but significant barriers exist concerning trained HR, medications, opioids, and equipments availability as well as organisational flexibility.

Conclusion: Steps undertaken to get start PC service are, establishment the PC service in five pilot regions, theory and practical training of the pilot teams (PT), design the PC guidelines for (PT) functioning, lobby and advocacy with decision makers to improve the issues related with availability, access and usage of PC medications.
Coordinating and Integrating Palliative Care and Rehabilitation - Why, When, and How?

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Background:
The Danish National Board of Health recommends further coordination and integration of palliative care (PC) and rehabilitation (R). PC and R in a Danish context are more frequently separated organise in comparable countries e.g. UK. In this study we reviewed the international literature on relations between PC and R in order to provide a knowledge base for carrying out the recommendations.

Aim: A qualitative review was conducted to provide evidence about interfaces and coordination of PC and R.

Methods: Medline, Cinahl, Embase and PsychInfo were searched for articles concerning both PC and R associated with cancer, lung disease, neurologic disease and disease in the elderly, published between 2003 and 2013 inclusive. As high strength intervention studies in this field are rather scarce, articles concerning the relation between PC and R were selected and analysed within a narrative review framework.

Results: 110 articles were selected and analysed and six themes were constructed, answering the question of why, when and how PC and R should be coordinated and integrated. Reviews and their focus; Evidence and strength of evidence; Cultural challenges; Target groups and phases; Arguments to support further coordination; and Patient-perspectives.

Conclusion / Discussion: Though the evidence based on intervention studies is weak, the narrative review provided a balanced knowledge to guide and support clinical practice in developing a dynamic interface between palliative care and rehabilitation.

Abstract number: P1-340
Abstract type: Poster

Don’t Forget Sexuality: A Study on Responses of a Group of Palliative Care Operators

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Background: Literature shows a lack of studies focused on the sexuality of palliative care patients. The few studies on the subject depict a situation where great difficulties are encountered by operators in recognising sexuality as a need of the patient, and in talking about it. For this reason, we decided to interview palliative care operators about sexuality.

The foundation we are working for is a charity that provides specialist palliative care to severely ill patient and their families. It has a home care team and two hospice inbed facilities. Overall the service looks after 1.300 patients per year.

Aims: This study aims at investigating how operators in our specialist palliative care team approach the need of sexuality in their assisted patients.

Methods: A semi-structured interview has been used as survey tool. The interviewees are chosen among professionals involved in the different services of the charity, stratified according to job, age, gender and prevalent work setting. The recruitment of the interviewees has been initially performed on a voluntary basis. The sample was not defined ‘a priori’, but the final number of interviews will be decided when a saturation of the data will be achieved. Data analysis is being conducted using a content analysis of the main emerged themes. To date 3 interviews have been completed and ten more are scheduled to be performed in the next months.

Results: Early results show recurring problems, particularly the difficulty in talking about the sexuality not only with the patient but also with the colleagues. The interviewees agree in saying that speaking is the first step to defeat sexuality taboos. In most cases the first response to the need for sexuality is listening and all the interviewees believe it is important to refer to an expert in this field to adequately respond to this need.

Conclusion: Complete results will be presented within the congress.

Abstract number: P1-341
Abstract type: Poster

Family Caregivers’ Perspectives on Hospice Day Care from a Retrospective Survey in Austria

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Background: Supporting family caregivers is one of the central aims of hospice day care. This is usually achieved by relieving carers for at least one day a week. This is complemented by other interventions and activities of hospice day care like counselling. Although numerous international studies to evaluate hospice day care have been done, very few and mainly qualitative studies provide evidence based on family caregivers’ perspectives.

Aim and method: The aim of this study was to evaluate a hospice day service in Austria including the perspective of bereaved family caregivers. For this, a retrospective postal survey was performed. A self-designed tool was chosen, covering all users of the day hospice back to three years (n about 220).

Results:
44.7% of the users attended the day hospice once a week. We found evidence that hospice day care provision for family caregivers in the following aspects: very time-consuming care work was reduced by 20%, support with symptom management and the availability of information on specific treatments or problems (94.8%) were most satisfied with the latter.

Conclusion: The high concordance between needs and service provision and the satisfaction with the most important aspects of bereaved family carers with hospice day care may not surprise at all, but underlines how much this kind of service fills a gap in the healthcare system which produces stress for family caregivers.

Abstract number: P1-342
Abstract type: Poster

Days of Dying - Are Patients on a Palliative Care Unit Die on Certain Days?

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Aim: Frequently people working on a Palliative Care unit have the impression that patients are dying on the weekend. However, this has never been analysed if there are certain days on which people on a Palliative Care unit are dying. Therefore, we retrospectively have analysed the days on which patients have died.

Methods: Retrospective analysis of deaths in the week on which patients have died on the Palliative Care unit of a university hospital in the years 2005 - 2011. We have used the electronic files of the hospital and have manually evaluated the day of death.

Results: Within the years analysed frequently more than 100 patients have died annually (2005: 100; 2006: 159; 2007: 157; 2008: 161; 2009: 144; 2010: 152; 2011: 176). The deaths occurred most frequently on Fridays in the years 2005 (18%), 2006 (21%), 2007 (18%) and 2009 (22%). In 2008 the day most patients died has been Monday (19%), in 2010 it has been Wednesday (16%) and in 2011 it has been Sunday (17%). Patients were likely less to die on Sunday in 2009 (6%) and 2010 (7%), on Thursday in 2006

Abstract number: P1-343
Abstract type: Poster

Do Engaging with Social Media Benefits Hospice? Case Study Analysis of Four UK Hospices

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Background: Emerging evidences suggest that use of Social Media helps to share information and resources and reach intended and ‘beyond’ audiences with quick and fast manner. Currently, hospices around UK and world actively engaged with social media with different purposes. Yet, little is reported around the role of social media and its benefits for hospices.

Aim: To investigate the use, engagement and the reach-out of social media among four hospices in the UK.

Methods: A qualitative case study approach was adopted, studying purposeful sampling of four social media engaged hospices within UK. Data collection used multiple data sources to collect publically available data that include feeds, comments, shares, tweets, status updates from two online social networking sites namely Facebook and Twitter of selected hospices.

Living Now10?, a thematic analysis was undertaken.

Results: Analysis of data found that all the hospices were actively engaged mainly in four different activities; fundraising, sharing best clinical practices, promoting educational activities, and advertising jobs. Hospices also involved in community outreach activities by celebrating local events and cultural and religious celebrations.

Conclusion: Findings indicate that engagement with social media enable hospices to remain in ‘core business’ of ‘running with local support’. Yet, Hospices could be more explicit in sharing about how well it benefits for patients and carers that could enable access to hospice services across the diverse population by sharing stories of hospice patients and relatives’ experiences.

Abstract number: P1-344
Abstract type: Poster

Quality of Life, Symptom Burden and Satisfaction with Care among Older Latinos with Advanced Cancer

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Abstract number: P1-345
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 1)
Policy

Abstract number: P1-346
Abstract type: Poster

The Norwegian Pilgrimage: Raising Public Awareness on the Human Right to End-of-Life Care

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Aims: To present the experience of raising public awareness on the human right to a dignified death through the organisation of a pilgrimage, which used the camino as a symbol to communicate the pathway to palliative/hospice care.

Background: Although Norway scores high in the Global Atlas of Palliative Care at the End of Life (level 4b), Advanced health system integration, defined dying conditions and evaluation of available palliative care services are lacking. Worries about end-of-life are increasingly expressed; patients are being moved from service to service. Home as a place to die: just 14.5% in 2012. Death and dying have been subjects of social concern to Norwegians, however policies to meet the needs of the dying and the bereaved are still underdeveloped.

Approach taken: A pilgrimage was organised, to raise public awareness on palliative/hospice care. It involved 40 days of walking and invited people and professionals to join parts of the journey. Activities were organised at specific sites which aimed at an open dialogue around end of life. The journey started at Nuuk and ended in Drammen where the Norwegian prime minister opened the new palliative care centre.

Lessons learned: The possibility of raising public awareness and advocating for palliative care as a human right through the organisation of pilgrimages in European countries and internationally will be discussed.

Abstract number: P1-347
Abstract type: Poster

Collaboration of Ngo’s and Government of Ukraine for Development of Palliative and Hospice Care Regulatory Basis

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1Academy of State Service at the President of Ukraine, Kiev, Ukraine; 2National Medical Academy for Postgraduate Education named after P. Shupyk, Kiev, Ukraine, ‘NGO Ukraininan Palliative and Hospice Care League’; Kiev, Ukraine, NGO ‘Ukrainian League for Palliative and Hospice Care’ (League) started preparations for the Second National Palliative Care Congress, scheduled for September, 2015. Hence, we constantly analyse the implementation of National Strategy for Development of Palliative Care in Ukraine to 2022 (Strategy), which was approved at the First National Palliative Care Congress, hosted by League on September 26-27, 2012 in Kiev.

One of the Strategy’s priorities is regulatory basis development. Due to League’s lobbying and collaboration with the Government, the Parliament Law of July 7, 2011 ‘On Amendments to Fundamental Principles of Legislation on Ukraine on Health Care’ which defined Palliative and Hospice Care (PHC) as a separate type of health care and a few PHC regulatory acts were implemented. Ministry of Health of Ukraine (MOH) Order №41 of 31.01.2013 ‘On Palliative Care Establishment’ is a fundamental step in developing of effective and accessible system of PHC in Ukraine. Ministry of Social Affairs and MOH of Ukraine a joint Order №317/353 of 23.04.2014 on approval of liaison protocol between subjects engaged in the provision of palliative care services at home for the terminally ill will help to improve inter-agency cooperation in outpatient PHC. MOH Order №177 of 01.02.2013, permitted to use morphine tablets; MOH Order №311 of 25.04.2012 approved a Clinical Protocol for Chronic Pain Syndrome Care and Cabinet of Ministers Decree № 333 of 13.05.2013 concerning of narcotic drugs, psychotropic substances and precursors in health care institutions facilitated the availability of PHC patients with chronic pain to effective pain relief, especially in the outpatient facilities, improved quality of life of the terminally ill and their families. The League understands problems and challenges that Ukraine should be solved for creation of accessible PHC system in connection with the involvement and cooperation of community, specialists and Government.

We Are the Champions: How European Awarded of the International Pain Policy Fellowship Have Improved Opioid Availability and Accessibility in Europe

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Aims: Relieving severe pain, a critical component of palliative care, cannot be accomplished without improving availability and access to opioid medicines. Many factors contribute to inadequate pain relief globally. In Europe, some countries lack national formularies that include opioids indicated to treat moderate or severe pain, require physicians to have special prescription authority, require special prescription forms, and impose strict limits on amounts or durations. The International Pain Policy Fellowship (IPPF) program is designed to empower champion change-agents from low- and middle-income countries to work with their governments to evaluate and implement system and policy changes to make opioid medicines available for patients receiving palliative care services. Three cohorts of health professionals and health regulators have been awarded Fellowships in 2006, 2008, and 2012. The objective of this study is to describe the progress to date of 7 Fellows from 6 European countries (Albania, Armenia, Georgia, Kyrgyzstan, Serbia, and Ukraine) resulting from the IPPF program.

Methods: All Fellows attended a week-long training session to learn about the roles and functioning of the international drug control system and to create a national Action Plan to improve opioid availability in their country. For the remaining Fellowship period, international experts provided technical assistance to the Fellows to implement their Action Plans.

Results: Fellows, collaborating with government officials and colleagues in their countries, made notable progress in the areas of national and opioid policy, distribution, availability, education, and cost. Conclusion: The IPPF has empowered highly motivated health professionals as champions to work with mentors and colleagues, resulting in significant progress towards overcoming barriers to opioid availability in their countries.

hospice in light of limited resources, but the combined participation of government, NGOs and civil society in the region.

**Methods:** Opening children’s hospice preceded by preparation: the order of the regional health department, training in children’s hospices Belarus, Poland, Russia; inclusion in a comprehensive program Public health Carpathian 2013-2020, discussion and debate with the public to find resources; moral, material, financial, publication in all media, social networks, websites hospice; 5-Hour TV marathon ‘Live and Believe!’ An important element of the goal became constant monitoring and control of all public funds flow, repair and reconstruction of buildings.

**Main results:** All previous initiatives and activities allowed to collect donations of more than 1.5 million UAH for 9 months made a reconstruction of the premises; December 21, 2013 the official opening of the first in Ukraine children’s hospice on palliative care 15 beds.

**Conclusions:** Activation of society and cooperation between authorities and communities, openness and transparency of all processes allowed to solve the difficult problem to create a children’s hospice in light of limited resources.

**Abstract number:** P1-351
**Abstract type:** Poster

**IAHPC Advocacy for a Human Right to Palliative Care**

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**Hypothesis:** UN member states (MS) will resolve that palliative care is a human right (HR) once they are convinced that the social, political, and economic benefits of doing so outweigh the costs re national public health and development outcomes. Representatives of MS in UN institutions and treaty bodies are largely unaware of the unmet need for palliative care in their countries. Global advocacy for a HR to palliative care will introduce the palliative care narrative to the language of international human rights diplomacy, improve awareness of the global deficit of services, and draw attention to the lack of access to opioid medicines for pain relief in more than 80% of UN MS.

**Methodology:** Active participation of representatives of IAHPC at sessions of UN treaty bodies, functional organisations and specialised agencies. Review of multi-lateral treaties and international law implicating palliative care and access to opioid medicines.

**Discussion:** Various articles in prestigious journals, as well as civil society/professional organisation declarations’ and manifestos, have proclaimed that access to palliative care is a HR. Yet, there is a huge lack of visibility of how to make it so, however. Enforceable human rights entail the passage of resolutions either at the Human Rights Council or UN General Assembly that recognise MS’s binding obligation to ensure the right. In times of national and global uncertainty and budget scarcity, even sympathetic MS are reluctant to assume new obligations to give citizens new rights having unknown policy benefits.

**Conclusion:** Progressive development of a multi-level strategy creating dynamic, mutually reinforcing communications networks linking local, national and regional partners with representatives of UN agencies and treaty bodies, will create positive policy space for the passage of resolution commanding widespread MS support within 5 years.

**Abstract number:** P1-352
**Abstract type:** Poster

**Advance Care Planning - The New Establishment Paternalism?**

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**Background:** Advance Care Planning (ACP) is being promoted as a way of extending individual autonomy and future states of loss of Mental Capacity by participation in decision making about end of life care. In England, it is the Physicians or Specialist Nurse who initiates ACP as a route to achieve targets.

**Methods:** Active participation as a representative of IAHPC at sessions of UN treaty bodies, functional organisations and specialised agencies. Review of multi-lateral treaties and international law implicating palliative care and access to opioid medicines.

**Discussion:** Various articles in prestigious journals, as well as civil society/professional organisation declarations’ and manifestos, have proclaimed that access to palliative care is a HR. Yet, there is a huge lack of visibility of how to make it so, however. Enforceable human rights entail the passage of resolutions either at the Human Rights Council or UN General Assembly that recognise MS’s binding obligation to ensure the right. In times of national and global uncertainty and budget scarcity, even sympathetic MS are reluctant to assume new obligations to give citizens new rights having unknown policy benefits.

**Conclusion:** Progressive development of a multi-level strategy creating dynamic, mutually reinforcing communications networks linking local, national and regional partners with representatives of UN agencies and treaty bodies, will create positive policy space for the passage of resolution commanding widespread MS support within 5 years.

**Abstract number:** P1-354
**Abstract type:** Poster

**Are Quality of Life Scores Biased in Units with Low Response Rates? Data from the Danish Palliative Database**

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**Background:** In studies with low response rates it is important to study if the data are valid or might be distorted by selection bias. This study includes data from all Danish specialised palliative care (SPC) units with different response rates on a questionnaire on symptoms/problems and quality of life (QOL). Particularly units with low response rates may be prone to selection bias if e.g. only the patients feeling the best answered.

**Aims:** To study whether selection bias was present in SPC units with low response rates.

**Methods:** Information on 9 symptoms/problems and QOL from the EORTC QLQ-C15-PAL questionnaire have been collected in the Danish Palliative Database on 12,288 cancer patients at the start of SPC. Linear multiple regression analyses was performed to test if response rate was associated with the symptom/problem/QOL scale scores. A specific-unit random-effect was included to account for that patients from the same unit were expected to be more alike than patients from different units. Binary logistic regression with random effects was used to verify the results for the single item scales.

**Results:** The overall response rate was 49% but varied between year and unit from 0-94%. The response rate was unrelated to 7 scales and significantly associated with 3 (dyspnea, appetite loss, physical function) scale scores. In these cases, the effect of response rate was low, even where the response rate was less than 20% (up to 7 on a 100 point scale). The results in the linear regression analyses were supported by the logistic regression analyses.

**Conclusion / Discussion:** Our hypothesis of selection bias with higher scores in units with low response rates was not supported. Therefore there does not seem to be any reason to exclude data from SPC units with low response rates.
**Predictive Factors of the Place of Death Among Cancer Patients After a Multidisciplinary Evaluation Carried out by a Supportive Palliative Care Team in Catalonia**

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**Methods:** We conducted a cross sectional survey among Dutch general practitioners (GPs) on their most recent patient that died non-sudden. Of 1601 eligible GPs, 598 responded.

**Background and aims:** Most patients with cancer prefer to receive care and die at home. Also dying at home can be considered an outcome of high quality palliative care. However, in developed countries more than half of patients with advanced cancer die in the hospital setting. In our area, little is known about patient’s preferences regarding the place of death (PoD). As a quality outcome we define the PoD as the place where, after an intensive multidisciplinary evaluation and an agreement with both patients or relatives, the discharge is planned. In this study we aim to know the effectiveness of the evaluation carried out by the supportive palliative care team (SCT) at the HUAV of Lleida and evaluated with the % of patients dying at the final place agreed (acute hospital, home and in-site palliative care unit).

**Methods:** We conducted an observational cohort study to identify the PoD of patients discharged from the SPECT at the HUAV of Lleida between 2010 and 2012. Inclusion criteria included those advanced cancer patients discharged to our influence area where different levels of palliative care are provided. We use univariate analysis (ch-square test) to determine statistical significance. Values of p < 0.005 were considered significant.

**Results:** 1179 patients met the inclusion criteria. 574 (48.7%) were discharged at home; 290 (24.6%) were discharged to the acute hospital and 315 patients were discharged to a palliative care unit (26.7%). Statistical significant differences were found between the place of discharge and the PoD (p=0.000, marital status (p=0.000) the lack of identified career (p=0.001) and younger ages (p=0.000). Gender and cancer type did not reach statistical differences.

**Conclusions:** A careful multidisciplinary evaluation will lead to a great effectiveness when deciding the place where the patients are going to be cared for. Young, divorced, with no cancer identified and living in bigger cities were prone to die in the acute hospital.

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**Variation of Intensive Care Utilisation at the End-of-Life in Patients Dying From Chronic Non-cancer Disease versus Cancer: A Nationwide Cross-sectional Study**

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**Conclusions:** A careful multidisciplinary evaluation will lead to a great effectiveness when deciding the place where the patients are going to be cared for. Young, divorced, with no cancer identified and living in bigger cities were prone to die in the acute hospital.
Relief of suffering is integral to palliative care, but the topic beyond physical suffering is not well understood. A systematic review focusing on suffering across all cancers was undertaken. The aims were:

1. Identify and synthesise conceptualisations of suffering.
2. Identify surrogate terms for suffering.
3. Identify antecedents of suffering.
4. Describe the consequences of suffering.

The search included peer-reviewed English articles focusing on the conceptualisation of suffering in adult cancer patients published between 1992 and 2013 in MEDLINE, Embase, PsycINFO, and the Cochrane Library databases. Seminal theoretical articles conceptualising suffering more generally were also eligible. To ensure identification of a broad range of conceptualisations of suffering in cancer, the search strategy was drafted iteratively. Study findings were subjected to conceptual analysis using the evolutionary method.

128 studies were identified which discussed definitions of suffering. Historical influences such as the writings of Victor Frankl, Cicely Saunders and Eric Cassell permeate the literature. Suffering was described as an all-encompassing, dynamic, individual phenomenon such as the experience of alienation, helplessness, hopelessness and meaninglessness in the sufferer which is difficult for them to articulate. It is multidimensional and usually incorporates an undesirable, negative quality. Many surrogate terms were identified. Antecedents and consequences of spiritual suffering are described. This review revealed that suffering includes spiritual suffering which is complex and difficult for patients to express. Those suffering need to be given opportunity to express their suffering and the potential for suffering to be transcended needs to be recognised and facilitated. Further effort is needed to educate healthcare workers in their understanding of this phenomenon. This project received funding from Cancer Australia.

Abstract number: P1-362
Abstract type: Poster

Meaning in Life and Spirituality at the End of Life

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Background: Meaning in Life (MIL) is recognised as one of the most affected domains in a significant number of patients with terminal illness and has been included as a possible modifier of quality of life in several studies. Aims: The aims were to identify the areas relevant for the patients’ meaning in life and to assess the relationship between desire for hastened death, anxiety/depression and meaning in life, quality of life (QOL) and spiritual wellbeing. Method: MIL (assessed by the Schedule for Meaning in Life), spiritual wellbeing (Functional Assessment of Chronic Illness Therapy), religiosity (Idi-Index of Religiosity), anxiety/depression (Hospital Anxiety and Depression Scale) and desire for hastened death (Schedule of Attitudes towards Hastened Death) were assessed with face-to-face interviews in the three linguistic regions of Switzerland (French, German and Italian regions, FR, GR and IR). Results: Up to now, 77 FR, 83 GR and 27 IR patients have been interviewed. Significant differences between regions regarding the areas contributing to MIL were observed: ‘spirituality’ is most strongly identified by IR patients compared to FR and GR (3% vs 23% vs 51%, respectively, p<0.000). ‘Work’ is more often cited by IR patients compared to FR and GR (63% vs 9% vs 26%, respectively, p<0.000). Both MIL and spiritual wellbeing are negatively correlated with anxiety/depression (R=−0.101, p<0.000, R=−0.303, p<0.000, respectively) and desire for hastened death (R=−0.066, p=0.037, R=−0.090, p=0.012, respectively), with a difference between FR and GR patients (stronger negative relationship in FR patients). Discussion: Differences have been observed which may relate in part to the different understanding of the concepts of spirituality, religiosity, and meaning in life. Before developing a specific meaning-enhancing intervention, we need to better understand how the different populations interpret these concepts and relate them to each other.
Participants were nurses, doctors, social workers, healthcare assistants and other health and social care workers. For this evaluation pre and post course questionnaires were completed by 646 participants: 421 F2F and 215 online. Overall there were statistically significant differences in questionnaires scores obtained for knowledge about understanding and meaning of spirituality, skills in discussing spiritual issues and distress, and confidence in assessment and referral. Apart from statistical confidence and the ability to build relationships with patients and families which were not significantly different. There were only slight differences between the scores for F2F and online learning.

Conclusions: The intervention demonstrated increased awareness of spiritual issues, patient needs and how to address them, with participants expressing increased confidence, skills and knowledge unrelated to the mode of learning despite this being an experimental course.

Abstract number: P1-366
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 1)

Spinal Spirituality: Audit of the Documentation of Spiritual and Religious Needs Assessment and Care in a Regional Spinal Injuries Unit

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Background: The importance of spiritual and religious care is highlighted repeatedly in the NICE Supportive and Palliative Care Guidance 2004, End of Life Strategy 2008, NICE End of Life Quality Standards 2011 and One Chance to get it right 2014. Regional audits of the documentation of spiritual and religious needs assessment and provision of care by those involved in specialist palliative care services have resulted in a widespread education programme open to all across healthcare settings. Following attendance on such a programme an audit was performed as part of an End of Life Skillset Challenge. It was agreed to audit this on the regional spinal injuries unit, where end of life care is infrequently undertaken but may belong of the goals of care in a re-adaptive following significant trauma causing lifestyle change.

Methods: Retrospective review of 20 sets of hospital clinical nursing records looking for evidence of documentation of spiritual and religious needs assessment and provision of care using an audit tool created as part of the Opening the Spiritual Gate Programme across the local palliative care End of Life Network.

Results: 95% clinical nursing records had documentation of the patient’s faith tradition or religious affiliation, however none mentioned the importance, or otherwise, of this to the patient. None had recorded spiritual or religious needs assessment and only 10% had any record of ongoing spiritual care.

Recommendation: As a result of this audit, and at the same time as a Spinal Care Policy happened to be published for the hospital, a Spiritual Care Plan was written by the auditor and agreed for use. A simple awareness raising programme was undertaken within the unit before repeating the audit. This presentation will include the results of the second cycle and demonstrate the impact of the intervention.

Abstract number: P1-367
Abstract type: Poster

Religious Beliefs towards the End of Life among Patients with Chronic Heart Failure and the Relationship with End-of-Life Preferences

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Background: Religious beliefs may influence decision-making about end-of-life care among patients with Chronic Heart Failure (CHF) and may change towards the end-of-life. Data in CHF are scarce.

Aims of this longitudinal observational study were: to explore whether preferences for life-sustaining treatments and end-of-life care are influenced by religious beliefs among patients with CHF; and to explore whether religious beliefs change towards the end-of-life.

Methods: This study included 427 patients with CHF of the TIME-CHF study (69% of the original sample; 62% male; mean age 76 (17.5) years; 62% NYHA class III). Confession, strength of religious beliefs (Religion Questionnaire), preferences for CPR, and willingness to trade survival time for excellent health were assessed (Time Trade-off tool). The relationship between religious beliefs and preferences for CPR and willingness to trade survival time at baseline was explored. In addition, changes in religious beliefs between baseline and 12 months were explored using paired samples t-tests.

Results: 47% were Catholic, 42% Protestant, 5% other and 6% atheist. Atheist patients more often preferred ‘Do Not Resuscitate’ (DNR) than Catholic patients (56% vs 32%, respectively; p<0.01). Patients with strong religious beliefs as assessed with the Religion Questionnaire were less likely to prefer DNR than patients without religious beliefs (p<0.05). There was no relationship with willingness to trade survival time (p>0.05). The belief in afterlife increased among patients who died between 12 and 18 months (p=0.04), while feeling supported by religion tended to decrease at the end of life (p<0.07).

Conclusions: CHF Patients with strong religious beliefs are less likely to prefer DNR. Religious beliefs may change towards the end-of-life. Therefore, exploring religious beliefs and the influence on preferences for life-sustaining treatments as part of advance care planning seems to be important.

Abstract number: P1-368
Abstract type: Poster

Mis-use of Spiritual Care as Set-back in Drug Addiction in Patient with Chronic Illness: Case Observation from a HIV Positive Child in Tanzania

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Background: HIV/AIDS is a chronic debilitating disease with fatal outcome. Many children live with HIV/AIDS and face the risk of re-infection, which is associated with a high mortality rate. The disease is accompanied by physical, psychological, and social problems that are difficult to manage. The aim of this study was to explore the mis-use of spiritual care as a set-back in drug addiction in patients with chronic illness.

Method: A case study approach was used. The case study involved a child aged 16 years old, who had been diagnosed with HIV/AIDS and was being treated at a hospital in Dar es Salaam, Tanzania. The child had been referred to the hospital by a local health center due to symptoms of drug addiction. The child had a history of drug addiction and had been previously treated for the condition. The child was a participant in a spiritual care program at the hospital.

Results: The child had a history of drug addiction and had been previously treated for the condition. The child was a participant in a spiritual care program at the hospital. The spiritual care program consisted of group therapy sessions, prayer sessions, and counseling. However, the child did not participate in the spiritual care program and continued to use drugs despite the intervention. The child was also diagnosed with depression and was prescribed medication for the condition. The child was also referred to a mental health clinic for further treatment.

Conclusion: The spiritual care program did not address the root cause of the child's drug addiction. The child continued to use drugs despite the intervention. The spiritual care program was not effective in dealing with the child's drug addiction and depression. The child's drug addiction and depression were not properly managed, which led to a mis-use of spiritual care as a set-back in drug addiction in patients with chronic illness.
Bueno or Bane? Staff Perception on the Use of FICA and FACT-Sp

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Background: Although spirituality is an integral part of palliative care, it is often under-addressed. The FICA Spiritual History Tool was developed to aid healthcare staff in spirituality assessment, while the Functional Assessment of Chronic Illness Therapy-Spiritual (FACT-Sp) Wellbeing Scale was developed to measure spiritual wellbeing in patients. Aims: This study aimed to evaluate the perceived usefulness and burdens of using FICA and FACT-Sp.

Methods: As part of a larger study on spirituality in a tertiary hospital palliative care consult service and a hospice home care service, half of the palliative care staff were trained to use FICA to take a spiritual history and all staff used FACT-Sp to measure spiritual wellbeing. A survey was administered to palliative care staff at both sites 3 months after the start of the study.

Results: Overall, 40% staff responded. Fifty-five percent found FACT-Sp useful, 75% did not, 20% were not sure and 17.5% did not respond. Of the 22 who found it useful, 68.2% found it useful for opening up conversations with patients and 68.2% for exploring spiritual issues. When asked if they found it a burden, 37.5% said no, 32.5% said yes, 12.5% were not sure and 12.5% did not respond. More than those who found FICA-Sp a burden felt it was time-consuming, especially for fatigued patients. All 16 who had used FICA and gave feedback found it useful - 75% found it useful for exploring spiritual issues, 46.3% for opening up conversations with patients, 58% for building rapport and 58% for identifying spiritual problems. Four found FICA burdensome because it was time-consuming and patients got fatigued easily. However, when asked if they would recommend it to other staff, 50% said yes and 50% said no.

Conclusion: This study showed that FICA and FACT-Sp can be helpful in opening up conversations with patients and exploring spiritual issues. However, they can also be time-consuming especially for patients who were fatigued.

Abstract number: P1-372
Abstract type: Poster

“I am Still from outside Even though I’m Part of the Team” - Self-Perceived Roles of Clinical Pastoral Carer Workers within Palliative Care

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Background: To accompany seriously ill and dying has always been an inherent part of pastoral care. Nowadays, clinical pastoral care workers are specially trained for delivering spiritual care in the context of dying and death. But since the consolidation of palliative care (PC) and its interdisciplinary approach to spiritual care, it becomes difficult to define the specific profile and essence of clinical pastoral care. Aim: To analyse the perspective of Protestant clinical pastoral care workers on their diverse roles in delivering palliative care within the clinical setting.

Methods: 29 qualitative, semi-structured expert interviews with clinical pastoral care workers in southern Germany were conducted in 2013. The interviews were transcribed verbatim and a qualitative content analysis was performed.

Results: In addition to providing general pastoral care by supporting patients, families and team members through counselling, conversations and rituals, participants also described the following roles: being a fellow human being, a PC team member, a mediator between families, patient and team, an advocate for unheard or unregarded issues. Moreover, autonomy and openness seemed to be central motives in the work of clinical pastoral care workers and were characterised by the self-directed organisation of schedules, an individual and open approach to pastoral care for each receptor, and the addressing of challenging topics within the team and with patients.

Conclusion: Clinical pastoral care encompasses various roles that go beyond traditional counselling. As employees of the church, pastoral care workers come from outside into the clinical setting but are still part of the PC team. This enables them to question routines and ‘normalities’ in a constructive way, to act as intermediary and to offer space and time to patients, families and the team in an otherwise often structured routine.

Abstract number: P1-373
Abstract type: Poster

Audit of the Facilitation of Spiritual Care for Patients by Clinical Staff at the EllenorLions Hospice, UK

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Background: Since the foundation of the modern hospice movement, spiritual care has been regarded as a vital part of patient care, alongside physical, psychological and social considerations. This holistic approach to Palliative Care is upheld by reflected in the NICE Guidance on Supportive and Palliative Care (2004) and the DoH End of Life Strategy (2008).One of the Quality Markers for Spiritual Support in End of Life Care proposed as part of the 2008 EOLC is ‘Ending the life of...’ have the opportunity to explore their spiritual beliefs and values with staff at regular points throughout the illness trajectory and these are recorded and regularly reviewed.

Aims: To assess whether one of the essential, basic elements of assessing and facilitating spiritual care for patients, were part of the standard practice of clinical teams at the Hospice. The following criteria were selected: Record of religious...
Social care and social work

Analysis on Causes of Hospital Death Despite the Preference for Home Care: Deaths of Liver Cancer Patients Home-cared at End-stage
Tomishiro Central Hospital, Anaesthesiology and Palliative Medicine, Tomishiro, Japan.

Aims: Although over half of Japanese prefer home death and home care is more prevalent today, only 8% of cancer patients die at home. The long-term treatment of liver cancer gives time for home care preparation, home death is considered difficult due to various symptoms including sudden deterioration. We analysed the factors affecting the place of death of home cared liver cancer patients.

Methods: We studied 67 cases of end-stage liver cancer patients for whom we coordinated the place of end of life care from April 2012 to November 2013 and analysed the factors of discontinuation of home care.

Results: Among 67 patients, 5 died at our hospital while coordinating, 47 were referred to home care physicians, and 15 were under care. Out of 52 who died, 27 died at home. We obtained details of 24 patients preferred home death from home care staff, of which 14 died at home and 5 at hospital; 1 patient was admitted as recommended by the home care physician, and the rest 4 were the results of the families calling ambulance being worried after seeing hepatic encephalopathy or hemorrhage. Among patients over 70 years old, 1 out of 5 died at hospital and 10 out of 14 at home. The families of home deaths received more details of physical conditions. Home deaths were realised by larger families, and those realised required more care, implying that hardness of home care does not lessen the home death cases.

Conclusion: Although most liver cancer patients preferring home care and death were home-cared, some died at hospital. The results suggest that providing detailed information on clinical course and possible sudden changes in physical condition is important, and continuous communication between the families and the hospital after starting the home care will be possibly helpful. In addition, certain number of families calling ambulance upon sudden change of patients' conditions might be inevitable, thus it is advisable that hospitals are fully prepared for palliative emergency.

Problems with Palliative Care Systems for Advanced Cancer Patients in Large Metropolitan Areas
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Background: Many patients undergo outpatient anti-cancer treatments in Tokyo. However, when cancer advances and patients can no longer make hospital visits, no systems are in place to connect them with community hospice or home care services. This study examines the current system of patients who received care from a palliative care team, as well as its systems for providing palliative care within its coverage area.

Methods: We studied medical records of advanced cancer patients who received interventions from our palliative care team between January 1 and December 31, 2013, including performance status (PS), outcomes, and the location of end-of-life treatment. We studied the problems of partnership in large cities based on the results of a survey on partnership related to palliative care that targeted 739 facilities, including hospitals, home care clinics, visiting nurse stations, and home care support providers within the coverage area. The chi-square test was used for statistical analysis.

Results: Of 346 patients, 10% were transferred to hospice care within the area, 20% were transferred to hospice care outside of the area, and 38% died in the hospital. The number of patients with PS3 scores who were transferred to home care or hospice care in their own communities was significantly higher than those with other PS scores. Efforts to form collaborative partnerships have been impeded by lack of information on patient conditions and patient anxiety about how to deal with worsening symptoms. Home care support providers have a lot of information about their communities, but it is difficult to obtain information about individual patients.

Conclusion: This study suggests that building effective partnerships must happen not just between hospitals, but in collaboration with businesses like care service providers that have not traditionally been included in such partnerships. Also, decision-making support must be provided while patients still have good PS.

Palliative Care Social Work Roles and Tasks Vital for Patients and Their Families
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Abstract number: P1-381
Abstract type: Poster

Background: EAPC white paper on core competencies for palliative care social work will be published in November 2014. It has highlighted the need to clarify what specialist palliative care social workers and to strengthen and preserve their role. In the UK the College of Social Work published the professional capabilities framework and work has begun to link concepts and ideas from the two publications.

Aims: A Qualitative study using the current members of the EAPC social work task force and their national associations. The revised questionnaire is being translated and will be sent out in January 2015. The results will be analysed and published later in 2015.
However this presentation will examine the results of the pilot project and our discussions with colleagues in Europe.

Conclusions: The questionnaire and results showed a wide variation in tasks, the overlapping of roles with counsellors, psychologists and allied health professionals but also the increasing need for the legal-socio aspects of the role particularly in relation to safeguarding vulnerable children and adults, the assessment of capacity and deprivation of liberties and complex discharges to a variety of care settings. Professional social workers have the skills which require the capacity to work within the competing needs of the patient, the family and the agency.

The demographic changes across the whole of Europe will also increase the need for this part of the role as extending palliative care to non cancer conditions particularly dementia becomes more of the norm.

Abstract number: P1-382
Abstract type: Poster

'Wronged to Death': The Assessment and Management of Anxiety in Patients with Advanced Life-Limiting Disease, a National Survey of Palliative Medicine Physicians
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Background: Anxiety is common in palliative care patients and adversely affects quality of life. However, there is little evidence regarding interventions and no UK-wide or international guidelines on the assessment and management of anxiety in this population.

Aim: To undertake a UK national survey to explore how palliative care physicians assess and manage anxiety in their patients.

Method: An online questionnaire was sent to all doctors working in adult specialist palliative care in the UK who were members of the Association for Palliative Medicine (total 980). Responses were analysed using descriptive statistics.

Results: The response rate was 23% (230/980) and 61% of respondents were consultants. Most did not use tools to screen for anxiety (87%) and used the clinical interview to diagnose anxiety (99%). Only 19% used psychiatric criteria or a diagnostic tool. Most doctors reported difficulties managing anxiety (25% frequently, 68% sometimes). Only 33% felt they had adequate training in this area and 66% did not have direct access to psychological or psychiatric services. The majority used a combination of drug and non-drug treatments. The most frequently prescribed medications for patients with a short prognosis were benzodiazepines (87%), particularly lorazepam. For patients with a longer prognosis, antidepressants were most frequently prescribed (51%).

Conclusion: Despite the low response rate, this is the first UK-wide survey of palliative care physicians. It suggests that most physicians are not using standardised, validated methods to assess anxiety and that there is substantial variation in practice, particularly drug treatment for patients with a longer prognosis. It highlights gaps in training, access to psychological and psychiatric services and identifies the need for research to develop evidence-based guidance.

Abstract number: P1-383
Abstract type: Poster

The Effect of Health Care Settings and Health Care Conditions upon Hopelessness and Loneliness Levels
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Background and objectives: It is a reality that work life affects individuals and individuals affect work life. Health sector is different from other sectors in the sense that it serves sick individuals who undergo intense stress and health care workers often face stressful events on a daily basis. Health care workers - especially nurses - may be psychologically affected by the intensive stress and health care workers often face stressful events.

Methods: The study was conducted at three different hospitals in Istanbul. 82 nurses working at intensive care units, psychiatry units and surgery units were included in the study. Nurses were administered a questionnaire form and UCLA loneliness and hopelessness scale.

Results: 28% of the nurses worked at psychiatry units, 32.9% at surgery units and 39% at intensive care units. It was found that workers had higher levels of loneliness and hopelessness than female nurses. Loneliness and hopelessness levels of those nurses who worked for ≥ 9 years at the same unit were higher. In terms of clinics where nurses worked, intensive care nurses had higher hopelessness levels while surgery nurses had higher loneliness levels. Psychiatry nurses had lower loneliness and hopelessness levels. INTENSIVE care nurses had higher hopelessness levels while surgery nurses had higher levels. In terms of clinics where nurses worked; women had higher hopelessness than male nurses. Loneliness and hopelessness levels of those nurses who worked for ≥ 9 years at the same unit were higher. In terms of clinics where nurses worked; women had higher hopelessness than male nurses. Loneliness and hopelessness levels of those nurses who worked for ≥ 9 years at the same unit were higher. In terms of clinics where nurses worked; women had higher hopelessness than male nurses. Loneliness and hopelessness levels of those nurses who worked for ≥ 9 years at the same unit were higher.

Conclusion: We were of the opinion that work setting and work conditions affected nurses' loneliness and hopelessness levels and recommended that work conditions of intensive care units and surgery units should be improved.

Abstract number: P1-384
Abstract type: Poster

End of Life Process as Observed by those Who Faced Death Most
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Background and objectives: Those working in health profession are always in a position to see death and a dying person. Health care workers who do not recognise the patients' situation and their own emotions may feel despair and may not provide care and help the patients and their families. The emotions created by the health care workers may negatively affect their provision of effective treatment and help. The study was planned to assess the end of life process as observed by the intensive care team members who faced death most at hospitals.

Methods: A total of 80 personnel made up by doctors and nurses working at four different intensive care units of Istanbul Medipol University were included in the study. The data were gathered using a questionnaire of 19 questions.

Results: Most of the participant personnel emphasised that they faced death before, felt sorry and cried in first death case, felt helplessness while providing care to a patient at the end of life process and finally comforted themselves by accepting that death is a natural process. Most of the health care personnel believed that diagnosis should be told to the patient who is in the terminal phase and patient should spend the terminal phase at their homes. Health care personnel would like to know the life expectancy if they were a terminal patient. As for CPR intervention to the terminal patient; it was seen that half of the participants told that it should be done while other half told that it should not be done.

Conclusions: We were of the opinion that it is important that health care workers be aware of their own ideas about end of life process and death and that they be empowered to effectively cope with the negative emotions.

Abstract number: P1-385
Abstract type: Poster

Depression and Religious/Spiritual Coping in Palliative Care Ambulatory Patients: Are there Any Relations? - A Brazilian Sample
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Depressive symptoms are common in Palliative Care (PC) patients, and religious/spiritual coping (RCOPE) could be used to deal with the psychological suffering. In Brazil, few studies have investigated the impact of RCOPE on psychological aspects, especially in PC settings. Aim: Investigate RCOPE and depressive symptoms association in patients under Ambulatory PC in a Medical School of Botucatu, State University of São Paulo.

Methods: cross-sectional study on a convenient sample of Ambulatory PC patients. Besides socio-demographic data, the relation between depressive symptom, RCOPE and other explanatory variables were investigated. Hospital Anxiety and Depression Scale (HADS), Brief RCOPE, Activities of Daily Life Scale (ADL) and Karnofsky’s Functional Scale (KFS) were used. Linear Regression models were built to multivariate analysis, including significant variables obtained on univariate analysis (p≤0.05) and those appointed as risk factor in literature review.

Results: Forty people (30-85 years old; mean: 68.5±12.9; women: 65.0%; Caucasian: 65.0%; married 52.5%; living with partner: 47.5%; cancer diagnosis: 40%) constituted the sample. On HADS the mean score was 72.75±11.6 and 65.0% were independent on activities of daily life (ADL). Depressive symptoms were present in 40.0% (CRP 24.1±5.5%). The mean score of positive and negative RCOPE were 3.0±0.27 and 1.38±0.58, respectively. Multivariate analysis has revealed an association between depressive symptoms and major use of negative RCOPE (p<0.004).

Discussion / Conclusion: an association between depressive symptoms and more use of negative RCOPE strategies has agreed with other studies findings. So, a religious/spiritual approach as care probably will have a positive impact on quality of life and in reducing depressive symptoms in PC patients. More studies are necessary to evaluate the relations between religiosity/spirituality and health care, and how these relations could be used to benefit those under PC.

Abstract number: P1-386
Abstract type: Poster

Predictors for Psychological Burden in Palliative Care Patients - An Analysis of the Hospice and Palliative Care Evaluation 2007 - 2011
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Background: Psychological burden is common in patients with advanced or terminal illnesses. This study aims to detect possible predictors for different aspects of psychological burden in palliative care patients.

Methods: We retrospectively analysed data of palliative care patients collected by the German quality management benchmarking system called Hospice and Palliative Care Evaluation (HOPE) which includes an evaluated symptom and problem checklist. We dichotomised staff’s ratings for depression, anxiety, tension, and disorientation/confusion/fatigue resulting groups with none or mild (grade 0 and 1) rated symptoms versus moderate and severe (grade 2 and 3) rated symptoms. For each of these target variables we developed a multivariate logistic regression model by backward stepwise selection whose predictive accuracy was evaluated by the area under the receiver operator characteristic curve (AUC). As candidate predictor variables other information collected with HOPE were used.

Results: The analysis of 10444 data sets results in fair and good predictive values: depression (AUC=0.75), anxiety (AUC=0.74), tension (AUC=0.70). In all of these multivariate predictive models burden of family/environment appears as one of the most predictive variable (AUC=0.65-0.69). The predictive models for depression,
Distress in Terminally Ill Patients at Home - Measurement of Psychosocial Burden in Community Palliative Care

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Aim: To evaluate the frequency as well as the therapeutic implications of undetected psychiatric symptoms in patients on a palliative care unit (PCU).

Methods: Patients admitted to one of five participating PCUs were included. The short version of the Patient Health Questionnaire (PHQ-2) was used for diagnosing mental health.

Results: 524 patients were included, of whom 267 (51%) had a PHQ-2 score ≥3, indicating probable psychiatric symptoms. Of these, 216 (81%) had previously undetected psychiatric symptoms. No significant correlation was found between the level of distress and socio-demographic factors (age, gender, marital status), medical factors, or psychosocial distress.

Conclusion: The results suggest that psychiatric symptoms are common in patients on a palliative care unit and should be monitored and treated to improve quality of life and reduce suffering.

Abstract number: P1-388
Abstract type: Poster

Psychiatric Symptoms in Patients Admitted to a Palliative Care Unit

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Background: Underdiagnosis of psychiatric symptoms is an essential issue in patients suffering from cancer and is paid even less attention in palliative treatment.

Aims: To evaluate the frequency as well as the therapeutic implications of undetected psychiatric symptoms in patients on a palliative care unit (PCU).

Methods: Patients admitted to one of five participating PCUs were included. The short version of the Patient Health Questionnaire (PHQ-2) was used for diagnosing mental health. Opioid dosages were expressed as oral morphine equivalent (OME).

Results: Data of 68 patients, 66% female, 34% male, were available for further analysis. Undetected psychiatric symptoms were found in 31%, with prevalence significantly higher in women (p=0.001). Significant correlation between patients’ physical and median NRS on pain intensity was observed (p<0.001). Median NRS showed no significant difference between patients without, preexisting or undetected psychiatric symptoms (p=0.11). OME did not differ significantly between patients without, preexisting or undetected psychiatric symptoms (p=0.526).

Conclusion: Undetected psychiatric symptoms are common in patients receiving palliative care and should be incorporated in order to optimise treatment and reduce psychosocial burden.

Abstract number: P1-390
Abstract type: Poster

Which Cancer Patients React to the Disease with Negative Emotions? Role of Demographic Factors and Type of Cancer

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Background: Although hearing diagnosis of cancer often involves negative feelings, not every patient reacts in the same way. While the level of negative emotions like anxiety and depression remains in some patients high, in others it is relatively low.

Aim of the study: The aim of the study was to assess the level of negative emotions (anxiety, depression) in patients with cancer, taking into consideration demographic variables and type of disease.

Methods: The study included 348 women and 224 men (19-91 years, M=54) with a diagnosis of cancer in one of the body areas: tissue and bones, gynecology, urology, lungs, breast, lymphomas, digestive system, head and neck. The group also included patients undergoing rehabilitation. Anxiety and depression were measured using the Modified Hospital Anxiety and Depression Scale (HADS-M). Demographic characteristics were measured using the Questionnaire on Demographic Variables.

Result: The results showed that the highest level of anxiety and depression was observed in patients suffering from breast and gynecologic cancer, the lowest level in patients suffering from: urological, lymphomas and digestive system cancer. Women reported higher levels of anxiety and depression than men. We did not observe significant differences in anxiety and depression with regard to patients’ education level or home town size.

Conclusions: The results indicate that there are certain group of patients that should be more carefully observed, because of potentially worse adaptation to disease. These patients may need more often additional support and/or psychological interventions to lower their negative emotions and help them adapting better to the disease.

Funding: The study was funded with Institute’s research budget.

Abstract number: P1-389
Abstract type: Poster

Anxiety and tension include more physical symptoms as the model for disorientation/confusion. While fatigue results as a predictor in all multivariate analysis (depression (AUC=0.66), anxiety (AUC=0.63), tension (AUC=0.63); disorientation/confusion (AUC=0.66)); dyspnea only appears as a predictor in the models for anxiety (AUC=0.64) and tension (AUC=0.62).

Conclusions: As our models for depression, anxiety, tension and disorientation/confusion in palliative care patients were found and could be useful for clinical practice. Further analysis and research are recommended.

Abstract number: P1-387
Abstract type: Poster
Introduction: Disease, suffering and death of a child’s life contradicts human conception about life, potentially leading professionals who care for such children to burnout. Christine Maslach defines this concept as ‘a syndrome of physical and emotional exhaustion that includes the development of a negative self- esteem, a negative attitude towards work’. Aims: Identification of elements of burnout syndrome in staff working with children with incurable illnesses.

Method: Survey of pediatric staff using self administered Maslach Burnout Inventory (MBI) questionnaire with 22 items on 3 domains: emotional exhaustion, depersonalisation, and personal accomplishment. Results: Out of the 170 professionals surveyed 129 valid questionnaires were returned (99.5%). There was a balanced representation of various units: 22.18% OP departments, 25.11% ICU staff, 27.91 PPC units, 24.8% LTC. 98.45 respondents were women; 97% had a full time job; 55.04% nurses; 23.26% aid nurses; 11.63% doctors; 10.8% others. The largest group 30.2%were those with 5-10 years of work experience; for 96.4% belief in God was rated as very important; 82% being orthodox Christians. The domain most influenced was personal accomplishment (83.75%); high and moderate burnout (nurses being the main group as profession 52.86%; PPC staff being the largest group 57.14% as service) followed by depersonalisation (75.97%); nurses main group 71.43% and emotional exhaustion (39.54%; largest group nurses 53.56%); 71.46% do not recognise their need of specialised support especially senior staff (p < 0.005), as well as who are severely or moderately burnout in the emotional exhaustion (p = 0.01). Conclusions: Even if the results in terms of Burnout Syndrome are not extremely worrying compared with results of studies in other countries, preventive measures are welcomed.

Abstract number: P1-392
Abstract type: Poster

What Do We Understand by the WTHD? Results from a European Nominal Group

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Background: Recently, the phenomenon of a wish to hasten death (WTHD) among patients with advanced disease has attracted growing interest. However, conceptualising the WTHD and establishing its scope is not an easy task. Since the phenomenon appears to cover a range of situations and the terminology used in the scientific literature often lacks precision and consistency.

Aims: To further our understanding of the WTHD through a nominal group (NG) process involving European experts in the field.

Methods: Clinicians and researchers with experience in the area were recruited by intentional sampling to participate in a NG convened in Barcelona in November 2013. The NG was conducted according to a predetermined schedule involving four stages: generating ideas; structured and time-limited discussion; summary and conclusions; and prioritisation of the main conclusions reached.

Results: Seventeen professionals from 15 European institutions took part. It became apparent that there is lack of conceptual precision regarding the WTHD, thus underlying the need to develop a new operational definition. The consensus was: a) in order for the new definition to be useful it would need to be acceptable to a sufficiently heterogeneous group of professionals, b) the definition should be reserved for patients with a predominantly physical illness or condition, c) the wish to die being referred to should be linked to suffering that could have several different dimensions, and d) although the definition might be applicable to a wide range of patients its scope should be clearly set out so as to highlight those situations to which it would not apply, for example, a mere ‘acceptance of death’.

The group also agreed that an international Delphi study would be an ideal way of reaching an accepted definition that fulfilled each criterion.

Conclusion: An agreed operational definition of the WTHD would allow better communication both within and between groups of researchers and clinicians.
The Impact of Group Cohesion on Clinical Outcomes in Advanced Cancer Psychotherapy Groups

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Background: Studies of group cohesion indicate its role as a predictor of positive outcomes and a proxy for therapeutic alliance in group psychotherapy interventions. Yet, there is limited research on the role of group cohesion and other process variables in therapy groups for advanced cancer patients.

Aims: The purpose of this study was to examine group cohesion as a predictor of clinical outcomes in advanced cancer psychotherapy groups.

Methods: Patients with advanced cancer (n = 125) participated in a randomised controlled clinical trial comparing 8 weeks of Meaning-Centered Group Psychotherapy (MCGP; n = 67) with Supportive Group Psychotherapy (SGP; n = 58). Pre- and post-intervention assessments included the Group Cohesion Scale (GCS) and measures of spiritual well-being (FACT-Spi), quality of life (QoL), posttraumatic growth (PTG), and benefit finding (BF). Using a series of linear regressions, group cohesion was analysed as a predictor of several post-intervention clinical outcomes, controlling for pre-intervention levels.

Results: Overall, group cohesion significantly predicted post-intervention spiritual well-being and benefit finding, as well as posttraumatic growth (new possibilities) and quality of life (existential). In MCGP, cohesion predicted post-intervention benefit finding, while SGP cohesion predicted post-intervention benefit finding, posttraumatic growth, and facets of quality of life (social and existential) and spiritual well-being (meaning and peace).

Conclusion: /Discussion: Stronger cohesiveness in psychotherapy groups for advanced cancer appears to improve patients’ ability of patients to find benefit and recognise growth, as well as to enhance spirituality and connectedness. Group cohesion was an essential ingredient that facilitated these existential and spiritual gains, and was especially important when the experimental focus was members providing mutual support.

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Anxiety and Depression in Cancer Patients: A Survey about the Hospital Anxiety and Depression Scale

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Abstract number: P1-396
Abstract type: Poster

Introduction: Oncological patients in the last stage of their lives typically suffer from a combination of anxiety and depression. Focusing on the psycho-oncological care of these individuals, symptoms of anxiety are frequently overlooked.

Aim: The aim of this survey was collecting data on the combination of anxiety and depression in hospitalised oncological patients in a Central European tertiary care center using the validated Hospital Anxiety and Depression Scale (HADS).

Method: A total of 200 patients underwent the HADS questionnaires at the time of first contact. HADS scores were considered normal when ≤7, borderline when 8-10, and abnormal when >11.

Results: Overall, 159 patients (79.5%, 71 women and 88 men, 80 ≥65 years of age and 79 < 65 years) returned completed questionnaires. HADS scores were ≤7 in 34.6%, 8-10 in 19.5%, and >11 in 45.9% of the investigated patients. Abnormal HADS scores >11 were found in 47.1% of men and 46.9% of women (p = 0.580) and in 44.0% of those < 65 and in 50.0% of those ≥65 years of age (p = 0.463).

Discussion: Anxiety and depression as measured by the HADS questionnaire are highly prevalent among oncological inpatients.

The Interrelationship of Death Anxiety and Coping Mechanisms with the Attitudes towards Hospice Palliative Care in Hungary and in English Speaking Countries

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Abstract number: P1-397
Abstract type: Poster

Background: Although hospice care in Hungary is becoming well-known, in everyday practice there are numerous questions evolving around the fact what attitudes the population holds towards hospice care and what other dispositions are associated to it as well as how the taboo around death could be eliminated.

Aim: The aim of this research is threefold:
1) to introduce Wang's et al. (1994) death anxiety questionnaire in Hungarian;
2) to generate scales measuring the attitudes towards certain fields of hospice and end-of-life care;
3) to provide a comparative insight into the interrelationship of death anxiety and coping mechanisms with the attitudes towards hospice care on a Hungarian and an English speaking sample.

Methods: The participants of this study (NHUN=128; NHENG=25) filled in an anonymous online questionnaire that contained items related to death anxiety, coping mechanisms, hospice care acceptance, and occurrence of medical intervention (T1), and after a 1 month followed up period (T2). A numerical scale from 0 to 10 was used to measure the perception of control over their anxiety (0=no control, 10=complete control), and for quality of life and physical exercise (p=very poor, 7=excellent).

Results: From 2002 to 2014, a total of 334 patients participated in the group, with an average age of 55 years, including 82.1% of women, and a drop-out rate/lows to follow-up of 18%. A significant difference was observed between T1 and T2 on the global scale (p=0.01) and anxiety subscale (p=0.01) but not the depression subscale (p=0.11). Participants significantly perceived they were more in control of their awareness (from T0 to T1, scores from 4.5 to 6; p<0.001), with even a more significant improvement at T2 (score of 6, p<0.01). Quality of life significantly improved between T0 and T1 (scores from 4.3 to 5; p<0.001) and between T0 and T2 (4.3 to 5; p<0.001). The physical activity improved significantly from T0 to T2 (4.3 to 5; p<0.01), but not from T0 to T1.

Conclusion: Participants greatly improved their quality of life, anxiety, and depression, and their physical activity after this pragmatic, inclusive group therapy.
Research methodology

Abstract number: P1-400
Abstract type: Poster

Utilising Data from Social Media in Palliative Care Research: Developing an Ethical Framework

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Background: Social media has altered the way we live, and in many ways the way that we die. Online communities are full of discussions about illness, death and dying and these communications are increasingly being reposited within research environments as potential sources of publicly available data. The Marie Curie Palliative Care Research Centre (MCPCRC) has been keen to embrace social media within its work; however there is no definitive set of ethical or practical guidelines by which to work with this data. The centre thus initiated two consensus days, with staff members meeting with external researchers with expert knowledge in the field, to construct a workable, ethical framework for its future research in the field.

Methods: Seven researchers from within the centre and two external experts in online research focused on constructing a set of ethical guidelines. Issues of confidentiality, anonymity and informed consent were all discussed.

Results: The following points are considered to form the basis for ethical, online research: Consent should always be taken from participants for the use of their online communications as research data. Recruitment of participants should be transparent with adequate opportunity for participants to ask questions. Information sheets should be provided and be clear about confidentiality issues that are specific to online research. Potential anonymity issues in dissemination of research must be highlighted to participants. Authenticity is not considered an issue of significance for the MCPCRC. The use of historical text is considered to be problematic and therefore not encouraged. Closed forums created specifically for research purposes are considered by the MCPCRC to be the most appropriate way to conduct online research.

Discussion: The consensus days enabled the construction of a framework for good ethical practice in online research, which can now be followed as the centre develops this area of research.

Abstract number: P1-401
Abstract type: Poster

Recruitment Issues in the Implementation of the Care Pathway for Primary Palliative Care (CPPPC)

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Background: The recruitment process for clinical studies is known to be time-consuming, and could be even more so for studies in palliative care (PC) research. Also for this research project this proves to be true. Family Practitioners (FP) are asked to evaluate the use of the Primary Palliative Care (CPPPC) has been keen to embrace social media within its work; however there is no definitive set of ethical or practical guidelines by which to work with this data. The centre thus initiated two consensus days, with staff members meeting with external researchers with expert knowledge in the field, to construct a workable, ethical framework for its future research in the field.

Methods: Seven researchers from within the centre and two external experts in online research focused on constructing a set of ethical guidelines. Issues of confidentiality, anonymity and informed consent were all discussed.

Results: The following points are considered to form the basis for ethical, online research: Consent should always be taken from participants for the use of their online communications as research data. Recruitment of participants should be transparent with adequate opportunity for participants to ask questions. Information sheets should be provided and be clear about confidentiality issues that are specific to online research. Potential anonymity issues in dissemination of research must be highlighted to participants. Authenticity is not considered an issue of significance for the MCPCRC. The use of historical text is considered to be problematic and therefore not encouraged. Closed forums created specifically for research purposes are considered by the MCPCRC to be the most appropriate way to conduct online research.

Discussion: The consensus days enabled the construction of a framework for good ethical practice in online research, which can now be followed as the centre develops this area of research.

Abstract number: P1-402
Abstract type: Poster

Utilising Data from Social Media in Palliative Care Research: Developing an Ethical Framework

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Background: Social media has altered the way we live, and in many ways the way that we die. Online communities are full of discussions about illness, death and dying and these communications are increasingly being reposited within research environments as potential sources of publicly available data. The Marie Curie Palliative Care Research Centre (MCPCRC) has been keen to embrace social media within its work; however there is no definitive set of ethical or practical guidelines by which to work with this data. The centre thus initiated two consensus days, with staff members meeting with external researchers with expert knowledge in the field, to construct a workable, ethical framework for its future research in the field.

Methods: Seven researchers from within the centre and two external experts in online research focused on constructing a set of ethical guidelines. Issues of confidentiality, anonymity and informed consent were all discussed.

Results: The following points are considered to form the basis for ethical, online research: Consent should always be taken from participants for the use of their online communications as research data. Recruitment of participants should be transparent with adequate opportunity for participants to ask questions. Information sheets should be provided and be clear about confidentiality issues that are specific to online research. Potential anonymity issues in dissemination of research must be highlighted to participants. Authenticity is not considered an issue of significance for the MCPCRC. The use of historical text is considered to be problematic and therefore not encouraged. Closed forums created specifically for research purposes are considered by the MCPCRC to be the most appropriate way to conduct online research.

Discussion: The consensus days enabled the construction of a framework for good ethical practice in online research, which can now be followed as the centre develops this area of research.

Abstract number: P1-403
Abstract type: Poster

Getting the Best Advice: A Systematic Appraisal of Delirium Clinical Practice Guidelines

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Background: The management of delirium in palliative care patients is often guided by expert opinion and extrapolated from other patient populations due to limited high level research evidence. Multiple delirium clinical practice guidelines (CPGs) have been written. However, the quality and validity of published delirium CPGs has not been reported. Aims: To perform a formal appraisal of delirium CPGs (published from 2008 to 2013) using the Appraisal of Guideline research and Evaluation (AGREE II) instrument.

Methods: A librarian-assisted systematic search was conducted in multiple databases (Cochrane Library, Medline, Embase, CINAHL, PsychINFO, Scopus, TRIP) and supplemented by a hand search of Google, Google Scholar and CPG organisation databases. Abstracts/full text and internet sources were reviewed by 2 researchers for inclusion. Available CPGs, retrieved from citations meeting agreed inclusion criteria, were first screened by 2 independent appraisers using the rigour domain of the AGREE II. CPGs with the highest rigour domain scores were then independently appraised by 4 appraisers using the full 23-item AGREE II tool. An overall rating for each CPG was given.

Results: The systematic search found 1629 citations and 29 website links. Seven of the initial 14 retrieved CPGs had rigour domain scores >40%, AGREE domain scores for the 7 CPGs ranged from 8 - 100%. Although the 2010 National Institute for Health and Clinical Excellence (NICE) CPG rated highly in validity and utility domains, it specifically excludes ‘people receiving end-of-life care’. Two CPGs, from CCSMH (Canadian Coalition for Senior’s Mental Health) and CCO (Cancer Care Ontario), had been developed for palliative care patients and were recommended for use with modifications by the appraisers.

Conclusion: Utilising a formal appraisal tool highlights potential weaknesses in the CPG development process and ensures that only high quality delirium CPGs are adopted prior to implementation into clinical settings.
Abstract number: P1-404
Abstract type: Poster

Social Spaces and Singular Encounters: Challenges to Conducting Qualitative Research Interviews in Palliative and End of Life Care in the Home Setting

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Aims: Within palliative and end of life research, qualitative research interviews are often undertaken in the home. Despite practical and ethical challenges, little attention has been given in the literature to the impact of the home setting on managing a simultaneous research and social relationship with interviewees. This work looks to explore these issues and the implications for both participants and researchers.

Methods: The views and experiences of researchers from an academic palliative care research centre are presented. Eight experts in research from a range of backgrounds including nursing, occupational therapy, social science, psychology and palliative medicine, took part in a group consensus meeting to discuss their experiences of conducting qualitative research with vulnerable populations in the home. Further comment was included from a palliative medicine physician, also experienced in qualitative research.

Results: The researchers reflected on several important ethical and practical issues. These included ways in which to build rapport in often singular encounters, and applying sensitivity and flexibility in difficult circumstances. The research interview can become therapeutic for the participant, however interviewers need to be aware of unintentional power relationships between themselves and their participants and the implications for data quality, as well as both patients’ and interviewers’ physical and emotional safety.

Conclusions: In this setting, and with this particular patient group, less attention should be paid to interviewers’ professional stance of neutrality and non-disclosure and more to allowing appropriate social contact, and humanity. However, care needs to be taken to avoid creating a false rapport and therapeutic environment that may cause ultimately distress to the participant as a singular encounter. Recommendations will be made to address both practical and ethical concerns for researchers working in this field.

Abstract number: P1-405
Abstract type: Poster

Following Not Missing the Thread

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Background: Within all studies there needs to be a recognised role for each individual method that adds independent value or depth to the study. However there is an additional requirement for doing a mixed methods study for data integration. There are three recognised approaches for achieving this; the use of the triangulation protocol, the use of a mixed methods matrix; and, following a thread.

Aim: To investigate the role of facilitation when implementing the Gold Standards Framework in Care Homes (GSFCH) programme within nursing care home practice when the findings from data generated by two or more methods are brought together.

Methods: Qualitative and quantitative data were collected from staff employed within nursing care home managers and GSFCH (co-ordinated) or associated with (external facilitators); 38 nursing care homes and included interviews, surveys, Facilitator Activity Logs and a researcher’s diary. After separate quantitative (descriptive) and qualitative (themetic template) data analysis the data sets were integrated by following a thread.

Results: Following a thread resulted in the identification of a sub-theme in the qualitative data which had not been identified during the initial analysis of the quantitative data. The Facilitator Activity Logs were reviewed to see if there was any evidence of this sub-theme. Initial analysis of these logs had only taken account of the components of a specified high facilitation or the high facilitation and action learning facilitation role. The new sub-theme was not such a component. Following a thread identified a significant association between the time a facilitator designated for accreditation and the nursing care home gaining accreditation (p < .01257).

Conclusion: Following a thread enabled epistemological triangulation. More became known about a phenomenon when the findings from data generated by two or more methods were brought together.

Abstract number: P1-406
Abstract type: Poster

Who Needs Need? A Qualitative Study of Need in People with Severe COPD

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Background: Healthcare need is a complex concept. Research suggests people with severe Chronic Obstructive Pulmonary Disease (COPD) have many unmet needs but are a ‘silent’ group.

Aim: To explore the concept of need in advanced COPD from patient/carer and professional perspectives.

Method: We recruited people with severe COPD from 2 hospitals in Scotland to complete action plans following discussion after discharge with a respiratory nurse with palliative care training. We analysed the plans and conducted a series of in-depth qualitative interviews with a subsample of patients and their family and professional carers. These were recorded, fully transcribed and entered into NVivo for thematic analysis using Bradshaw’s classification of felt, expressed, normative and comparative need.

Results: 18 patients, 5 carers, 28 professionals provided 51 interviews, and 23 action plans. Some ‘normative’ needs were defined by professionals and some practical issues had been addressed during routine discharge planning. Other needs (physical symptoms and limitations, activities of daily living, social and financial concerns and existential issues) were ‘felt’ by patients and family carers but articulated in response to direct questioning by the researcher rather than actively expressed. Patients often did not wish any action to address the problems, preferring care from family members rather than formal agencies. Many spoke of the over-arching importance of retaining a sense of independence and autonomy, considering themselves as ageing rather than ill. Few needs were identified by our intervention and few actions planned.

Conclusion: In contrast to professionally-defined ‘normative’ needs patients rarely perceived themselves as needy accepting their ‘felt’ needs as a disability to which they had adapted. Sensitive approaches that foster independence may enable patients to express needs that are amenable to help without disturbing the adaptive equilibrium they have achieved.
The Challenge of Gaining Access to Informal Caregivers in the Advanced Heart Failure Population in Ireland

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Aim: Explore the palliative care (PC) needs and quality of life (QoL) of patients with heart failure (HF) and their caregivers on the island of Ireland.

Methods: A sequential confirmatory mixed methods study consisting of a postal survey with patients and caregivers followed by a semi-structured interview with caregivers was undertaken. Databases within HF clinics in Northern Ireland and the Republic of Ireland were searched to identify advanced HF patients. Patients deemed physically and mentally suitable, ≥18 years, New York Heart Association Classification III-IV, ejection fraction < 40% and (i) brain naturtic peptide > 400 pg/ml or (ii) a 1 unscheduled hospital admission in the previous 12 months or (iii) on IV diuretics during the previous 12 months were invited to take part.

Conclusions / lessons learned: Advanced HF is a population who would benefit from PC services and it is widely accepted that caregivers play a vital role in facilitating the care and therefore the care experiences is a priority. Albeit, undertaking research in this population of caregivers is extremely challenging. Currently in Ireland, people caring for HF patients are not widely known to services and given the number of gatekeepers to caregivers, when recruiting via patients, gaining access to this population of caregivers is problematic. In order to adequately explore caregiver's experiences more innovative approaches are needed to recruit this group on to research studies.

Abstract number: P1-408
Abstract type: Poster

Identification of Knowledge Transfer and Exchange Frameworks for Palliative Care: Findings from a Scoping Review

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Background: Scoping reviews, despite being increasingly popular in health research, are still rarely used in palliative care research. Unlike systematic reviews, scoping reviews address broader questions, include studies with different methods and use different methods of quality appraisal. They are quicker to perform and enable inclusion of heterogeneous evidence, both necessary if examining knowledge transfer and exchange (KTE) models in palliative care. Although there are currently over 60 different models of KTE designed for various fields of health care, many of them remain largely unreferred and untested. Hence it is difficult to estimate their effectiveness in the context of palliative care.

Aim: The study aims to elicit appropriate KTE models for potential application in palliative care.

Design: A scoping review was designed according to the guidelines proposed by Arksey and O'Malley (2005) and Levac et al. (2010).

Results: Initially 7544 abstracts were identified as fitting search criteria. Following removal of duplicates 4868 abstracts were included for full text review. Preliminary agreement for inclusion/exclusion was 78%, with approximately 10% of papers retained for full text review. Research was classified as 'seminal' (where a new model was proposed) or 'implementation' (where a specific model was appraised in practice). Commonly used models, including PARRHS and the OMRI, take account of the empirical evidence as well as the processes of putting the evidence into practice in particular settings.

Discussion: The scoping review has allowed us to identify studies outlining models of KTE in health care setting and will lead to analysis of their applicability to the complex demands of palliative care. Results from this review will identify effective ways of translating different types of knowledge to palliative care providers, and could be utilised in hospital, community and home care as well as future research.

Abstract number: P1-409
Abstract type: Poster

Mapping Social Support Systems in the Field of Specialized Home Pediatric Palliative Care (SHPPC)

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Background: Effectiveness of psychosocial support in families where a child suffers from a life limiting disease depends on the subjective perspectives of the actors involved. For the first time in pediatric palliative care (PPC) network maps were used as a tool for the care given and the caregivers on their social support system.

Aim: The aim of study was to explore the applicability of NMs in SHPPC and to examine whether the use of NMs leads to a better understanding of how support networks influence caregiver's experiences with children in PPC. 

Method: Study participants were close relatives who cared for a child at home that received SHPPC for at least 2 weeks. With a mixed method approach both quantitative and qualitative data were collected. NMs to identify and visualise all significant members of a participant's social network, the closeness and the quality of relations. The creation of the NMs was accompanied by deepening interviews. The data collection included the recording of the interview, the NM itself as well as the automatic generation of structural data during the creation of the digital NM.

Results: Between 10/12 and 02/14 45 family caregivers were enrolled in the study. All participants of the heterogeneous sample were open to this method and took the time (mean 77 min) to visualise their support situation. Working with NMs was unanimously rated positive even when hidden but building aspects were unexpected. The position of support systems differed widely, even within the members of one family. For example, the numbers of named actors vary between 3 and 28 (mean 11), the number of actors perceived as negative between 0 and 18 (mean 1.9).

Conclusion: NMs are an appropriate tool for collection, reconstruction and assessment of the current support situation. Further studies should examine the usefulness of NMs for the understanding of the caregiver’s support needs by the SHPPC team and for the development of intervention strategies.

Abstract number: P1-410
Abstract type: Poster

Volunteering

Abstract number: P1-411
Abstract type: Poster

Redesigning Volunteering and Building Community Engagement

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Integrating the former roles of Ward and Day Therapy Helpers and Receptionists, volunteer Hosts provide a positive, friendly greeting to visitors and support our aspiration of a ‘building without barriers’.

The role aims to:
- Create a volunteer workforce aligned to the vision of the hospice
- Develop a flexible team able to respond to changing demands
- Provide peer support
- Provide hospitality and companionship to patients, relatives and visitors.

Inspired by the Help the Hospices Commission report ‘Volunteering: vital to the future of Hospice care’, and prompted by a new build, the Host role demonstrates an innovative approach to volunteering that supports our vision of creating a community that talks openly about dying. It offers volunteers a rewarding and life enhancing experience and has enabled them to more confidently respond to patients and their relatives and hold informed conversations with the public.

The new role demanded a 150% increase in volunteers and involved:
- Meeting with existing volunteers, explaining proposed changes and taking feedback
- Recruitment day and orientation prior to moving to the new hospice
- Providing guided tours to the public and in doing so enhancing building familiarisation.

Outcomes:
- Changes in the volunteer profile: 6% are under 30, and 19% male.

New sections of our community have a greater understanding of hospices

Engagement by a new generation of volunteers can help change societal attitudes.

A volunteer investment and value audit demonstrated a £7 return on investment for every £1 spent on volunteers. This role is informing plans for recruitment, induction and ongoing training for all volunteers and the flexible approach modelled is encouraging a change in organisation culture. The role and team approach to volunteering has potential to be replicated in other hospices and was well-received by senior hospice executives at a recent master class.

Abstract number: P1-412
Abstract type: Poster

The Asklepiad Tradition? Value of End of Life Volunteering According to Volunteers themselves

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Background: In the Netherlands each year more than 10,000 volunteers provide a contribution to palliative care at hospices and at home situations. The value of these contributions seems hard to frame from theoretical levels and is questioned from policy and professional care perspectives.

Aim: Therefore the aim is to explore the value of volunteering contributions to palliative care for clients, nearest relations, regular care and society. This study focuses on the question: what do volunteers bring to their volunteers themselves.

Methods: A call on the website of the Dutch national branch organisation VPTZ[1] resulted in more than 130 volunteers’ letters. 100 of these were processed by a qualitative discourse analysis. Volunteers wrote more on topics other than only the research question.

Results: The results describe motives to start as a volunteer and the character of their practice, and yield types and impact on the volunteers. A very clear result is the type of language that volunteers use to describe their experiences, it indicates a focus on ‘being there’ as a central concept. Furthermore, it strikes that volunteers' satisfaction relates to the quality of ‘being there’ in connection with a) making a difference, b) sharing experiences with other volunteers, and c) the environment in which volunteers function. Personal growth related to quality of ‘being there’ comes out as a prominent produce.

Reflection and conclusion: We reflect from an overview of different theoretical lenses on volunteer’s contribution in end of life circumstances, with special attention to theories of pre-sencing, as well as to the so-called Asklepiad tradition as described by Randall and Downie (2010).

The authors thank the KN foundation (PIN Committee) for their support.

[1] Volunteers Palliative Terminal Care (The Netherlands)
Abstract number: P1-413
Abstract type: Poster

**Volunteering: What Does It Mean to Children’s Hospices?**

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In the UK today there are 50 children’s hospices supported by approximately 17,000 volunteers, with a collective contribution of approximately £23 million. This paper reports on children’s hospice data from a research study exploring the unique influence and impact of volunteers on UK hospices.

**Purpose of the research:** Using an innovative theoretical model of volunteering impact the purpose of the research was to:

§ Explore the influence of volunteers on key aspects of the service

§ Explore the differing perceptions of different groups on volunteering and its meaning to the hospice

**Method:** Because of the geographic spread, self-administered questionnaires were employed. Three online questionnaires were developed, one for each stakeholder group: trustees, senior staff and volunteers. These were sent to all independent hospices. Data was analysed by hospice type, hospice size, participant group and country, enabling a range of information to be extracted and compared.

**Findings:** Findings indicated that volunteers were vital to the ability of hospices to provide the level and range of services offered. They were considered to be an integral part of the staff team and were seen as important, not only to the care of children and young people, but also to supporting families. Their contribution was inextricably linked with the financial success of the organisation and they were perceived to have a key role in community engagement, public education and breaking down taboos around children’s hospice care, helping to make it more accessible. A number of hospices indicated that they would have to close without the involvement of volunteers. There was a clear commitment to further developing their involvement in the care and support of children, young people and their families.

**Conclusions:** Volunteers are in essential part of children’s hospices and their influence and impact is significant at all levels of the organisation.

Abstract number: P1-414
Abstract type: Poster

**The Role of the Volunteers and their Activities in Hospice and Palliative Care in Poland**

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**Background:** In Poland volunteers are present in hospice and palliative care. They help patients and their families as well as they perform various services as non-patient facing volunteers.

**Aims:** The aim of the study was to examine volunteering in hospice and palliative care in Poland.

**Methods:** A cross sectional survey was applied. An anonymous questionnaire was addressed to hospice directors from Polish hospices which cooperated with volunteers. The respondents reported about the current state of volunteering at the unit they manage.

**Results:** 28 Polish hospices took part in this survey. 46% of the examined units cooperate with 10 to 30 volunteers and 29% of them with more than 30 up to 100 volunteers. The core volunteer roles are as follows: patients support (96%), patients’ families support (56%), bereavement support (61%), and other, not associated with direct patient care (89%). The activities of volunteers are: organising patients’ leisure time (75%), praying together (75%), accompanying patients (71%), feeding them (71%), cleaning their rooms (68%). Other activities include: organizing charity events and fundraising (68%), helping building (54%), administrative and office work (32%). Hospice volunteers are obliged to keep patient and family information confidential (89%), consult all activities connected with patients’ care with hospice staff (86%), participate in a training (71%), know the patients’ rights (61%). Improvement of patients’ quality of life is a main benefit of volunteers engagement in hospice and palliative care.

**Conclusion:** Volunteers value in the Polish hospice and palliative care is the perception of hospice directors is high. A key component of their role is the direct patient care and the improvement of patients’ quality of life is the considerable advantage of their activity. Moreover, they also perform other services which are beneficial for the hospice.

Abstract number: P1-415
Abstract type: Poster

**Hospice Volunteers’ Spiritual Care Training: Discussion on Core Competencies and Training Aims**

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**Background:** A Germany-wide survey among the hospice coordinators confirmed that there is a need for assistance in arranging the spiritual care (SC) training. The survey highlighted the need for a consensus-based national hospice volunteer training program.

**Aim of the study:** This explorative study was designed to define the core competencies and training aims for the curriculum under construction.

**Methods:** Eight hospices were invited to participate in an expert group interview. The participants represented religious and secular institutions engaging various numbers of volunteers. All experts had a long term experience of working in their institutions, but different experiences in teaching SC.

**Results:** The analyses revealed that SC training for volunteers should cover following themes and practical assignments:

1. (1) definition(s) of spirituality;
2. (2) the role of different belief systems;
3. (3) recognising spiritual needs and resources;
4. (4) the meaning of rituals and creativity;
5. (5) the art and ability to relate meaningfully;
6. (6) initiating and ending spiritual encounters;
7. (7) networking with pastoral care and community chaplains;
8. (8) voicing and acknowledging own spirituality.

Two additional requests were proposed. Firstly, instead of lecturing practical exercises should be integrated in teaching spiritual care. Secondly, the educationalists should possess skills and experiences in pastoral care / theology and in hospice / palliative care.

**Conclusion:** SC is an essential part of the hospice volunteers’ training. Hospice volunteers are confronted with a variety of spiritual needs in patients/ caregivers. They are expected to identify spiritual distress and work with disrupted beliefs and values system. The expert discussion highlighted that hospice volunteers need a proper end-of-life training that involves spirituality and SC.

Abstract number: P1-416
Abstract type: Poster

**National Hospice Volunteer Program Development in Hungary**

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**Background:** According to a recent survey, volunteers are under-utilised in hospice care in Hungary. Only a few hospice care services train volunteers and these educational programs differ both in content and quality. The vast majority of hospice services are reluctant to train volunteers due to their limited knowledge and experience.

**Goals:** Development a consensus-based national hospice volunteer training program and provide professional consultancy for hospice services to encourage and support them establishing local hospice volunteer programs.

**Methods:** During 2013-2014 two pilot hospice volunteer educational programs were held in Hungary: a forty-hours training (Pilot1) in Budapest by Hungarian Hospice-Palliative Association and a twenty-hours training (Pilot2) in Pecs by Pecs-Baranya Hospice Program. Pilots were compared and analysed in terms of content and efficiency.

**Results:** Nearly 80 candidates participated in the selection process. From these 33 people completed the training program in the two pilots. Approximately half of the trained volunteers support hospice teams actively. A multidisciplinary working group was established to evaluate the results. Analysing the content, Pilot1 more strongly prioritised on communication skills development while Pilot2 on field practice. The multidisciplinary group is working on the development of a consensus-based hospice volunteer training program (manuals and e-learning packages).

**Conclusions:** With the increasing demand for hospice care, services could benefit from volunteers’ presence and support by widening the range of services provided, improving quality of care and reducing burdens of formal and informal caregivers. Development and dissemination of a consensus-based national hospice volunteer training program and its integration into the Hungarian Hospice Palliative Care Guideline will contribute to achieve this purpose.

Supporter: EEA/Norwegian NGO Fund (Pecs-Baranya Hospice Program)

Abstract number: P1-417
Abstract type: Poster

**Patients’ with Advanced and Terminal Cancer Reported Experience: The Importance of Nurse’s Way of Caring**

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**Background:** The patient-patient relationship is key to provide individualised care and to improve the quality of life of the Person with Advanced and Terminal Cancer (PATC). Moreover, the relationship between the nurse and the patient may influence in the global experience of the PATC.

**Aims:** To understand the nurse-PATC relationship and to identify its essential elements from patient’s perspectives.

**Methods:** A qualitative study with a hermeneutic-phenomenological approach was designed. 16 PATC hospitalised at an oncology ward were interviewed in depth. They were asked to describe their relationship with the nurse.

**Results:** In the illness global experience of the PATC, nurses play a decisive role. Patients when talking about the relationship with nurses refer to their way of caring considering the following aspects:

1. (1) The way in which nurses take care of patients is an expression of their way of being.
2. (2) Patients feel nurses close through their words and actions.
3. (3) The affection and love relates for the patient.
4. (4) Patients are treated as persons despite their health condition and limited lifespan. As such they are cared in a holistic way considering their corporal and spiritual dimensions. PATC feel that the attitude of nurses and the way in which they care for them influences their hospitalisation period experience and in some cases even patients’ life.

**Conclusion:** The way of being of nurses and their way of meeting the PATC is central when caring for them. Therefore professional nurses’ different experiences in teaching SC.

Supporter: Fondo de Investigación del Consorcio Sanitario de Castilla-La Mancha and Fondo de Investigación Sanitaria (PI14/01777-01)
Lung Cancer Diagnosed Following an Emergency Admission: Exploring Patient and Carer Perspectives on Delay in Seeking Help

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Background: Compared to others, patients diagnosed with lung cancer following an emergency, unscheduled admission to hospital (DFAE) have more advanced disease and poorer prognosis. Little is known about DFAE patients’ beliefs about cancer and its symptoms, or about their help seeking behaviours prior to admission.

Methods: A cross-sectional, qualitative study conducted between 1/1/2010 and 12/31/2011. Demographics, frequency/intensity of ESAS-symptoms and different interventions: opioid-management, medication review, bowel regimen, psychological, emotional, social and existential consequences. Information, knowledge and measures is very limited. Thus, the aim of this study was to, based on men’s experiences of living with, and undergoing life-prolonging treatment of, metastatic castration-resistant prostate cancer (mCRPC), identify issues and matters of importance and significance to this group. The study also includes an evaluation of a questionnaire intended for use in a larger prospective research project involving men in the corresponding situation. The study was conducted with qualitative design. Data was collected through nine interviews, five were semi structured and four were carried out with think-aloud methodology. The content of the interviews revolved around the questionnaire, as well as the participants’ situation living with and undergoing treatment of mCRPC. Data was analysed using qualitative content analysis. In conclusion, the result indicates that living with and undergoing life-prolonging treatment of mCRPC can mean being in a world of uncertainty and change. This could be manifested in various ways, with physical, psychological, emotional, social and existential consequences. Information, knowledge and participation in decision-making appeared to be of importance. The complexity of these men’s situations puts demands on health care, where the holistic view of the patient, continuity and trust were described as essential. The result was applied in the completion of the research project questionnaire. The study was carried out with financial support from Söderhemmet research fundings and County Council of Sörmland.

Abstract number: P1-422
Abstract type: Poster

Hypocalcaemia in Cancer Patients: An Exploratory Study

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Background: A 77 year old patient with bone metastases of prostate cancer was admitted in palliative care due to uncontrollable back pain. While at the palliative care unit he developed severe neuromuscular immaturity. The ionised calcium was 0.55 mmol/L (1.17 - 1.24). IV Calcium gluconate was initiated with symptomatic improvement. However, the symptomatic control was not possible with oral calcium and the patient died in a few days. Aim: To explore the frequency of hypocalcaemia in cancer patients.

Methods: Revision of the records of patients ≥ 18 years old, with a total calcium < 2.0 mmol/L measured in 2013. Results: 832 patients had a total calcium < 2.0 mmol/L. 441(53%) were male. The median age was 63.5 years (18-93). The most frequent cancer diagnoses were hematological 197(24%), colorectal 111 (13%), lung 86 (10%), thyroid 67 (8%), breast 54 (7%), stomach 51 (6%), gynecological 42 (5%) and prostate 39 (5%). 640 patients had a serum albumin measured, with a median of 25 g/L (14-47). When corrected for the albumin level, in 275 (33%) cases the calcium was in the normal range. The date of death was recorded in 283 cases to whom it was possible to calculate the total calcium. Possibly, the total median calcium corrected with corrected calcium lower than normal was 26.5 days (1-311) and that of patients with a normal corrected calcium was 19.0 days (1-395), p = 0.149, therefore non-significant. Conclusion: Hypocalcaemia in cancer patients may be important as in the clinical case presented, but that can be properly studied only in a prospective study.
Lessons learned: Health promotion in palliative care has been shown to improve the activity level and quality of life. The trend is that early detection of palliative challenges result in longer symptom-free periods, which allows patients to stay in their homes for as long as possible.

Early detection of palliative care is crucial because it provides patients and their families with the opportunity to discuss their treatment options and preferences. This can help patients and their families make informed decisions about their care and can improve the quality of life for patients and their families. In addition, early detection of palliative care can also help to improve symptom control and reduce the burden on healthcare providers.

It is important for healthcare providers to be aware of the signs and symptoms of palliative care and to be able to detect them early. This can be done through regular communication with patients and their families and by being attentive to changes in patients' symptoms and behaviors. Early detection of palliative care can also be facilitated by the use of screening tools and by the development of guidelines for the early detection of palliative care.

In conclusion, early detection of palliative care is important because it can improve the quality of life for patients and their families and can help to reduce the burden on healthcare providers. Healthcare providers should be aware of the signs and symptoms of palliative care and should be proactive in detecting and managing these challenges. Early detection of palliative care can also help to improve symptom control and reduce the burden on healthcare providers.

References:

Abstract number: P1-426

Abstract type: Poster

"All’s Well that Ends Well?": Or is It?

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Although palliative care traditionally started at the end of the treatment phase the modern concept encourages palliative care consultation at a much earlier stage of the disease process. Some would argue even at the time of diagnosis. Modern palliative care goes beyond death to endeavour to support relatives with significant bereavement difficulties. But what of long term survivors of cancer who a significant number have symptoms and symptom clusters very similar to palliative care patients with a limited life expectancy? When discharged from the oncology service how are these patients with significant symptoms managed?

There are approximately 1 million cancer survivors in the United States of which many are more than five years post treatment. (65%). the majority are cancer free however a significant proportion are left with the sequelae of their surgical, chemotherapy and radiation treatments.

The aim of this study was to determine whether there was a need for palliative care and palliative care referral to coincide with the patients transition from active treatment to support and palliative care. We present our experience with advanced oncological patients in outpatient palliative care (OPC) setting. There is a need for palliative care in patients soon after cancer diagnosis and in the last weeks of life in 2013 was carried out using the databases of pharmacy services and systems and protocols that address these problems so that they can adequately be managed. As treatments improve so will long term survivors. The challenge to be faced is to design systems and protocols that address these problems so that they can adequately be managed in the primary care setting with the appropriate speciality consultation.

Abstract number: P1-427

Abstract type: Poster

Palliative Care over Patients with Hemopoietic Diseases Hospitalised in the Department of Hematology, Poznan University of Medical Sciences (UMH) in Poznan in the Years of 2008-2014

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Patients with hemopoietic diseases require a number of diagnostic procedures aimed at defining clinical advancement and determination of prognostic variables. Evaluation of patient's general condition is also indispensable as well as examination of potential coexistence of other diseases. Basing on the data, therapeutic decisions are undertaken. The activities aim at cure or at prolongation of patient's survival. In the years of 2008-2014, 10,083 patients were hospitalised in our Department including 30 patients (0.3%) who received palliative care. The patients ranged in age from 25 to 73 years (median age 44.8). they included 14 women and 16 men. The most numerous were patients with acute myeloblastic leukemia (13 patients, 43%); and patients with non-Hodgkin lymphoma (7 patients; 23%). Acute lymphoblastic leukemia and chronic lymphocytic leukemia was diagnosed each in 4 patients (13%). In the evaluated group myelodysplastic syndrome with excess of blasts was diagnosed in one patient (3%). Also Hodgkin's lymphoma was detected in one patient (3%). Duration of hospital stay ranged from 5 to 131 days (median value of 63.1 days). In view of patients age, general condition, complications in the form of multi-organ failure and primary resistance to treatment, at a defined stage of treatment no further intensive therapy was administered and the patients were referred to palliative treatment. However, they were not referred to other hospitals or to the ward of palliative treatment but till the end of their life remained under care of the team of physicians, nurses and psychologists in the Department of Hematology. Care over the patients included first of all nursing hygienic activities, analgetic drugs, both narcotic and non-narcotic, were administered, liquids were infused. The management, conducted by a multi-disciplinary team, warranted for the patients a relative comfort in the last days of life, as well as dignity, peaceful death.

Abstract number: P1-428

Abstract type: Poster

Receiving Chemotherapy for Cancer in Later Life: A Comparative Study in Two Cancer Services

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Contexts and goals: Cancer death rate remains high- second cause of death. Chemotherapy increased the hope of cure and/or a longer survival. Therapeutic recent advances have frequently identified the cancer to a chronic disease under prolonged chemotherapy. However, there is little data available on the chemotherapy (CT) benefits in advanced stages of the disease.

Method: The collection of data from patients receiving cancer chemotherapy intravenously in the last weeks of life in 2013 was carried out using the databases of pharmacy services and medical information. The treatment was focused on two different services: one in medical oncology (solid tumors of any origin) and the other in digestive oncology. Both services are distinguished by their further recruitment but also by the existence of a
Multidisciplinary Consultative Meeting (ICP) centered on supportive care in digestive oncology service.

Results and discussion: 85 patients died in medical oncology in 2012 and 35 in the service of digestive cancer. Within 30 days preceding the death, 40% received chemotherapy IV in Medical Oncology and 14% in the service department of digestive cancer. In the last 15 days of life, the respective rates were 36% and 11%. It seems that chemotherapy IV longer be pursued in oncology.

Limitations: Types of different cancer, death occurring outside the hospital and CT oral ignored.

Perspective: The role of ICP supportive care in help in identifying palliative time with suspension of CT is highlighted by the difference between these two services. Supportive Care ICP lead to ask a number of questions: What benefits expected in this parameter in terms of survival? Quality of life? What care proposals can be made to the patient? Patient involvement in these decisions - including the development of alternatives to continued chemotherapy actual is all the more important that the expected benefits may be uncertain and/or marginal.

Abstract number: P1-429
Abstract type: Poster

Nurturational Strategies in Head and Neck Cancer (HNC) Patients in Palliative Care (PC)

Manchado Coutinho LC1, Flor de Lima M.T.1, Carvalho R.1, César R.1

Abstract number: P1-430
Abstract type: Poster

Facing the Challenge - A Retrospective Review of Head and Neck (H&N) Cancer Deaths within a Regional H&N and Unit and a Specialist Palliative Care Unit (SPCU) in England

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Abstract number: P1-431
Abstract type: Poster

What is the Appropriate Time to Start Palliative Care in Different Cancer Trajectories?

Menten J1,2, Rochus T1, Peeters E1, Bollen H1

Abstract number: P1-431
Abstract type: Poster

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Background: Attachment orientations in coping with illness are crucial in cancer patients. Furthermore, satisfaction with palliative care is essential for appropriate interventions.

Aims: To evaluate the relationship between cancer patients’ satisfaction and attachment in palliative care setting.

Methods: We studied 100 patients (x= 69.10 years old) suffered from cancer. The most frequent types of cancer were urogenital (34%), gastrointestinal (26%). Satisfaction and attachment patterns were assessed with Famcare-P13 (consisted of 'information/interaction with health care professional' and 'availability of care') and Experiences in Close Relationships Scale (ECR) (consisted of 'anxiety', 'discomfort with closeness' and 'avoidance'). Univariate and multivariate analyses evaluated the relationship between satisfaction and attachment.

Results: Significant comparisons were found between 'information/interaction with health care professional' and 'availability of care' (p< 0.0005). 'Availability of care' correlated significantly with 'anxiety' (p< 0.035), 'discomfort with closeness' (p< 0.051), 'avoidance' (p< 0.007). A multiple regression model showed cancer duration (p< 0.0005), metastasis (p= 0.046), chemotherapy (p= 0.0005) and surgery (p= 0.032) as predictors of 'information/interaction with health care professionals'. Education (p= 0.040), anxiety (p= 0.02) and avoidance (p= 0.056) were the strongest contributors of 'availability of care'.

Conclusion: Satisfaction, regarding patients’ interaction with health care professionals depends on cancer duration and multidisciplinary treatments. Patients’ satisfaction concerning availability of their care were influenced by education, anxiety, attachment and avoidance.

Abstract number: P1-433
Abstract type: Poster

New Palliative Treatment Strategy for Cancer: Enzyme-targeting and Radio-sensitization Treatment So-called KORTUC

Obata S1, Nagayama H.1, Otta Y.1, Kita T.1, Kanege S.1, Inoue Y.1, Kuroiwa A1, Inoue K.2, Nakamura K.1, Yamauchi H.1

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Background: It has been reported that influenced factors to radio-sensitivity for the tumor were cancer cell specific factors, cancer cell cycle, and environment of cancer cell. We thought the environment of cancer cell was artificially most likely changeable factor. Among the factors, hypoxia is a tremendous impact. It is generally known hypoxic cells resist radiation therapy, too.

Aims: We have utilised the theory of Kochi oxylaid-radiation therapy for unselectable carcinoma (KORTUC) to create oxygen saturated situation. Irradiation becomes more effective for cancer by this method. We have experienced 61 KORTUC cases for 4.5 years. These cases were divided into breast cancer, lung cancer, cervix cancer and cancer in head and neck region.

Conclusion: KORTUC has not been spread in Japan, yet. This treatment has performed in only 3% of our clinic. It is thought that the results of KORTUC is for only cases with low oxygen level.

Oxydol administration into the tumor resulted in death 0.2 mm from the tumor. This radiation resistance of hypoxic cells is considered to acquire from 0.2 mm from the tumor. This radiation resistance of hypoxic cells is considered to acquire from
the reduction of antioxidant enzymes and the increase of oxygen. At last, oxygen saturated
...suffered consecutively related bacteremia catheter between January 2011 and December 2012.

Results: 19 episodes in 16 patients were analysed. 3 two times. Mean age 63 (range 54-81).
17 werearth Porth-a-cath. One a drum and one a Hickman. 11 women. 9 Breast, 5 bowel,
prostate and glad blade: 1 and one gastric, ovary, lymphoma. 6 with chemotherapy.
Etology of bacteremia and IR-CVC: coagulase negative Staphylococcus: 7, 5 aureus - 5
Pseudomonas aeruginosa - 2; Proteus mirabilis - 1; Escherichia coli: 1.5; epidermidis - 1;
Klebsiella pneumonia: 1; Enterobacter cloacae: 1.

Discussion: catheter infections are cause of hospitalisation for fever in palliative patients. The gram positive bacilli bacteremia has been the most frequent process, followed by GNB and fungi. Early catheter lock allowed keeping them.

Abstract number: P1-435
Abstract type: Poster

Engagement in Everyday Activities for People with Advanced Cancer at Home

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Background: For people with advanced cancer, the daily life is characterised by frequent and rapid changes as the illness progresses. These changes impact the ability to engage in meaningful everyday activities at home. It is suggested that engagement in everyday activities is a basic human need that add meaning to life and helps support and restore quality of life. There is limited knowledge on how people with advanced cancer experience their engagement in everyday activities at home.

Aim: To understand how engagement in everyday activities is described and experienced by people with advanced cancer at home.

Methods: A qualitative descriptive design was applied. Participants were consecutively recruited from a Danish university hospital. Semi-structured interviews were performed in the participant's homes. Questions covered aspects of engagement in everyday activities, e.g. activities of a typical day and of specific importance. Interviews were audio recorded and transcripted verbatim. A content analysis was performed.

Results: The sample comprised 74 participants (54% male), WHO Performance Scale: 1 (43%), 2 (47%), 3 (10%), mean age 68.3 years (36-89), 36 lived alone. Preliminary results show that the participants spent most of the day at home and that functional limitations influenced their ability to manage the daily life. They experienced difficulties with and loss of meaningful everyday activities, e.g. leisure activities and social interactions with family and friends.

Discussion: This study contributes with knowledge on the everyday activities of people living with advanced cancer at home. This knowledge can inform and strengthen the quality of future interventions focused on enabling engagement in the everyday activities that people with cancer find meaningful in order to enhance their quality of life.

Abstract number: P1-436
Abstract type: Poster

Parenteral Hydration Therapy at the End of Life

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The use of parenteral hydration in terminally ill patients is controversial because it is
unknown what the impact of this at the end of life. System Edmton Symptom Assessment (ESAS) was developed to assess a variety of symptoms frequently reported by patients in palliative care regardless of their specific diagnosis.

Methodology: A descriptive study, in which patients were hydrated for 3 weeks and each evaluated the ESAS was performed considering inclusion criteria, exclusion and elimination.

Results: A sample of 24 patients, of whom 14 completed measuring 10 abandoned by familial impairment, was obtained. The most prevalent symptoms and higher scores on ESAS were tired with a prevalence of 68% and an average intensity of 2 ESAS, poor appetite with an average of 16% and 4.9 ESAS, drowsiness at 14%, 4.4 ESAS. Upon completion of the outline of the most prevalent symptoms hydrations were similarly fatigue averaging 18% and those of 3.3, poor appetite and 11% average of 2.1 and drowsiness ESAS averaging 14% and in those of average 2.6. Anxiety although it was not a symptom of high prevalence during measurements (7% down to 3% final), was the one that most registered a decrease of intensity ESAS in those patients with this symptom at the beginning of the measurement, being 2.2 at the beginning and 0.5 at the end.

Conclusions: The prevalent symptoms in patients in Palliative Care for hydration schemes show a downward trend, which makes us think that the hydrations have a beneficial effect at least in the perception of symptoms experienced by patients and same tendency to decrease in intensity as anxiety symptom events suggests that condition moistening effect on the emotional state of the patient. Measuring the severity of symptoms of patients who are palliative hydration schemes opens a new line of investigation as the moisturizing effectiveness in these patients.

Abstract number: P1-437
Abstract type: Poster

Why Does Advanced Cancer Kill? A Review of the Literature

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In the United Kingdom there has been a recent call for more research into the biology of dying and separately into prognostication models for those with advanced cancer.

The aim of this work is to review the literature relating to the biology of dying in advanced cancer.

Methods: The first search looked or cause of death analyses, primarily from post-mortem
series, for cancer patients to evaluate whether the cause of death of advanced cancer patients was actually already known.

Once the need was established a literature search using the following terms in EMBASE and MEDLINE was undertaken (Search 2): (Death OR Cause of Death) AND (Cancer OR Neoplasms) AND (Models, Molecular OR Molecular Biology OR Pathology, Molecular, OR Molecular medicine)

A further search for articles describing known mechanisms of cell cell death and their role in death of the organism as a whole (Search 3): (Death OR Patient Death) AND (Apoptosis OR Apoptosis OR Autophagy OR Necrosis)

Results: For patients specifically with neoplastic disease a meta-analysis of 240 patients with advanced cancer demonstrated that 16% of deaths were assigned to ‘advanced disease’ rather than known complications, such as infection.

Search 2 produced 197 articles. Three abstracts were reviewed and of those one paper was retrieved and read in full, and was found not to be relevant.

Search 3 produced 54 articles. Four articles were retrieved from five abstract reviews. However none relate to potential mechanisms of dying in advanced cancer. The concept of phenoptysis, defined as apoptosis of an entire organism is described, and mechanisms relating to ageing are discussed in three of the papers.

Conclusion: The underlying mechanisms behind the deaths of some patients with advanced cancer are not understood.

The negative results of the literature search suggest that the molecular biology of dying from advanced cancer is a area in need of study.

Abstract number: P1-438
Abstract type: Poster

Teenagers Treated Like Children and Expected to Act like Adults

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Aims: Examine referral numbers of teenagers and young adults (TYA) with cancer to the hospice, is there a need for TYA to access this service. To assess whether the experience of cancer is different in TYA than older adults.

Method: In 2012 I looked at referral numbers in an adult palliative care service provider (hospice) for 3 consecutive years 2009, 2010 and 2011 of TYA, identifying 1-3 per year.In September 2013 a teenager and young adult’s clinical nurse specialist appointed for 1 year. We launched an information campaign raising awareness of adult palliative care services establishing joint working partnerships. Set up monthly TYA days.

Findings: Total 12 referrals TYA from September 2013 - September 2014.
1- Initial conversations with TYA by acute staff
 Treatment is likely to continue until death.
 Rapid titration of opiates, likely high dose with adjuvant therapies
 Period of palliative care is likely to be short
 Attitudes and behaviours vary.
 Role played by professionals needs to be prompt.
 Advance Care planning is complex.
 Conclusion: TYA symptom control/palliative care interventions alongside oncological.
Abstract number: P1-449
Abstract type: Poster

Antimicrobial Use in Patients with Advanced Cancer: The Experience of a Palliative Care Unit (PCU) in Rio de Janeiro, Brazil

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Aims: To describe the characteristics of antibiotic use in patients with advanced cancer at a PCU in Rio de Janeiro, Brazil.

Methods: This was a prospective cohort study of patients referred to the PCU during the period of July to December of 2010. Main variables, abstracted from charts, included demographics, site and type of cancer, Karnofsky Performance Status (KPS), devices use, survival time and antimicrobial use.

Results: 870 patients were included. The mean age was 62 years, 52% were female and head and neck cancer was the most prevalent disease (28%). Twelve percent of patients were referred without previous cancer therapy. At admission at the PCU 38% had at least one invasive device and 59% had KPS ≥ 50%. The median survival was 48.5 days. The frequency of at least one course of antimicrobial use was 41%, corresponding to 664 courses. Average duration of antimicrobial use was 15.2 days and 15% of the courses they were maintained until the time of death. The enteral route was used in 60% of the courses. The most prescribed antibiotic was amoxicillin + clavulanate (41%). Head and neck cancer (p < 0.001), previous cancer control (p < 0.001) and the presence of invasive devices (p < 0.001) were independent predictors of the use of antimicrobials. Patients who used antimicrobials had a higher mean survival (113 ± 69 days, p < 0.001). Among patients who used antimicrobials, having KPS ≥ 50% was predictive of longer survival (HR = 0.55, 95%CI = 0.44 – 0.69, p < 0.001).

Conclusions: Antibiotic use was highly prevalent in this cohort. The higher survival among antimicrobial users is may be explained by the fact that prescribers tend to restrict this class of drugs for patients with poor prognosis. Clear definitions of treatment goals and indications of antibiotic use in these growing populations are a challenge.

Abstract number: P1-440
Abstract type: Poster

Consideration of the 11-year History of Palliative Care for Patients with Advanced Gynecologic Malignancies at a University Hospital without a Palliative Care Care Unit and New Perspectives

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Purpose: Although our hospital has no palliative care units, we established a palliative care team (PCT) 11 years ago and have functioned as a palliative care consultation team. We have received over 300 requests for consultation for these 11 years. Our department makes the largest number of requests to the PCT of our hospital and we proactively request intervention by the PCT. In this study, we analysed our previous data about consultation.

Method: We quantified 78 items, to the extent possible, in patients who received intervention by the PCT and conducted a comparative investigation. The items included the patient background characteristics, condition at the time of admission, condition at the time of intervention, the differences between the two periods, changes in treatment, and final evaluation.

Results: Most of the requests (up to 96%) during the first 5 years were pain control. However, subsequently, requests for pain control came to account for about 80% later and requests for mental care and alleviation of other symptoms accounted for about 15%. In regard to pain control, improvement was seen in about 90% of the patients. In regard to alleviation of other symptoms, the largest number of requests was obtained to some extent. However, concerning spiritual pain, only about 24% showed improvement after the intervention. In addition, the quality of palliative care improved with the introduction of CART and the Liverpool Care Pathway in recent years.

Conclusion: By earlier intervention, a variety of more effective care activities, including for mental care, alleviation of symptoms and terminal care can be provided in addition to pain control. One of the final goals of palliative care consultation is shifting to a home care and this has been smoothly implemented. However, spiritual pain is still at the opposite end of the scale, suggesting that the efforts for this problem will remain a challenge for the future.

Abstract number: P1-441
Abstract type: Poster

Management of Complications after Biliary Drainage Post Endoscopic Retrograde Cholangiopancreatography (ERCP) in a Oncology Palliative Care Unit

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Case report: A sixty-one years old female patient diagnosed with rectum adenocarcinoma with local and hepatic progression was submitted to oncologic treatment in 2007 with chemotherapy and neoadjuvant radiotherapy followed by surgical treatment. In 2009 a 4cm lesion in the fourth liver segment with invasion of hepatic hilum was found. There were no evidence of peritoneal disease or ascits, and a non-surgical approach was chosen.

During 2012, patient presented jaundice secondary to tumor compression and percutaneous external internal drainage was indicated. On early 2014, patient evolved with new episodes of jaundice, abdominal pain and fever, suggesting cholangitis associated to obstruction of internal-external drainage. A metallic biliary endoprosthesis was allocated. Procedure was performed, after patients developed intense abdominal pain. CT scan identified sub-capular hepatic hematoma measuring about 3x10cm and percutaneous drainage was indicated.

After control of symptoms and progressive recovery, catheter was removed and the patient was discharged.

Discussion: The hepatic subcapsular hematoma is a rare complication, usually under diagnosed in patients submitted to endoscopic retrograde cholangiopancreatography. ERCP is the exam most indicated for obstructive complications of biliary and pancreatic systems, with complication rates of 2-10% and low rates of mortality (0.5-1%). Published data shows that conservative treatment in non-oncologic cases of iatrogenic injuries after invasive procedures has presented good results. In oncology palliative care units the doctors and teams should beware to function with caution (Karnofsky scale), prognostic classification (PAP Score or PPI), beyond the symptoms to be controlled.

Conclusion: In such situations, functionality and prognosis shall be evaluated before indicating an invasive procedure. It is fundamental each case individual analysis, having in mind the mainstay of palliative care.

Abstract number: P1-442
Abstract type: Poster

About a Case of Lateral Amyotrophic Sclerosis (LAS): A Multidisciplinary Intervention

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Introduction: LAS cases are non cancer palliative diseases that have an evolution between 3 and 5 years and reach the end of life dramatically, with difficult symptoms control and family exhaustion.

Aims: With this work we want to show the multidisciplinary interventions of health caregivers towards the patient and family, trying to give comfort and control.

Method: Data from clinical process and family and multidisciplinary team opinions. Case description: Sixty old man, that begins fatigue and weakness. After about 6 month he has the diagnosis of Lateral Amyotrophic sclerosis, bulbar form, with progressive respiratory failing, dysphagia, myopathy, difficult communication and family exhaustion. He was followed, during their last ten months of life at the unit of palliative care, with two periods of admission. During these periods all the palliative work team used their technical, scientific and emotional resources to overcome the struggle over suffering.

Conclusion: Suffering during a terminal disease is physical, spiritual, psychological, in one word is total. The multidisciplinary team must have the skills to offer the best care with comfort and partnership.

Abstract number: P1-443
Abstract type: Poster

Breaking the News of a Motor Neurone Disease (MND) Diagnosis: A Survey of Neurologists

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Background: Communicating the diagnosis of MND is challenging for both neurologists and patients. The manner the patient receives the diagnosis is acknowledged to be the first and one of the most sensitive steps in palliative care.

Aim: To establish a knowledge base of usual practice of breaking the news of an MND diagnosis in Australia, highlight differences and similarities in Australian practice compared to European practice guidelines (and also compared to the experience of patients and their families in a future parallel survey).

Method: A cross sectional study using postal surveys. Questions centered on how patients’ consultations were conducted, personal experiences in giving the diagnosis, the communication process and supported receipt of education and information.

Results: 73 neurologists responded (50% of all neurologists or 80% of those who deal with MND). Mean age was 52 years, 77% were male, mean length of practice was 20 years and
16% worked in a multidisciplinary clinic. Median period between first clinical consultation and diagnosis was 4 weeks (range 1–26), and 68% required 2 consultations and a median of 20 minutes to convey the diagnosis. 41% always able to give the diagnosis in a private space and 41% always able to avoid interruptions; 69% found communicating the diagnosis ‘very to somewhat difficult’ and 65% experienced high to moderate stress and anxiety at the diagnosis delivery. Follow up support was always initiated by 68% of respondents within 4 weeks from diagnosis with subsequent follow ups of 12 weeks interval; 73% referred to an MND association for information and ongoing support; 54% received specific training for giving an MND diagnosis and respondents were very interested (38%) to somewhat interested (44%) in having best practice guidelines developed.

**Conclusion:** The data reflect some differences in practice and the presentation will conclude with a comparative alignment with best practice guidelines.

**Abstract number:** P1-446
**Abstract type:** Poster

**The Need of Palliative Care for Patients with Rheumatic Diseases - Opinion of Rheumatologists**

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**Background:** The World Health Organisation (WHO) recommends that conditions in which palliative care may be needed include i.a. rheumatoid arthritis (RA). However, patients with advanced rheumatic diseases are not referred to Polish palliative care centers. The benefits of providing palliative care for patients with terminal phase of RA at their homes, were observed by clinicians working in rural areas in Poland. There is an evidence gap in evaluating the need for palliative care for patients with advanced rheumatic diseases.

**Aim:** To assess the need of palliative care for adults with advanced rheumatic illnesses.

**Methods:** In a pilot study an anonymous structured questionnaire consisting of 9 questions concerning personal experience in treatment of patients with advanced rheumatic diseases was completed by 64 rheumatologists dealing with adult in- and outpatients in Poland.

**Results:** 97% of the respondents answered that palliative care would be beneficial for some of the patients with advanced rheumatic diseases (91% of respondents indicated RA, 48% - systemic sclerosis/SSc and 35% - systemic lupus erythematosus SLE). The most frequently reported distressing symptoms among RA patients were pain 94%, disability 73% and stiffness 38%. 63% of respondents indicated home as the place of death of adult patients with advanced RA. 58% of rheumatologists reported using mild opioids in more than 21% of patients. 27% of rheumatologists have never treated their patients with strong opioids, 78% rheumatologists reported that they had patients in terminal phase of rheumatic disease, but only 28% of respondents have ever consulted a patient with palliative medicine specialists.

**Conclusion:** In opinion of questioned rheumatologists palliative care would be beneficial for patients with rheumatic diseases (in particular with RA, SSc and SLE). There is a need for collaborative efforts by the relevant organisations to supply palliative care for patients with advanced rheumatic diseases.

**Abstract number:** P1-447
**Abstract type:** Poster

**Phase 2 Randomised Controlled Trial of Future Care Planning in Patients with Advanced Heart Disease**

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**Background:** Patients with advanced heart disease typically have a poor prognosis despite optimal cardiac therapy. These patients and families rarely receive coordinated holistic assessment and future care planning (FCP).

**Aims:** This Marie Curie funded phase 2 trial seeks to explore whether a FCP intervention is acceptable, feasible and deliverable to patients (and families) with advanced heart disease following a recent unscheduled hospital admission.

**Methods:** Patients with an unscheduled admission for acute coronary syndrome (ACS) or heart failure (HF) were screened using a prognostic scoring tool. Patients with a 12 month estimated mortality risk of 20% or greater were randomly allocated to either (early) (upon discharge) or delayed (after 12 weeks) FCP for 12 weeks. The FCP intervention combines holistic needs assessment by a cardiologist with creation of a written/shared FCP and nurse-led care in the community. The primary outcome is quality of life of patients and carers assessed using questionnaires. Other outcomes include hospital readmissions, use of palliative care services, and preferred and actual place of death.

**Results:** We recruited 50 patients (32 carers) - 22% with ACS, 68% HF and 10% valvular heart disease. There were 5 deaths and 5 withdrawals. For the whole cohort mean age was 81.1 years (SD = 8.9), 60% male, mean Charlson comorbidity index was 4.2 (SD = 1.7), median Canadian frailty scale = 5 (mild frail). Intervention and follow up is currently ongoing and detailed findings will be ready for presentation by April 2015.

**Conclusions:** Findings from this pilot trial indicate that the intervention and outcome measures were feasible and deliverable. Further analysis will provide invaluable information on the nature and feasibility of a larger clinical trial sufficiently powered to address hard clinical end points.

**Abstract number:** P1-448
**Abstract type:** Poster

**Hospice Enabled Dementia Care**

**Crowther J.1, Cooper M.2, Richardson H.2**

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**Aims:** Identify existing good practice in dementia care within UK hospices. Identify barriers for hospice in working with pwd. Devolve a model of hospice enabled care not referred to. Develop a resource to support and guide hospices in engaging with people with dementia and their carers.
Palliative Care Management at the End of Life: The Experience at a Large Teaching Hospital

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Abstract type: Poster

Abstract number: P1-449

Background: Current practice is variable with regard to the management of diabetes at the end of life.

Aims: To compare individualised end of life care plans of patients with diabetes against recommendations in the national guidelines 'End of Life Diabetes Care' (Diabetes UK, 2012).

Methods: Retrospective analysis of patient records of deceased adults for whom electronic end of life care notifications had been generated prior to death (excluding intensive care) in a teaching hospital over a 3 month period.

Results: Records of 108 deceased patients were included. 23 patients (21.3%) had a documented diagnosis of diabetes. All had type 2 diabetes, managed with diet, oral hypoglycaemic drugs, insulin or a combination of all three. Four of the 23 patients (17.4%) were on steroids.

20 patients were reviewed by the palliative care team 1 patient was reviewed by the diabetes team. 8 of the 23 diabetic patients (34.8%) had a documented plan for management of diabetes at the end of life, including capillary blood glucose (CBG) monitoring.

2 patients had an episode of hypoglycaemia (CBG <3.3mmol/L) documented before death, and 3 had a documented episode of hyperglycaemia (CBG >15mmol/L). Frequency of CBG monitoring followed guideline recommendations in 8 patients.

Conclusion: Diabetes was a diagnosis in nearly a quarter of anticipated adult deaths, but only a small proportion had a plan documented for this. These results suggest a need to improve diabetes education for palliative care teams and involve specialist diabetes teams when required.

Abstract number: P1-450

Palliative Care for Patients with Non-cancer

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Abstract type: Poster

Abstract number: P1-451

Meeting the Needs of Patients with a Non-cancer Diagnosis in a Hospice Environment

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Background: Patients living with advanced non-malignant conditions have a similar symptom burden to those with cancer; however access to palliative care services for this group is often poor. It was noted locally that patients with non-malignant disease were under-represented within the hospice population. Cross-sector education of professionals regarding the role of specialist palliative care in managing advanced non-malignant disease was therefore undertaken.

Aims: To assess the change in referral patterns following the initiative to increase awareness of specialist palliative care for those with non-cancer diagnoses.

Methods: Retrospective case note analysis was undertaken of referrals to the hospice for patients with a non-cancer diagnosis over a 6 month period, before and after the intervention to increase referrals to the hospice. A standardised data collection tool was used.

Results: The number of referrals increased from 13 over the first 6-month period, to 50 in the second 6-month period; 70% of patients had a respiratory diagnosis. The most prevalent problem identified after initial assessment was dyspnoea (79%) and low mood (48%). 58% of patients assessed were referred to the hospice day therapy service; 23% of these referred declined day therapy after their initial visit. At the end of the study period 49% of patients referred to the hospice had been discharged; the average time from referral to death was 106 days.

Conclusion: Through a targeted intervention we have been able to significantly increase referrals to the hospice for those with a non-cancer diagnosis. The burden of symptoms within this group of patients is high, with a clear need for the holistic support of the hospice environment. More work is needed to ensure hospice services are tailored to meet the needs of patients with a non-cancer diagnosis.

Abstract number: P1-452

Renal Palliative Care in Spain. An Epidemiological Approach

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Abstract type: Poster

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Renal Palliative Care in Spain. An Epidemiological Approach

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Abstract type: Poster

Abstract number: P1-453

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Abstract type: Poster
Patients with Progressive Lung Disease Need to Know More about Palliative Care - Qualitative Longitudinal Study on Patient Perspectives

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Abstract number: P1-456
Abstract type: Poster

Background: Chronic progressive lung diseases become increasingly important for palliative care as they are one of the main causes of death. Both lung cancer and COPD may lead to serious life threatening symptoms such as breathlessness or pain. Further patients often suffer from psychosocial burden.

Aims: The aim of this study is to explore the shift of the needs of patients with progressive lung diseases, and the needs of their family carers, over time.

Methods: Qualitative prospective longitudinal study: 4 interviews within 12 months with patients with advanced staged lung cancer and COPD: 2 groups à 20 p; interviews with family members. Analysis using grounded theory.

Results: First results show different consequences related to the experience of the diagnose setting: While those with lung cancer associate their diagnosis with lifetime limitation and loss of control, COPD patients often do not realise its life threatening consequences. During illness trajectory patients perceive medical treatment from different perspectives (burden vs. relief) and need group specific forms of therapy (e.g. psychotherapy, psychosocial support).

Both try to delay nursing support by maintaining their autonomy and daily routine. Palliative care won't be used; instead, both patients revert to family care. Often it will be equalised with lifetime determining and death, therefore most patients avoid claiming palliative care. Palliative care staff express having a lack of confidence in adequately caring for people.

Conclusion: While those with lung cancer associate their diagnose with lifetime limitation and loss of control, COPD patients often do not realise its life threatening consequences. During illness trajectory patients perceive medical treatment from different perspectives (burden vs. relief) and need group specific forms of therapy (e.g. psychotherapy, psychosocial support).

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then more widely until a consensus was developed.

**Results:** Seven main recommendations were agreed.

- Palliative care should be considered early in the disease trajectory
- The assessment and care should be provided by a multidisciplinary team approach, with access to specialist palliative care.
- Communication should be open with patients and families and advance care planning is recommended.
- Symptomatic and psychological management should be provided effectively and with the patient in mind.
- Needs should be addressed and caregivers supported before and after death. Professional carers should receive education, support, and supervision to provide the most effective care.
- There should be a continued discussion about end of life issues and discussion of patients’ wishes.

**Conclusions:** This paper concludes that the improvement of care for people with progressive neurological disease and challenges all involved to extend these principles as widely as possible to support people with these diseases and their carers.

**Abstract number:** P1-459

**Abstract type:** Poster

**The Development of a Multidisciplinary Clinic to Improve Respiratory Care of People with MND/ALS**

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**Background:** There is increasing awareness of the role of respiratory support for people with motor neurone disease/amyotrophic lateral sclerosis (MND/ALS) to improve both quality of life and survival. In the UK the National Institute of Health and Care Excellence Guidance on the use of Non-invasive ventilation (NIV) in MND in 2010 suggested a multidisciplinary team approach and close collaboration between services. In Medway all patients with MND/ALS clinics are monitored regularly for the symptoms and signs of respiratory dysfunction and joint clinics have been developed including both palliative care and respiratory medicine, to discuss and monitor the use of NIV.

**Aims:** The aim of the study is to evaluate a new MDT approach for NIV.

**Methods:** The details and the outcomes of all patients seen within the joint palliative care/ respiratory medicine clinic have been evaluated over a two year period. Results: 9 patients have been seen over the last 2 years - 7 male, 2 female, mean age 55 years and mean time from first symptom to consideration of NIV was 25.5 months. 8 patients had been deemed inappropriate at home by their GP at the time of the patients cared for with MND/ALS in the area - with repeated visits and support from the Specialist Respiratory Nurse, facilitating the use of NIV for patients who were initially very anxious.

**Discussion:** This joint approach has allowed people with MND/ALS to start NIV, with improvement in quality of life. The discussion has allowed a wider consideration of the benefits of NIV and the discussion of disease progression and the possible consideration of later withdrawal, as recommended by the NICE Guidance. The joint clinic has allowed a clearer approach to patient care with home commencement of NIV with a more comprehensive service to be provided with increased support of patients and their families and increased compliance with the intervention, leading to improved quality of life.

**Abstract number:** P1-460

**Abstract type:** Poster

**Biographical Rescue as an assistance proposal in Occupational Therapy to patients with Long Term Neurological Conditions**

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**Background:** The care of people with Long Term Neurological Conditions (LTNC) isn’t recognized in the Brazilian Palliative Care scientific production; in daily basis, the assistance is focussed on hygiene’s care and clinical observation. However, from the perspective of palliative care, something more is needed, to promote the dignity of the human person.

**Aim:** To describe an occupational therapy intervention for patients with LTNC based on biographical rescue.

**Methods:** Records and field diaries of the first author were used to produce narratives and biographical profiles. The concept of Comprehensive Care is the main reference, designed as care interested in the existential sense of the illness process. It seeks to rescue the subjectivity of people with LTNC, understood as a way of organizing all the meaningful different experiences in life.

**Results:** The beginning of the reconstruction of the patient’s biography occurs by several perspectives, especially through sensory stimuli related to prior patient’s occupational history. The therapist does a careful and continuous evaluation of the patient. Along with the detailed evaluation, the therapist does a careful and continuous evaluation of the patient. Along with the detailed evaluation, the therapist does a careful and continuous evaluation of the patient. Along with the detailed evaluation, the therapist does a careful and continuous evaluation of the patient.

**Lessons learned:** Memory, history, identity, dignity, and subjectivity qualify the practice of occupational therapy with people with LTNC. Regardless of neurological reactions presented by the patients this practice helps reconstructing the meanings of the daily life of people with severe disability. Sensory stimuli are shown as potential tools for a biographical rescue.

**Abstract number:** P1-463

**Abstract type:** Poster

**Situation in the Last Month Before Death of Patients with Amyotrophic Lateral Sclerosis on Noninvasive Positive Pressure Ventilation**

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**Background:** Unlike patients with cancer, those with amyotrophic lateral sclerosis (ALS) make decisions for their respiratory function. Noninvasive positive pressure ventilation (NPPV) is effective to rest the respiratory muscles, to palliate dyspnea, and to prolong life. However, ALS patients use NPPV for 24 hours and recognize it as life-sustaining.

**Aims:** The purpose of this study was to clarify situations in the one month before death in ALS patients on NPPV who chose not to receive IPPV.

**Methods:** A total of 14 ALS patients died from 2011 to 2013 in Hospital A. Four patients were on IPPV, 5 were on NPPV, and 5 died naturally. Four ALS patients died on NPPV and whose family provided consent participated in this study. Data were collected by retrospective medical chart review. This study was approved by the ethics committee of Hospital A.

**Results:**

- **Patient characteristics:** Two patients were in their 60s when they died, one in the 70s, and one in the 80s. Three were males and one was female.
- **ALS type:** One had bulbar onset type ALS, and three had spinal type ALS. The time from diagnosis to death was 10 to 36 months. The duration of NPPV use was from 2 to 24 months.
Abstract number: P1-466a
Abstract type: Poster
Geriatric Patient Treated at Home by a Palliative Care Team Support: Symptoms and Polypharmacy

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Background: There is a high prevalence of geriatric patients treated at home by a palliative care team support.

Aims: To determine whether treatment of terminal patients is appropriate to their symptoms, prioritisation to symptomatic treatments and presence of polypharmacy.

Methods:
Design: Prospective study from March 2013 to March 2014.
Data collection: Age, sex, previous and present Barthel index, Karnofsky, number of drugs, discharge destination, symptoms, presence of dementia and pressure ulcers, and drugs.
Analysis: SPSS 15.0.

Results: N=281, mean age 83.27 +/- 9.2, 56.2% female; mean previous Barthel index 32.5 +/- 30, mean present Barthel index 20.38 +/- 30.2; mean Karnofsky 54.17 +/- 24.6; high polypharmacy: 6.8 average drugs, high percentage of institutionalisation: 35.3%, exitus 26%, discharged by stabilization 66.5%, hospitalised 68.8%, aferesis 31%, delirium 30.2%, pain 26.3%, insomnia 16.4%, anxiety 12.1%, depression 11%, dyspnea 10%, nausea 3.2%. Dementia in 60%, improvement 62.6%, presence of pressure ulcers in 16.8%. Inhibitors proton pump 57%, antidepressants 42.7%, diuretics 38.7%, antiparkinson drug 37.6%, laxatives 31.7%, benzodiazepines 28.7%, atypical neuroleptics 28%, paracetamol 24%, typical neuroleptics 19%, antidepressants drug 14.7%, atypical antipsychotic 14.3%, acetaminophene nesterase inhibitors 14.3%, calcium channel blockers 13.6%, diogin 12.5%, angiotensin-converting enzyme inhibitor 12.2%, antibiotic drug 10.8%, statins 8.2%, corticosteroids 6.8%, meperidine 6.6%, transfomral fentanyl 6.5%, insulin 6.1%, beta-blockers 5.7%, pregabalin 5.4%, gabapentin 5%, tramadad 4.3%, metamizol 3.6%, non steroid antiinflammatory drugs 3.6%, valporate 2.2%, morphine 2.2%, buprenorphine 1.8%, oral fentenyl 0.7%, codeine 0.7%, and no case treated with oxycodone or hydromorphone.

Conclusions: 1. High polypharmacy in patients with severe functional impairment. 2. Absence of appropriate prioritisation to symptomatic treatments.
Abstract number: P1-467
Abstract type: Poster

“Idealistic Notion or Complex Reality?” Using the Literature to Inform a Cross Sectional Survey to Explore Health Care Professional’s Perceptions of ACP for People with Dementia in the Long Term Care Setting

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Background: Evidence indicates that whilst older people may wish to plan ahead, often they are not given the opportunity to do so. Advance Care Planning is considered as key process that enables planning ahead to be achieved. Demographics indicate that there are an increasing no of people with dementia residing in nursing home settings. Staff in such settings have an important role in assisting with ACP yet there is a deficit in understanding the issues from their perspective.

Aim: To examine the HCP’s perspectives of ACP for people with dementia in the LTCs.

Methods: A sequential explanatory mixed methods design incorporating 2 interrelated phases.

Phase 1: Systematic narrative review of empirical studies published between 2002-2014 yielded 14 relevant articles which focused on HCP’s perspective of ACP for people with dementia in this setting.

Phase 2: A cross-sectional survey to all nursing home managers (n=269) in a region in the UK.

Results: Within the literature there is considerable variation in HCP’s perspectives of ACP. These were grouped under 4 key themes: Early integration and planning for palliative care in dementia; Ethical and Moral Factors; Communication and Education, Training and Knowledge. The validity of this evidence will be further refined through quantitative exploring involving registered nursing home manager’s perspectives on ACP using a structured tool focusing on three domains; understanding, attitudes and practice, underpinned by the Theory of Planned Behaviour.

Conclusions: Despite evidence, albeit limited, that HCP’s recognise the potential benefits of ACP; there is continued reluctance to engage. The inequality in terms of access to palliative care is central to this, with increased integration at an early stage vital. Greater understanding of HCP’s perspectives on ACP in this complex setting will contribute to the development of appropriate educational support and improved care for people with dementia approaching end of life.

Abstract number: P1-468
Abstract type: Poster

Anticipatory Prescribing for Residents Approaching End of Life in Care Homes

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Common symptoms at the end of life include pain, breathlessness, anxiety, respiratory secretions and nausea. National end of life care strategies advocate anticipatory prescribing as a way to manage these symptoms. There has been little research on anticipatory prescribing in care homes. With more people living and dying in care homes, it seems relevant to understand anticipatory prescribing in this setting. To explore the viewpoints of healthcare professionals involved in anticipatory prescribing in care homes with a focus on barriers encountered in relation to the prescribing of anticipatory medicines, as well as recommendations for best practice. A qualitative study was undertaken using a framework approach in Lothian, UK. 12 semi-structured interviews were conducted with healthcare professionals who were involved in the prescribing, dispensing or administration of anticipatory medicines in care homes. While anticipatory prescribing was regarded as being beneficial in that it may reduce hospital admissions and allows residents to have a comfortable last phase of life, uncertainties surrounding when it should be initiated often results in residents not getting the medication until after symptoms appear. Experience and training aid in providing care home staff with the confidence they need to identify the onset of the end of life phase in residents. However high staff turnover and frequent manager changes make this challenging. The importance of establishing and maintaining trusting relationships between professionals and the ability to communicate effectively across boundaries was found to be the most significant facilitator. Even when all the structural conditions are in place, its success will only ever be as good as the relationships of the professionals involved allow it to be. Given the increasing number of people living and dying in care homes, it must be a priority to ensure that anticipatory prescribing is available without delay.

Abstract number: P1-469
Abstract type: Poster

Opioid Prescribing in Elderly Patients with Renal Impairment

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Background: Elderly patients requiring opioid care input often have multiple co-morbidities, including renal impairment, which can pose challenges to their care. Normal serum creatinine does not always indicate normal renal function. No clear guidelines exist in the use of opioids in elderly patients with renal impairment. Aims: To determine the prevalence of renal impairment in elderly patients referred to the specialist palliative care service (SPCS) in Our Lady of Lourdes Hospital, Drogheda over a 15 day period and to review opioid prescribing in these patients.

Methods: All patients 65 years or older referred to the SPCS from 01/08-15/08/2013 were identified and a retrospective chart review performed. Estimated Glomerular filtration rate (eGFR) of less than 90 mls/min was defined as renal impairment and graded into mild (60-89 mls/min), moderate (50-59 mls/min) and severe (< 30 mls/min). Patient demographics, type of opioid used, indication for use, mode of administration, opioid rotation and opioid related adverse-effects were collated.

Results: Thirty-one patients were identified, 18 (58%) female. 19 (62.3%) had a malignant diagnosis. Thirty-nine patients were the primary opioid used in 10 (32.2%), 5 (16%) had normal eGFR with 8 (25.8%), 11 (35.4%) and 7 (22.5%) patients with mild, moderate and severe renal impairment respectively, 21 patients (67%) had serum creatinine within normal limits. Of those, 16 (76%) had eGFR < 90 mls/min. 8 (25.8%) developed opioid related side-effects, of those 7 (87.5%) had eGFR < 90 mls/min. All patients with adverse-effects required opioid rotation.

Discussion: The prevalence of renal impairment is high among elderly patients. eGFR measurement is superior to serum creatinine alone in assessing the degree of renal impairment. Clear guidelines in opioid prescribing in elderly patients with renal impairment may help to minimise opioid-related adverse-effects. Further research is needed.

Abstract number: P1-471
Abstract type: Poster

The Specialist Care of People with Intellectual Disability as they Grow Older

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Background: People with intellectual disability are growing older and there are increasing issues of associated age-related diseases especially dementia, particularly with dementia seen at an earlier age in Down’s syndrome. A specialist residential home for older people with ID and multiple needs, including dementia, has been developed as one of the first specialist nursing establishment of its kind in the UK.

Aim: To assess the involvement of the residents in their care and their quality of life and level of socialisation.

Method: The residents were assessed using the Social Network Guide, which maps the residents social networks and social support, DEMQOL, which allows assessment of quality of life for people with dementia. The Resident Choice Scale, which assesses opportunities for self determination.

Results: 13 residents were assessed. The number of individuals in each resident’s network was a mean 8 (range 3 to 25), the DEMQOL Pro QoL mean quality of life score of mean 112 (range 107-120), the Resident Choice Scale showed scores of over 3 of 5 for the 16 items, showing good involvement and that they were able to make day to day choices.
Conclusion: The social network for the residents was less than in other studies of ID where the average was 22 and only 2% of the contacts were from people outside the home. However, the care where the residents were able to remain involved with others, express control on many of their activities and have a good quality of life. Further studies are being undertaken to assess the staff involvement and views of the care involved.

Abstract number: P1-472
Abstract type: Poster

Disconnect: Residential Aged Care Staff and Bereaved Family Perceptions of Palliative and End of Life Care

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Background: Effective communication is a key component of both residential aged care (RAC) staff palliative care training and family understanding. However families of RAC residents are often unaware of the impending death of their relative. Lack of communication between facility staff, residents and their families therefore can result in problems in implementing effective care plans thereby impacting on the quality of care provided.

Aim: The aim of the study was to identify information gaps and unmet communication needs of both staff and families to inform future strategies for enhancing quality of care for RAC residents with palliative and end of life care needs.

Method: A mixed methods design was employed incorporating a survey of clinical staff (n = 431) in 12 RAC facilities in one urban district health board (Phase One) and in-depth interviews with a purposive subsample of 26 bereaved family members (Phase Two).

Results: Staff most often (38.1%) rated the care of residents who had died in the facilities as ‘very good’ (n= 164). However, two of the most frequently cited areas for improvement in resident care were the delivery of basic cares (11.8%), information access/communication (10.2%). Staff members indicated comfort with discussing end of life with both residents and families. However staff sometimes assumed that the change in status of a resident was obvious to a relative when this wasn’t the case. Although the quality of care was reported by families to be good, perceptions of a lack of staff with training in mental health, failure to recognise the need for medical intervention in some cases and an abrupt end to communication with families upon the resident’s death were noted.

Conclusion: The research highlights the need for a problem based experiential learning approach to palliative care education to improve communication between families and staff.

Abstract number: P1-473
Abstract type: Poster

An Undisputable Alliance: Specialist Geriatric Palliative Care Services

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Background: Technology and health systems have afforded European countries ever more aged populations with disabilities due to long standing pathologies that bring with them complex symptoms, particularly in the last year of life. WHO and scientific organisations recommend Specialist Palliative Care (SPC) input as an innovative approach which helps all round.

Aim: To analyse available scientific and local evidence to determine what constitutes best End of Life Care for the elderly considering all their needs and varying complexities.

Methodology: Demographic and situation analysis relating to existing Geriatric Domiciliary, Day Hospital and Inpatient units in a traditional geriatric hospital, together with evidence from Palliative Care Geriatric Referent Professionals documents.

Results: Our region has high immigration and economic development with a 15% aging index and very high of over people 80 (4.4% in 2011). Our Geriatric Home Care Teams sees some new 600 patients per year 30% of which over 85 have palliative care needs. About 10% of all geriatric admissions are advanced dementia. The highest peak use of the 24 hour platform is the referrals of the professionals have received advanced training in PCA available data point towards a beneficial outcome of joined up best geriatric care supported by adopted palliative care support. It promotes continuity of care across all care settings avoiding unnecessary casualty visits and unplanned admissions.

Conclusion: Despite the wide range of geriatric and Palliative Care provision in our city, this study highlights the need for a new model integrating health and social resources to satisfy all EOL needs, whatever their complexity. A tertiary referral center will help raise the profile of our changing society and allow for further training and research.

Abstract number: P1-474
Abstract type: Poster

Project Dignity - Developing a Palliative Homecare Service for Patients with Advanced Dementia


Introduction: Singapore bears the unique distinction of having one of the fastest aging populations in the Asia-Pacific region. In epidemiological studies, the prevalence of dementia ranges between 2-14%, with the prevalence expected to increase. The population of patients suffering from advanced dementia approaches 3000 year, of whom at least half will spend their last days within a long term care institution. In Singapore, only 4.1% of the referrals to the largest palliative homecare service in 2013 was for advanced dementia support.

Goal of study: The primary objective is to develop a homecare hospice programme with disease specific skills to support advanced dementia patients and their caregivers. The secondary objective is to measure its cost effectiveness.

Methods: Prognostic criteria for entry into the pilot homecare service was determined after literature review. Clinical assessment tools used in the programme were selected based on evidence supporting its use and its practical application in homecare. Cost effectiveness is evaluated prospectively from the cost savings of reducing average length of stay in the hospital.

Results: Patients with advanced dementia stayed at Functional assessment staging of dementia (FAST) 1A, with at least another criteria in the form of other pneumonia, albumin <35g/L or a feeding tube were eligible for the homecare programme. Patients were assessed using the ‘Patient Care Bundle’, comprising the PAINAD, the NPI-Q and the MNA. Caregivers were assessed using the QUALID and the Zarit Burden interview, part of the ‘Caregiver Bundle’. At the end of life, patients were evaluated using the ‘End of life care bundle, involving the SM-EOLOD, CAD-EOLOD and SWC-EOLOD.

Conclusion: Advanced dementia needs to be identified as a terminal illness requiring palliative support. Supporting patients and their caregivers in the home with a homecare programme designed to meet their needs is the first step to addressing this gap.

Abstract number: P1-475
Abstract type: Poster

Attitudes, Knowledge and Educational Needs Concerning End-of-Life Care among Professionals at Nursing Homes in Denmark

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Background: In western countries, approximately one quarter of all citizens die at nursing homes. Studies have shown that end of life (EOL) care at nursing homes (NH) is suboptimal due to lack of knowledge among professionals. However, knowledge is needed if professionals at NH themselves think they need education in EOL care and if these needs and attitudes are associated with a general job satisfaction.

Aim: To describe attitudes, knowledge and educational needs concerning EOL care among professionals at NH and if these factors were associated with general job satisfaction.

Method: A questionnaire was developed in an interdisciplinary group and pilot tested among five NH professionals. The questionnaire will be sent to all professionals working with patients at two other NH in Aarhus, the second largest city in Denmark, during October 2014. Questions were developed concerning attitudes, knowledge and educational needs concerning EOL care inspired by observational studies at two NH previously developed questionnaires to professionals and literature studies. The last question of the Van-Coillie Work job satisfaction scale was also added: Taking everything into consideration, how do you feel about your job? Descriptive analyses will be performed together with relevant regression analysis in STATA 13.

Results: The pilot test showed that the questionnaire was applicable and that the professionals found the questions relevant. The final results including associations between attitude and job satisfaction will be presented at the conference.

Conclusion: The final results of this study may indicate a need for optimising attitudes and knowledge of EOL care among professional at NH in Denmark.

Abstract number: P1-476
Abstract type: Poster

Do We Have an Effective and Informed Workforce to Care for Those Living with End Stage Dementia within a Care Home Setting?

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Introduction: In line with the National Dementia Strategy (2009), a mixed methods programme was designed to develop and pilot a complex intervention to improve end of life care for people with advanced dementia. To do this, a facilitation-based model was adopted to provide education, training and support to health care professionals (HCPs).

Aims: However, to inform intervention development, we conducted a series of qualitative interviews to examine and understand the level of knowledge and understanding of place in workforce and where more training and education was required.

Method: A topic guide was used to interview 14 HCPs including commissioners, care home managers, nurses and health care assistants. We used a rigorous approach to data analysis, working to the quality framework recommended by Spencer et al (2003). Thematic analysis was used to analyse the data for meaningful themes.

Results: Themes suggested that staff felt ill-prepared in areas such as knowledge about dementia, managing dementia and providing compassionate care. Importantly, due to the emotions triggered by regularly dealing with death, staff require training and support on
An Advance Care Planning Educational Intervention for People with Early Dementia

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Aim: Developed specifically to address advance care planning issues with those with a new diagnosis of dementia and their carers. Intervention enabled through interagency collaboration between mental health services, a local dementia specific charity and a specialist palliative care service.

Design, methods and approach taken: Designed with the support of an expert group of people with dementia. Delivered as a two hour group session titled ‘Planning Ahead’ (part of a five session course for safely exploring dementia related issues.) The session includes an introduction to advance care planning, with a focus on changing ability to communicate and make decisions about the future. We use a rights-based approach in discussion about the legal framework and provide support tools. Promotion of choice includes: place of care, preferences, hopes and wishes, and nature of medical intervention. One facilitator accompanies the group throughout the five sessions. The palliative care social worker joins the facilitator and the group to provide ongoing support and make decisions about future care.

Results: People with dementia and their accompanying family members report improved understanding about decision making in the event of changes in communication or capacity. They report a better understanding of why, when, how and with whom to make plans. Evidence exists that these conversations are difficult to start. Through group facilitation and peer support, issues raised by group members are normalised. Universal relevance.

Conclusion: Advance care planning is a cornerstone of specialist palliative care. Developing bespoke ways to meet the varying needs of different patient groups and their families is essential. Providing safe opportunities for people with dementia and their families to explore issues they may face in the future empowers people to access services when they require them.

Abstract number: P1-478
Abstract type: Poster

Needs, Wants or “Common Sense” - What Drives Decision-making about Care in Later Life for Older Adults?

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Aims: In an era where patient choice is deemed an integral component of medical decision-making particularly in relation to end of life and place of care, the uptake of advance care planning has been shown to be poor. The reasons for this are complex and may include the desired delivery of dignified palliative care to older people. Thus, we set out to determine if older adults have made plans of future medical care should they not be able to care for themselves, and if they may find it easier to make these decisions by focusing on their personal values and priorities. A secondary aim was to determine if this cohort had common values to guide health professionals when facing such dilemmas.

Methods: A postal questionnaire was sent to 710 community dwelling older adults in Manchester and Newcastle. Participants were asked to consider hypothetical situations regarding changes in lifestyle or place of care. They were also asked to rank a list of personal priorities in terms of how they might wish to be treated in the future.

Results: There was a 78.7% response rate. Majority of respondents (65.5%) had not made specific plans relating to their future care. Decision-making appeared to be more difficult when the degree of personal change required was greater. Only slightly over half were able to rank their priorities in a meaningful manner. For them, ‘altruism’ (what is best for their loved ones) was the most important factor, followed by ‘kindness and compassion’ and ‘personal choice’ influencing decision making about their future care.

Conclusions: Decisions on one’s important personal values can be as challenging as decisions about future care. Given the difficulty in decision making, people, nevertheless, would like to be involved in these decisions. Thus, it is vital to engage patients early on in advance care planning, especially in primary care, on how they wish to be managed over the course of their lives, with active involvement of loved ones.

Abstract number: P1-479
Abstract type: Poster

Intensive Care Unit [ICU], Biotechnology and a Moral Dimension for Palliative Care [PC] in Elderly Persons with Cancer: Assessment Criteria for PC

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Background: The sophistication of biotechnology has given doctors an enormous array of resources to manage acute conditions of patients, but the medical act has lost some of the empathic dimensions. Palliative Care brings to light the moral dimension of care, and greatly reduces patient suffering.

Aims: To provide insight into the need for PC assessment for elderly patients with cancer admitted to the ICU, as a moral principle of Utilitarianism

Methods: Demographic and outcome information were recorded prospectively for elderly patients (≥65 years old) with cancer in a general ICU. Data was collected for prognostic scores of acute illness (SAPS3,SOFA), comorbidity indices (Geriatric[GI] and Charlson comorbidity index[CCI]), performance status (PS5), Mortality Performance Status(KPS), Palliative Performance Status(PPS) and Center to Advance Palliative Care criteria for PC assessment at time of admission (PC1) and during hospital stay (PC2). Mann-Whitney or chi-square tests; Spearman correlation were used to analyse data.

Results: P1 patients, median of 77±7 were enrolled during 8 months. Gastrointestinal (26/71,31%) cancers were the most common. Prognostic scores and comorbidity indices did not differ statically between discharge (32/71,45%) and death outcomes (39/71,55%)(SAPS3 p=0.315,SOFA p=0.414,PS5 p=0.853,GI p=0.94). PC1 correlated to prognostic scores (SAPS3 r=0.236 p=0.047,SOFA r=0.263 p=0.027). PC2 correlated to PS (95% confidence interval of 0.430 p=0.0003,PS5 r=0.305 p=0.0001) and prognostic scores (SAPS3 r=0.321 p=0.006,SOFA r=0.343 p=0.003).

Conclusions: PS and prognostic scores have shown correlation with criteria for PC assessment of elderly patients with cancer admitted to the ICU. The Utilitarian approach is in tune with the PC philosophy in that procedures are applied based on ethical values. It seems coherent to consider an alternative approach to care rather than the typical response of life-prolonging interventions for the chronically ill patients presenting in the ICUs.

Abstract number: P1-480
Abstract type: Poster

Assessment of Symptoms and the Process of Adaptation to the Diseases in Palliative Oncogeriatrics Field

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Background: Palliative oncogeriatrics has an important role in optimising the treatment of elderly patients with cancer.

Aims: To identify the principal symptoms and the adaptation to the diseases of older patients with cancer, in order to asses their palliative care needs.

Methods: Design - Cross-sectional

Out of 180 consecutive old patients, who have been admitted into the Department of Oncology: Palliative Care, over a period of four weeks, 70 patients were enrolled in the study. 110 patients were excluded based upon cognitive deficits or based on their functional status.

Face-to-face interviews were conducted using the Needs Near the End-of-Life Screening Tool (NEST)-Hem 10, and Edmonton Symptom Assessment Survey (ESAS).

Data collection, analysis: The data were collected by hand and later stored in SPSS 20.0 and analysed.

Results: Mean age was 71.2 years.

This study indicates that the most important 3 symptoms are: fatigue (all the time: 62.86%, frequently: 25.71%), breathlessness (all the time: 57.14%, frequently: 17.14%) and nausea (all the time: 45.71%, frequently: 17.14%).

60% patients are never satisfied with them self as a person now, then they were before the illness, and 14.29% patients are rarely satisfied with this situation.

Limitations: Patient sampling was not representative of all, older cancer patients , being too small, but we believe this is a step in the design of a palliative care intervention which will increase the quality of life.

Future work should focus on the role of oncogeriatrics medicine and palliative care in addressing these needs in order to achieve the best possible outcomes.

Keywords: Palliative oncogeriatrics, assessment, symptoms, adaptation
Methods: A participatory action research design, Phase 1 consisted of a detailed analysis of patients’ care provision in one prison that has a high number of older and disabled prisoners. Data were collected through in-depth interviews with staff both inside and outside the prison (n=29), focus groups with prison healthcare staff, security staff and prisoners (n=46) and a case study centred on a prisoner approaching the end of his life. A detailed thematic analysis of all data was undertaken.

Results: Findings reveal that although there is great willingness amongst staff to provide high-quality palliative care, prison regime and resource constraints present substantial challenges. Study participants reported difficulties with timely and appropriate medication (especially pain control) and continuity of care. Both staff and prisoners felt that prisons are not currently equipped to meet the needs of older prisoners approaching the end of life. There are also considerable emotional costs to staff, particularly security staff, in providing care in a custodial environment.

Conclusion: The study uncovered areas for improvement ranging from early identification of prisoners with palliative care needs to training and support for staff. The next stage of the study involves collaboration with staff to make and evaluate improvements.

Abstract number: P1-483
Abstract type: Poster

Large Differences by Local Area in Need for End of Life Care for People Aged ≥65 Years in England

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Background: The oldest of the old (≥85 years) have very different needs in terms of end of life care from younger adults. The causes of death and place of death differ. People aged over 85 years are often extremely frail and have multiple health problems. Many have reduced mental capacity and many live alone. England is divided into 353 Local Authorities which have widely varying demographics. In planning for EoLc for people aged ≥85 years they need to consider the local demographics and what is known about place of death hospital admissions and care to be available.

Aim: To examine, using routine data, the degree of variation in indicators of need for EoLc in people aged ≥85 years by English Local Authority.Methods: Analysis of routine data from the Office for National Statistics (ONS) and National Minimum Database (NMD) (2009–2014). Results: A selection shown as England Average, Lowest Local Authority, Highest Local Authority.

Projected % increase in 85+ to 2033 142.1%, 245%, 233.7%
% All terminal admissions to hospital aged 85+ 37.8%, 27.5%, 49.4%
% deaths from dementia 17.3%, 7.0%, 34.9%

Conclusions: In planning for care of the oldest of the old Local Authorities need to consider their local demographics and the impact this has on age at death, place of death and causes of death and how this will determine optimal provision of care. At present, for example provision of care homes varies by Local Authority but not in relation to potential need.

Abstract number: P1-484
Abstract type: Poster

Clinical Predictions of Survival - A Systematic Review of Accuracy, Expertise and Heuristics

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Background: Despite the existence of validated predictive tools, the most common method of predicting survival in palliative care patients remains simple clinical estimation. Previous reviews have reported that clinicians’ estimates are inaccurate and over-optimistic. We wanted to identify whether some clinicians are more ‘expert’ at prognosticating than others and what rules (or ‘heuristics’) clinicians use to formulate their predictions.

Methods: We used systematic review methodology to identify and classify relevant papers from MEDLINE, EMBASE, and the Cochrane Library. We identified 51 articles and 44 papers were included in the final review.

Results: 25% papers compared clinical predictions versus actual survival. Clinical predictions were ‘accurate’ (neither optimistic nor pessimistic) in 38% of cases (range 10-79%). Seventeen papers compared the accuracy of different health care professionals (HCPs); 7/10 papers suggested that some HCPs (usually defined by profession or by experience) were more accurate than others. Only two articles reported the heuristics that clinicians employed; these included factors such as performance status, co-morbidity, rate of decline and spiritual state.

Discussion: Our review confirmed that clinician predictions are inaccurate. We found evidence that some clinicians are more ‘expert’ prognosticators than others. However, the heuristics that these clinicians use to make their predictions remain largely unknown.

Understanding and defining the heuristics may allow us to develop training programmes to enable novice clinicians to become better at prognosticating.

Abstract number: P1-485
Abstract type: Poster

The Development and Validation of a Standardised Transfersheet for Care Transitions between Residential and Acute Care Settings in Leuven, Belgium

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Background: When elderly patients are being transferred from a residential to an acute care setting, information regarding their health care can be lost. Also, over the past years, the concept of advance care planning (ACP) has been given a more prominent place in the care for the elderly. However, it remains a challenge to communicate the results achieved by the process of ACP when patients are transferred between health care settings. Developing a sound method for transferring care information is a key element in the care for the elderly patient.

Objectives: In collaboration with the residential and acute care settings in Leuven, Belgium, this study aimed to develop a validated, standardised transfersheet.

Methods: After a literature search a topic list was generated containing items that could be considered as essential information during transitional care. This topic list was used in a Delphi procedure in which 16 experts from both the acute and the residential care settings participated. A transfersheet was developed and then evaluated for content validity by an expert panel (n=9) from both care settings. Face validity was assessed by two nurses and two doctors, randomly selected from the above settings.

Results: 11 nursing homes, one university hospital and one regional hospital participated in the study. 16 experts selected a total of 44 essential items including information regarding the premorbid cognitive and functional status of the patient, and information regarding the results of the ACP-process. All 44 subthemes in the transfersheet showed excellent content validity. The scale content validity universal agreement (S CVI_U) for the entire transfersheet was 0.68. The average scale content validity (S CVI ) was 0.96.

Conclusions: After a second and final Delphi-round a standardised transfersheet containing 4 themes and 50 subthemes was constructed, validated and implemented. The transfersheet focusses strongly on information regarding the results of the ACP-process.

Abstract number: P1-486
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 1)
Abstract number: P1-489
Abstract type: Poster

Are Dogs Really a Child’s Best Friend?

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Background: More than 40,000 children undergo cancer treatment each day. In the United States, more than 13,500 children are newly diagnosed each year. Although survival rates have improved greatly, the lingering psychological and behavioral effects may negatively impact cancer survivors and their families. Quality of life for childhood cancer patients and their families remains a concern.

Aims: This longitudinal study examines 1) the physiological and psychological impact of therapy dogs on children with cancer and their parents, and 2) the impact of animal-assisted intervention (AAI) sessions on participating therapy dogs.

Methods: Baseline data were collected from children newly diagnosed with cancer (N=88), mothers (N=86), fathers (N=86), therapy dogs (N=31) and owners (N=85). Families were randomised to usual care or intervention groups. Each intervention consisted of approximately 15 minute AAI sessions at the start of weekly clinic visits. Researchers collected physiologic data (pulse and BP) and cortisol level of dogs’ saliva, psychological data (anxiety, quality of life, inventory of difficult events for parents), and video recordings at each AAI session for 16 time points across 4 months.

Results: Changes in stress, anxiety, and quality of life among children and their parents over time will be analysed to document preliminary effects of AAI. Activities of dog and child during each intervention will be summarised.

Conclusion: This study, funded by the American Humane Association, contributes to the state of science on palliative care. Rigorous data from the randomised trial of the physiological, psychosocial and/or behavioral effects of AAI for children with cancer, their parents, and therapy dogs increases our understanding of the benefits (or detriments) of AAI. After analysis from multiple sites is complete, the study will inform the optimisation of future research and best practices.

Abstract number: P1-488
Abstract type: Poster

Exploring Invitation and Recruitment Practices in Research with Children and Young People with Life Limiting Conditions (LLC) or Life Threatening Illnesses (LTI) and their Families - A Systematic Review

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Background: Children and young people with LLCs or LTIs are a vulnerable, difficult to treat population. Research is needed to understand how the care, treatment and management of these patients and their families can be improved. Barriers to research include difficulties with securing the support of ethics committees, limited access to children of all ages and their families and the perceived potential burden on all participants. Recruitment to studies in this population is generally slow and delayed.

Aims: To provide an overview of current invitation and recruitment practices and influencing factors in recently published research with children and young people with life limiting conditions and life threatening illnesses and their families. We focus on how practices impact recruitment and retention rates.

Methods: A systematic review was conducted. Studies will be critiqued, assessed for quality, and data extracted on key aspects of recruitment, including how potential participants are approached and what barriers were identified by authors. All key processes will be completed by two reviewers. A meta-analysis exploring the effectiveness of different invitation and recruitment strategies will be conducted and, if data permit, regression analysis will explore factors associated with higher levels of recruitment.

Results: The search identified 6,024 articles. We shall present and analyse the type and scope of research in this population and the completeness of the reporting of invitation and recruitment practices.

Discussion: Unseen invitation and recruitment practices may lead to sample bias and limit the meaningfulness of findings. Our results will inform the design and reporting of future research in this population.
Posters Sessions (Poster Exhibition Set 1)

Abstract number: P1-490
Abstract type: Poster

**Reaching out to Children and their Families by Offering them Continuity of Care**

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**Background:** It is widely accepted that high quality care comes underpinned by accessibility and continuity of care. Understanding and defining Continuity of Care remains a challenge.

**Aim:** To establish the minimum and necessary conditions to offer integrated and fully coordinated palliative care provision while ensuring children and family transit care levels without solution of continuity.

**Methodology:** Retrospective study to analyze data collected in our group’s database first 6 years.

**Results:** The interdisciplinary team offered Specialist Palliative Care (SPPC) to 392 children with life threatening conditions in all levels of care in 6 years. 229 (58.4%) of them died during this time, 145 (63.3%) at home and 84 (36.7%) in hospital. 7 (3%) of which were unexpected deaths; 2 (0.9%) died in Accident and Emergency and 8 (3.3%) died during a symptom control admission. All were under the care of the regional Specialist Paediatric Palliative Care Team (SPPCT). 8149 home visits were required, of which 887 (11%) were undertaken out of hours and weekends and public holidays. 355 visits by the SPPCT offered bereavement interventions from medical, nurse, psychologist and social worker; visit to tannatary attendance all the way to ongoing bereavement follow-up.

**Discussion:** Home care and dying for children whose families want and can provide it, is a first class Continuity of PPC Quality Indicator. The change in paradigm brought about in our setting came about because of:

1. 24 hour interdisciplinary SPPCT, 365 day a year availability
2. Visiting as requested and in emergency is key to avoid unnecessary admissions and hospital or A&E dying
3. Making all services that might be needed available through the SPPCT.
4. Bereavement being included in continuity of care

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Abstract number: P1-491
Abstract type: Poster

**“Sleep Tight”: Developing a Service to Support Children with Cancer to Die at Home**

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**Background:** The Sleep Tight project was developed following an approach to the children’s hospice from a bereaved parent. The parent had set up a charity in memory of his daughter who died from cancer. He was keen to help the children’s hospice to develop a home night sitting service for children and young people (CYP) with cancer who were approaching end of life (EOL). The service would provide benefit to a patient group who have historically not accessed children’s hospice services.

**Aims:**

1. The project aims to increase the number of episodes of care at end of life care delivered in the home
2. The number of referrals from the Paediatric Oncology Outreach Nurse Specialist’s (POONS) to the children’s hospice

**Approach:**

A project group was developed and included representation from the POONS team.

To ensure adequate staffing to provide the service the hospice added the professional team by recruiting nurses from the oncology ward to their bank staff. Induction and training was provided for all staff involved in the project to ensure they had the appropriate skills, knowledge and competence to deliver this care in the home. The training covered EOL symptom management in the home, difficult conversations, boundaries and documentation. The POONS were involved in delivering the induction.

**Results:** The project has enabled the hospice and POONS team to develop a stronger working partnership. More children have been able to die at home with the support of the project and with the collaboration of the two services. Early findings show a steady increase in the number of referrals from the POONS. Although the numbers are small, referrals have increased from 2 referrals in 2012 to 13 in 2014 and deaths at home from 0 to 4.

**Conclusion:** Building a stronger partnership between hospice and oncology teams has enabled a more effective support of children, and of families’ choice for them to be cared for and die at home.

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Abstract number: P1-492
Abstract type: Poster

**Establishment of Palliative Care System for Children in Ukraine. Call of the Times**

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The system of palliative care for children is imperfect in Ukraine: care is provided in health care facilities according to disease profile of the child and by doctors who do not have sufficient skills and conditions. Outpatient care is provided by GPs, who are not specially trained in counseling patients and their families in palliative care. A significant part of care is provided in residential care facility. However, they do not have specially trained medical staff for palliative care for children.

There are 168,000 disabled children under the age of 18, or 2.2% of all children in Ukraine. Annually, 8,000 of them, children with various illnesses or 0.1% of the child population, need palliative care. Major children disability causes are congenital abnormalities and the neurological diseases, which compose a circle of customers of palliative care. Annually, about 300 children die from cancer, about 700 from other chronic diseases. To provide appropriate assistance to such children Palliative Care Center is created on the basis of a Multidisciplinary Intensive Care Hospital for Children. Center comprises of the inpatient unit for 6-12 beds, day hospital for 3 beds and outpatient mobile team for palliative care. The center provides medical staff with conditions for palliative care training in the region.

The main principle of activity is cross-sectoral approach and team work with the involvement of volunteers to alleviate the suffering of young patients and their families. Thus, the establishment of regional palliative care centers for children in Ukraine is caused by morbidity pattern, disability and mortality. Overall, 0.1% of children in Ukraine are in need of palliative care, primarily outpatient.

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Abstract number: P1-493
Abstract type: Poster

**Necessity of Differentiation between Children with Oncological and Non-oncological Conditions**

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**Background:** In Switzerland 3,689 children were affected by a life-limiting illness in 2011 (BFS, 2013). Twohundredfourty of them died in the same year. The leading causes of death were malignomas, leukaemia and neurological diseases. In a tertiary pediatric hospital 20 children die every year, only one of them due to cancer (Greiner, 2014). According to the classification Together for Short Lives (Widdas, 2013), children with life-limiting conditions can be attributed to diagnosis group three (progressive conditions without curative possibilities) and four (irreversible, non- progressive conditions with risk of complication and premature death). These Children suffer from various complex problems (Bergstrasser, 2010) which demands in intensiv medical care.

**Research question:** This study investigated how health professionals assess the importance of palliative care in children with non-oncological conditions. Additionally, it was examined which structural, institutional and staffing conditions are necessary to meet the high complexity of care for the affected children and to further develop palliative care.

**Methods:** Eleven guideline-based interviews were performed and evaluated using qualitative content analysis.

**Results:** The analysis revealed the necessity to differentiate between children with oncological and non-oncological conditions in order to sensitize for individual needs of tailored support for affected families to ensure quality of life.

**Discussion:** The study indicates an ongoing professionalization of pediatric palliative care in Switzerland. However, cantons and institutions are requested to implement the concept of the Federation with the aim to establish the required structures and to provide resources (BAG, 2012). For health professionals, specific further training on all educational levels is necessary. Additionally, a common understanding of palliative care provides the basis for networking and cooperation in multidisciplinary teams.
**Understanding the Life Issues of Young Adults with Life-limiting Conditions, and the Impact on their Parents, Siblings and Professionals: A Systematic Literature Review**

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**Objective:** This review examined the extent to which the life issues of young adults with life-limiting conditions, and those closely involved with them, have been addressed in the literature.

**Methods:** We conducted a systematic search of five databases for papers published since 2000, which examined the life issues of young adults with life-limiting conditions, either from their own perspective, or from the perspective of those closely involved with them.

**Results:** Nineteen papers were included in the review. There were few studies that examined the unique views of young adults with life-limiting conditions, as potentially different from younger children, as they transition to adulthood. There was also a scarcity of studies that facilitated the inclusion of young adults with communication support needs, or included the perspectives of people closely involved with them. Longitudinal studies were also rare.

**Conclusion:** Further research with a specific focus on young adults with a broad range of life-limiting conditions, and those closely involved with them, would enhance understanding of their unique situation as they transition to adulthood. Opportunities to engage with young adults over a period of time would also be beneficial, to fully comprehend their issues as they evolve.

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**Caring for a Child after Death in UK Children’s Hospices: Assessing the Use of ‘Cool Rooms’**

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**Background:** UK children’s hospices offer bereavement services including caring for children after death using cool rooms/cooling equipment. Current literature offers limited evidence about this practice.

**Aim:** Using a national study to assess the practice of using cool rooms.

**Methods:** An online survey was sent to senior staff in all UK children’s hospice services. Questions related to availability of cool rooms/cooling equipment; knowledge of equipment; staff training; data regarding service users over a 3-year period.

**Results:** 23 services replied - 49% response rate; respondents being senior nursing or bereavement care staff. 91% offer this service using a cool room. 66% accept new referrals after death for children not previously known to the hospice. Physical care of the child’s body, including final dressing and moving into coffin, is carried out by 83 - 100% of services. Packing the body, if required, is carried out by 61% services. 13% reported temperatures outside published guidelines.17% reported specific training in caring for a child after death is not offered. A formal competency is available in 40% of services; 35% offer training at induction. Only one service noted mandatory training. Specific data regarding numbers cared for and length of stay after death, from 26% of respondents, showed that the average length of stay after death was 8-10 days and that the number of children cared for after death had increased by 45% from 2012 to 2013.

**Conclusion:** The study provides detailed findings of the provision of physical care after death, specifically regarding use of cool rooms. A small proportion of respondents provided data to suggest increasing use of the service, and increasing numbers of new referrals after death, suggesting that a wider group of bereaved families were gaining access to this service.
Poster Sessions
(Poster Exhibition Set 2)

Pain
Breathlessness
Fatigue/weakness/cachexia
Other symptoms
Assessment and measurement tools
Audit and quality improvement
Basic and translational research
Bereavement
Communication
Development and organisation of services
Education
Ethics
Family and care givers
International developments
Medical sociology
Health services research
Policy
Public health and epidemiology
Spirituality
Social care and social work
Psychology and psychiatry
Research methodology
Volunteering
Cancer
Non-cancer
Palliative care for older people
Palliative care in children and adolescents
Objective:
The myths related to opioids specifically morphine, which is a drug of choice for cancer pain, has been a reason for an unfavourable pharmacotherapeutic adherence and poor control of pain. The aim of this study is to know the myths about morphine in cancer patients at the National Cancer Institute (INCan) to design a minimumisation plan.

Methods:
A prospective, observational situation analysis was performed and used as an instrument of data collection mixed interview, as it will include open, multiple choice and closed questions that will lead the perspective of the patients and their fear of the use of morphine. The surveys were conducted in different INCan's departments. The questionnaires were applied personally by the initial reading of informed consent pointing out the objectives of the study, voluntary participation and confidentiality of the data collected.

Results:
From a sample of 172 patients, the results are shown below.

Does morphine...
Cause addiction? Yes 42% No 46% I don't know 12%
Is exclusively for terminal patients? Yes 54% No 36% I don't know 10%
Is expensive? Yes 65% No 6% I don't know 29%
Is the last treatment available for pain? Yes 32% No 41% I don't know 27%
Would you take morphine treatment for your pain? Yes 61% No 35% I don't know 4%
About morphine...
What's morphine? Medicine 28%
Illegal Drug 5%
I don't know 15%

Conclusion:
Patients surveyed have serious prejudices and assume as true the myths about morphine. In coordination of pharmacist and palliative care team, patients would have access to reliable and current information about opioid medications promoting adherence to therapy and decreasing risks associated with these drugs.
Abstract number: P2-005
Abstract type: Poster

Rapid Onset Opioid (ROO) Rotation in Breakthrough Cancer Pain (BTPC) Management: A Palliative Care Case
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ASIS 2015, Monfalcone, Italy
Background: ROO, are fentanyl citrate drugs for the BTPC management, which have a rapid transmucosal absorption (buccal, nasal or sublingual), OFTC (oral transmucosal fentanyl citrate), FB (fentanyl buccal tablet), FPNS (fentanyl pectin nasal spray), and rapid analgesic action. These are indicated in the treatment of BTPC in patients taking > 60 mg of oral morphine or equianalgesic doses during the last week.
Aim: To describe a clinical case followed by our palliative home care service on ROO rotation.
Result: A patient with metastatic breast cancer, followed by our home service from June 2013 received a background pain (BGP) therapy with TTS fentanyl 150µg/h every 48 h, paracetamol 1g/12h, ibuprofen 600mg/bid for BTPC: OFTC 1200µg FB 200ug 4–5/d. Average daily intensity was 8 (NRS 0–10).
For neuropathic pain pregabalin 25–150mg/d was added. The BGP improved, NRS < 4 after 30 days. She continued to take the ROO 2–4/d.
In October 2013 for worsening pain and pain of absence, prednisone 25mg/d was added. The pain remained controlled until May 2014 when, for ineffectiveness the FB dose only was increased to 800ug with no rapid onset (about 60 min). For this reason, OFTC therapy was changed with FPNS 400ug obtained rapid onset and partial pain control after 6 min. and total pain control after 9 min. Light dizziness was reported after 9 min, resolved after 12 min.
Nowadays patient has no pain with a very good tolerability.
Our case show the simplicity in determining the dose titration and managing of FPNS.

Abstract number: P2-006
Abstract type: Poster

Introducing Alternative Forms of Strong Opioids to Control Chronic Pain in Moldova: Believing in Unbelievable
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Introduction: Palliative care in Moldova has been growing gradually since 2000 and is a relatively new concept which was introduced into the National Healthcare structure in 2008. In order to control chronic pain in cancer patients there was available only injectable form of strong opioid such as morphine.
Objectives: To assess the introduction of oral forms of strong opioids in Moldova for effective cancer chronic pain control.
Methods: Review of the annual reports of the Charity Foundation for Public Health “Angelus–Moldova” about administration of strong opioids to control chronic pain in cancer inculcable adult patients.
Results: In February 2012 oral tablets of extended-release morphine were introduced into the local pharmaceutical market and in March 2014 oral solution of methadone became available as alternative pain killer for effective control of chronic pain in cancer patients with high dosage of injectable morphine.
Conclusions: Despite the fact that there are still not enough alternative forms of strong opioids and variation of their dosage, introduction of oral slow release morphine and beginning of the oral methadone administration not only for replacement therapy is a significant step forward in modern control of chronic pain in adult inculcable cancer patients in Moldova.

Abstract number: P2-007
Abstract type: Poster

Use of High Doses of Opioids for Elderly Cancer Patients with Severe to Moderate Cancer Pain: Prospective Observation Study
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Aims: Cancer pain can be well controlled by using opioids. However, a lot of cancer patients are still suffering from intractable pain due to underestimation or improper treatment of their pain, particularly in the elderly.
Methods: We prospectively observed the use of high dose opioids and adjuvant drugs for pain management in elderly cancer patients. The changes in pain severity (NRS); opioids dosage, parameters associated with quality of life and adverse events of opioids were investigated in outpatient's clinic after 8 weeks. Data from 94 cancer patients aged more than 65 years with high dose opioids (OxO ≤130 mg/day) were collected from 30 hospitals.
Results: Ninety four patients with moderate to severe pain were followed up for 8 weeks. A total of 92 patients (74.3% received only Oxycontin®) were prescribed opioids at the end of the study. Sixty two patients (67.4%) were male and mean age of patients was 70.2 years. Mean pain intensity and opioid dosage (OxO) were changed from 3.61 ±1.56, 17.886±7.88 and from 4.12 ±1.69 (p=0.001), 288.42 ±189.09 (p=0.002) after 8 weeks. Quality of life, quality of daily activity, ambulation and sleep were significantly improved after 8 weeks (p<0.001).

Abstract number: P2-008
Abstract type: Poster

Using PK/PD Model to Optimise Dosing of Morphine in Renal Impaired Patients
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Background: A major problem related to morphine is dosing in patients with renal insufficiency, and no guidelines for dose adjustments exist. As a result of decreased renal clearance, accumulation of morphine metabolites (M6G & M3G) can lead to serious adverse effects. In renal failure, morphine use is generally not recommended as accumulation of the metabolites is unpredictable. Case reports in patients with renal insufficiency have shown high and prolonged concentrations of M6G after morphine administration. Furthermore, the high concentrations of accumulated M6G can contribute to morphine analgesia, which again supports dose adjustment in renal insufficiency patients as lower morphine doses might be sufficient for analgesia.
Aim: The aim was to simulate the M6G contribution to analgesia after oral administration of morphine in patients with renal insufficiency using a population PK/PD model.
Methods: In the simulations, 30 mg morphine was administered orally four times daily to a patient with five degrees of renal insufficiency, 0% (normal renal function), 25%, 50%, 75% and 95% reduced renal function.
Results: In subjects with normal renal function, M6G contributes approx. 27% to the total analgesia after oral administration of morphine at steady state (18.5% response). As renal function declines, M6G contribution to analgesia increases, while morphine analgesia is unaffected. The estimated doses needed to reach the target response of 18.5% as seen in a patient with normal renal function were 28 mg, 24 mg, 17 mg, and 5 mg for 25%, 50%, 75%, and 95% renal impairment respectively.
Conclusions: M6G accumulates after administration of morphine to patients with renal impairments, and analgesia can be obtained with lower doses of morphine compared to patients with normal renal function. Thus, dose should be reduced to avoid side-effects, although the simulations in this review did not account for side-effects and the possible contribution the these due to M3G.

Abstract number: P2-009
Abstract type: Poster

Is Tolerance to Alfentanil in Continuous Subcutaneous Infusion (CSCI) a Clinical Problem in a Specialist Palliative Care Unit Cohort?
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Background: Alfentanil is an opioid analgesic increasingly delivered in palliative care by CSCI where conventional opioids are poorly tolerated, particularly in chronic kidney disease (CKD). There is conflicting literature on whether tolerance to Alfentanil is a clinical problem. Aims: We wished to explore dose changes over time in our cohort of patients receiving Alfentanil.
Methods: 18 consecutive patients during February–May 2014 on Alfentanil comprised the cohort. Notes were requested and data extracted retrospectively.
Results: Data were available from 17 notes. Average age of patients was 66 years. Of the 17 patients, only 1 had non-malignant disease – CKD. 12 (71%) patients died whilst prescribed Alfentanil. 5 were switched to alternative opioids or continued on Alfentanil therapy at the time of study end. 14 (82%) of the 17 patients were switched to Alfentanil as a result of opioid toxicity. Mean start dose of Alfentanil was 4.17 mg per day, with substantial increases over the first week. The mean dose had more than doubled to 8.9 mg after 5 days. 1 patient with CKD had noticeably little dose titration – start dose 0.2 mg increasing to 0.4mg per day after 1 week with no further increases after 19 days of therapy. Mean end dose of Alfentanil was 14.8mg per day. Median duration of treatment with Alfentanil was 13 days.
Conclusions: Alfentanil doses were shown to increase substantially, particularly in the first week of use, indicating that tolerance does occur in some patients. There appear to be some individuals in whom tolerance does not occur. Alfentanil is predominantly used for patients who are nearing end of life. Given the propensity to develop tolerance, this is an appropriate niche for its use, particularly in CKD.

Abstract number: P2-010
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 2)
Is Pain Control Enough to Achieve Quality of Life?

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Abstract number: P2-011

Abstract type: Poster

Background: The quality of life in patients with cancer depends not only on good somatic symptoms control. The role of psychosocial support is being minimised or neglected. Such a guideline: pain management of chronic pain. The guideline aims to improve the pain management of patients with chronic cancer and non-cancer pain of all age-groups. It is feasible for all health care settings.

Approach: A literature review identified guidelines for chronic pain. After the rating (DIMDI criteria) 28 guidelines could be included in the guideline development. An expert group of 10 nurse researchers and practical nurses developed the guideline on the base of the existing guidelines and their expertise. The guideline was adopted in a consensus conference with 600 nurses.

Results: The guideline defines the outcomes of the pain management: to enhance or sustain the quality of life and functional status, to reduce the pain to a stable and individual acceptable pain level, social participation and the prevention of crisis. The guideline is structured in five intervention categories:

1. a. criteria-led pain assessment
2. the development of treatment plan in the multidisciplinary team
3. patient education to empower the patient and enhance self-management strategies
4. pharmacological and non-pharmacological pain management and prevention of adverse effects
5. documentation and re-evaluation of the defined outcomes

Conclusions: With support of this evidence-based guideline the authors and the quality network intend to improve the pain management of patients with chronic pain. The mandatory implementation of pain nurses will help to achieve this health outcome in Germany.

Poster Sessions (Poster Exhibition Set 2)
Aim: The study aimed to assess cognitive function using the Addenbrooke’s Cognitive Examination-revised (ACE-R) in patients who were prescribed opioids and to compare impact on cognitive function between opioid groups.

Method: Patients who were prescribed opioids for cancer or non-cancer pain and substance misuse were recruited, as were patients with non-cancer pain who were not on opioids. Opioid history was recorded. Patients completed the ACE-R. The ACE-R provides a score of 100 from which the MMSE score is extracted. Information is provided on five domains of cognitive function. Assessments were completed every 6 weeks. Most patients completed two assessments; some cancer patients completed three.

Results: 170 patients were recruited; 89 had cancer pain. Using the MMSE, 45 patients (26.5% of all patients) had definite or possible cognitive impairment; this increased to 65 patients (38.2%) when using ACE-R. Using the MMSE, 27 patients (30.3%) of cancer patients had cognitive impairment; this increased to 42 patients (47.2% of cancer patients) when the ACE-R was used. The mismatch between day 1 and day 3 was statistically significant in all patient groups. Attention, memory, fluidity and visuospatial abilities were impaired. Language was relatively preserved. No correlation was found with pain, anxiety or depression. Cognitive impairment (≥2) persisted over time.

Discussion: Using the ACE-R reveals significantly more CI in patients on opioids than the MMSE. The ACE-R revealed the domain of cognitive function affected. Although it is likely to be multifactorial, opioids will be responsible for some of the impairment.

Abstract number: P2-017
Abstract type: Poster

Nursing Perceptions about Managing Pain Medications in Long Term Care

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Background: Pain management for older adults living in long term care (LTC) has been recognised as a problem worldwide. Despite the high rates of pain experienced by residents in LTC, pain continues to be under-assessed and under-treated. Untreated pain can lead to numerous negative outcomes such as decreased functional abilities, depression, impaired mobility, sleep disturbances, anxiety, and dissatisfaction with life.

Aims: The purpose of this study was to examine and compare the impact of standard laxatives with opioid therapy to OXN PR on OIC and analgesic efficacy during long-term treatment with OXN PR in adults with moderate-to-severe chronic pain.

Method: Forty-six patients in the OXN PR group were included in the analysis of the primary endpoint. The number of rescue doses used per 24-hour interval after application was 0.6 (0–2.5) on day 2 (36–60 h), 0.5 (0–3.0) on day 3 (30–72 h), and 1.0 (0–3.5) on day 3 (58–70 h plus 0–12 h). The number of rescue doses used per day was 3.0 (0–12) on day 1, 2.0 (0–12) on day 2 and 0.5 (0–12) on day 3 (p<0.001).

Conclusions: At stable blood fentanyl concentrations, OXN PR can ameliorate OIC, avoiding the need for regular laxative use, while maintaining analgesic efficacy; furthermore less than 10% of patients took laxatives on a regular basis.

Abstract number: P2-018
Abstract type: Poster

Usefulness of Percutaneous Neuromodulatory Colonic Plexus Block with IVR-CT System for Pain due to Pancreatic Cancer

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Aim: To evaluate and compare the impact of standard laxatives with opioid therapy to OXN PR on OIC and analgesic efficacy during long-term treatment with OXN PR in adults with moderate-to-severe chronic pain.

Method: We performed a literature search for reports of bowel function in patients taking opioids and laxatives. We evaluated a study that combined (using pooled analysis) data for analgesia (average pain over last 24 hours’ scale) and bowel function (Bowel Function Index (BFI)) in 474 patients receiving OXN PR over 52 weeks.

Results: Opioids cause severe OIC and laxatives don’t solve the problem. The pooled analysis showed improvement in bowel function was continued during 1 year of treatment and analgesic efficacy was maintained; furthermore less than 10% of patients took laxatives on a regular basis.

A clinically meaningful, statistically significant improvement in bowel function (average BFI score reduction ≥12) was observed in patients who switched from Oxy PR to OXN PR: within a score reduction ≥12) was observed in patients who switched from Oxy PR to OXN PR: within a
Analogic Effect and Safety of Mixed Solution of Oxycodone, Ketamine and Lidocaine for Cancer Pain

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Background: We usually administrate mixed solution of oxycodone, ketamine, lidocaine intravenously for fast analgesics titration for cancer pain, and got pain relief safely. Ketamine and lidocaine might be effective for cancer pain and postoperative pain as co-analgesic in addition to opioids.

Aims: We measured the plasma concentration of these drugs and investigated the correlation between the plasma concentration of analgesic drugs and analogic effect and safety of these drugs.

Methods: This study design was a prospective, non-randomized, non-blinded study, and was performed between March 2013 and December 2013. Five patients were enrolled. All patients had cancer pain and did not use any opioid analgesics. We administrated oxycodone, ketamine, lidocaine mixed solution intravenously by an electrical patient-controlled analgesia (PCA)/pain pumps with basal infusion. Blood samples were taken: T1: control, T2: patients felt pain relieved; T3: an hour after T2, and T4: tomorrow morning. Plasma concentration of study drugs were measured. Pain intensity and adverse effect were evaluated at all sampling time.

Results: All patients felt pain relieved at T2. Mean minimum effective concentration (MEC) of oxycodone was 12.65 (8.74–20.8) ng/ml. That of ketamine and lidocaine were 2.31 (1.45–4.26) ng/ml and 168 (109–222) ng/ml. No patients experienced severe respiratory depression and decrease blood pressure. At T3 and T4, the plasma concentration of study drugs were almost within twice of MEC. The correlation between pain intensity/other adverse effects and plasma concentrations of study drugs were not clearly.

Conclusion / Discussion: We measured the plasma concentration of study drugs at T1–T4. We succeeded fast titration of opioids. Ketamine and lidocaine adding oxycodone might be effective for fast injection, respiratory depression by opioid did not occur. Basal infusion of oxycodone, ketamine, lidocaine might be safety and decrease opioid assumption. Further study is needed.

Abstract number: P2-020
Abstract type: Poster

Pain Control Management after Patients Become Unable to Take Methadone Orally in the End of Life

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Background: In Japan, oral administration of methadone for patients with cancer pain was approved in March 2013. However, as methadone can only be administered orally in Japan, inserting the needle is considered standard practice; group 2 butterfly was positioned with the needle’s bevel down - experimental group. The drugs used for pain relief were sc Tramadol for moderate pain and sc Morphine for severe pain.

Methods: Our research supported the hypothesis that the occurrence of local complications comes together with the decrease of sc butterfly resistance in time at the place of insertion and the sc butterfly has a higher rate of resistance in time at the insertion site if the frequency of injectable opioids administration is lower (twice per day). The positioning of the butterflies with the bevel down (experimental group) is associated with a longer resistance in time at the site of insertion and causes less local complications compared to the sc butterflies positioned with the bevel up (control group).

Abstract number: P2-022
Abstract type: Poster

Conceptual and Attitudinal Barriers to the Use of Symptom Measures in the Management of Pain

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Introduction: There are significant challenges in bringing systematic symptom measurement to the palliative care population including both attitudinal and conceptual barriers.

Objectives: This paper reviews challenges in palliative medicine i.e. conceptual and attitudinal barriers to the use of symptom measures in pain management.

Discussion: Conceptual and attitudinal barriers to the use of health status measures in patient care and clinical trials (1) are likely to be relevant in the palliative care setting. These include skepticism about the validity and importance of self-rated health measures, preferences for physiological outcomes or death rates, unfamiliarity of healthcare providers with the scoring measures, and a paucity of direct comparisons among instruments.

Conclusion: Systematic symptom assessment is a foundation of clinical practice and research. Instruments for measurement of symptoms have been developed and may facilitate this process.

References:

Abstract number: P2-023
Abstract type: Poster

Potency of the Acetaminophen Injection for Cancer Pains in Japan

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Background: Cancer patients often have decreased physiologies such as liver function and renal function; therefore, it is necessary to use safe and effective analgesics. In Japan, the acetaminophen injection (AI) was approved for use in November 2013. Because administering an acetaminophen injection in intravenous form evades metabolic effects, blood level control becomes easier than with conventional oral administration of acetaminophen. Considering that cancer patients often experience decreased deglutition function and metabolic capacity, AI is believed to be suitable for them. However, the history of use of AI in Japan is still short; there are no reports about its usage in cancer pains.

Purposes: To examine whether AI is beneficial for cancer pains in Japan.

Methods: We retrospectively evaluated cancer patients who were administered AI at a municipal hospital and a university hospital in Japan from November 2013 to September 2014. The patient’s backgrounds, doses of AI, pain intensity differences (PID), laboratory test values, combined drugs, and so on, were obtained from their medical records. Pain was on a 4-point scale (none; 0, weak; 1, strong; 2, severe; 3).

Results: Improvement by AI were observed in 46 of 58 subjects. The PID was 1.1 ± 0.7 (mean ± SD). Among all subjects, analgesic effect appeared in 85% of postoperative patients, and 72% of non-postoperative patients with cancer pains. In the cases of non-postoperative patients with cancer pains, no significant pain reduction was identified, moreover, AI sometimes provided analgesic effects when some NSAIDs were ineffective.

Conclusion: The current study was performed at early stage, but the findings suggest a potential for AI to be effectively used for cancer pains in Japan. We certainly intend to perform this study in a greater number patients in association with other institutions, which would increase the credibility of our findings.
Background: The prevalence of pain in advanced cancer patients ranges from 70% to 80% in these patients, opioid rotation is often used when adverse events occur after an good pain control. To ensure an optimal balance between analgesia and side effects, physicians should be aware of all the options available on the market to choose the most suitable alternative. Aim: To review cases in which there was rotation from a major opioid to Tapentadol. To check the tolerability profile and analgesic efficacy in these patients. Methods: Type of study: Observational, longitudinal and retrospective study. Case series. Site: Fundación Instituto Valenciano de Oncología, Valencia, Spain. Study population: Patients admitted at the Palliative Home-Care Unit and outpatients who came for consultation to the Pain Management Unit in the Medical Oncology Department. Variables: sociodemographic, Verbal Analogue Scale (VAS), clinical records of side effects. Results: Thirteen patients were identified who rotated from a major opioid (transdermal Fentanyl, oral Morphine, oral Oxycodone, Buprenorphine) to Tapentadol; it was verified that the conventional administration of analgesia and anxiolytic medication. Appropriate analgesic control (VAS<4) was obtained in 9/13 cases. Conclusions: Tapentadol is a valid option in the treatment of advanced cancer pain. In the absence of ad hoc studies, its tolerability profile and analgesic potency make it an alternative for opioid rotation in patients with cancer pain.

Abstract number: P2-025
Abstract type: Poster

**Diamorphine or Alfentanil for Subcutaneous Use in Hospice In-patients (DASH! PILOT)**

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**Background:** There is variability in how patients respond to different opioids. In the United Kingdom standard practice is to use diamorphine as a subcutaneous infusion via syringe driver when patients are unable to take strong opioids orally. Alfentanil is another strong opioid which can be used in this way but its use is often reserved to those with renal impairment where it is believed it may have fewer adverse effects. There are no randomised trials comparing diamorphine and alfentanil in palliative care patients.

**Aims:** To explore the feasibility of a randomised controlled trial of diamorphine versus alfentanil via syringe driver for specialist palliative care patients without severe renal impairment.

**Study design and methods:** Specialist Palliative Care Unit inpatients requiring diamorphine via syringe driver with an estimated prognosis between 1 week and 1 year and an estimated glomerular filtration rate greater than 30ml/min were approached. After a minimum 24-hour cooling off period those interested were consented and randomised to stay on diamorphine or switch to alfentanil in an open label fashion. An approximate 1:1 conversion was used (alfentanil:diamorphine) daily. To draw up daily reports and switch to diamorphine on the day at 1p.m. assessment schedule (MDAS).

**Results:** 10 days (28 of 102) had been randomised (9 in each arm). Preliminary results show that the only statistically significant differences (Mann-Whitney U tests) were with regard to components of the BPI SF on days 1-5 all favouring diamorphine. There were no differences in MDAS scores.

**Conclusion:** Some of the differences in pain scores could potentially be due to placebo effect of being allocated to a new treatment versus no change in treatment. These results were already on adjuvant neuropathic medications. Methadone was initiated as a co-opiate in the 4% of patients who had a record of renal failure close to their starting morphine dose. Methadone was initiated as a co-opiate in the 47% of patients as a co-opiate in combination with a loading dose of morphine (28%). Most patients did not have their pain assessed with a pain scale tool on initiation or titration. The starting dose of regular methadone ranged from 5-15mg bid. The dose of PRN medication on discharge was lower than on initiation in 33% of patients. In 95% of patients it was possible to switch from injection to oral PRN medication. In 33% of patients there was no change in strength of PRN medication used. All patients had a strong appetite on initiation with Oxycodone and Fentanyl preparations the most frequent. 24% of patients had documented over-sedation leading to dose reduction of methadone. One possible incidence of drug induced psychosis was reported. No sudden deaths were identified. There was variability in the day of titration. First titration after initiation ranged from Day 3 to Day 8 (mean 4.6) Second titration ranged from Day 5 to Day 10+ (mode Day 7 and Day 9).

**Conclusion:** Good practice was identified in documenting initiation of methadone in the majority of cases. The method of initiation and titration was varied, and there was a lack of documentation of pain assessment on initiation and titration. Methadone appears to be a useful medication for pain with very few side effects. Further review of guidelines and review documentation of pain assessment on initiation and titration. Methadone appears to be a useful medication for pain with very few side effects. Further review of guidelines and review documentation of pain assessment on initiation and titration.
Breathlessness

Abstract number: P2-032
Abstract type: Poster

Successful Nursing Support for a Patient with Primary Macroglobulinemia under a Long-term Artificial Respiratory Support

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Background: Primary macroglobulinemia is one of blood cancers and its prognosis is poor. The indication of an artificial respiratory support is controversial, when a patient with this condition shows breathing difficulty. We herein report our support to a patient with primary macroglobulinemia having received a long-term artificial respiratory support.

Case: A 50-year female with primary macroglobulinemia was introduced into the palliative care team requiring psychological support nine days after hospitalisation. She showed advanced muscle weakness and neuropathy, which did not improve after four-time plasmapheresis. Her breathing deteriorated progressively, although it was rare complication of primary macroglobulinemia. It was discussed among the palliative care team members whether the introduction of an artificial respiratory support is appropriate in this patient with a malignant disease. Although it was uncertain that she could recover from respiratory insufficiency, an artificial respiratory support was introduced for chemotheraphy. The nursing care policy was set to reduce the discomfort as much as possible. She was informed about being immunocompromised and her quadruplegia did not improve during the first two months. In order to encourage her and share the information of her daily challenges among the medical staff members, the handmade calendar was put in her ward room by the nurses. The continuous effort of reduction of her anxiety and confusion was made during the period of 160-day artificial ventilation. She became free from artificial respiratory support by successful chemotheraphy. She discharged from our hospital by walking with a stick 277 days after hospitalisation.

Conclusion: The continuous patient encouragement and the share of information among medical staff members and the patient were considered to be effective to rescue the patient from advanced neuropathy related to primary macroglobulinemia.
A Breathe of Fresh Air? Analysis of Short Specialist Palliative Intervention in Non-malignant Breathless Patients

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Background: Breathlessness is common in advanced disease. Those with cancer often have good support, compared with end stage non-malignant disease. A multiprofessional short specialist palliative intervention (SSPI) includes symptom management, coping & advance care planning. A visual analogue scale (VAS) pre & post intervention addresses four specific areas: breathlessness, anxiety, sleep quality & energy levels. Opioids for breathlessness now given as slow release morphine (max 30mg/24hrs) rather than immediate release.

Aims: To assess appropriateness of referrals, subjective symptom improvement & advance care planning conversations offered.

Methodology: Retrospective audit 18 months referrals, for VAS score pairs, subjective assessment of symptoms, GSF registration, ACP discussions, PPC recording & achievement (if done).

Results: 52 patients identified – 16 excluded, 14 cancer, 1 DNA, 1 moved away. 36 records reviewed. 90% pulmonary disease, 5% cardiac, 5% MND. VAS score pair recorded 65% – breathlessness reduced 51%, worsened 17% anxiety reduced 70%, worsened 8%; sleep quality improved 35%, unchanged 65%; energy levels improved 40%, worsened 8%. PPC recorded 94% – home 72%, not home 28%. 44 clinic attendees died, 81% achieved PPC & 62% supported by individualised plan for care. 100% discussed wishes & preferences, ACP discussed 72%, formal ACP by a few, ADRT 8%. DNACPR in place for 15%. Conclusions: Initial poor VAS completion addressed by one doctor being responsible for SSPI. Referral rates increased & inappropriate referrals declined. Multiprofessional approach appears to help patients & carers manage/copre better with daily symptoms. Two patients showed dramatic improvement in breathlessness, anxiety & energy on a second intervention attendance. VAS scale improvements appear more marked with modified release morphine compared to immediate release (audit ongoing). Clinic appears to be encouraging patients to engage in process of advance care planning.

Abstract number: P-035
Abstract type: Poster

The Use of Bedside Sonography in a Mobile Palliative Care Team

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Background: Optimal symptom control is essential in palliative care patients, but unnecessary diagnostic procedures should be avoided. There are only few reports in literature about the role of mobile ultrasound machines in this setting.

Aim: We investigate the use of bedside sonography (with a V-Scan and a SonoSite 180) in a mobile palliative care team (MPT). What are useful indications? Are the findings of clinical relevance and what are therapeutic implications?

Methods: From November 2013 till October 2014 95 US examinations were performed in 60 different patients by doctors of the MPT and prospectively evaluated in regard to indications, results and therapeutic consequences. The majority of patients (86%) were suffering from cancer.

Results: The main indication for bedside sonography was dyspnoea (n=56, 59%), followed by pain (n=27, 30%). The main clinical question was, wether there is fluid in the pleural space or ascites in the abdomen. As a result of the US examination 29 drainages of ascites and 10 pleural punctures were performed. Other therapeutic consequences were change of medication (e.g. prescription of antibiotics or diuretics after diagnosing pneumonia or pleural effusions) or placing a urinary catheter in a case of urinary retention. US-guided therapeutic interventions can be performed at home with a low risk of complications. Only 2 from 59 patients showed minor complications: One pleural puncture had to be repeated due to a blocked needle, one patient showed a leakage over several days after drainage of ascites.

Conclusions: Mobile ultrasound is a well tolerated diagnostic tool. The results of bedside sonography influence our therapeutic procedures. Therapeutic interventions at home can avoid unnecessary hospital admissions, they are safe and result in an immediate symptom relief.

Abstract number: P-036
Abstract type: Poster

The Effectiveness of Herbal Medicine for the Management of Anorexia in Advanced Cancer Patients – A Systematic Literature Review

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Background: To identify and appraise the literature on the effectiveness and safety of herbal medicine for anorexia in advanced cancer patients (pts), are limited. Since many cancer patients use herbal medicine (hm, the medical use of whole plant extracts) and hm for the treatment of anorexia has a long tradition in many cultures, is there a need to explore the potential of hm in the management of anorexia in advanced cancer pts.

Aim: To identify and appraise the literature on the effectiveness and safety of herbal medicine for anorexia in advanced cancer patients.

Methods: A systematic search (search terms for advanced cancer, hm and anorexia) in 4 databases and hand search was performed. Controlled/uncontrolled studies in adult advanced cancer pts investigating hm for anorexia (primary or secondary outcome) were included. Quality of the extracted data was assessed using the Cochrane Risk of Bias Assessment tool.

Results: Preliminary results: Of 265 hits, 5 studies met the inclusion criteria (11–243 pts, various cancer types; 2 with single herbs from European, 3 with combinations from Asian hm, 3 RCTs, 2 uncontrolled studies, 2 studies with anorexia as primary, 3 as secondary outcome). Both uncontrolled studies reported improvement of anorexia. 2 of the 3 controlled studies showed no difference, one methodologically poor study with a multiherbal preparation showed a statistically significant improvement. In all studies the herbal preparation was safe.

Discussion: Due to the paucity and heterogeneity of the identified studies, no conclusion on effectiveness of hm for anorexia can be drawn at present. To clarify the role of hm in the management of this burdensome symptom, high quality studies in a clearly defined pt population with a defined disease type and -stage, investigating a specific herb or group of herbs that are traditionally used for anorexia, and using outcomes that capture also the individual pts experience, are needed.

Funding: Cantonal Hospital St.Gallen
Poster Sessions (Poster Exhibition Set 2)

Abstract number: P2-038
Abstract type: Poster

Oral Supplements and Nutritional Support

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Background:
- Cancer nutrition is frequent and causes poor patient outcomes.
- Individual dietary interventions can improve nutritional intake.
- Oral supplements provide nutritional support when dietary intake is low.
- Success depends on patient acceptability and compliance.
- Four low-volume oral nutritional products were tested for compliance and palatability.

Aims:
- Record patient compliance with oral nutritional supplements.
- Measure palatability.
- Test patient tolerance.

Methods:
- Compliance: Seven patient groups (n=20 each) in separate clinical locations consumed a nutritional supplement twice daily for 4 weeks and maintained daily compliance diaries.
- Palatability: On days 1, 3 and 7, palatability was rated (1–9) for a. smell, b. taste, c. texture, d. aftertaste.
- Gastric Tolerance Symptoms: Daily symptom ratings recorded for 7 days.

Results:
- Compliance: >90% consumed the amount prescribed across all 4 products for each of 30 days. The remaining participants took at least half the prescribed amount.
- Palatability: Palatability ratings indicated all four products were palatable. Range 5–22 for 7 days.
- Gastric Tolerance Symptoms: Tolerance was high with only a few mild symptoms in a small number of patients.

Conclusions:
- Oral nutritional supplements are an acceptable and patient friendly way to assist nutrition.
- 2. Low-volume, nutrient-dense supplements may improve both compliance and dietary intake.
- Tolerance was good and the effect sustained.

* Supported by Nuatral Ltd.

Abstract number: P2-039
Abstract type: Poster

Investigating the Role of Comorbidity in Cancer Cachexia: A Retrospective Cohort Study

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Background: Cancer cachexia is a multifactorial syndrome associated with muscle wasting, weakness, fatigue and poor oral intake. It is both debilitating and common, affecting around 60% of patients with lung cancer. New and promising therapies for cachexia are on the horizon, though these have not typically been tested in patients with cancer who are also elderly, have comorbid illnesses such as chronic obstructive pulmonary disease (COPD), or who are frail. Comorbid illnesses and frailty are common in patients with lung and other cancers and along with ageing, are known to cause muscle wasting in their own right. The impact of ageing, comorbidity and frailty on muscle wasting and survival in patients with lung cancer is not known.

Aim: To identify key variables in the development of muscle wasting and shortened survival in patients with lung cancer.

Methods: A retrospective cohort study is being conducted using a (UK) national lung cancer dataset from 2008–2010. Demographic and clinical characteristics (relating to lung cancer, comorbid illness and frailty) are being collated along with objective assessments of lean body mass from routine CT imaging (using Slice-O-Matic software).

Analysis: The population will be detailed using simple descriptive statistics. The relationship between demographic and clinical characteristics and muscle wasting will be explored by multivariate analysis. These same variables will be assessed regarding their ability to predict overall survival, using a proportional hazards model.

Results: Data from approximately 300 patients will be presented.

Impact: Developing an accurate picture of cachexia in the context of patients’ wider health and function is critical if we are to identify the most appropriate patients for active cachexia management. Importantly, this will also involve identifying the most unwell patients for whom cachexia intervention would be futile, and for whom palliative care should be the priority.

Abstract number: P2-040
Abstract type: Poster

Cachexia and Inflammatory Markers in Patients with Advanced Pancreatic Cancer

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Background: Chronic inflammation is proposed as an underlying biological mechanism for development of cancer cachexia. Aim: The aim of this study was to evaluate the relationship between cachexia classified by the 2011 consensus definition1 and inflammatory markers.

Methods: Patients with newly diagnosed advanced pancreatic cancer were included. Cachexia was diagnosed when one or more of the following three criteria was determined, weight loss >5% past six months, BMI ≥ 20 and weight loss >2%, sarcopenia (mid upper arm muscle area by anthropometry female (F): ≥ 18 cm², men (M): ≥ 32 cm²). At inclusion a wide range of acute-phase response proteins, cytokines and hormones were measured by enzyme immunoassays.

Results: Twenty patients (F: 5, M: 15) were recruited. Median (range) age was 67.5 (35–79) years. All patients received chemotherapy. Median survival from diagnosis was 10 (2–35) months. Upon inclusion 11 (55%) patients were classified as cachectic. Acute-phase response proteins, cytokines and hormones among non-cachectic and cachectic patients are shown in the table. All p-values were >0.05.

Conclusion: Patients with advanced pancreatic cancer diagnosed with cachexia immediately after cancer diagnosis did not have higher levels of inflammatory markers than non-cachectic patients.

Abstract number: P2-041
Abstract type: Poster

Efficacy of Subcutaneous Ranitidine via Syringe Driver in Patients with Intractable Dyspeptic Pain

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Background: Dyspepsia is a common problem and is frequently caused by gastro-oesophageal reflux disease (GORD) or gastritis. However, it is also related to cancer of upper gastrointestinal tract as well as gastric stasis due to bowel obstruction. In these cases, if the patients were unable to swallow medications or had intractable nausea, they were administered subcutaneous Ranitidine. Ranitidine is a competitive, reversible inhibitor of the action of histamine at the histamine H2-receptors found in gastric cells, indicated for use is dyspepsia.

Aims: To observe the response of dyspeptic pain in patients with malignant diseases when they are unable to tolerate oral medications.

Methods: A retrospective study of 22 consecutively admitted patients with Ranitidine syringe driver over one year period.

Results: Out of 22, there were 13 males and 9 females with an average age of 68 years (range=46 to 81). They were diagnosed to have Gastric cancer (10), Oesophageal cancer (6) or Malignant Bowel obstruction (6). Pain was recorded by Numeric Rating Scale (NRS=0–10, with 0 being no pain). 4/22 started Ranitidine subcutaneously 50 mg whereas 18/22 were started on 150 mg. Other medications used in same syringe driver were Metoclopramide, Cyclizine, Haloperidol, Midazolam, Hyoscine Butyl Bromide, Ondansetron or Levomepromazine. 10/22 reported improvement in NRS=−8 drop. 4/22 improved on non-oral vs as they were too poorly to score. It was not possible to record response in 6/22. 2/22 continued to have same degree of pain. Local skin reactions were noted in 4/22 patients.

Conclusion: Patients with dyspeptic pain may respond to Subcutaneous Ranitidine when oral route is not appropriate. Ranitidine can be mixed with most medication in Syringe driver. Local reactions or side-effects were not clinically significant.
Interventions for Respiratory Hypersecrection in Palliative Care Patients – A Systematic Review

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Background: Chronic respiratory hypersecrection is a common and distressing symptom for palliative care patients. Yet most research on hypersecrection at the end of life focuses mainly on death rattle.

Aim: To synthesise the existing evidence evaluating interventions for respiratory hypersecrection in patients in the last year of life (excluding death rattle).

Methods: A systematic review was conducted using Medline, Web of Science, Cinahl, and 5 other databases to identify randomised controlled trials (RCT) and observational studies (OS), published prior to August 2013. Titles and data extraction were completed independently by two reviewers.

Results: 842 papers were identified, of which 18 met the inclusion criteria. Citancking and reference searches resulted in an additional 5 papers. Interventions included: mechanical insufflation-exsufflation – ME (16) and expiratory muscle training (22). Studies with ME mainly assessed patients with neuromuscular diseases. One RCT with a small sample found that ME increased lung vital capacity. OSs enrolling ME showed an increase in peak cough flow, which may explain improved oxygenation, higher survival rates, less complications and need for tracheostomy. Two RCTs assessed the expiratory muscle training in patients with multiple sclerosis, and found higher maximum expiratory pressures and an improved cough efficacy, subjectively assessed by the Pulmonary Index. Other interventions were manually assisted cough (7), tracheotomy (4), chest physiotherapy (3), suctioning (2), and nebulised saline (2), positive expiratory pressure masks (3), percussive ventilation (2), high frequency chest wall oscillations (1).

Conclusions: Evidence is scattered and largely in support of ME, but there was insufficient high-level evidence to make strong recommendations.

Financial support: CAPES – Brazil.

Abstract number: P-043
Abstract type: Poster
The Management of Paraneoplastic Sweating in a Palliative Care Setting

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Background: Excessive sweating is an unpleasant symptom experienced by patients with advanced malignancy. While the causes of sweating in this population are multifactorial, management of paraneoplastic sweating has proven challenging. Existing evidence for treatment of paraneoplastic sweating in palliative populations is poor.

Aims: To review and summarise the evidence for treatment options in the management of paraneoplastic sweating. To develop a clinical practice guideline for paraneoplastic sweating.

Methods: A targeted literature search was completed. Search terms were ‘sweating in palliative care’, ‘hyperhidrosis in palliative care’ and ‘paraneoplastic sweating’. Drugs used to treat this phenomenon were also entered in conjunction with ‘hyperhidrosis’ or ‘paraneoplastic sweating’. Seven relevant articles were identified, dating from 2000 to 2013. Local guidance documents were obtained from St Elizabeth’s Hospice and St Christopher’s Hospice and the Palliative Medicines Information Service of Our Lady’s Hospice in Harold’s Cross for review.

Results: Existing evidence for the treatment of paraneoplastic sweating in palliative populations is poor. There have been minimal publications and existing evidence is largely anecdotal. Many of the clinical trials were methodologically flawed, underpowered, uncontrolled and unblended. Outcome measures were often non specific or unvalidated and little accountability demonstrated in regard to recruitment bias or drop outs. However, promising results from some case studies could provide hypotheses for future research.

Existing publications and guidance documents were reviewed and utilised in the development of a local practice guideline for the management of paraneoplastic sweating.

Conclusions: Paraneoplastic sweating remains a distressing symptom for patients and families. The phenomenon that remains under represented in the medical literature.

Further studies are urgently required to support pharmacological management strategies.

Abstract number: P-044
Abstract type: Poster
The Use of Subcutaneous Levetiracetam for the Control of Seizures in Adults at the End of Life

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Aim: Management of seizures in the dying patient is challenging. Seizures have been reported in 35 to 50 percent of brain tumor patients in the last month of life and cause distress to patients and families. As patients approach end of life, increasing dysphagia may warrant adjustments of oral therapy. Subcutaneous Levetiracetam is a suitable first line and anti-epileptic drug (AED) in patients who are unable to take oral AEDs and require seizure control without sedation.

Study population: Patients presenting with new or recurrent seizure who are unable to take oral AEDs and require seizure control without sedation.

Methods: A prospective case series of patients on SC Levetiracetam in the palliative care inpatient unit and community palliative care teams. Patients selected by their medical consultant as being suitable for inclusion. A survey of routinely collected data and independently by two reviewers. Response to Levetiracetam therapy. Secure data management employed.

Results: 15 patients accrued. Average age 66.3 years. Three patients had 1st ONS malignancy, one COPD and epilepsy, six malignancy with cerebral metastasis. Two patients had first seizures, eight had recurrent seizures. Nine patients were on baseline AED (Keppra in 8/10 patients). A 1:1 PO:SC conversion ratio was employed. SC Levetiracetam was commenced for patients who were NPO and deteriorating but aware. Median starting dose 1100mg/24hr, range 500–2000mg/24hr. All patients had seizure control at 24hr. One patient required titration on day three. Average duration of therapy 3.5 days, range 1–7 days. No site reactions or adverse reactions noted.

Conclusions: Levetiracetam is a suitable first line anti-epileptic in patients who require seizure control without sedation but are no longer able to take oral anti-epileptic medications.

Abstract number: P-045
Abstract type: Poster
Study the Use of Continuous Ondansetron Infusion to Control Nausea in Patients with Hematologic Malignancies

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Background: Persistent nausea is a common side effect in patients receiving chemotherapy for hematological malignancies.

Aims: To evaluate the effectiveness of continuous infusion of ondansetron in managing uncontrolled nausea in patients with hematological malignancies undergoing chemotherapy.

Methods (design, data collection, analysis): A retrospective chart review is being conducted to study the effectiveness of continuous infusion of ondansetron. This intervention was used in patients who had uncontrolled response to 4mg of intravenous ondansetron given intermittently (typically every 4 hours). They were then placed on an intravenous infusion of ondansetron at 1mg/hr. The data points being collected are: patient demographics (including age, sex, and ethnicity), diagnosis, chemotherapy start and stop date, date of transplant (if transplanted), start and stop date of ondansetron infusion, use of needed antemetic 72 hours prior to start of ondansetron drip, use of any antiepileptic 72 hours after the start of ondansetron drip, use of additional antiepiletics, efficacy as documented in patient chart, EKG (if collected after the start of the ondansetron drip), headache as documented in patient chart, list of concomitant medications that can prolong QTc interval (including fluoroquinolones, macrolides, azoles and amiodarone).

Results: Our clinical experience suggests that continuous infusion of ondansetron is clinically effective in treating persistent nausea responsive to intermittent doses of the medication. Results will be presented at the EAPC conference.

Conclusion / Discussion: We anticipate our study to confirm our clinical observation that intravenous ondansetron infusion is a potentially safe and effective intervention in controlling persistent nausea in those patients that respond to its intermittent use with uncontrolled nausea. Prospective studies will be needed to further validate our findings.
Clinical Usefulness of the BCM (Body Composition Monitor) Method in Advanced Cancer Patients under Hospice Care

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Background: BCM is fast, painless device that determines individual fluid status and body composition (lean and adipose tissue mass) employing the bioimpedance spectroscopy techniques. Some authors suggest that the accumulation of body fluids detected in BCM method, is a factor of shorter expected survival time. Therefore, BCM method seems to be useful tool especially in the group of advanced cancer patients and may have an impact on both therapeutic decisions and effective communication with the patient and his family. It has not been tested in terminal stage cancer patients so far.

Aims:
1. evaluation of the technical possibilities of implementation of BCM in advanced cancer patients
2. comparison of the BCM hydration and nutrition status measurements with physical examination and laboratory tests
3. to find whether BCM method measurements correlate with the survival time.

Methods: The survey is conducted among adult cancer patients in terminal stage consecutively admitted to stationary Hospice in Sopot. After informed consent patient’s hydration and nutritional status is assessed with clinical scale of hydration based on physical examination, Subjective Global Assessment scale, hand grip and arm circumference measurements, BCM device. Blood samples are collected for laboratory indicators of nutrition.

Results: We assessed 68 subjects. Due to both technical and clinical reasons (peripheral oedema, ascites, lower limb amputation, severe shortness of breath, inability to lie down on his back, agitation and agonal status) 23 patients were not tested. In 12 patients we observed poor measurement quality.

Conclusions: It is difficult to obtain good quality measurements with BCM. Preliminary observations showed that more than half of the patients could not be evaluated properly. Statistical analysis will be carried out after examining approximately 50 subjects. The predicted survival time on the basis of BCM measurements from natural causes can be determined at a later date.

Abstract number: P2-048
Abstract type: Poster

The Effect of "Therapeutic Tactile Touch" Practices Done for the Patients in the Intensive Care Units upon their Fears, Anxieties and Pain Levels

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Background and objectives: Being at intensive care unit is a rather traumatic and fearful experience for the patients. In intensive care units; on the one hand, condition of the patients may quickly change, there may be ambiguities and death threat; on the other hand, sounds of monitoring systems, ventilators, liquid and/or medicine infusion pumps lead to anxiety and fear among the patients. These feelings experienced by the patients may negatively affect not only many parameters but also patient’s pain perception. The study was planned to determine the effect of “therapeutic tactile touch” practices done for patients upon their fear, anxiety and pain.

Methods: The study was conducted at adult general intensive care unit of Istanbul Medipol Mega University Hospital. 11 patients who were treated at the general intensive care unit for at least 24 hours, were eligible for the study criteria and accepted to participate, were informed and signed consent form. Patients were included in the study. They were daily given a 30-minute “therapeutic tactile touch protocol” for four days. Visual materials which were designed in line with the literature and through which patients could manually point the emotion experience were used before and after the protocol in order to assess the anxiety and fear experienced by the patients. Meanwhile visual analogue scale for pain was used to assess the pain perception of the patients.

Results: It was found out that before and after the protocol, there were statistically significant differences between patients’ mean scores obtained from visual analogue scale for pain and facial expression pain scale and their mean anxiety and fear scores and that patients’ pain, fear and anxiety levels reduced (p < 0.05).

Conclusions: We believe that using therapeutic tactile touch practices should be used by health care personnel – particularly by nurses – in order to eliminate intensive care patients’ pain, fear and anxiety as a complementary therapy.

Abstract number: P2-049
Abstract type: Poster

Palliative Care Inpatient Oncology

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Introduction: The current model of Palliative Care in oncology (PC) needs a dynamic and rapid response to cases requiring hospital-based support teams. In our hospital the Palliative Rapid Response Team (PRRT) was formed for the growing number of cases complex biopsychosocial and spiritual, with the mission of supporting the medical team in the care of the patient and his family for taking making at the end of life.

Methods: We included all patients treated in the ward of the palliative care unit from January to June 2014.

Results: Were evaluated 120 patients, 50% were women, mean age 53.2 (SD 16.47) years. The most frequent diagnosis was head and neck cancer, 37 (37%), followed by lung cancer, 27 (27%). The protocol was used correctly 584 times, from 1 to 31 times in each patient, median 3 times. Differences in the incidence of agitation during the day were observed. The day was divided in prebedtime 2 hours with a 14.7% of expected episodes of agitation per period.

Conclusions: Patients were referred to CP after 12 days of hospitalisation, the PRRT has on average 3.5 days to execute the strategic treatment plans for stabilisation and hospital discharge. Collaborative work with Oncology optimises advanced cases and promotes timely referral, impacting favorably quality of life and quality of death.

Abstract number: P2-050
Abstract type: Poster

Gender, Social or Psychology Related Risk Factors for Developing Delirium at the End-of-Life: A Literature Study and Case Report

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Background: Delirium is cause of much suffering. If professionals were able to predict risk factors for developing delirium it may be possible to prevent some of the cases. In the daily clinic we found that more men, more patients with complicated social situations and premorbid personality development delirium.

Aim:
1) to explore gender, social and psychological risk factors for developing delirium as described in the literature
2) to study whether gender, personality traits and social problems are risk factors.

Methods: Pub Med was searched from 1990 to 2013. Inclusion criteria: Original data on adult patients, diagnosed delirium.

Case-review on 50 consecutive patients referred to the specialised palliative care team in Hemming, Denmark. The patients were grouped into two groups. One with delirium (D+) and one without (D-) Two-sided Fisher’s exact test was used looking at age, gender earlier psychiatric problems and social problems.

Results: Literature search: One study found male gender as a risk factor. No evidence for social or psychology related risk factors was found.

Case-review: Information on delirium was lacking in 20 cases. Of the remaining 30 cases 18 patients developed delirium (D+) and 12 did not (D-). The proportion of males in D+ were 61 % and in D- 33% p=0.26. Of the 18 delirious patients one had earlier psychiatric problems (9%) and in D- none had earlier psychiatric problems. Three patients in D+ had social problems (17%) versus three in D- (25%) p=0.66. It was not possible to examine patient’s personality trait prospectively.

Conclusion: The literature study did not identify significant social or psychological risk factors, but male gender seems to be a potentially factor to consider as the case review also indicate. More knowledge is needed to determine whether social or psychological factors are risk factors for developing delirium.

Abstract number: P2-051
Abstract type: Poster

Variation in the Incidence of Agitated Delirium during the Day in a Palliative Care Unit

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Background: In the literature regarding delirium and agitation in palliative care, there are references to their worsening as the hours of the day flow from afternoon on, with an inversion of the awake-sleep cycle.

Aim: To study the incidence of agitation during the day in a palliative care unit.

Methods: We studied the frequency of the use of our protocol for the control of agitation during the day from June 18, 2007, to December 31, 2013.

Results: During the period in study 1558 were admitted and the protocol was used in 135 (9%). 152 (10%) were males and the mean age was 65.75 years (SD ± 12.99). The most frequent diagnosis was head and neck cancer, 37 (27%), followed by lung cancer, 27 (20%). The protocol was used correctly 584 times, from 1 to 31 times in each patient, median 3 times. Differences in the incidence of agitation during the day were observed. The day was divided in prebedtime 2 hours with a 14.7% of expected episodes of agitation per period.

However, the number of observed episodes was higher than the expected one in some periods: 22:00–23:59, 100; 0:00–1:59, 92; 2:00–3:59, 80; 4:00–5:59, 65. In all other periods the number of episodes was lower than the expected one. The chi-square goodness of fit test proves that the differences are statistically significant (p < .001).

Conclusion: This study confirms that the episodes of agitation are more frequent at night.
Poster Sessions (Poster Exhibition Set 2)

Abstract number: P2-057
Abstract type: Poster

**Does a Pacemaker Lengthen the Dying Process in Palliative Care Patients?**

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Background: The influence of a pacemaker on the duration of stay in the palliative care unit (PCU) is unknown. We aimed to evaluate whether a pacemaker is associated with a lengthening of the dying process in palliative care patients.

Methods: We performed a retrospective study of consecutive patients who died in a palliative care unit of a tertiary hospital. The study group consisted of 1600 patients who died between 2010 and 2014. Data were collected on the presence of a pacemaker and the duration of stay in the PCU until death.

Results: Of the 1600 patients, 33 had a pacemaker implanted before death. The median duration of stay in the PCU until death was 21.9 days (IQR: 10.2-34.6) in the pacemaker group compared to 14.1 days (IQR: 7.2-22.4) in the non-pacemaker group (p = 0.018). There was no difference in duration of stay in the PCU for patients >80 years of age (median: 14.1 days in the pacemaker group vs. 14.1 days in the non-pacemaker group, p = 0.996). In a multivariate analysis, the presence of a pacemaker was associated with a longer duration of stay in the PCU (OR: 1.59, 95% CI: 1.02-2.45, p = 0.041).

Conclusion: Pacemakers are associated with a lengthening of the dying process in palliative care patients. Further research is needed to determine whether this finding is due to a true lengthening of the dying process or other confounding factors.

Abstract number: P2-058
Abstract type: Poster

**Analyses of Opioid-induced Adverse Effects Based on PMDA Japanese Adverse Drug Event Report Database (JADER) in Japanese Patients Receiving Palliative Care**

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Background: In Japan, monitoring of the adverse effects of opioids is performed with the Japanese Adverse Drug Event Report database (JADER). However, there is limited information on adverse effects induced by potent opioids such as fentanyl and oxycodone. The present study aimed to analyze the adverse effects of opioid analgesics in Japanese patients receiving palliative care.

Methods: Data from the JADER database were analyzed from January 2014 to December 2016. Patients were divided into two groups: those receiving opioids as the main analgesic (group A) and those receiving opioids in combination with non-opioid analgesics (group B). Adverse effects were classified based on the World Health Organization’s Common Terminology Criteria for Adverse Events (CTCAE). The frequency and severity of adverse effects were compared between the two groups.

Results: A total of 292,720 reviews were analyzed, of which 7,125 were related to opioid analgesics. The most common adverse effects were nausea (58.3%), vomiting (17.2%), and constipation (14.9%). The frequency of adverse effects was similar between group A and group B. However, the severity of adverse effects was higher in group A than in group B (p < 0.05).

Conclusion: Opioid analgesics are commonly used in Japanese patients receiving palliative care. The frequency of adverse effects is comparable between those receiving opioids as the main analgesic and those receiving opioids in combination with non-opioid analgesics. However, the severity of adverse effects is higher in the former group.

Abstract number: P2-059
Abstract type: Poster

**Ultrasound-guided Rectus Sheath Block for Improvement of the Abdominal Distension Feeling**

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We report a case in which abdominal distension feeling and discomfort of the abdominal wall caused by malignant ascites were relieved by ultrasound-guided rectus sheath block.

Case report: A 56-year-old male patient with malignant ascites experienced abdominal distension feeling, but did not have nausea, dyspnea, poor mobility, and limb edema. The patient had a history of colorectal cancer and was treated with chemotherapy. Despite the treatment, the patient developed signs of abdominal distension feeling, which persisted despite multiple attempts to manage the symptoms. A search for alternative pain management strategies was initiated.

Methods: A literature review was conducted to identify potential treatments for abdominal distension feeling. The patient was also reviewed for potential causes of abdominal distension that could be managed with ultrasound-guided rectus sheath block.

Results: An ultrasound-guided rectus sheath block was administered, resulting in immediate relief of abdominal distension feeling.

Conclusion: Ultrasound-guided rectus sheath block can be an effective treatment for abdominal distension feeling caused by malignant ascites. Further research is needed to confirm the efficacy and safety of this approach.

Abstract number: P2-060
Abstract type: Poster

**Parenteral Hydration: Review of Prevalence and Rationale in Hospice Inpatients**

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Background: Decreased oral intake of fluids in the last days to weeks of life is common due to anorexia, nausea, dysphagia, and/or delirium. Parenteral hydration (PH) may be administered to reduce the risk of dehydration or to manage symptoms. To date, there are no established standards for hydration at the end of life. Each patient’s circumstances must be individually assessed.

Aim: To evaluate the prevalence of PH in hospice inpatients.

Methods: A retrospective chart review of 102 consecutive deaths between January and April 2013 was conducted. A data recording form captured hydration episodes. Descriptive statistics were generated by Microsoft Excel.

Results: 31/102 (30.3%) received PH during their admission. In 19/31 (61%), PH was administered intravenously. 7/12 (58%) on subcutaneous fluids received one litre of fluid over 12 hours; a rate that is higher than recommended by clinical guidelines. 58 hydration episodes were recorded. Of 58 episodes, 51 (88%) had a start rationale, 36 (62%) had a stop rationale and 41 (71%) had an outcome recorded. 24/41 (58%) outcomes reported an overall improvement post hydration.

Discussion: 30% of hospice patients received PH, which contradicted with the North American literature on the topic. Physician preference for intravenous route was evident despite literature suggestions that subcutaneous is preferable. Physician documentation of start rationales was superior whereas nurses recorded stop rationales and patient outcomes more frequently.

Conclusions: 1. Parenteral hydration is prescribed frequently, with the intravenous route most common
2. Over half reported clinical benefit within 48 hours
3. Start rationales were most likely to be recorded
4. Opioid toxicity was the commonest indication
5. Future studies should prospectively evaluate the effect of hydration on symptoms and quality of life

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Abstract number: P2-061
Abstract type: Poster

**Orthostatic Hypotension in the Diagnosis of Autonomic Nervous System Dysfunction in Cancer**

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Background: Limited studies suggest autonomic nervous system dysfunction (AD) is common in advanced cancer. It predisposes to multiple problems that include blackouts, falls, fatigue & sudden death. Orthostatic hypotension (OH) is a known feature of AD. Rates of OH vary from 10-20% in advanced cancer patients. To date, there are no established standards for hydration at the end of life. Each patient’s circumstances must be individually assessed.

Aims: 1. Evaluate the prevalence of orthostatic hypotension in hospitalised cancer patients
2. Determine the proportion with persistent orthostatic hypotension
3. Examine the relationship between orthostatic symptoms and hypotension
4. Assess factors related to orthostatic symptoms and hypotension

Methods: A prospective observational study was conducted. Consecutive oncology inpatient admissions to a tertiary referral centre were recruited over 4 weeks. Autonomic symptoms were evaluated by questionnaire. OH was assessed by one Active Stand Test. Patients were reviewed at baseline and 14 days post baseline.

Results: 20 (11 male, 9 female) participants with heterogenous solid tumours were recruited. 55% had metastatic cancer. Median age was 66 (range 40-81). Median Eastern Cooperative Oncology Group performance status was 1 (range 0-2). OH was demonstrated in 3 of 20 (15%). No participant with OH reported postural symptoms on standing. 1 (5%) met the criteria for persistent OH. The median number of autonomic symptoms was 7 (range 1-17). Participants with OH described 6, 8 and 16 symptoms respectively.

Conclusions: 1. Autonomic symptoms lacked sensitivity and specificity for OH
2. There was a low prevalence of OH in cancer patients with good performance status
3. Postural BP and symptoms were recorded. Data was recorded in Microsoft Excel and descriptive statistics generated.

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Comparative Study of Palliative Sedation at the End of Life in the Hospital vs. Palliative Care Home Unit

Martin-Urlúa S.1, 2, Herencia Vicente C.2, 3, Gómez Ramírez E.2, Manchón Álvarez A.2, Pasqual Páez F.1, Ruiz Ortega P.2, Vicente Benavente M.2, García Gimeno E.1, Climent Durán M.A.1, Guillem Porta V.4, Group of Investigation in Cuidados Paliativos, Universitat Católica de Valencia "San Vicente Mártir" (GRCV-UCV)
1Fundación Instituto Valenciano de Oncología, Oncology Department, Palliative Care Home Unit, Valencia, Spain, 2Hospital Universitario de Valencia, Hospital Universitario San Juan de Alicante, Valencia, Spain, 3Hospital Universitario de Valencia, University Hospital of Valencia, Valencia, Spain, 4Fundación Instituto Valenciano de Oncología, Emergency Department, Valencia, Spain

Background: The clinical practice of palliative sedation (PS) at the end of life is based on clinical guidelines and recommendations that depend on the resources available at home or in the hospital.

Aims: To describe the profile of cancer patient receiving PS, drugs and doses used and the time from the PS to the end of life, and differences by location.

Methods: To describe the drugs used for PS at the end of life, the reached doses and the duration of sedation

Results: 343 patient who died were recorded, 212 of them received PS. 151 in the hospital and 61 at home. The age average was 61 years. 112 patients were women. The most common primary tumors were gastrointestinal (41), breast (39), genitourinary (32) and lung (32); all of them at stage IV. The mean from the last antitumor treatment to death was 21 days. Common refractory symptoms were: delirium (37%); dyspnea (33%) and pain (29%). The drug used was Midazolam in 190 cases. The route of administration was intravenous in 80% of the patients died. The mean from the PS to death was 48 hours after starting the PS.

Conclusions and discussion: Statisticaly significant differences found between hospital and home in the administration route and doses can be explained by different clinical management. The different groups were similar in sociodemographic and pathological patient profile and time from sedation to death. This is the first comparative study carried out in our region.

Abstract number: P2-063
Abstract type: Poster

Correlation of Distress Score with Edmonton Symptom Assessment Scale (ESAS) Score in Patients Referred to Palliative Care: A Prospective Correlational Study

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Background: Distress is a multifactorial unpleasant emotional state that may affect how one feels, thinks, and acts as per National Comprehensive Cancer Network (NCCN), and includes feelings of unease, sadness, worry, anger, helplessness and guilt. Patients with cancer have some distress at some point of time. The Distress Thermometer is a tool that can be used to assess distress; it is postulated that its correlation with ESAS will help us identify factors causing distress and thus intervene at the appropriate time.

Aims: Assessment of Patient’s Distress And its Correlation with ESAS Score.

Methods: English version of NCCN DISTRESS THERMOMETER (available tool for measuring Distress) was translated in MARATHI and HINDI. This Scale was served to total of 40 referred patients, along with the ESAS scale (symptom burden), at first visit. Data was collected and analysed using SPSS. We Categorised the distress score into- none(0), mild(1–3), moderate(4–7) and severe(8–10) similar to ESAS Scale.

Results: Mean distress score was found to be 5.32. In patients with Mild distress, Negative correlation was found between symptoms and distress. In Moderate distress, Positive correlation was found with ESAS symptoms: Pain, Breathlessness, loss of appetite and loss of sleep. In Severe distress, Positive correlation was found with ESAS symptoms: Fatigue, nausea, pain in descending frequency was observed. Other factors in distress scale are not addressed with ESAS (spiritual, emotional, practical and physical).

Conclusions: Our data suggest that we cannot rely totally on ESAS symptoms for determining distress. Other factors (problems) should also be taken into consideration. Timely diagnosis and Proper intervention for problems would help to alleviate the distress.

Abstract number: P2-064
Abstract type: Poster

Subcutaneous Route in Palliative Situation: Between Practices and Recommendations. Survey among French Palliative Care Units in 2011

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Background: Subcutaneous route is a standard practice in palliative situations, because it is simple, minimally invasive and possible when oral and intravenous administrations are no longer an option. However, in order to provide relief from many symptoms to dying patients, the subcutaneous use of drugs is often without pharmaceutical authorisation application.

Aims: This case study focuses on various level of scientific evidences of the molecules used subcutaneously and determines real practical experience of those that turns out to be the most effective ones in palliative care.

Method: This is a descriptive and multicenter study. First, 12 molecules were chosen through a pre-study that was carried on with the help of 5 physicians in the field of palliative care.

Then a survey was carried on among practitioners and nurses from the 11 palliative care units of France, to collect data regarding the use and side effects of the 12 pre-selected molecules.

Results and discussion: We received answers from 38 physicians and 31 nurses. Physicians have worked in palliative care units for 11 years on average. 19 of them were in a management position. Prevalence of patients that benefits from subcutaneous perfusion was of 18%. Haloperidol, metyprednisolone, furosemide, clonazepam and metoclopramide were prescribed by at least 30 physician and considered as the most effective ones. No molecule has been seen as inefficient. Haloperidol, metyprednisolone, clonazepam and amitryptilin were prescribed to get 3 specific pharmacological effects.

All molecules were mainly use discontinuously except from sodium valproate and clonazepam. The main local side effects were induration, oedema, redness/paleness, occurring more frequently in case of discontinuous injection and pain in continuous administration.

Conclusion: This study brings out the potential need for a specific pharmaceutical study that would focus on these 5 molecules in order to increase their level of scientific evidence.

Abstract number: P2-065
Abstract type: Poster

IV Antibiotic Use in Hospice Care

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The use of IV antibiotics differs from hospice to hospice in the £ London and Essex areas of UK. There is little research on IV antibiotics and their use/place in palliative and EOL care in hospices. A snapshot of IV antibiotic use in 10 local hospices was gained via an 11 question survey emailed to hospice medical directors. The survey was a mixture of multi-choice questions and free-text.

Results: The response rate was high (8/10 responded). There was some correlation between the size of the hospices and the tendency to use IV antibiotics: the larger hospices (≥20 beds) all used IV antibiotics several times per month or several times per week. Smaller hospices tended to use IV antibiotics less frequently with one small hospice never using them at all.

Conclusion: Challenges of using IV antibiotics were:

- the training and continuing competency of staff to prescribe and administer IVs especially in units with low frequency of IV antibiotic use
- having non-resident doctors on call so IV antibiotic regimes had to be achievable within working hours
- knowing which patients would likely benefit

All 10 hospices who used IV antibiotic use had increased over the last 5 years. There were polarised views: from thinking IV antibiotics rarely add benefit to a patients care to feeling that it is essential that hospices offer IVs to maximise active holistic care and lift the stigma of the hospice being the place you only go to die.

Conclusions: This small survey suggests that even in a small area there is a lot of variation between hospices in the use of IV antibiotics. The trend is for increasing antibiotic use: patients and families expect that hospices can deliver this. There is very little available evidence to show useful IV antibiotics are in the palliative population. In the short term, a larger survey of IV antibiotic practice is planned. In the longer term we need larger scale research into the outcomes of using IV antibiotics in palliative care.

Abstract number: P2-066
Abstract type: Poster

Saudi Experience of Using Neuroleptics to Treat Delirium in Dying Cancer Patients

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Background: Delirium is a neuropsychiatric problem encountered in terminally ill cancer patients and treated with neuroleptics. However, prescribing patterns are believed to substantially vary among high health professionals, limiting potential for benchmarking. The aim is to determine the pattern of prescription of neuroleptics for treating agitated delirium in cancer patients dying in a tertiary palliative care unit in Saudi Arabia.

Method: Medical records of adults with advanced cancer who died in a palliative care unit over a 23 months period were reviewed. In addition to patients’ demographics, data collection included the pattern of neuroleptic prescribing for the treatment of agitated delirium in the last week of life. The study was approved by the institution review board.

Results: For the 271 patients included (57.6% females), the median age was 54 years. All patients had either metastatic (90%) or locally extensive (10%) disease. While 62% of patients were on regular neuroleptics, only 63% of these were prescribed rescue doses as well. The regular neuroleptics included haloperidol (88.7%), levomepromazine (2.4%) and both (8.9%). All neuroleptics were administered via parenteral route. On average, the maximum daily doses used of regular neuroleptics were 4 mg for haloperidol and 15 mg for levomepromazine. For 82.3% of patients on regular haloperidol, the drug was administered until death. Patients with brain metastases were less likely to be on regular neuroleptics (P = 0.001).

Conclusions: Haloperidol is the drug of first choice to treat the common problem of agitated delirium in patients dying with advanced cancer in our tertiary palliative care unit. The generally low doses of haloperidol of using IV antibiotics were to receive the drug until the time of death may support its effectiveness and safety for use in this clinical scenario. Prescribing rescue doses for patients who require regular neuroleptics is suboptimal and needs to be reinforced.

Abstract number: P2-067
Abstract type: Poster
Poster Sessions (Poster Exhibition Set 2)

Abstract number: P2-067
Abstract type: Poster

P2-059

Is Re-irradiation a Viable Option in Metastatic Spinal Cord Compression?

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Introduction: Metastatic spinal cord compression (MSCC) is a devastating and frequent event for patients with cancer. The majority of the patients has a short life expectancy and is treated with short-course palliative radiotherapy only. Short course palliative radiotherapy has been shown to be effective in maintaining neurological function. Historically, a selected group of patients has been treated with re-irradiation of a previously involved part of the spine. The usefulness of re-irradiation might be compromised by radiation dose limiting toxicity e.g. myelopathy.

Aim: To investigate the frequency of patients being re-irradiated because of MSCC or impeding MSCC in a previous irradiated field. Secondly, we wanted to record their time of survival after secondary course of radiation.

Methods: All patients treated by the indication of MSCC or impeding MSCC were identified using treatment allocation codes in our treatment planning software. Information of patients’ primary cancer diagnosis and demographic data were obtained from patient charts.

Results: From 2010 until 2012 1597 patients were treated for MSCC or impeding MSCC at our tertiary cancer facility. Out of these thirty-three patients received re-irradiation. Patients mean age was 63 years (18-84) with 14 females and 19 males. The primary cancer diagnoses were prostate (8), lung (5) and colorectal cancer (4). Median survival was 122 days (range: 2-1148 days) after start of secondary radiotherapy. Three patients were still alive at analysis, with follow-up of 619-1172 days.

Conclusion: A selected group of cancer patients with progression of MSCC have a surprisingly long survival after their secondary course of radiotherapy. Therefore, maintaining neurological function is of utmost importance during the patient’s remaining lifetime and re-irradiation could be an option when considering the risk of radiation induced myelopathy.

Abstract number: P2-068
Abstract type: Poster

Use of Acetazolamide as Palliative Treatment of Malign Intracranial Hypertension


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Objective: Knowing therapeutic utility of acetazolamide in malignant intracranial hypertension as adjuvant to corticosteroids treatment.

Material and methods: Descriptive, retrospective and multi-center study of a number of cases collected between 1st of January and 1st of November of 2012, by three palliative care teams dependent of Primary Care.

Following variables were collected, age, gender, intracranial hypertension causing pathology, symptomatic treatment taken, reason of using and doses of acetazolamide, treatment results, duration of effects after treatment.

Results: The number of cases comprises 7 patients, five women and 2 men, age rate between 51 and 80. One of them suffered a nervous central system primary tumor, the rest of patients suffered metastases from other tumors (3 lung tumors, 2 breast tumors, and one nerve tumor). Clinical was varied, for every case symptomatic treatment based on dexamethasone, with doses between 4 mg/24h and 32 mg/24h, was initiated. In all of seven cases dexamethasone secondary effects (irritability, nausea and agitation) forced to reduce the doses. In order to avoid clinical worsening acetazolamide was added to reduce cerebral edema. All seven experimented realistic symptomatic improvement. Beneficial effects lasted from 15 to 60 days, depending of each patient, until illness progression forced to take other therapeutic options.

Conclusions:

- Acetazolamide is a known drug in cerebral edema treatment.
- In a number of cases the clinical benefits managing malignant intracranial hypertension are realistic.
- Allows a less known therapeutic option for this clinical situation, as adjuvant.
- Acetazolamide allows to reduce corticoids doses and secondary effects.
- Deep studies in order to prove acetazolamide clinical utility are pending.

Abstract number: P2-069
Abstract type: Poster

Off-label Use of Drugs in Palliative Cares


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Introduction: Off-label use of some medicines is enshrined in Spanish “Real Decreto1015/2009”, this use will be exceptional, being doctor’s responsibility to inform the patient and obtain consent. Off-label use of medicines is a usual practice in palliative cares, for both symptomatic control and administration route.

Objective: Describe which medicines, of those used in palliative cares, are used off label.

Methodology: We describe the palliative care most used medicines, from several sources:

1. Those included in the list of essential medicines for palliative cares, published by WHO and EACP.
2. Those existing in the medical kits of three palliative cares teams of our community.
3. Those proposed in Manual Symptoms Control in advanced and terminal cancer patients (Porta Sales et al.

Results:

- Drugs whose data sheet doesn’t collect subcutaneously administration indications:
  - Fursemide, haloperidol, chlorpromazine, N-Butillborumoro Hyoscine, midazolam, dextifenac, levopromacina, metclopromida.
  - Drugs that do not have neuropathic pain indication approved: topiramato, clonacepam, oxcarbazepina, baclofeno, venlafaxina, carbamazepina.
- Other not collected in data sheet situations:
  - Dexametasona Astenia 
  - Anorexia
  - Metilfenidato: Astenia, Drowsiness caused by opioids
  - Morfina inyectable: Dyspnea
  - Vicosastra: Intestinal occlusion
  - Olanetzan citrato: Breakthrough pain without opioid treatment based
  - Lorazepam sublingual
  - Ondansetron: Prurito
  - Acetazolamida: Brain edema by maligial intracranial hypertension.

Conclusions: Lots of the medicines which are used in palliative cares are used in off-label situations. This situation is regulated by the Spanish legislation and must be known by the prescribing doctor. Most times off-label use of drugs is supported by scientific evidences.

Abstract number: P2-070
Abstract type: Poster

Pheonobarbital a Better Drug for Palliative Sedation in Homecare?

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Background: The prevalence of palliative sedation for refractory symptoms in terminal patients at home is 6% in our centre. Midazolam is commonly used for palliative sedation but insufficient sedation and tolerance to midazolam are common problems. Due to these problems phenobarbital was introduced in our centre and we set up a titration scheme.

As we used phenobarbital more frequently, we noticed that the number of awakenings decreased. The greatest difference between these two drugs is the T½: phenobarbital 27mg/h. Every 3h (peak dose of the drug used SC) the dose was increased until RASS -4 or -5 was reached.

Method: We performed an observational study, including 14 patients, using phenobarbital for sedation. Evaluation of the sedation depth was made using the Richmond Agitation Sedation Scale(RASS). The starting dose of phenobarbital was 2.7mg/h. Every 3h (peak dose of the drug used SC) the dose was increased until RASS -4 or -5 was reached.

Results: Mean time to deep sedation was 7h (1.3h-1.7h). The best result (less time to deep sedation) was achieved when the nurse used sufficient bolus doses in the loading up period (100mg-400mg, mean bolus dose=250mg). Mean drug dose was 92.3mg/kg (50mg/h-140mg/h). Once sedation depth -3 or more was reached there were no more awakenings.

Conclusion: Phenobarbital SC used in a titration scheme is a very useful drug for deep sedation in home care. Stable and deep sedation was achieved, in some cases the time to deep sedation was too long. Based on these results we adapted our scheme by skipping intermediate steps and by giving more systematically bolus doses. In order to evaluate the phenobarbital titration scheme and compare the results to the standard use of midazolam, we are setting up a multicentre prospective study in Flanders.

There was no funding.

Abstract number: P2-071
Abstract type: Poster

Prospective Study of Changes in Patient Characteristics in Persons with Intellectual Disabilities at the End-of-Life

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Background: According to the definition of the WHO, early identification of physical, psychosocial and spiritual problems is an important aspect of palliative care. Professional caregivers of people with intellectual disabilities (ID) experience many barriers in the identification of these problems. Data on the problems people with ID encounter and the needs they have at the end of life are scarce.

Aims: In the present study we aim to describe the changes in patient characteristics of patients with ID in the at the end-of-life in 5 month follow up. Characteristics include activities of daily living (ADL), mobility, comorbidity and symptoms.

Methods: A cohort of 150 patients with ID is currently prospectively followed for 10 months. Patients were selected by the physician through a negative answer on the Surprise Question. Physicians and daily caregivers fill in questionnaires at T0, T1 (after 5 months) and T2 (after 12 months). We use the Barthel-index to measure ADL, the Cumulative Illness Rating Scale to measure comorbidity and the Edmontom Symptom Assessment Scale to measure symptoms.

Results: T1 is currently in progress and will be completed for the start of the conference. Therefore, no results are yet available. Results of changes in patient characteristics will be presented at the conference. Off-label use of medicines is specifically interested in describing the mutual relationships between characteristics, for example the relationship between changes in daily functioning (ADL and mobility) and changes in health status (comorbidity and symptoms).

Conclusion/discussion: Based on this study this will be the first to describe characteristic of patients with ID at the end of life in a prospective manner. The results will generate more insight in the problems and needs of people with ID in this phase of life and thereby contribute to the quality of palliative care in this population.
Assessment and measurement tools

Validation of an Arabic Questionnaire for Symptom Assessment

Al-Shafihi M.Z.1, Al-Zaheera A.1, Alasan A1, Abdullah A.1, Alhakim M., Motar A.1, Hassan A.1, Shoukri M.1, Sekyi1
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Background: Arabic speaking minorities are distributed worldwide. This study aims at
Abstract number: P2-073
Abstract type: Poster

Validation of an Arabic Questionnaire for Symptom Assessment

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Background: Arabic speaking minorities are distributed worldwide. This study aims at
Abstract number: P2-073
Abstract type: Poster

Effects and Meaning of Music Therapy at the End of Life

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Abstract number: P2-072
Abstract type: Poster

Effects and Meaning of Music Therapy at the End of Life

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Abstract number: P2-072
Abstract type: Poster

Validation of an Arabic Questionnaire for Symptom Assessment

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Independent Validation of the Modified Prognosis Palliative Care Study (PiPS) Predictor Models throughout Three Palliative Care Settings
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Aim(s):
The primary aim of this study is to examine the accuracy and to validate the modified PiPS (using physician-proxy ratings of mental status instead of patient interviews) in 3 palliative care settings: palliative care units, hospital-based palliative care teams and home-based palliative care services.

Methods:
This multicenter prospective cohort study was conducted in 58 palliative care services including 16 palliative care units, 19 hospital-based palliative care teams and 23 home-based palliative care services in Japan from September 2012 through April 2014. A total of 2425 subjects were recruited. Due to lack of follow up and missing variables (principal blood examination data), we obtained a total of 2022 and 1385 analysable data for the modified PiPS-A and PiPS-B, respectively. In all palliative care settings, both the modified PiPS-A and PiPS-B identified 3 risk groups with different survival rates (P<0.001). The absolute agreement ranged from 56 to 60% in the PiPS-A model and 60 to 63% in the PiPS-B model.

Conclusion:
The modified PiPS was successfully validated and can be useful in palliative care units, hospital-based palliative care teams, and home-based palliative care services.

Abstract number: P2-077
Abstract type: Poster

Supportive & Palliative Care Indicators Tool (SPICT): Transforming Identification of Patients for Palliative Care Worldwide
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Background: Access to palliative care for people worldwide is a healthcare priority. This requires effective ways of identifying patients at risk. People at risk of deteriorating and dying often go unrecongnised particularly if they have non-malignant disease. Tools designed to predict mortality from individual conditions or manage access to specialist palliative care services do not work well in day to day clinical practice.

Design: SPICT consists of evidence-informed clinical indicators in a one page guide to help GPs, hospital doctors and other professionals to identify patients at risk of deteriorating and dying. Initial and ongoing development includes web-based dissemination and refinement through a growing network of online, SPICT Collaborators.

Result: In 12 months (2013-14), the SPICT website had 6080 visits. Registrations to download SPICT are growing; UK 600 and international 400- Europe, Australia, New Zealand, USA, Canada, 5 America and Africa. Translations into French, German and Spanish are under way. Our analysis of 4800 SPICT communities shows a very high level of engagement.

Conclusion: The SPICT should continue to be developed collaboratively by and with individual professionals, multi-disciplinary teams, health service managers, educators, researchers and service users. It is a practical guide to help us identify many more people who stand to benefit from supportive and palliative care. We will present the SPICT and show what it offers the palliative care community. The SPICT (www.spcit.org.uk) is a valued tool internationally.

Abstract number: P2-078
Abstract type: Poster

The Patient Dignity Inventory for Cancer Patients, Families and Clinicians in the Home Palliative Care
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Aim(s):
The first consultation it was most necessary to evaluate patients’ personality. To share the PDI data with families improved the perception of their competence and role in home care. It improved the communication between patients and their families. Some questions promoted the cognitive and emotional processing of the sense of burden to others, the loss of independence and the loss of the role in family and society.

Conclusions: We used the PDI screening tool, in order to organise the personalised project for patients and to evaluate the emotions and thoughts of the clinicians.

Abstract number: P2-079
Abstract type: Poster

Recognizing the Need for Palliative Care in People with ID: The Perspective of ID-physicians
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Background: A trend of longevity is seen in people with intellectual disabilities (ID). Because of this longevity more people with ID are suffering from cancer or other life-threatening illnesses and therefore are in need for palliative care. In general, it is difficult to recognise the need for palliative care in and with people with ID it even more difficult, due to problems with communication. Timely recognition, however, is essential for adequate provision and planning of palliative care which leads to a better quality of life. Aims: The aim of this study is to investigate how ID-physicians recognise people with ID who are in need for palliative care.

Methods: A qualitative interview study was conducted among 10 ID-physicians in the Netherlands.

Conclusion: Results: ID-physicians describe the recognition of the need for palliative care mostly as a process in which multiple signals and moments on which decisions have to be made accumulate and raise a certain awareness. This awareness makes them take a closer look at the client. The conclusion of this closer look may be that a patient has palliative care needs. The signals can be noticed directly by the ID-physicians, but also by clients, professional caregivers and family caregivers. Facilitators for the recognition of palliative care are, for example, good collaboration and communication between all the caregivers involved and the frequency of the contact between the physician and the patient.

Conclusions / Discussion: Recognition of the need for palliative care can be a moment, but is mostly described by ID-physicians as a process during which multiple signals accumulate and raise awareness. In addition to these findings, it would be worthwhile to examine the perspective of professional caregivers and family caregivers on this process. More insight in the recognition of the need for palliative care is crucial for early identification, adequate planning and provision of palliative care which leads to a better quality of life.

Abstract number: P2-080
Abstract type: Poster

A Comparison of Faecal Loading and Colon Transit Times in Palliative Patients
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Background: Clinical guidelines continue to recommend plain abdominal radiographs as a recommended component of the palliative assessment of constipation. This is despite the fact that this practice is not recommended in the assessment of functional constipation. Aims: This project is aiming to compare the appearance of faecal loading on plain abdominal radiographs against the objective reference of colon transit times for this work, colon transit times will be calculated according to the number of radio-opaque markers visible after 6 days.

Methods: The abdominal radiographs with radio-opaque markers used to measure colon transit times in a study of constipation will be reviewed. This is with the intent of comparing the degree of faecal loading visible and comparing this with other factors which include: 1) whether there is inter-observer agreement between the degree of faecal loading; 2) whether measured colon transit times and the degree of faecal loading correlate; 3) whether patient’s self-reported constipation symptoms and the degree of faecal loading visible correlate.

Results: To date, abdominal radiographs of colon transit time studies are available for 25 patients, all of whom have a malignancy underlying their referral to palliative care. The radiographs were taken in people who all self-identified themselves as constipated and requiring regular laxatives. Nearly all (n-23) had opened their bowels within the previous 3 days. Colon transit times were deemed slow for 10 of the 25 patients. The correlations are not reported here as the study is still recruiting.

Conclusion: The optimal outcome of this study would be to reduce the number of unnecessary investigations that are being ordered for patients in palliative care.
Abstract number: P2-082
Abstract type: Poster

Implementing Outcome Measures in Palliative Care: Putting the Evidence into Practice

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Background: Measuring palliative care outcomes is widely advocated with little evidence on how best to implement measures into practice. The UK-based Outcome Assessment and Complexity Collaborative (OACC) is implementing outcome measures (OMs) into palliative care practice and building evidence on how best this can be done.

Aim: To apply systematic review recommendations on implementing OMs into clinical practice across palliative care and review results.

Method: A systematic review recommends 4 strategies which were undertaken by Quality Improvement Facilitators (QIFs):

i) Tailored implementation using appropriate facilitators tailored to the characteristics of each team
ii) Educational intervention prior to implementation on how and when measures are used and suggestions of how they may be integrated into practice
iii) Timely feedback of results at both patient and service level
iv) Use of a facilitator working alongside clinicians throughout the implementation process to address concerns as they arise.

Results: OMs were implemented with 9 teams across 6 services. Core components of the intervention were fixed, but local adaptation occurred. Most clinicians are unfamiliar with OMs and question their clinical relevance. Attitudes to use change as benefits become apparent. Resistance is offset by increasing rapport and support from the QIF.

An adjustment phase before main data collection enables teams to consider how best to integrate OMs into practice. Feedback impacts on individual patient management, distribution of team workload, organisational quality improvement and understanding of complexity.

Conclusions: The four strategies were successful. Feedback is especially powerful in influencing attitudes towards the use of OMs but implementation needs time, facilitation and encouragement. The role of QIFs throughout implementation process is key to embed OMs into routine practice.

Funder: Guy’s & St Thomas’ Charity

Abstract number: P2-083
Abstract type: Poster

The Content Validity and Utility of a Screening Tool to Improve Detection of Problems of Substance Use and Healthcare Access for People with Dementia in Residential Care Homes: The Palliative Care Outcome Scale for Dementia – Screening (POS-Demi)

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Background: The global prevalence of dementia is estimated at 44.4 million and expected to increase to 135.5 million by 2050. People with dementia experience untreated problems due to challenges of poor detection. Residential care home staff, many without clinical training, need to detect and communicate resident problems to health providers to access treatment. Screening tools introduced into routine care have the potential to improve care processes and health provision.

Aims: To explore the content validity and develop the utility requirements of a screening tool used to detect and communicate problems to inform care provision.

Method: A qualitative study was conducted in three London care homes using focus groups and in-depth interviews with family and friends, using criterion sampling, and care home staff. A Palliative Care nursing using maximum variation sampling. Content analysis and verbatim transcripts was conducted.

Results: From 26 participants, results fell into three categories: content validity, utility and processes. Content validity: Comprehensive screening must not be compromised by brevity. Additional dementia-specific items were included for identification and six items combined into three for brevity (hallucinations/delusions, nausea/vomiting, appetite weight loss). Utility: a routinely implemented tool may improve detection of problems, inform care plans and support integrated working but risks to utility, including problems of reliability, feasibility, recall and clinician use, must be minimised. Processes: resident need should inform implementation, including flexible use and comprehensive information sourcing, while complementing existing care processes.

Conclusions: The use of comprehensive yet brief screening measures, informed by resident need and embedded in care processes, will influence care processes, including detection of problems and improved communication.

Funders: Cicely Saunders International
AtlanticPhilanthropies

Abstract number: P2-084
Abstract type: Poster

Changes in Pain Classification during the Care Trajectory

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Background: The Edmonton Classification System for Cancer Pain (ECS-CP) has been extensively validated and consists of five pain features: mechanism of pain, incident pain, nociceptive pain, neuropathic pain, incident pain (present, absent), which may additionally change over the course of care. 

Aims: To test the following assumptions:

1. The use of comprehensive yet brief screening measures, informed by resident need and embedded in care processes, will influence care processes, including detection of problems and improved communication.

Funders: Cicely Saunders International
AtlanticPhilanthropies

Abstract number: P2-085
Abstract type: Poster

A Symptom Prevalence Study of Outpatients with Chronic Liver Disease

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Background: Liver disease is the fifth largest cause of death in the UK and its incidence is increasing. There are few current studies that have examined symptom prevalence and quality of life in patients with cirrhosis of any cause. Categorising symptom prevalence and severity in this patient group may make a case for collaborative working between hepatology and palliative care teams to improve quality of life in a population with advanced liver-limiting disease.

Aims: To evaluate symptom prevalence and severity in patients with cirrhosis of any cause, identify factors which determine symptom presence, and evaluate predictors of symptom severity.

Method: Symptom data were collected from patients with cirrhosis who attended a hepatology clinic. Data were collected using a validated version of the Palliative Outcome Scale, the POS-5. Demographic data were also collated.

Results: 16 patients expressed interest in taking part but only 10 were recruited due to clinical deterioration. Mean age was 55.8 years (95% CI, 47.79 – 63.81). 60% of patients had cirrhosis due to alcohol. 70% met criteria for liver transplant on UKELD score. Only 1 was listed. 50% of the study population had significant comorbidity. The median POS-5 score within the study population was 14. No patient was symptom free. The most commonly reported symptoms were dyspepsia (100%), weakness (90%) and pain (80%). 70% of the study sample identified additional symptoms. For 5 patients these symptoms were severe. Patients with dyspepsia, weakness and nausea were significantly more likely to have high overall symptom burden.

Conclusions: This is the first study to describe symptom prevalence and severity in patients with cirrhosis using the POS-5 tool. Both symptom prevalence and symptom severity were demonstrated in this group, regardless of aetiology of cirrhosis. This study suggests that collaboration between hepatological and palliative care services is appropriate, to optimise organ function while addressing symptom control.
Textile-based Monitoring System in Palliative Home Care: An Exploratory Study

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Background: Transitions and trajectories are characteristic for acute incidents, yet little research has been devoted to details. By now, portable sensor-based monitoring systems are available to assess vital parameters and to draw conclusions concerning quality of life. Additionally, they allow to derive transition processes in acute incidents.

Aims and research questions: The current project intends to utilize innovations in the areas of sensor technology and smart textiles for palliative care. The long-term objective consists of developing solutions for tailored palliative care in the domestic setting. The research questions are as follows: Which parameters can be identified as indicators for critical incidents in patients at the end of life in the scientific literature as well as from the relatives’ and experts’ point of view? How can a textile-based monitoring system be utilised for detecting critical incidents?

Methods: International scientific literature on trajectories and transitions was analysed. Afterwards, interviews with 21 relatives of patients who have died in a palliative care unit were conducted, supplemented by expert interviews concerning the importance and the significance of the results for palliative care.

Results: Five key aspects of critical incidents could be identified: 1) fear and insecurity of relatives with regard to care, 2) dyspnea: affected persons rarely contact health care institutions, 3) reduced or impossible food intake, 4) pain: relatives often do not know how to react and focus on hospitalisation, 5) lack of night sleep in dying persons and/or relatives.

Conclusion: The results reveal differences in grief of relatives, depending on “acute” or “targeted” care of the dying person in the palliative care unit. On the basis of these results approaches to a textile-based monitoring system can be derived.

Abstract number: P2-087
Abstract type: Poster

Patient-reported Outcome Measures: How Frequently Are they Completed by Patients with Palliative Care Needs?

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Background: Determining the outcome of care given to patients is fundamental in any clinical care area. Patient-Reported Outcome Measures ( PROMs) are important to determine the perspective of those receiving the care. However, there can be challenges to achieve this in patients with palliative care needs, for example, patients may feel too unwell, too distressed, or have altered cognition to complete or and healthcare professionals may gatekeep giving such measures. A systematic review of the use of PROMS revealed that most evidence has been obtained from the outpatient oncology setting.1 There is little literature to inform us how frequently PROMs are completed in an inpatient palliative care setting.

Aims: To determine
a) how frequently PROMs are completed by patients with palliative care needs during an inpatient stay, and
b) if not completed, the reasons for non-completion.

Methods: A validated questionnaire exploring symptoms and quality of life (St Christopher’s Index of Patient Priorities – SKIPP) is given to every patient admitted to two hospices and at intervals during their stay. We are retrospectively collecting data on 200 consecutive admissions to two hospices in the UK to determine how frequently these are completed.

Results: Data collection is in progress, but will be fully reported.

Conclusion: This will depend on the results that are found. 1. Eikland S, Davesson B, Kweek W, Wijt J, Bauseven C, Higginson IJ, Murtagh FEM, Capture, transfer and feedback of patient-centered outcomes data in palliative care populations: Does it make a difference? A systematic review. JPSM 2014 in press.
Objective: Evaluation of the current situation of palliative care (PC) in Albania – PC needs, barriers and its future.

Methodology: Information and data were collected from the study report – PC needs assessment in Albania CITATION Con 10 1 1033 (Conner & Huta, 2010).

Results: Based on the current situation of PC results show: PC in Albania is provided only to cancer patients. The cause of death for approximately 3400 patients/year 2015 patients received partial PC 1927 are provided with PC 7865 patients diagnosed with a non-cancerous disease require PC but are not provided with this service. Base on this estimation, currently in Albania patients have access to opiates. In the ambulatory service the use of opiates is limited because of the opiospharmacology of GPHC doctors are allowed to prescribe opiates without limit. This needs assessment highlights the need for staff in PC based on the population number and the epidemiologic data.

Goals and future plans of the National PC Working Group – Development of the national PC standards; national PC needs assessment; preparation of a unified curricula for the PC training; development of a strategic plan for the implementation of PC; development and approval of a law for PC; preparation of a national public education program on PC in accordance with the National Cancer Control Plan for Health care providers; increasing number of home based PC providers; establishing PC services in the major hospitals of the country.

Recommendations: Considering the increasing number of patients that require PC, we recommend PC available for all patients diagnosed with incurable diseases; inclusion of PC in the Public Health Services. Inclusion of PC in the education curricula of the medicine, nursing and social work faculties. Monitoring and evaluation of the situation and needs from all PC providers that operate in the entire country.

The aim of this study is evaluate the decisional and therapeutic process of PS in a hospice hospice in Albania. From May 2011 to 2014 we’re having an observational, non-intervened, prospective study on PS in Bentivoglio Hospice, using the questionnaire when PS is evaluated.

Results: After the first period of six months 67 of 284 patients dead in our Hospice (23%). After the first period of six months 67 of 284 patients dead in our Hospice (23%).

Conclusions: A multidisciplinary questionnaire for assessment and follow up of PS in inpatients hospice leads to a real shared clinical and multidimensional evaluation among professionals, patients and caregivers.
Effects of Family Caregiver’s Anxiety and Depression on Retrospective Ratings of Quality of Dying and Death (QoDD) of their Loved Ones

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Background: In studies using informal caregivers’ (IC) of patients in palliative care (PC) it has to be ensured that findings are not influenced by factors such as mental disorders. This study aims to describe the influence of anxiety and depression on bereaved ICs retrospective ratings of Quality of Dying and Death (QoDD) of their loved ones.

Methods: IC of deceased patients from two German PC units (Erlangen took part in a validation study of the QoDD at the earliest in the fourth week after the patient’s death). Depressive and panic disorders were assessed via the Patient Health Questionnaire (PHQ). Group comparisons (Ch², T-test; significance level p< 0.05) analysed whether IC with versus without depressive or panic disorder differ in their estimates of quality of dying and death (QoDD) of their deceased loved ones.

Results: A total of 236 IC participated during August 2012 to December 2013. The mean age of participants was 55.5 years (range 22.3 – 85.0 years) with 61.1% female. The PHQ of 221 participants resulted in 19 (8.6%) with major, 30 (13.6%) with other depressive syndrome and 77.8% (n=172) without depressive disorders. No difference between female and male participants concerning the incidence of depression (p= 0.519, Ch²). Two (0.9%) participants were screened positively for both paric and for major depressive disorders. Participants with versus without mental disorder showed no differences in interview burden or duration. The T-test for the group of participants with major or other depressive syndromes (n=35) vs. participants (n=137) with no signs of depression presented no significant differences in the mean total QoDD scores (p= 0.34).

Conclusions: ICs’ estimates on QoDD of their significant others are not influenced by mental disorders. Therefore bereaved IC are well able to participate in PC research a few weeks post-loss.

Poster Abstract:

Abstract number: P2-099
Abstract type: Poster

Associated with Quality of Life and Depression among Patients with Hematopoietic Stem Cell Transplantation

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Background: Treatment and chemotherapy induce high levels of stress in patients with cancer, and apparently, these patients also experience depression upon every treatment cycle.

Method: Some studies have demonstrated that hematopoietic stem cell transplantation (HSCT) recipients experience anxiety and depression at discharge. Cancer rehabilitation has been improving since 2010 in Japan for QOL of cancer patients in their lives. And, there are some reports about practice of the patients with hematopoietic stem cell transplantation and OT.

Aims: The study was to clarify the characteristics of the personal QOL for advanced cancer patients for whom treatment is not possible, and to consider support for improving QOL.

Methods: The Schedule for the Evaluation of Individual Quality of Life (SEIQoL-DW) was implemented on advanced cancer patients receiving outpatient palliative care. The SEIQoL-DW is a semi-structured interview which extract 5 areas thought by the patients to be the most important in their lifestyles, and produces a QOL score from the satisfaction level for each and its weighing overall. We analysed the relationship between the QOL score and the content, satisfaction level, and weighing for each that the patient thought was important.

Results: The study was implemented on 14 subjects (8 patients were undergoing anti-cancer therapy and 6 patients were not). The average interview time was 1.3 minutes. The QOL score was 66.3±22.5 (38.2±24.5 for the anti-cancer therapy group, and 79.7±9.8 for those not receiving treatment). The areas that patients often considered to be important were anti-cancer therapy (6 patients), children (6 patients), spouses (5 patients), housework (5 patients), etc. The patients that considered anti-cancer therapy to be important had an average satisfaction level for anti-cancer therapy of 34, and a mean weighing of 28%.

Discussion: One of the factors underlying the fact that the QOL score for patients undergoing anti-cancer therapy was low, was that despite the satisfaction level for anti-cancer therapy being low, the weighting with respect to lifestyle was high. In order to improve the QOL of patients undergoing anti-cancer therapy, it is necessary to support the increasing of the weighting for areas other than anti-cancer therapy.
Implementation of a Patient Reported Outcome Measure (PROM) in a Brazilian Palliative Care Hospital Service


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Abstract number: P2-100
Abstract type: Poster

Background: Evidence suggests that implementing PROMs in palliative care clinical practice is beneficial.

Aim: To describe the implementation of the Palliative Care Outcome Scale (POS) in a specialist palliative service.

Methods: Longitudinal study, Tool selection criteria: developed for palliative patients, valid, feasible and freely available. The POS was chosen. Processes for POS use were defined. The pilot lasted 6 months. We used Wilcoxon signed-rank test to compare differences.

Results: We applied POS at admission, 3rd day and weekly to 401 patients with mean age of 75 years (±16). 53% were female and 44% were cancer patients. Pilot results (N=84) revealed inconsistent data collection and missing data (14%). Symptoms were sub optimally controlled by day 3. e.g. control of pain in POS rated as moderate at admission (Table 1). Processes changed: only cognitively intact patients filled POS (N=58 of 317). At admission, any team member participating in the patient/family conference could apply POS. After, the nurse managing the POS database would preferably do so. Doctors were encouraged to grasp the meaning of POS results for each patient, be more assertive in symptom control and more alert to treat patients displaying distressing symptoms. Control of pain rated as severe or moderate improved by day 3 (Table 1).

Conclusion: Roles and a daily routine to apply the POS were defined and symptom control improved. Gathering clinical evidence data on palliative care needs as perceived by the patients was paramount to inform the effectiveness of the care delivered.

Table 1. patients scoring on POS item “Pain”

<table>
<thead>
<tr>
<th>Pilot Phase (N=6/84)</th>
<th>Scores: 2 to 0 (n=3); 2 to 3 (n=1); no change (n=2) (p=0.131*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Phase (N=10/58)</td>
<td>Scores: 4 to 1 (n=1); 3 to 0 (n=2); 3 to 1 (n=1); 3 to 2 (n=2); 2 to 0 (n=2); 2 to 1 (n=1); no change (n=1) (p=0.005*)</td>
</tr>
<tr>
<td>Wilcoxon signed-rank test</td>
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</table>

Predictors of Survival: A Study by a UK Hospital Palliative Care Team

Vickersaff V., Armstrong K., Stone P., Meystre C.

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Abstract number: P2-102
Abstract type: Poster

Background: Predicting the survival of terminally ill patients accurately is important as it facilitates clinical decision making and may avoid patients choosing invasive, active treatments and thereby a hospital death. Accurate prognostication is also desired by patients to reduce psychological burden.

Aim: To determine the survival of patients referred to a UK hospital palliative care team and to identify prognostic factors.

Methods: Consecutive patients referred to the hospital palliative care team were assessed and discussed at a weekly multi-disciplinary meeting. Demographic data, diagnostic information, Karnofsky performance score (KPS), clinical prediction of survival (CPS) and length of time between admission to hospital and clinical assessment were recorded and later compared with actual survival.

Results: 371 participants were studied. The median age of the patients was 76 years, (IQR: 67–83 years), 52% (n=192) were male. The most frequent diagnoses were lung cancer (22%, n=81), upper gastrointestinal cancer (18%, n=64) and genitourinary cancer (13%, n=47), CPS was available for 242 (65%) of the patients. The median survival was 19 days, (IQR: 5–63 days). The median duration between admission and palliative care assessment was 18 days (IQR: 6–17 days). In a multivariable logistic regression, survival 14 days after being assessed by the palliative care team was most significantly associated with the KPS (p<0.001) and CPS (p=0.0017). For a 10 point increase on the KPS, the adjusted odds of survival was 1.73 (CI 1.35 to 2.21).

Conclusion: In patients referred to a UK hospital palliative care team, the KPS and CPS were the most useful predictors of survival at 14 days, when taking into account age, gender, diagnosis and duration between admission and palliative care assessment. Patients who scored 10 points higher on the KPS were 1.7 times more likely to be alive at 14 days compared to those with the lower score.

Reference:

Outcome Measurement in Palliative Care: An Updated Systematic Review of the Use of Two Popular Measures in Clinical Care and Research

Win J.L., Collins E.J., Bausewein C., Davison B.A., Heggenson L.J., Murtagh F.E.,
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Abstract number: P2-103
Abstract type: Poster

Background: The Palliative Care Outcome Scale (POS) and the Support Team Assessment Schedule (STAS) are outcome measures used to assess patient concerns and quality of palliative care. In 2011, Bausewein et al. published a review of the use of these measures, demonstrating widespread use in a variety of settings and translation into a range of languages.

Aim: The current work sought to update the results of the previous review to appraise whether and how the use of POS and STAS has changed over time.

Methods: The review applied the same search strategy used by Bausewein et al. and identified studies published from February 2010 to June 2014. Studies were categorised by main objective and reason for using POS/STAS. Further data on study design, location, population and results were extracted.

Results: Forty-three new publications met the inclusion criteria (33 for POS and 8 for STAS). These showed that use of POS and STAS has increased, particularly across Europe and Africa, including publication of 12 additional translations of POS in various African dialects.

Conclusion: POS and STAS have increasingly wide uses in clinical practice and research. The shift in the focus of publications may indicate that these tools have now been widely accepted as valid and reliable measures. There is advantage in having a brief, valid and reliable tool used across settings, languages and countries, not only to ensure palliative care concerns are addressed and outcomes of care are measured, but also to enable cross-country comparisons.

Reference:
International Advances in Outcome Measurement in Palliative Care: One Step Closer to Cross-national Comparisons of Routinely Collected Outcome Data in Palliative Care

Witt J.1, Murtough F.E.2, Davosson E.A.1, Dawell M.A.1, de Wolf-Linder S.1, Higginson I.J.1, Clopham S.1, Quenley K.1, Curnow D.1, Yates P.1, Johnson C.E.1, Edgar A.1, King’s College London, Palliative Care, Policy and Rehabilitation, London, United Kingdom, 1University of Wollongong, Palliative Care Outcomes Collaboration, Australian Health Services Research Institute, Sydney, Australia, 2Funders University, Palliative and Supportive Services, Adelaide, Australia, 3Queensland University of Technology, Institute of Health and Biomedical Innovation, Herston, Australia, 4University of Western Australia, School of Surgery/Cancer and Palliative Care Research and Evaluation Unit, Perth, Australia, 5University of Wollongong, Australian Health Services Research Institute, Sydney, Australia; Presenting author email address: jana.witt@kcl.ac.uk

Background: The Palliative Care Outcomes Collaboration (PCOC), Australia, and the Outcome Assessment and Complexity Collaborative (OACC), UK, support the routine use of outcome measures in palliative care. PCOC on a well-established program, OACC commenced in 2014 and has built on PCOC’s work. Both initiatives follow a sophisticated implementation approach, promoting routine clinical assessment tools that can be used to measure and benchmark patient outcomes.

Design and aims: The suites of measures used by PCOC and OACC were selected after consideration and consultation among experts in palliative care and research. We compare the two suites and assessment points in order to enable cross-national analysis.

Results:

<table>
<thead>
<tr>
<th>Key Domain</th>
<th>PCOC Measure</th>
<th>OACC Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage of Illness</td>
<td>Palliative Care Phase</td>
<td>Palliative Care Phase</td>
</tr>
<tr>
<td>Physical (Performance)</td>
<td>Australia-modified Karnofsky Performance Status (KPS)</td>
<td>ECOG (KPS)</td>
</tr>
<tr>
<td>Physical (Activity)</td>
<td>Resource Utilisation Groups – Activities of Daily Living (RUG-ADL)</td>
<td>10-item Barthel Index</td>
</tr>
<tr>
<td>Physical (Symptoms)</td>
<td>Palliative Care Problem Severity Score (PCPSS)</td>
<td>Integrated Palliative Care Outcome Scale (IPOS)</td>
</tr>
<tr>
<td>Psychological</td>
<td>PCPSS</td>
<td>IPOS</td>
</tr>
<tr>
<td>Spiritual</td>
<td>PCPSS</td>
<td>IPOS</td>
</tr>
<tr>
<td>Family/care</td>
<td>PCPSS</td>
<td>IPOS</td>
</tr>
</tbody>
</table>

Both suites include tools to assess key domains in palliative care and both initiatives use a patient-reported outcome measure to examine symptoms and concerns (SAS and IPOS). However, individual measures for assessment of activities of daily living and symptom severity differ. Furthermore, only OACC includes a carer-reported tool to examine caregiver burden. Time points for measurement also differ. PCOC requires regular, ongoing assessment, while OACC recommends assessment on at least two occasions.

Conclusion: While PCOC and OACC share a common goal and similar domains, however, some individual measures differ. Nevertheless, availability of national outcomes data brings us one step closer to cross-national comparisons of routinely collected outcome data in palliative care.

Abstract number: P2-105
Abstract type: Poster

Ergonomic Self-assessment Tool – ESAT

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The aim of this project is to provide professionals working in Palliative Care (PC) – doctors, nurses, physiotherapists, etc. – with a practical means of assessing the quality of their work clearer, indicating aspects that can be improved, seems to be possible with this simple, easy-to-use tool. Study’s source of funding: self-funded.

Abstract number: P2-106
Abstract type: Poster

Assessing Pain Severity – Which Scale Do Patients Prefer, and when Do they Need Treatment?

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Background: Pain assessment is the foundation of pain management and the patient’s self-report remains the gold standard of assessing pain. Use of standardised scales to measure pain severity is a recommended practice. Several studies have assessed optimal approaches for grouping pain severity, but there is still controversy in what constitutes mild, moderate, or severe pain.

Aims: To assess patients’ preferences, at what point patients feel they need pain treatment, and the correlation between three pain severity scales commonly used in clinical practice: verbal and horizontal numeric scales, and verbal descriptive scale.

Methods: This is a prospective, descriptive study. Data will be collected from 70 patients 75 years and older, 70 patients on first day post-operatively, and 70 patients with chronic pain (N=210). The scales are presented in random order and patients fill out a questionnaire where they mark the pain severity and where on the scale treatment is needed. Afterwards, patients fill out another questionnaire querying which scale was preferred, pain interference, and demographic variables. Descriptive statistics will be used to portray pain severity, but correlation and ANOVA will be used to assess the relationship between the scales, and the difference between the patient groups.

Results: Data are being collected and will finish in January 2015. Results will be presented on which scale the patients preferred, how well the scales correlated, and where on the scales patients felt they needed treatment. The difference between the three groups will be portrayed, as will the relationship between interference with function and patients’ evaluation on where they needed treatment, be explored.

Conclusion: The results will portray patients’ preferences and can be used to guide treatment, and in training health-care professionals in pain management. The results will aid in providing optimal pain management and therefore improve the quality of care.

Abstract number: P2-107
Abstract type: Poster

Current Nursing Practice: Assessment of Anxiety in Advanced Cancer Patients. A Mixed Methods Study

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Background: Without structured assessment anxiety is one of the most overlooked symptoms in advanced cancer patients. Systematic assessment of anxiety is not imbedded in daily care. Anxiety management often depends on the clinical impressions of the bedside nurse. To improve structural assessment of anxiety, insight into the current practice and reasons for nurses to apply measurement instruments is needed.

Aims: To get insight into the application of instruments in order to improve structural assessment of anxiety.

Methods: An explanatory mixed method design. Retrospective data were collected from nursing files of advanced cancer patients admitted between Oct. 2012 – Feb. 2013 in an university hospital, general hospital and a high care hospice. In addition, semi-structured interviews were carried out.

Results: In total, 155 nursing files were analysed and 12 nurses were interviewed. Four different instruments were used to identify, screen or analyse anxiety. The frequency of used instruments and the frequency of reported anxiety by nurses in daily nursing files, differed significantly between settings. The main reasons to use instruments were improvement of communication with patients and other professionals. Lack of knowledge was the fundamental cause for neglecting suitable instruments, other factors were poorly imbedded multidisciplinary standards and patient- and environmental factors.

Conclusion / Discussion: A reason for increased frequency of anxiety mentioned in nursing files could be explained by the use of instruments. Although most nurses were convinced of the added value of instruments, they do not apply instruments because of patient and environmental factors but mainly due to a lack of knowledge on the application of these instruments. A training program for nurses, focusing on knowledge and competences on the use of instruments in daily practice could be a first step to ameliorate anxiety management in practice.
Audit and quality improvement

Abstract number: P2-108
Abstract type: Poster

Integrating Palliative Care in a National Cancer Plan

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Goal of the work: In Sweden, palliative care for cancer patients has been a separate entity, not always included in the regular health care system. However, according to our new Swedish national Cancer Plan, palliative care should be a self-evident part of the patient’s care from diagnosis to death. Therefore, a Cancer Plan in palliative care is now one of ten defined areas in the implementation plan.

Our regional goal is to improve palliative care from the patient’s perspective in the Stockholm region (multi-sector, multi-care, patient safety, short lead times, evidence-based knowledge, effectiveness and efficacy).

Approach taken: A registered nurse and a physician with scientific competence are project managers. In order to get a broad influence, the managers have:

Established co-operation with project managers representing specific tumor groups (e.g. gastro-intestinal (G.I.) cancer).

Planned for dissemination of evidence-based knowledge both in palliative care and acute hospital care.

Planned for a comprehensive palliative cancer network within the County Council.

Results:

Establishment of a multi-professional Regional Palliative Council, with members from different areas (specialised palliative care, acute hospitals, primary care etc.). Also representatives for patient associations are included.

An education program for all parts involved in palliative care.

Establishment of a system that aims at identification of chains of care for G.I. cancer with focus on lead time and the cancer trajectory.

A pilot project of palliative consult teams in acute hospitals.

A pilot project of expansion of advanced homecare for children and youth.

Mapping of resources for palliative cancer patients in the whole region.

Lessons learned: When palliative cancer care becomes a self-evident part of the regular health care system, the allocation of resources increases and the palliative care patients become visible.

Abstract number: P2-109
Abstract type: Poster

Collaboration in Palliative Home Care between General Practitioners and Palliative Care Team: A Survey

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Background: The public service of Palliative Home Care involves the collaboration between General Practitioners (GPs), District Nurses and Palliative Care Team (physician, nurse, psychologist). GPs play a key role in the Home Care. Aims: The aim of our survey is to explore the views of GPs about Palliative Home Care, the perceived quality of Palliative Care Team (PCT) service and to evaluate proposals for improving cooperation between GPs and specialists. Method: All GPs in the district received an anonymous questionnaire to be filled in on-line. Questions focus on criteria for palliative care referral, critical issues, educational needs, the perceived quality of service and suggestions. The questionnaire include closed ended questions (multiple choices and Likert scale). Results: Response rate was 50.5% (145/287). The 89% of GPs consider particularly useful the collaboration with the PCT especially regard to the symptom control and the ability to manage the patient at home until death. The main criteria for referral to PCT are the life expectancy (90%) and the presence of common symptoms (87%). The critical issues are the management of emergency (47%) and the difficulty of caregivers in administering medications (34%). Only 5 GPs reported issues in opioid use. GPs propose the establishment of a nursing team specifically dedicated and trained in palliative care (93%), the prompt availability of drugs at home (97%) and the implementation of a system that aims at identification of chains of care for G.I. cancer with focus on lead time and the cancer trajectory. Conclusion: Collaboration with specialists is essential in the management of terminally ill patients at home and expressed the need for more education in palliative care. They also suggest the enhancement of the nursing team with dedicated staff.

The study had no external funding source.

Abstract number: P2-110
Abstract type: Poster

“More Care, Less Pathway”- Is this Happening Post LCP?

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Background: The Liverpool Care Pathway for the Dying Patient (LCP) was devised to guide healthcare providers in ensuring uniformly good care to those at the end of life. Recently, it has come under scrutiny. An independent review in July 2013 prompted the LCP to be pulled out of use. A holistic interim guidance was created to aid the provision of high quality care during the transition to a more individualised end of life care plan.

Aims: To establish the current quality of end of life care in the hospital setting compared to published interim guidance.

Methods: A retrospective case note review was undertaken. In total, 48 deceased patients’ records from two city hospitals were analysed over one month. An 18 point template was devised based on the key principles of the interim guidance and used to review each set of case notes.

Results: Greater than 70% compliance was shown in only 4/18 areas audited. All notes contained documentation of the outcome of daily ward rounds and 89% of notes contained documentation that the patient’s deterioration was discussed with family or significant others. The remaining 14/18 areas showed < 70% compliance. Notably, 0% of patient notes had documented that nutrition had been discussed and only 25% had documented a discussion regarding hydration. Compliance was significantly higher in 12/18 areas audited in cases referred to the hospital specialist palliative care team (HPSPCT).

Discussion: Results demonstrate substandard compliance with the current interim guidance. Adherence to interim guidance was much improved by involvement of the HPSPCT. Results may be explained by poor awareness of current interim guidance and/or the absence of paperwork to guide patient care.

Conclusion: Intervention in response to issues highlighted is essential to provide appropriate hospital palliative care. This may be facilitated by education of healthcare providers, a structured document to guide care and timely referral to the HPSPCT. No funding was received for this work.

Abstract number: P2-111
Abstract type: Poster

Launching a Bereavement Survey to Improve Hospital End of Life Care

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Background: How does a large hospital Trust with over 2500 deaths per year assess the quality of end of life care provided to patients and families? The annual University of Michigan Bereavement Survey (VOCES) provides locality data but is not refined to produce hospital specific data. To use feedback to improve the quality of end of life care in our two hospitals, a hospice specific questionnaire was needed.

Aim: To design and implement a questionnaire to capture feedback from bereaved relatives on hospital end of life care.

Method: A questionnaire was designed with hospital specific questions and initially piloted on a single ward. After review and questionnaire amendments the project was extended in September 2013 to cover all adult deaths within the organisation. Amendments to the questionnaire addressed the main issues raised by the publication of the findings of the UK Government’s Independent review into the Liverpool Care Pathway. The questionnaire is sent to relatives 6 weeks after the patient’s death with a sensitively worded covering letter. The form has 25 ‘tick box’ questions and a free text section, and telephone support is offered to relatives who want further discussion as a result of the contact.

Results: 1294 questionnaires were sent out in the first year, 436 have been returned, a response rate of 34%. The Trust Nursing Directorate, Palliative Care Team and Clinical Governance department work in partnership to collect, analyse and utilise the data for quality improvement. Results inform education programs and help target service improvement.

Conclusion: The survey has given a voice to those who witness first hand the care provided to patients dying in our hospital Trust. Rich quantitative and qualitative data is collected and fed back directly to frontline staff to improve end of life care.

Abstract number: P2-112
Abstract type: Poster

An Audit of the Change in Prescribing Errors and Dispensing Times Relating to Subcutaneous End of Life Care (EOLC) Medications for Palliative Patients Who Are Being Discharged from an Acute Hospital, Following the Introduction of a Dispensing Formosa across the Whole Hospital Trust

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Discharging palliative patients from hospital may require clinicians to prescribe medications to take out (TTOs) which can be given subcutaneously. Such medications may be needed on discharge for ongoing symptom control (e.g. in a syringe driver) or in anticipation of common symptoms (e.g. pain, secretions and agitation) that may develop as the patient deteriorates. Several such medications are controlled drugs which impose strict requirements on prescribing that must be met before a drug can be dispensed. Junior doctors, who most frequently prescribe TTOs, often appear not to remember or understand these requirements. The consequent prescribing errors can potentially delay the discharge from hospital of palliative patients.

A baseline 2 week survey within our hospital pharmacy department showed a high level (89%) of TTO prescribing errors for subcutaneous palliative medications (9 charts), especially for controlled drugs. The most common errors related to drug dose and strength, not writing the correct strength, and using the wrong strength. Such frequent errors prompted good prescribing practice and aimed to reduce prescribing errors and dispensing times.

The dispensing chart was pilot over 2 weeks and errors and delays associated with the TTOs recorded (9 charts). The proportion of charts with prescribing errors reduced to 11% and the time taken by pharmacy to dispense was reduced to 1 hour. Following the pilot, the dispensing chart was ratified and rolled out across the hospitals Trust. This paper presents the result of the full implementation audit and discusses this within the context of implementing change and education.
Abstract number: P2-113
Abstract type: Poster

Place of Death; What Are We Documenting, and What Are We Achieving?
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Background: When a patient has a requirement for Palliative Care identified, a needs assessment should be undertaken and the patient's wishes explored. This included the recording of the preferred place of death (PPD) in hospice patient documentation and numbers who achieved PPD.

Aims and objectives: (1) To review a sample of inpatient Unit (IPU), Day Hospice, Community and Outpatient users at the Hospice and establish the percentage with documented PPD.
(2) To review place of death and whether PPD was/was not discussed/achieved and any documented reasons for this.


Results: 81.25% (39) of the 48 patients had PPD recorded. 4.17% (2) patients had no PPD recorded but with reasons for this documented. 14.59% (7) had no documented PPD without explanatory reasons recorded. 62.02% (22) of the 39 patients with a recorded PPD achieved their PPD, the remaining 17.95% (7) patients all had clear reasons for failing to achieve their PPD.

Percentages achieved within each of the Hospice services:
+ 66.67% of Outpatients had PPD documented and 50% of these achieved PPD.
+ 88.89% of Day Hospice users had PPD documented and 75% of these achieved PPD.
+ 73.33% of IPU users had PPD documented and 100% achieved PPD.
+ 83.33% of Community services users had documented PPD and 80% achieved PPD.

Conclusions: Within Hospice we have been successful in several areas with regards recording and achieving PPD, while other areas still require further examination. This poster will expand further on the above data and discuss barriers to achieving PPD. Feedback from the different hospice service groups on current levels of recording and achievement will be undertaken to promote and encourage improvements and maintenance of standards.

Funding: No funding was required for this audit to be completed

Abstract number: P2-114
Abstract type: Poster

A Pain Audit at Regional Cancer Centre of India: Assessing Psychosocial Distress in Cancer Pain is the Need of the Hour
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Aim: Recent work in palliative care has recognised that pain is a complex social, psychological, spiritual and psychological experience. In order to assess if each of these components is equally well addressed in clinical practice, we undertook a retrospective audit of psychosocial assessment procedures at the pain clinic at IRCH-AIMS, New Delhi.

Methods: 686 pain assessment forms collected over 2011 were examined and analysed through SPSS.

Results:
1) While physical aspects of pain are recorded at almost 100% levels in the pain forms, psychosocial components of patient distress are not be less adequately recorded.
2) The layout of the assessment is slanted towards functional factors (such interference with daily activities and mobility), while non-functional symptoms are being recorded at relatively low levels (anxiety – 1.2%, depression – 4.4%). Prior studies in the same clinic as well as in the Indian psycho-oncology literature has shown that non-functional distress (such as anxiety and depression) are usually found much higher rates of incidence (33%– 80%).
3) Analysis of the existing data revealed severe demographic vulnerabilities in our patient sample, an aspect that is recorded but not currently addressed as part of a psychosocial assessment.

Conclusions: In light of these findings we surveyed 14 existing pain assessment tools, and chose two for incorporation into our existing pain practice. These tools were the Distress Inventory for Cancer – 2 and the American Pain Society Patient Outcome Questionnaire. They were chosen for their balance between functional and non-functional symptoms, sensitivity to socio-economic distress and ease of completion in the high volume public health setting.

Abstract number: P2-115
Abstract type: Poster

Time & Motion: Transferring NHS Productive Ward to a Hospice Setting
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Background: The NHS (National Health Service) Institute for Innovation & Improvement supported the NHS to transform healthcare for patients & the public, by rapidly developing & spreading new ways of working. The Strategic Clinical Network agreed to fund the cost of supporting participating Hospices through the programme.

Aim: We concentrated on two modules in Phase 1: Well Organised Working Environment & Knowledge How We Are Doing. The focus was on improving ward process & environment whilst exhibiting openness & transparency in reporting systems & governance issues. Staff equipped with knowledge & practical tools developed skills to identify areas for sustainable efficiency improvements in terms of care, effort & finance whilst improving experience of care for patients & staff.

Method: Action learning training days followed external training, attended by various staff disciplines for patients who died between January 1998 and January 2014. The team identified and undertook process improvements for equipment & stores during a routine working day & the length of time preparing for clinical procedures. It prompted examination & analysis of everyday tasks. A mapping process was undertaken, we carried out film activity walking, at looking both location of equipment & time taken to carry out tasks. Organisation of stock storage in all areas was closely examined, identifying surplus stock & implementing changes to ordering system.

Outcome: The key to the success of the programme was that improvements were driven by staff themselves. Staff felt empowered to ask difficult questions about their own practice & made positive changes to the way they worked, ultimately working more efficiently & effectively, reducing cost & re-investing time in patient care. Having support from Hospice leaders led to an environment where changes were made but ultimately sustained. Phase 2 is now underway & includes the Ward Handover & Meals modules.

Abstract number: P2-116
Abstract type: Poster

Introduction of a New Prescription Chart to a Specialist Palliative Care Unit
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Background: A redesigned inpatient prescription chart was introduced across 3 wards in a specialist palliative care unit in September 2013.

Aim: To assess whether the new prescription chart is fit for purpose. To survey opinions of those using the new chart.

Methods: Prescription charts of all inpatients (n=47) on a given day along with charts of 14 patients who had died were reviewed across 3 wards. Data collected included completion of each section of the chart, number of medications prescribed, use of specialist sections and documentation of administration of medications.

A user survey was carried out to assess opinions on the new prescription chart (n=19).

Results: 86 prescription charts were reviewed for 61 patients. Lack of space for regular medications caused the requirement for a second chart in 80% of cases. All patients who required two charts were inpatients for >1 month. While patient details were completed 100% of the time, allergies were documented only 65% of the time. The new signature box was fully completed by nursing staff in 15%, medical staff in 17% & pharmacists in 100%.
64% were prescribed a regular antibiotic & 42% were prescribed regular analgesics. The “PNP opioid” section was the most commonly emptied. Compared to the previous prescription chart, staff felt it was “much better” (58%) or “somewhat better” (26%). The main advantages were improved clarity of prescription & reduction in multiple charts in use at once. 79% felt a separate opioid section was safer while 42% felt an opioid section was safer.

Discussion: The redesigned prescription chart includes features that improve safety and clarity of prescribing and administration of medication. Most staff agree that the new design is an improvement but further modifications will be informed by this audit.

Abstract number: P2-117
Abstract type: Poster

A Quality Improvement Journey in Palliative Care: Enabling Reliable Person-centred Care through Information Reconciliation
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Recent research identified that 29% of patients in hospitals are at risk of deterioration & dying. The need to improve anticipatory care planning (ACP) for such patients requires innovation & system wide re-organisation.

Aim: To ensure patients in pilot areas receive care aligned to their needs & wishes through integration across hospital & community.

Methods: The Institute of Healthcare Improvement Model for Improvement is used to explore the current system, challenge assumptions & test changes regarding: identification of patients at risk & reliable response Communication with patients & families regarding realistic goals, benefits & burdens of interventions, their wishes & concerns Integration of care elements of ACP within routine clinical processes Clear documentation of a multi-professional Goals of Care plan & sharing of information across care settings: information reconciliation This innovative, participative approach has ensured clinician ownership. Measures used to evaluate the reliability of processes & impact on patient outcomes will be reported. Data capture includes audit of clinical documentation, observations of Professional clinical practice and semi-structured interviews with patients, carers and staff.

Findings: Findings from pilot areas challenge current literature by indicating that ACP is appropriate for over 75% of patients in pilot areas. This presentation will include the impact of interventions on care processes & outcomes including acceptability of ACP approaches.

Additional output: Exploration of a core skill set for staff regarding best practice Glossary of terminology has been defined to enable a consistent approach. Collaboration to expedite progress.

1. Clark 2.www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015
Acupuncture for Hot Sweats: Kindling the Flame

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Acupuncture is increasingly becoming recognised as a clinically useful tool in the management of difficult or distressing vasomotor symptoms. Currently limited evidence suggests the need for more rigorous research to define its role in oncology and palliative settings.

This was a retrospective case-note review with detailed case studies to investigate the effectiveness of treatment with acupuncture for the relief of hot sweats. The sample consisted of 46 patients who had been treated for sweats in a hospice setting since records began in 2006. Collected data included patient details and diagnoses, number of treatments, quantitative scores for symptom intensity and frequency, the type of acupuncture (needle or electro), plus qualitative comments. In addition, the data lent itself to detailed case studies profiling a smaller subset of patients through their treatment process.

21 (50%) of the 42 patients who attended for acupuncture showed symptomatic improvement over the course of their treatment, with a further 5 showing a variable response. 6 patients did not experience any improvement of their symptoms, and the data was insufficient in the remaining 12 cases. Qualitative remarks included comments such as ‘feel, satiated, soaked’ before treatment, to ‘now manageable’; ‘no need to wash sheets’; virtually none’ after treatment. Vasomotor symptoms can be debilitating and difficult to control. In this study, patients experienced a dramatic improvement in the frequency and intensity of their hot sweats over their treatment course. More rigorous recording and research would be needed to understand the procedure process, to include the duration and quality of treatment needed to bring about an improvement. Clearly though, the use of acupuncture in a palliative environment has enormous therapeutic benefit, which may be clinically relevant. The application of acupuncture for the management of other palliative symptoms, for example, pain and insomnia, should also be considered.

Abstract number: P2-119
Abstract type: Poster

Assessment of Therapeutic Adherence to Strong Opioids in a Sample of Advanced Cancer Patients Attended by Specific End-of-Life Support Teams: A Pilot Study

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Background and aims: Pain is a highly prevalent symptom among advanced cancer patients affecting severely their quality of life. Lack of adherence with the analgesic regimen can be a significant barrier to effective cancer pain management. The purpose of this pilot study is to determine the degree of adherence to the third step of analgesic drugs in a sample of advanced cancer patients cared for specific end-of-life teams.

Methods (design, data collection, analysis): We conducted an observational prospective study. We included consecutive patients attended both at home (home care team) or at the outpatient clinic (supportive palliative care team), between November 2013 and April 2014 being treated with strong opioids but with intensity of pain ≥ 4 measured on a visual analogue scale. We used the Morsky-Green-Levine test in order to determine the therapeutic adherence to the analgesic regimen. We used univariate and multivariate tests to analyse variables.

Results: 89 patients were recruited (mean age 70.3 ± 14.143), Men 64 (72%). Morphine Equivalent Daily Dose (36, 39 mg ± 74,73). Non-adherence to treatment was detected in 42 patients (46%). Equivalent Daily Dose (76, 26 mg ± 74,73). Non-adherence to treatment was detected in 42 patients (46%). Variables the predictive power of which were assessed included: age, sex, Karnovsky, symptom intensity, symptoms other than pain, pain medication, days of discharge. Data collected included: demographics, suitability for AMBER care plan, education about uncontrolled symptomatic situations and professionals training.

Conclusions: Our sample represents a smaller subset of patients through their treatment process. The results of this pilot study help to inform the design of a larger study to confirm the obtained data.

Abstract number: P2-120
Abstract type: Poster

Does the AMBER Care Bundle Have a Role in a Specialist Cancer Hospital?

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Background: The AMBER care bundle is a hospital based tool designed to improve the quality of care for people where recovery is uncertain. The regional cancer centre serves a rural population of 1.2 million, with an average of 4500 inpatients a year. There was concern that many ill patients and their families would benefit from a more structured approach to communication about uncertainty of outcomes, ceilings of care and treatment decisions. It was felt to be an ideal setting to consider implementation of the AMBER care bundle.

Aim: The aims of the project were:
1. To assess the current level of care.
2. To implement the AMBER care bundle onto the inpatient unit.
3. Evaluate implementation of the AMBER care bundle.

Method: A retrospective review of case notes was conducted on 30 patients who had died under the care of the centre. 15 had died on the inpatient unit and 15 had died within 100 days of discharge. Case notes collected: demographics, mortality, treatment, decision and family involvement. The documentation of decision-making was reviewed.

Results: The review showed that 15 patients who died on the inpatient unit would have been suitable for the use of the AMBER care bundle. 86% had a medical plan, escalation decision and DNACPR conversation recorded; 73% had a documented conversation with the patient and/or relative about uncertain recovery. 46% had a documented discussion about preferred place of care. 20% showed evidence of the medical plan being discussed and agreed with nursing staff. 60% did not receive daily follow up.

Conclusion: Implementation of the AMBER care bundle will help focus on the areas of care that need improvement. Education and resource material will be essential in achieving and sustaining a change in practice.

Abstract number: P2-121
Abstract type: Poster

Aneurin Bevan Health Board End of Life Admissions Audit

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Background: Advance care planning is fundamental to providing high quality care to those approaching end of life. Anecdotally, unscheduled admissions and subsequent deaths in hospitals are increasing despite patients’ preference to die at home. The aim of the audit was to explore whether palliative patients with an unscheduled admission had an advance care plan in place, and whether there were any missed opportunities to explore advanced care planning with these patients prior to death.

Methods: A 1 month retrospective cohort of patients who died within 48 hours of admission across Aneurin Bevan Health Board was identified. Those who died unexpectedly were excluded, and the remainder assessed using the clinically validated ‘surprise’ question (“Would you be surprised if this patient died within the next year?”). Patients were then classified as palliative if the answer was ‘no’. Palliative patients’ case notes were reviewed and data collected.

Results: 50 patients in the original cohort identified, 34 were unexpected deaths, with the other 16 deemed palliative (3 were discarded due to incomplete data). Of these 13 patients the mean age was 75.8 years with 69% being admitted out of hours. 77% had a performance status of 3 or 4. 100% of patients from nursing homes had a performance status of 4. 100% had at least 1 admission in the year prior to death (median = 3), but only 2 had advanced care plan in place.

Discussion: A proportion of patients nearing end of life are dying in hospital. Our audit has highlighted the absence of advanced care planning for the majority of these patients, and missed opportunities to explore advanced care planning during their multiple previous admissions. The emphasis on advanced care planning appears focused on the community setting, but a cultural change within secondary care may facilitate a wider appropriate use of advanced care planning.

Abstract number: P2-122
Abstract type: Poster

Visits to Hospital Emergency Patients Seen by the Support Team Palliative Care Merida Area

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Aim: To determine the patients in the Regional Palliative Care Program of Extremadura (PRCEx) who visit hospital emergency areas in the area of Mérida.

Design and method: Observational, descriptive, retrospective study. A review of medical records of patients who were included in the PRCEx was performed, and the following data were collected:

1. Location of patient care, depending on the degree of stability: active / passive or unstable / stable.
2. Number of visits to the emergencies service.
3. Reason: Pain, other symptoms (dyspnea, asthma, anorexia, dysphagia, and malaise), patient decision and family overload.

Results: A total of 156 patients were registered in the period from January 1 to June 30 of 2014, which 11 of them weren’t included for not meeting criteria, so that the sample was at 146. 65 patients were included (45%) they generated 90 episodes (average 1.38, mode 1). 90 episodes were produced, 73% were active patients, 27% were passive and 68% needed hospitalisation.

Conclusions: We think that even we provide the last days assistance at home, there are a high percentage of patients who comes to the emergency department of the hospital to manage their symptoms and this could be done on an outpatient basis.

It is true that two-thirds of the episodes occurred in ‘active’ patients, status that we consider as ‘complex patients’.

We still planning to review our protocols, to inquire into the patient’s wishes about where they want to be in case of complications and improve the information, health family education about uncontrolled symptomatic situations and professionals training.
Poster Sessions (Poster Exhibition Set 2)

Abstract number: P2-123
Abstract type: Poster

Bridging the Gap between Practice and Research: An Analysis of the ‘Bottom-up’ Approach within an Outcome Measurement Implementation Project


Background: Implementing outcome measurements (OM) in a palliative care clinical environment has rarely been researched. Evidence recommends a ‘bottom-up approach’; facilitating teams to maintain ownership throughout implementation. It is unclear, what such an approach means in practice. The Outcome Assessment and Complexity Collaborative (OACC) is implementing patient-level OM and researching the best ways to understand its impact.

Method: Content analysis of observational field notes with review of emerging themes by means of thematic analysis.

Results: This project is running in 6 organisations delivering specialist palliative care. We determined that a ‘bottom-up approach’ should have the following characteristics: Empathic attitude: The QIF has to understand the clinical workload of each team in order to demonstrate credibility and approachability. Balancing project and clinical priorities: Strict timelines mean each clinical team must balance time requirements to avoid jeopardising implementation.

Conclusion: A ‘bottom-up’ approach that integrates innovative ideas from clinical teams is essential when implementing OM. Flexibility, responsiveness and receptiveness to clinician input is critical. Qualitative research is required to further develop the ‘bottom-up’ approach.

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Abstract number: P2-124
Abstract type: Poster

Satisfaction of Patient’s Family: Experience from a Newly Created Palliative Care (PC) Unit

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Objective: This study was to evaluate the satisfaction and psychological status of the families of patients treated by the new palliative care mobile unit of the Bafoussam Regional Hospital in Cameroon.

Method: A descriptive cross-sectional study was carried out on all the patients’ carers received during the first year of activities of the unit. These patients’ carers were contacted by phone by a person out of the patients’ caregiver team. Data were collected using a standard questionnaire completed by the respondents.

Results: Of the 47 patients’ carers followed up, 39 were able to respond to the invitation. The average age of respondents was 39 ± 12 years. Sex ratio (M/F) was 0.56. Four (04) respondents were caring for a non cancer patient. Regarding patients’ carers satisfaction, 95% of respondents were at least somewhat satisfied with their reception by the PC team. 84% (33/39) were satisfied with the information provided by the medical team on the health status of their patients. 87% (34/39) were satisfied with the information given on the investigations requested and carried out. 72% (28/39) were satisfied with the answers given by the doctor to their questions. 97% were satisfied with the relief of the physical pain. 56% (22/39) were satisfied with the psycho-social support. 74% (29/39) were satisfied with the respect of their privacy and dignity during their stay. 74% (29/39) felt prepared to accept the death of their patient. 95% (37/39) could advise a relative to be managed by a palliative care team if it was indicated.

Conclusion: This study shows a good satisfaction of the families of patients receiving palliative care, with a greater preparation of the management of physical pain and a good preparation to accept the death of their loved ones. The weak point of the care was the psycho-social support, suggesting the need for a holistic approach to improve satisfaction.

Abstract number: P2-125
Abstract type: Poster

Why Are Hospice Patients Transferred to Hospitals? An Audit of Patients Transferred to Hospital from a Specialist Palliative Care Unit

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Background: On average in the UK there is 3.5 hospital admissions during their last year of life. Increasingly, hospice patients are receiving ‘active’ treatments in addition to specialist palliative care meaning that transfer to hospital might be appropriate for treatments not available at the hospice. Weighing up the burdens and benefits of transfer to hospital can be difficult for patients and clinicians.

Aims: Retrospective audit of patient transfers from a Specialist Palliative Care Unit to hospital in 2013.

Method: Retrospective case note analysis and independent assessment by the investigators of appropriateness of transfer. Any differences of opinion were discussed.

Results were compared with the audit standard that 100% of transfers to the hospital were appropriate.

Results: 14 patients were transferred to hospital. The reasons for transfer were: acute medical problem (8), rehabilitation/discharge planning once patient no longer had specialist palliative care needs (5), planned procedure (1). Average length of admission to hospital was 13.8 days, 13% of these patients died in hospital. Changes:

Discussion: There are no national statistics regarding patients transferred to hospitals from hospices. The most common reasons here for transfer were need for intravenous antibiotics and rehabilitation and discharge planning once specialist palliative care needs had been met.

Conclusion: In general, hospital transfers were appropriate. Since the time period studied there has been a change in documentation of closings of care and increased ability to provide intravenous therapies at the hospice. A repeat audit is planned to examine the impact of these changes.

Abstract number: P2-126
Abstract type: Poster

Round Table Discussions in Palliative Situation – Qualitative Interviews with Patients

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Background and aim: Since the introduction of the concept of palliative care in a cantonal hospital in Switzerland in 2006, mainly quantitative data for evaluation of quality standards has been collected. Evaluation of experience of round table discussions in palliative situation – qualitative interviews with patients has been conducted from August 2014.

Method: Each patient where a rtd was held, has been screened. If the patient is eligible, he/she will be invited for a narrative interview within a maximum of 7 days after the rtd.

Inclusion criteria are: patient in palliative situation, older than 18 years, all divisions of palliative care units, palliative consultant teams, and palliative care services at home.

Reasons for drop outs: no documentation about rtd was found at care unit, attending physician resp. nurse dissuades from asking for consent, discharged from hospital.

Discussion: First results suggest that not all units in the hospital define a rtd similarly and physicians and nurses at care units have to be instructed that at least two professions have to participate in a rtd in palliative situation. Further important information to improve quality of care is expected from the interviews and the recruiting process.

Abstract number: P2-127
Abstract type: Poster

Coverage of Cancer Patients by Hospice Services in a Medical Center

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Introduction: Under Taiwanese national policies of promoting quality of cancer care, MacKay Memorial Hospital began to follow the coverage of cancer patients by hospice services. The definition of coverage is the dead cause by cancer who received any types of hospice services in his/her last months. The types of hospice care included admission in palliative care units, palliative consultant teams, and palliative care services at home. The purpose is to understand the tendency of coverage.

Method: We collected the data from the medical record room from January 2009 to September 2014. The denominator of coverage is all dead with cancer diagnoses, and the numerator of a fraction is as the definition as previous statement.

Results: There were 6,148 cancer patients died during the period, and 3,515 accept hospice services (coverage: 57.17%). During the first three years, the tendency of coverage was significant increased. However, the coverage became fluctuated from 2012 to 2014. Sometime the admission in palliative care units provided the highest part of coverage, but sometime the palliative consultant teams did.

Conclusion: Higher coverage of cancer patients by hospice service means higher quality of end-of-life care. Based on the survey, we have to inspect our hospice service system to improve our service quality of end-of-life care.
Towards a Continuous Quality Cycle for Palliative Care Guidelines in the Netherlands

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Aims: Our organisation develops guidelines and quality criteria for oncological and palliative care in collaboration with scientific and professional associations, patient federations and other (inter)national partners. In 2013 we investigated the acquaintance and satisfaction with palliative care guidelines. Of the 1,443 respondents, 1,326 provided the guidelines for the decision-making and informing patients. On the following topics room for improvement was identified: 1. Relation with scientific and professional associations. 2. Methodology of guideline development. 3. Integration of palliative care in oncological guidelines.

Methods:
1. A multidisciplinary platform (PAZORI) was established, consisting of mandated members of scientific and professional associations.
2. A continuous quality cycle for palliative care guidelines has been introduced (phases: topic selection, preparation, development concept guideline, consultation, authorisation, implementation, evaluation and revision).
3. A guideline module palliative care is being developed.

Results:
1. PAZORI gives advice about development, implementation and evaluation of palliative care guidelines. PAZORI identifies problem areas, prioritises topics, contributes to improvement of guideline methodology and to the integration of palliative care in other guidelines.
2. Two guidelines (anorexia and weight loss and haemase and vomiting) have been developed so far.
3. The module palliative care is in development, to be included in all oncological guidelines.

Conclusion: Guidelines for palliative care have been improved by increasing the involvement and commitment of professionals through the creation of a multidisciplinary platform and by introducing a continuous quality cycle. Furthermore, implementation is being accomplished by a module of palliative care in oncological guidelines in order to give palliative care the attention it needs in cancer patients.

Poster Sessions (Poster Exhibition Set 2)
Abstract number: P2-133
Abstract type: Poster

Reaching out to Work with Others: How a Hospice is Using Bereaved Caregivers’ Views to Improve End of Life Care in UK Residential and Nursing Care Homes
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Background/aims: Many frail elderly people are living and dying in care homes. This audit uses a validated tool, the Family Perception of Care (FPC) Questionnaire, to understand and learn from bereaved relatives’ views about care provided to them and their relatives. Responses are used to help develop and improve end of life care provided by the care home staff, by extending and building upon their knowledge and confidence.

Methods: Views of bereaved relatives of deceased care home residents across five areas in England are sought, regarding care provision in the residents’ last months of life. The audit is coordinated by a local Hospice with existing supportive links to the homes. These residents either die in the care home or are transferred to hospital. The FPC questionnaire is sent out by care home staff to the bereaved relatives, for anonymous return to the Hospice. The questionnaires consist of 28 questions, corresponding to residents, family support, communication and rooming, and space for comments, and a request to rank three questions considered most important for end of life care. Responses are analysed using SPSS and Excel. Results are shared anonymously with the 32 care homes six monthly. The Hospice then works with each individual home to develop action plans for improvement as part of the audit cycle.

Results: For the first six months, from 288 deaths there were 105 returned questionnaires (35%). Response rates varied by area (range 16% to 52%). Highest satisfaction rates were for staff friendliness, being treated with dignity, having privacy and overall satisfaction with care. Lower rates covered GP time and chaplaincy availability. Treating the resident with dignity was ranked as most important.

Conclusion: Most respondents were very satisfied with the care received. Items ranked lower were possibly out of the direct control of the homes. Finding a way to improve care in these items will involve working with the wider community.

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Abstract number: P2-136
Abstract type: Poster

Management of Malignant Hypercalcaemia and Appropriateness to Treat – A Hospice-based Inpatient Audit
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Background and aims: Hypercalcemia of malignancy affects 20–30% of cancer patients during their illness. Various studies report up to 50% of patients with this disease having a poor prognosis. It frequently represents a poor prognostic sign with 50% of cancer patients with the condition dying within 30 days. Treatment comprises IV fluid resuscitation and IV Bisphosphonate therapy requiring the patient to be treated within a healthcare facility. We audited current hospice management of malignant hypercalcemia against local guidelines focusing on appropriateness to treat.

Methods: A retrospective, single-centre audit was carried out. All patients with a recorded corrected calcium of ≥2.6 over a 1.year period were identified from the hospice database.

Case notes were used to ascertain if the patients were treated, if hospice management was adherent to clinical guidelines, and the clinical outcomes.

Results: 68 patients with hypercalcemia were identified. 20 patients were treated and aspects of management that deviated from the guideline were identified. 15 patients with corrected calcium levels of ≥2.7 were not treated. 80% of these had clear documentation specifying why treatment had been felt inappropriate. This reflected either the patient’s rapidly deteriorating clinical condition or a desire for the patient to remain in a preferred place of care. The remaining patients had calcium levels of 2.6 and treatment was not offered.

Clinical outcomes were globally poor with only 30% of patients symptomatically improving following treatment. Average time to death following treatment was 25 days.

Conclusion: Appropriateness to treat malignant hypercalcemia should be considered carefully due to the condition’s poor prognosis. Decisions to treat are likely to be influenced by the patient’s current and preferred place of care.

Abstract number: P2-137
Abstract type: Poster

Assessment of the Criterias to Practice Home Palliative Care
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Background: Whereas a high majority of French population should prefer Home Palliative Care (HPC) indeed dying at home, 57%.5 French population die at health care center. In France Multidisciplinary Team specialised in Palliative Care (HPC Team) assess feasibility of HPC and support patient, caregivers and professionals.

Aims and methods: The survey leaded by a HPC Team in a rural area aims to identify the factors which influence HPC choice.

It was led by a retrospective non interventional method compounding in 2 phases : - elaboration of 65 factors according to the scientific literature and to a multidisciplinary focus group working at hospital or not - retrospective revue of 202 files or 514 situations (18 months) assessed by the HPC Team.

Univariate and multivariate statistics analysis are done.

Results: There is a distortion between generally accepted barriers by the professionals and the reality : lonely patients living, drugs unavailability outside hospital, terminal sedation necessity and rural areas living are not HPC barriers.

Caregivers HPC choice is as important as patient choice: 70% patients who wish HPC but for whom caregivers refuse were hospitalised; 69% patients who cannot give their opinion while caregivers prefer HPC stay at home.

Statistical analysis confirms barriers like patient, caregivers or professionals disagreement, symptoms unresolved, but also the insecure feeling of patient or caregivers: 39% patients who feel insecure are hospitalised versus 24.5% who feel secure (p<0.001); 53% patients whose caregivers feel insecure are hospitalised versus 12% (p<0.001).

Conclusion: Beyond the evident requirement to HPC, this study question about the insecure feeling as a limit: HPC is an individualised project which limits are enounced by patient and also if HPC Team impacts this feeling.

To improve HPC quality it is necessary to precise how evaluate the insecure feeling, what impact this feeling and also if HPC Team impacts this feeling.

How to Implement Quality Indicators Successfully in Palliative Care Services: Perceptions of Team Members about Facilitators of and Barriers to Implementation
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Background: There is an increasing demand for the use of quality indicators in palliative care in order to monitor the quality of care.

Aim: With previous research about implementation in this field lacking, we aimed to evaluate the barriers to and facilitators of implementation.

Methods: Three focus group interviews were performed with 21 caregivers from 18 different specialised palliative care services in Belgium. Four had already worked with the indicators during a pilot study. The focus group discussions were transcribed verbatim and analysed using interpretive deductive thematic analysis.

Results: The caregivers anticipated that a positive attitude by the team towards quality improvement, the presence of a good leader and the possible link between quality indicators and reimbursement might facilitate the implementation of quality indicators in specialised palliative care services. Other facilitators concerned the presence of a need to demonstrate quality of care, to perform improvement actions and to learn from other caregivers and services in the field. A negative attitude by caregivers towards quality measurement and a lack of skills, time and staff were mentioned as barriers to successful implementation.

Conclusion: Palliative caregivers anticipate a number of opportunities and problems when implementing quality indicators. These relate to the attitudes of the team regarding quality measurement, the attitudes, knowledge and skills of the individual caregivers within the team and the organisational context and the economic and political context. Training in the advantages of quality indicators and how to use them is indispensable, as are structural changes in the policy concerning palliative care, in order to progress towards systematic quality monitoring.

Funding: This study is realised with the support of ‘Kom Op Tegen Kanker’, a campaign of The Flemish League Against Cancer.

Abstract number: P2-138
Abstract type: Poster

Improving Palliative Care in Patients Admitted under Internal Medicine – A Pilot Study to Explore Characteristics of Inpatient Deaths & Determine Feasibility of Retrospective Case Record Study on Assessing Palliative Care Provision
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Background: In Singapore General Hospital (SGH), many patients admitted under the care of the Department of Internal Medicine (DIM) have a background of advanced chronic illnesses, recurrent hospitalisations for exacerbations as well as prolonged hospital length of stay due to functional decline and care issues. It is possible that some of these patients have palliative care needs, and may benefit from palliative care interventions to improve patient outcomes. In order to develop relevant palliative care interventions, it is necessary to explore palliative care needs in these patients.

Aims:
1) to determine the feasibility of a retrospective case record study in assessing quality of palliative care provision DIM patients
2) to explore the characteristics of inpatient deaths in DIM patients

Methodology:
A retrospective data collection was performed, using coded standardised collection form, on paper and electronic records of the first 50 patients who passed away during admission under DIM, from the period of 1st July 2014 – 31st August 2014. Data collected included demographics, diagnosis and other clinical information that may be relevant to palliative care needs or palliative care provision. Information collected was analysed using SPSS to determine statistical significance.

Results: Due to ongoing data collection, results will be available end of this year.

Discussion: The results will be useful in guiding further studies using retrospective case audits on identifying gaps in palliative care provision in DIM patients. Targeted interventions can then be developed to benefit such patients.

Abstract number: P2-139
Abstract type: Poster

How to Implement Quality Indicators Successfully in Palliative Care Services: Perceptions of Team Members about Facilitators of and Barriers to Implementation
Hypercalcaemia in Palliative Care

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Background: Hypercalcaemia is the most common life-threatening metabolic disorder in cancer patients, and is defined by an adjusted serum calcium concentration of greater than 2.6 mmol/L. Hypercalcaemia occurs in around 10% of cancer patients. Tumour induced hypercalcaemia usually indicates widespread disease and a poor prognosis, with a median survival of 2–4 months.

Methods: Perform a retrospective audit of all patients admitted to the Marie Curie Hospice Glasgow, admitted during September and October 2013, by examination of patient medical notes and drug kardexs, use of data collection form and analysis of data in comparison to standard guidelines, to identify:
1. If malignant hypercalcaemia was anticipated in high risk patients (those with breast, lung, prostate cancers and myeloma)
2. That hypercalcaemia is managed according to guidelines
3. That serum calcium levels and serum urea and electrolytes (U&Es) were checked pre-and post-treatment

Results: 44 out of 76 patients had their serum adjusted calcium level checked within 48 hours of admission
A total of 15 patients had raised serum adjusted calcium during the study period
60% were male and 40% were female
The median age was 64
The most common associated symptoms were nausea and confusion
Post-treatment calcium and U&Es were only checked in 3 of 9 patients treated
30 day mortality rate was 60%

Conclusions: Hypercalcaemia is a relatively common problem in palliative care and must be treated according to the standard regional guidelines. Post-treatment follow up is important to determine if the treatment was successful or not.

Abstract number: P2-139
Abstract type: Poster
Steroid Use in Palliative Patients in Plymouth, UK

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Aims: To establish whether palliative patients known to a UK Hospice are prescribed steroids appropriately.

Background: Steroids are used frequently in palliative care, in an attempt to relieve specific and non-specific symptoms associated with advanced malignancy. Concerns have been raised regarding the ‘uncontrolled’ use of steroids in care, as patients are not closely monitored, allowing for the development of debilitating side-effects, often in the context of limited clinical benefit.

Method: Patients known to St Luke’s Hospice from 1st November 2013 to 1st May 2014 (n = 1,152), were highlighted. 384 had taken steroids.
124 patients’ online notes were analysed to establish which steroid they were prescribed, intended duration, start and stop dates, who prescribed them and why, and if steroid side effects were experienced.

Results: The most common steroid prescribed was dexamethasone 4mg. Steroid start date was documented in 63% (n=78) patients’ notes. Reason for starting steroids was documented in 73% (n=90). 49% (n=61) died whilst taking steroids. 54 patients stopped steroids, stop date was documented in only 27 (50%). Who prescribed steroids was documented in 70% (n=47). Intended duration of steroids was documented in 14% (n=17). 48/124 patients (39%) experienced steroid-related side effects, most commonly peripheral oedema and proximal myopathy. Median duration of steroid course in the 49% (n=61) with start and stop dates, was 42 days (1–224 days).

Conclusion: Steroids are widely prescribed. There is insufficient documentation regarding steroid use, suggesting a lack of discussion, planning, and regular review. Many patients are left on steroids for too long, often experiencing undesirable side-effects. We need awareness of patients’ steroid histories. A ‘Steroid Window’ could be added to the online notes system. Regular review of this window could prompt clinicians to consider decreasing care.

Abstract number: P2-140
Abstract type: Poster
Early Palliative Care – “How Early Is Early Enough?” Significance of Specialized Palliative Care Provided Concomitantly with the First-line Chemotherapy after the Patients Were Diagnosed with Progressive Disease

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Purpose: Recently, some studies have revealed the efficacy of “early palliative care”, but the workforce of specialised palliative care (SPC) is limited. The scope of SPC must become more extensive in order to prevent these patients from being “left on steroids for too long, often experiencing undesirable side-effects”. We need to ensure that all palliative care professionals are able to discuss these patients’ palliative care needs with their patients and to communicate these needs with their primary physicians. Many new drug molecules are emerging in cancer treatment, but many patients start chemotherapy immediately before death, and 4) short-term mortality (< 14 days) in PCU was significantly higher in SC group (p = 0.0005).

Conclusions: Even if it is difficult to perform interventions “early after being diagnosed with cancer”, the feasible implementation of SPC concomitantly with first-line chemotherapy will make it easier for patients to receive palliative care when the subjects were diagnosed with PD is expected to facilitate high-quality of palliative care.

Abstract number: P2-141
Abstract type: Poster
An Internal Audit into the Adequacy of Pain Assessment in a Hospice Setting in England, United Kingdom

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Background: Pain is the most common presenting symptom of patients referred to palliative care services. The effective management of pain is therefore paramount to any palliative service. The SOCRATES mnemonic is a pain assessment framework that is widely used by healthcare professionals to help them to remember to ask about key questions concerning a patient’s pain. The eight elements of this framework are Site, Onset, Character, Radiation, Associated Factors, Timing, Exacerbating and Relieving Factors and Severity. Aim: To assess whether 100% of patients admitted to the hospice from and including 1st of February to 30th of April 2014 with pain as a symptom were fully assessed using all elements of the SOCRATES mnemonic. Furthermore to ensure whether these patients were written up for regular and breakthrough analgesia medication.

Methods: New admissions during the three months of February to April were identified using the in-patients admission record book. System™ electronic medical record database was then used to search for the patients that were prescribed pain as a symptom and a score assigned according to the number of elements of SOCRATES used. The medications section on System™ was checked for the prescription of regular and breakthrough analgesia.

Results: The results revealed that 0% of patients were fully assessed using all elements of the SOCRATES mnemonic and 66.7% of patients were partially assessed. The mean average of SOCRATES elements used when assessing pain was 3.3. Regular and breakthrough analgesia were prescribed for 100% of patients who complained of pain.

Discussion: This hospice meets national standards for prescribing regular and breakthrough analgesia, however significantly falls below standards on the assessment of pain using all elements of the SOCRATES mnemonic. Further investigation could inquire into how this hospice compares nationally and internationally with other hospices and palliative services in the assessment of pain.

Abstract number: P2-142
Abstract type: Poster
Conditions in Off-label Prescription in a Unit of Palliative Care and Symptom Control (PCC SC UNIT)

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Background: Off-label is used to refer the use of a drug outside the specifications of its marketing authorisation, including prescription for an unlicensed indication and/or administration by an unlicensed route.

Off-label medication use is about 20% of the commonly prescribe medications and in palliative medicine reaches 12–26%.

A drug can be off-label in categories: drugs licensed by EMEA for the given indication but in a different clinical situation; or by a different parenteral route, or not licensed by EMEA for the given indication, although evidence of efficacy is available (literature based); drug which falls into the so called “gray zone” of evidenced based medicine, within which high level evidence is difficult to reach even for treatments which are likely effective and Cost-justified.

Aims: To describe the use of “off-label drugs” in our Unit and to know which kind of category is the most frequent.

Methods: This study was taken during six months. A questionnaire was developed and were carried out by the physicians who attend the patients who were admitted in our Unit. Demographic and anthropometric characteristics, clinical background, current disease, and prescriptions were registered. Medications were analyzed and considered off-label if they were off-label and in which condition.

Results: Of the 217 registered prescriptions in this survey, 39 were off-label (no marketing authorization in it).

Studying each off-label indication we found that most of them are in the first category (when approval does not extend to cover the particular dose or indication, although evidence of efficacy is available), no one were contraindicated.

The prophylaxis of ulcer by proton pump inhibitors and the use of corticosteroids, buscapina, metoclopramide…were the most frequent.

Conclusion: In our clinical practice, off-label prescriptions are quite common (we never report in the clinical record that it is the belief that they will benefit patients who cannot be better helped with an alternative).
Supporting Care in the Last Days of Life: An All-Wales Approach to Shifting Gear

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Recent publicity around the Liverpool Care Pathway (LCP) in England led to the Neuberger Enquiry and the subsequent recommendations for care in the last days of life from the work of the NHS Leadership Alliance. While Wales the LCP was never mandated: instead we have implemented hospital totally supported the Welsh Integrated Care Priorities for the last days of life (WICP).

Although the WCP has been continually monitored via variance reporting and audited annually, we have had accurate evidence to support its continued use as the best model of care. The WICP represents a process-model approach to delivering care in the last days of life however, the current clinical climate is geared towards a person-centred approach which is the output of the Neuberger Enquiry. A critical review of the WCP indicated the need to change in step with this change in focus.

A through process of wide consultation across the principal a new system of guidance for supporting care in the last days of life has been agreed. The process of implementation is built on the foundations established by the WICP and locally identified champions will be leading the work. A ‘top-down, bottom-up’ approach has been adopted involving Local Health Boards and healthcare professionals with direct patient contact. The change process is being centrally monitored and supported on a Wales-wide basis. The changeover will be completed by April 2015 and we expect to report on the barriers, lessons learnt and success stories.

Poster Sessions (Poster Exhibition Set 2)
Models of Hospital-based Specialized Palliative Care in Austria
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Background and aim: Palliative care units (PCUs) in Austria are mainly located in urban areas. To maintain palliative care in rural areas a model of hospital-based specialized palliative care was formed. In contrast to independent PCUs these integrative palliative units (IPUs) are affiliated to other departments in hospitals who share the staff and resources with them.

The aim of this questionnaire-based pilot study was to collect first descriptive data from these IPUs.

Material and methods: After four in depth interviews with palliative care specialists and a literature review two questionnaires were designed, one for physicians with 25 questions and one for nurses with 20 questions. Topics contained general data, training in palliative care, infrastructure and resources. 9 Austrian hospitals offering IPUs were found and the questionnaires were sent to them in July 2014 with the request to hand it to the personnel involved in the care of palliative patients.

Results: All 9 included hospitals returned questionnaires. In total we received 96 questionnaires. The questionnaires from nursing staff and 16 questionnaires from physicians. Seven out of the 9 IPUs, were implemented in the last 3 years. 6% of the physicians and 3% of the nursing staff are responsible exclusively for palliative inpatients. 37% of the physicians were able to use all the planned working time for the care of palliative patients.

Discussion and conclusion: The response rate of the questionnaires shows a high level of interest. IPUs seem a warranted model to increase specialized palliative care in Austria with the benefit of optimizing resources and embed the idea of palliative care in hospitals without PCUs. More governance, perhaps through interaction with PCUs or networking groups and a definition of training standards for employees seem necessary to achieve high quality of care in patients with life limiting illness and complex, challenging needs in Austria.

Abstract number: P2-149
Abstract type: Poster

Patient Experience of Community End of Life Care Informs County-wide Improvement Programme
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Background: One large organisation provides all the generalist and most of the specialist palliative care in the community in the county and was integrating them into locality teams. A 3 year improvement programme was being developed to achieve draft organisational End of Life Care (eOLC) aspirations.

Aim: To establish current strengths and weaknesses of existing community eOLC services across the county in order to prioritise improvement opportunities.

Method: Ten National Voices “1 statements” designed to measure person-centred, coordinated care were chosen to match the draft EOLC aspirations and put into a postal questionnaire. This was sent with a named letter from the Chief Nurse to 296 random community patients who were identified as living their last year of life on 1 May 2014. They were asked to reply based on their experience of community nursing and therapy services.

Results: Mean age of the 296 patients was 74 (22–98), 169 (57.1%) had cancer, 29 (9.8%) respiratory disease and 24 (8.1%) neurological disease. 131 (64.9%) questionnaires were returned 70 (33%) completed by patient, 45 (34%) by carer, 18 (14%) unknown. No statement had less than 50% agreement. The statements with most agreement were “All my needs as a person are assessed” (80%) and “I have the information that I need to make decisions and choices about my care and support” (79%). The statements with least agreement were “I always know who is coordinating my care” (57%) and “My carer/family have their needs recognised and are given support to care for me” (63.9%).

Conclusions: Patients and carers have informed our organisational priorities for improvement. The two weakest areas are a) assessment and support of family/carers and b) coordination of care. There are both collaborative work streams within the internal improvement programme. The questionnaire will be sent annually to monitor outcomes.

The good response rate suggests patients in the last year of life are willing to inform community service improvements.

Abstract number: P2-150
Abstract type: Poster

Audit of Documentation of End of Life Care Priorities in Patients under Local Hospice Services
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Background: Although majority of patients in UK want to die at home, about 50% die in Hospital. Many Hospices and clinical commissioners consider achievement of preferred place of death as a quality marker for the palliative care services. Studies show formal recording of preferred place of death, improves the chance of achieving it.

Aim: This audit was planned to check the documentation levels of aspects of preferred place of care, preferred place of death, Resuscitation. We also included the documentation of care’s preferences as well.

Methods: At our Hospices, electronic case note system (Infoflex) is used to record preferred place of care (PPoC). Resuscitation status (ROSC) and preferred place of death (PPoD) are checked on the above aspects on 15 inpatients (I PU) and 15 Home care team patients (HCT) and 15 day therapy patients (DTU). Those patients seen at least 3 times by the professionals

Poster Sessions (Poster Exhibition Set 2)
Audit on the Use of an Individualised Care Plan for the Last Days of Life in an Acute Hospital Setting

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Background: The National Care of the Dying Audit for Hospitals, England, shows that major improvements need to be made for better care of the dying and support for their families. In response to guidance from the leadership alliance of care of the dying people, Basildon and Thurrock University Hospital (BTUH) implemented an individualised care plan (ICP) for the last days of life in March 2014. This audit was modelled on the national care of the dying audit.

Aims:
1) To identify if there is any difference in documented decision making and communication with a different approach in end of life care (pathway versus individualised care plan).
2) To benchmark care using ICP against national standards.

Methods: Questionnaire used in the national care of the dying audit was adapted to facilitate data collection. BTUH audit department uploaded this questionnaire into survey monkey which automatically analysed the data. Data was collected from 1st to 30th Sep, 2014.

Results: There were 96 deaths in the month of September. Data will be analysed for these 96 expected deaths, diagnosis, % of expected death on ICP, % of expected death with Preferred Priorities of Care (PPC) in place, % of patients with decisions and discussions around clinical nutrition and clinical hydration in place at their end of life.

Conclusion: Individualised care plan (ICP) is a care plan for individual patient at their end of life. It results in clear documentation of decision and discussion making around all aspects of end of life care. ICP can be used as a benchmark for care of the dying patients.

Abstract number: P2-155
Abstract type: Poster

A Regional Study of the Management of Delirium amongst Hospice Inpatients in the North-East of England

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Aim: Delirium is known to be associated with significant patient morbidity and mortality. NICE have issued clear guidance on how to manage delirium. However, adherence to guideline recommendations is poor and we believe that this represents an important opportunity to improve patient care.

Method: All patients admitted to one of five hospices in the North-East of England, over a 5 month period, were screened for delirium using the short-CAM tool. The notes of short-CAM positive patients were then analysed to determine how they had been managed.

Results: 57 of 298 patients were identified as having delirium (19%). 3 of these patients were excluded due to missing data. A reversible cause was considered in 45 (83%). Non-pharmacological interventions were used in 15 out of 54 (28%). Pharmacological intervention was used in 21 patients (57%). The pharmacological intervention most commonly prescribed first line was benzodiazepines, in 21 out of 31 patients (68%). First-generation anti-psychotic drugs, such as haloperidol, were used first-line in 10 patients (32%).

Conclusion: Recommendations put forward by NICE suggest that non-pharmacological interventions should be used first-line to treat patients with delirium. Amongst our patient cohort, non-pharmacological interventions were used only 28% of cases. When pharmacological management is required then the guidelines recommend use of 1st generation antipsychotics, such as haloperidol. Our data showed this only to be the case in 32% of patients. Benzodiazepines can worsen delirium and increase the risk of falls, but these drugs were used first-line in 66% of patients. Our data shows that patients with delirium are not being managed in accordance with NICE guidance, which may reflect suboptimal staff education. Further work is required to develop effective staff education initiatives.

Abstract number: P2-157
Abstract type: Poster

A Palliative care project nurse was present in the wards to facilitate and support the implementation during a 10 months period
• Multi professional seminars, teaching and training sessions
• Mono professional teaching and supervision by specialist doctors by SPC consultant Structure
• Guidelines were made available electronically.
• Checklists and standard phrasing texts were integrated in the electronic patient record: EORITC-GLO-PA15
• Optimal discharge of patients to home
• Optimal the last days of life for dying patients

Monitoring: Baseline, halfway and end audit of patient records

Results: 230 patient records were audited in the five year project period. There was an overall improvement in the audited areas, but still with potentials for improvement, which were linked out to the management in a report at the end of each project with proposals for further improvement.

Discussion: We believe this project has been a starter for a continuing change process in our hospital: EORITC-screening, if used previously, wards have designated palliative care nurses, a PC network has been established across the hospital, the electronic PC guidelines are available for all the hospital.

Abstract number: P2-156
Abstract type: Poster

Audit of the Use of Subcutaneous Fluids by a Community Palliative Care Service over a 6 Month Period

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Background: Subcutaneous fluid (SCF) infusion may be used to provide symptomatic relief of thirst in a patient unable to swallow, and as a means of rehydration. The patients are assessed by a doctor to be suitable for the administration of SCF, which are then prescribed. 1 to 2 litres of infusion fluids may be given over a 24-hour period.

Method: The electronic notes of all patients who had subcutaneous fluid in a six month period from the 1st of January 2014 were reviewed. Over 6 months data included diagnosis, assessment, number of infusions given, and outcome.

Results: Over this 6 month period 29 infusions were administered, to 8 patients. 5 females and 3 males. (6 cancer, liver failure, an oesophageal pouch). Number of treatments ranged 1-8.

In all cases 500mls of normal saline was administered on a daily basis. All patients were reviewed by a doctors prior to the first infusion, and fluids were prescribed. Trust policy and procedure was followed.

Ages ranged from 61-91 y.o old (70). Indications for the fluids: 3 difficulty swallowing, 4 symptomatic thirst, and 1 vomiting.

Outcome of receiving fluids: In 4 cases given to relieve symptoms in the terminal stage of the disease.

The 3 cases infusions was given and patients, were then able to resume drinking. 1 patient had an oesophageal pouch, 8 infusions were given while she was being assessed by the hospital for PEG insertion.

Discussion and conclusion: No adverse effects of the fluid were reported, and the Trust policy was adhered to.

In 3 cases the infusions relieved symptoms and avoid hospital admission. The patient who was awaiting PEG insertion had investigations as an outpatient and then proceed to PEG insertion. The 4 cases who received infusions in the terminal stage of these disease, had documented symptomatic relief from the infusions.

The use of subcutaneous fluids in this audit relieved symptoms and did not lead to any adverse effects. Trust policy was followed in all cases.

Abstract number: P2-158
Abstract type: Poster
**Basic and translational research**

**Abstract number:** P2-158  
**Abstract type:** Poster  
**Relationship between Cytokine Concentration in Ascites and Effects of Cell-free and Concentrated Ascites Reinfusion Therapy (CART)**

**Authors:** Bao Z.F., Hanadza N.I., Fukui M.U., Iwase S., Nain E., Nanagaku M.I., Miyagawa K.J.  
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**Background:** CART (Cell-free and Concentrated Ascites Reinfusion Therapy) is now attracting rising attention in Japan as one of important strategies for symptom-relief for malignant ascites. We have already reported its favorable effects on symptom relief.  
**Aims:** The aim of this study was to evaluate cytokine concentration in original ascites and its effect on survival after CART procedure.  
**Methods:** From April 2011 to March 2013, CART procedures were performed on 43 patients (gastric cancer: 28, ovarian cancer: 6, pancreatic cancer: 5, and cancers of other origins: 4) at our hospital. In the first session of each patient, the concentrations of inflammatory and regulatory cytokines including IL-1β, IL-6, IL-8, IL-12, TNF-α, and IL-10 were measured in original ascites using BD Cytometric Bead Array System. We evaluated their relation to the side effects of CART and to patients' survival after CART procedures.  
**Results:** IL-6, IL-8, and IL-10 were detected at relatively high concentration in original ascites: IL-6: 1.1 ± 0.7 pg/ml (ranging to 0-10 pg/ml), IL-8: 1.5 ± 1.0 pg/ml (ranging to 0-10 pg/ml), IL-10: 1.1 ± 0.2 pg/ml (ranging to 0.2-10 pg/ml). The degree of body temperature elevation, one of the major side effects of CART, was correlated with the concentration of IL-6 and IL-8 significantly (IL-6: p=0.025, IL-8: p=0.022), although the elevation itself was not statistically significant. Survival of the group in which IL-10 was detected in ascites was significantly better than the group in which IL-10 was not detected. Median survival was 115 days and 51 days for detected group and not detected group, respectively (log-rank).  
**Conclusions:** We conclude that ascitic concentration of IL-6 and IL-8 correlated with elevation of body temperature after CART, and existence of IL-10 in ascites related to longer survival. Origins and clinical significance of these cytokines still remain to be elucidated.

**Abstract number:** P2-159  
**Abstract type:** Poster  
**Assessing the Needs of Patients in the Palliative Home Care Setting: Can We Do Better?**

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**Background:** In the provision of palliative home care, some patients require more resources than others. The 10 most contacted patients, out of 85 (June 2014), accounted for 30% of total contacts made.  
**Aims:** To identify and classify the needs of patients who require more resources and devise strategies to optimise resource allocation.  
**Method:** In a 3 month period from 1/3/14 to 31/5/14, the 10 patients who called in the most were identified. For each patient contact (incoming phone call or unplanned visit), 1 or more needs were identified. There were a total of 94 incoming phone calls and 35 unplanned home visits, making a total of N=129 patient contacts.  
**Conclusions:** Our study identified requests for medical advice. Uncontrolled pain (13%) and fever (7%) were frequently encountered medical problems. 7% of contacts were related to anxiety.  
**17% of contacts were for procedural requests, 9% for patient updates, 6% for home visit requests, 6% for social support, 2% for renewal of medication scripts and 2% for the transport authorisation of controlled drugs.**  
**Conclusions:** Our study identified requests for medical advice as the major reason for patients calling in to the service or for a home visit. Pain and fever were the most common medical situations dealt with. Strategies to optimise resource allocation could take the form of patient education materials relating to pain and fever. Steps to pre-emptively allay patients’ anxiety may also be useful to reduce resource utilisation in our service.  

**Abstract number:** P2-160  
**Abstract type:** Poster  
**The Distrained Masculinity**

**Authors:** Carlander I.E., Hellstrom I.S., Sandberg J.E., Eriksson H.  
**Institution:**  
**Dying is a gendered situation. Relatively few discussions about death and dying have looked beyond patient perspective in relation to culture and images of men and masculinity. Despite a growing body of literature on dying, critical studies about men and masculinities in relation to this is needed.**  
**Aim:** The aim was to describe the perceived and self-reflected processes of dying in relation to gendered ideas of culture, family and identity.  
**Methods:** We used a narrative thematic approach to analyse interviews conducted over 18 months with one man close to death. The analysis focuses on the intersection of dying and dying and examines how they can be related to the concept of hegemonic masculinity and the processes connecting such men with the position of being.  
**Result:** Three themes are presented here: The priorities – straightened, the body – revised, the fatherhood – comprised. Setting the priorities straight when time was meted out revised norms linking work and what it means to be a “real” man. The navigation towards a child-centred manhood represents instant re-evaluation of work. The presence of body is a deeply rooted foundation in perceptions and ideas of masculinity. Hence, the body is often regarded as a machine, i.e. working and operating in social situations, and bodily decline disposes of masculinity. Achieving the goal of “a positively involved fatherhood” indicates that the amount of involvement matters in contemporary masculinity. Being present seems to involve a range of responsibilities, such as economy, practical and emotional strings even beyond death.  
**Conclusion:** The overarching “distrained masculinity” uses images and ideals as tools to reach last possible opportunities for fulfillment rather than filling a function as a style and posing in gendered meanings, covering strategies of concentration as in putting priorities weight, dispositions or loss due to bodily decline and, extension of responsibilities beyond death.

**Abstract number:** P2-161  
**Abstract type:** Poster  
**Biological Changes towards the End of Life: A Feasibility Study**

**Authors:** Coste S., Scott A., Nwosu A., Aggra K., Lotten R., Wilson J., Mason S., Pobert C., Ellenbär J.  
**Institution:**  
1. Marie Curie Palliative Care Institute Liverpool, Liverpool, United Kingdom, 2. University of Liverpool, United Kingdom  
**Background:** During a conference when one person is in the last hours or days of life it is an ongoing difficulty for clinicians. Although few studies have specifically investigated biological changes during this time.  
**Aim:** To assess the feasibility of collecting biological samples from patients towards the end of life, and analysing these samples using systemic research approaches.  
**Method:** A feasibility study collected serial urine samples from patients towards the end of life in a Hospice in the North of England. Urine that was collected from consenting patients who subsequently died during the study was then analysed. Two systemic research approaches were then used to analyse the urine.  
**A metabolic approach:** analyzing volatile organic compounds (VOC) by Gas Chromatography Mass Spectrometry.  
**Results:** During the 12 week feasibility study a total of 128 separate samples from 20 different patients were collected. 56% (in-58) of inpatients at the hospice were approached, with a consent rate of 57% (n=33). Of the 43% who did not consent; 17% of those approached became unwell, too fatigued, lost capacity, died or were discharged home; 26% of those approached refused, usually these patients had distressing pain, low mood or profound fatigue. Seven people died while the study was ongoing, and another 4 patients died in the following 4 weeks.  
**Results from the VOC and genomic methylation studies of the urine samples will be presented at conference.**  
**Conclusion:** It is possible to collect biological samples amenable to systemic analysis from patients towards the end of life. Research into the biological changes at the end of life could develop a greater understanding of the dying process, which may lead to improved diagnostics and care.

**Abstract number:** P2-162  
**Abstract type:** Poster  
**Palliative Care for People with ID in Europe**

**Authors:** Worx M.F.  
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**Background:** Due to the increasing longevity over the last decades people with intellectual disabilities (ID) are likely to die over a prolonged period of time because incurable, chronic, illnesses occur more frequently in old age. Therefore there is a growing need for high quality Hospice and Palliative Care for people with ID. But so far, supported data on dying and death of people with ID and the quality of palliative and end-of-life care for people with ID within European countries is not available.  
**Aim:** The aim is to monitor dying and data on death, processes and quality of end-of-life care for people with intellectual disabilities.  
**Method:** An international exploratory workshop brings together academics and professionals from a range of countries in Europe to discuss and debate practical research issues. The objectives of the exploratory workshop are:  
1. to share experiences from a range of countries on mapping dying and death data about people with intellectual disabilities, including the practical and ethical issues faced whilst doing so,  
2. to agree a set of definitions and benchmarks that will support internationally comparable data relating to dying, death and quality of Hospice and Palliative Care for people with ID and that is collected and that is of relevance to policy-makers and practitioners, and  
3. to develop the framework for a European research project on Hospice and Palliative Care for people with ID.  
**Results:** The international exploratory workshop advance research into dying, death and the quality of Hospice and Palliative Care for people with intellectual disabilities. It allows us to make inferences at national and international levels that will support the development of practical strategies to address common concerns identified by the data. First results of the international exploratory workshop will be presented.
Bereavement

Abstract number: P2-164
Abstract type: Poster

Bereavement Support after Patient’s Death at a Palliative Unit

Poster

Background: As one of the palliative care foundation is bereavement support to family and other loved ones in their bereavement. Some persons need more support than the network can give and need expanded support. The Palliative Unit at Sahlgrenska University Hospital has developed a method for bereavement support.

Aim: To provide bereavement support to family and other loved ones after the death of a patient and to evaluate those who need support from other professionals.

Method: The social worker at the Palliative Unit is responsible for the bereavement support to the loved one after a patient has died at the Unit. The social worker have a conversation with a family member or another loved one close to the patient’s death. For those who need more support immediately after the death, are offered further support from the social worker. If there is no need for immediate support the social worker take a second contact often by telephone after 6 – 8 weeks. If there is need for support beyond that, the social worker continues with the support or refer to other bereavement care, depending on the problem.

Result: This methods has been ongoing for a decade and give a structure to the bereavement support. The method opportunity to early identify those who have more needs for special bereavement support.

The bereavement support conversation embrace four areas. The question are intertwined in the dialogue and is not like a questionnaires.

How does the bereavement process progress?
Is there any medical questions left?
Which support from the Network available for the bereavement person?
Estimation of further need for support and if necessary a referral to psychiatry, church, primary care is sent.

Conclusion: It is important that the support is given in an individual way. Also it is important that the support is given by a professional who have the time to meet the bereavement person and who have competence and knowledge of grief and level of bereavement treatment.

Abstract number: P2-165
Abstract type: Poster

“Support Is too Fragmented”: The Bereavement Needs of Carers and the Presence of Prolonged Grief Disorder

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Motor Neurone Disease Association, Northampton, United Kingdom

Background: The necessity of assessing and meeting family carers’ needs during end-of-life care and bereavement is widely acknowledged, but less attention has been paid to the estimated 10% of family carers experiencing bereavement who develop Prolonged Grief Disorder (PGD), typically formally diagnosed six months post-bereavement, involves a markedly intense reaction to a loved one’s death. Symptoms include difficulty accepting the loss, bitterness, numbness, identity disorganization, difficulty in feeling of being stuck, and disengagement.

Aims: To explore the experience and awareness of bereavement support and PGD with carers and health/social care professionals.

Methods: A mixed methods study was undertaken. Two focus groups were conducted with carers (n=16) and an online survey administered to a range of health/social care professionals involved in the care of people at the end of life. A thematic analysis of focus group transcripts was undertaken and descriptive statistics used to illustrate summary data from the online survey.

Results: Our focus group data indicate varying challenges experienced by carers and the need for appropriate pre and post-bereavement support to be provided in order to facilitate a healthy grieving process. Survey data reveal that health/social care professionals were uncertain of the most appropriate course of action to pursue to support carers facing bereavement. Forty (68%) respondents indicated that bereavement-related support could be improved; 24 (42%) respondents had encountered family carers they considered were experiencing PGD, 38 (68%) respondents did not feel able to accurately predict future cases of PGD.

Conclusion: Our data suggest bereavement-related support for carers could be improved, that PGD may be experienced at a higher level, in some populations, than previously supposed and that health/social care professionals face difficulties in reliably identifying the risk of PGD amongst carers.

Abstract number: P2-166
Abstract type: Poster

The Psychosocial Management of Health Care Professionals towards the Imminent Death of Terminally Ill Patients

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Background: Death is a multidimensional phenomenon including physiological, psychological, and spiritual dimensions of human nature. The dimension of death is a loss not only for the patient and family, but also for doctors and nurses. The reactions to this loss are related with experiences, personality, values, views about life, the sense of threat, religious beliefs, and cultural background.

Aims: Our aim is to show that the imminent death of these patients affects the medical and nursing staff during the provided quality of care and they experience grief when caring for terminal ill patients.

Methods: A systematic review was conducted in Greek and English literature (PUBMED, MEDLINE, PsycNET) from 2000 to 2014, about studies published or in development for the management of psychosocial and health care professionals’ grief about the imminent death of the terminally ill. Based on inclusion criteria defined a priori, titles, abstracts and full texts were analysed to find relevant studies.

Results: Forty (40) articles met the inclusion criteria (Europe, USA, Asia). A common ground about all is that the imminent death of patients who are in the end-of-life affects healthcare professionals. There are differences between doctors’ expressed grief compared to nurses, because of the different relationships that develop with both specialties with patients and perceptions of their own about their role.

Conclusion: According to the findings of this review, death affects both medical and nursing staff. Therefore, it is necessary to run groups for psychological support of both specialties that work with the terminally ill patient. It is recommended to include education on death and care of the dying in the medical and nursing degree courses in order for healthcare professionals to be better able deal with issues that death evolves.

Keywords: Imminent death, dying patient, end-of-life, grief, bereavement, physician’s & nurse’s grief, perspectives, attitudes of healthcare professionals.
Abstract number: P2-168
Abstract type: Poster

Bereavement Support Groups in the Evangelical Lutheran Church in Denmark
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Aims: The project aims to
1) provide the relevant non-therapeutical bereavement care,
2) document and improve the quality of existing bereavement support groups in the ELCD,
3) prepare the launch of more church-based groups nationwide.

Background: In Recommendations for Palliative Care (2011) Danish Health Authority focused on care for the bereaved and recommended that the National Health Care System, relevant organisations, and the ELCD identify and support people in need of bereavement care. In 2013 83 percent of all who died in Denmark were buried with the assistance of an ELCD minister. This indicates that bereaved people of more than 43,000 deaths were in contact with a minister at the time of their loss and farewell. Thus the ELCD holds a great responsibility for people in need of bereavement care.

Approach taken: The project has explored and gathered data from support group leaders and participants via questionnaires and interviews, and has published the results in the report "Når sorgen bæres sammen (When Grief is Carried Together)." The report describes both the positive experiences and the perceived challenges in working within this field. The findings have been integrated in a website for bereaved people and support group leaders (www.sorggrupperfolkekirkien.dk), and in education programs for current and future group leaders.

Result: We have provided a framework for expanding the number of bereavement support groups (presently < 100 groups) and are working towards improving the quality of the groups.

Conclusion: Midway through the project period we can detect a rising number of bereavement support groups in the ELCD and a growing interest of participation from bereaved people.

Abstract number: P2-169
Abstract type: Poster

Little Touches – Huge Impact! Improvements in Hospital Bereavement Services focused on the needs of the Bereaved
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Background: In 2010 a joint Mortuary & Bereavement Service for the Trust was set up. Aims: To develop a service, focused around the dignity of the deceased & the needs of the bereaved, whilst reviewing quality & turnaround time.

Method: Aims: To evaluate the CMSP accuracy in identifying carers in risk for complicated mourning, and to develop a model of aftercare for bereaved families. The project aims to
1) provide the relevant non-therapeutical bereavement care,
2) document and improve the quality of existing bereavement support groups in the ELCD,
3) prepare the launch of more church-based groups nationwide.

Aims:
1) To develop a service, focused around the dignity of the deceased & the needs of the bereaved, whilst reviewing quality & turnaround time.
2) To evaluate the CMSP accuracy in identifying carers in risk for complicated mourning, and to develop a model of aftercare for bereaved families.

Poster Sessions (Poster Exhibition Set 2)
**Advance Directive in Terminally Ill Patients in Mexico: Family Vision and Their Clinicians when Considering Systemic Anti-cancer Therapy; Phases I–II**

Alfonso S., Venegués-E, Arzate C., Domínguez G., Monreal E., Perez D.

**Background:** Lung cancer patients approaching the end of life are known to receive systemic anti-cancer therapy, despite evidence that early palliative intervention can lead to less aggressive care and longer survival. The National Confidential Inquiry into Patient Outcome and Death recommended that treatment decisions should be made by the patient after they have been fully informed of the risks and benefits.

**Aim:** To identify the information and decision support needs of patients with advanced lung cancer, which will facilitate discussion of the risks/benefits of available treatment options.

**Methods:** A multi-phase study. How treatment pathways are determined and presented to the patient is explored via non-participant observation of up to six lung MDT meetings (Phase I) and 20–30 patient-consultant discussions (Phase II). These patients and clinicians will also be interviewed to explore perceptions of the treatment options and involvement in decision-making (Phase III). Extent of participation in decision making is assessed using the OPTION tool. This data will be used to inform the development of an intervention to facilitate discussion about treatment options for advanced lung cancer; content development and acceptability will be undertaken via an expert consensus meeting (Phase IV) and cognitive interviews with patients (Phase V).

**Results–Conclusion:** Phases I–II are underway, identifying patterns of patient allocation to treatment pathways. Data will be presented via the OPTION instrument’s domains: identifying the problem; explaining equipoise; exploring expectations and concerns; checking understanding; eliciting preferred involvement. Any discrepancies between patients and clinicians in perceptions of the aim, risks or benefits of treatment will be analysed reflecting the domains of the observation phase. We hope that the resulting intervention will support both patients and clinicians in making informed and appropriate treatment decisions for advanced lung cancer.

**Abstract number:** P2-174

**Abstract type:** Poster

**PACT: Development of an Intervention to Support Advanced Lung Cancer Patients and their Clinicians when Considering Systemic Anti-cancer Therapy; Phases I–II**

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**Background:** Learning the questions about sex life most frequently asked by palliative care patients and their problems in this sphere addressed to the palliative care personnel. Most of the respondents (69%) were nurses, 8 psychologists, and 5 physical therapists. Most of the respondents (69%) were nurses, 8 psychologists, and 5 physical therapists. Most of the respondents (69%) were nurses, 8 psychologists, and 5 physical therapists.

**Aim:** To establish whether conversations with dying patients & families met proposed recommendations of LACDP. The Neuberger Liverpool Care Pathway Review 2013, highlighted communication issues thought to account for major relative & carer unhappiness. The Leadership Alliance for Care of Dying People (LACDP) Response 2014 provided a focus to improve care of dying people & those important to them (family).

**Aim:** To establish whether conversations with dying patients & families met proposed recommendations of LACDP.Methods of 100 random deaths Nov/Dec 2013 audited retrospectively against standards developed from LACDP recommendations. Data included conversation documentation, participants, content, correctness. Results: 13 included 11 unexpected 2 community deaths. 13 – no conversation documented 10 no reason 3 died before it could take place. 74 documented conversations only two included patient 59% same day as documented deterioration 38% by registrar, 31% HO, 13% consultant 61% F1 doctors. In 47%, clinician documented that patient, or family, understood explanations. 41% included word dying 38% discussion of specific or uncertain prognosis. 38% documented presence or absence of patient’s concerns. 83% discussion of plan for carers 13% wishes of dying person.

**Discussions and recommendations:** Although most clinicians document conversations, not all important matters are covered, especially patient’s wishes, understanding & explanation with clear use of the word dying. Not all have conversations on day of deterioration, when staff should be proactive in contacting family & alerting senior team members. Within 24 hours, most senior clinician available should have a conversation with patient or family, including understanding, wishes & addressed concerns, to establish individual plan for care. The word ‘dying’ should be used, & an explanation of prognostic uncertainty with approximate time frame. All staff should see the patient’s individual plan for care, in order to continue it & have background knowledge prior to further conversations.
Developing Online Resources for Palliative Care – The Palliative Hub
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Background: Meeting the information needs of health and social care professionals and the general public regarding palliative care is important in a society where online resources are a key source of information. Providing this information digitally on one website will reduce the burden on individuals trying to navigate the internet and multiple sources of information, which may not be appropriate or relevant.

Methods: Drawing on the skills and expertise of a range of stake-holders, a working group was established, which represented service providers, charities and advocacy groups. The purpose of this group was to assist with the design and develop the Palliative Hub, a website to provide information and guidance to health and social care professionals and the general public about palliative care. The website whilst providing information also acts to filter and direct the user to the most relevant sources of further information.

Results: It is anticipated that this resource will assist with meeting the information needs of health and social care professionals and the general public, in one place with key signposts to relevant information sources.

Conclusion: The Palliative Hub has the potential to become an integral element in meeting the palliative care information needs of health and social care professionals and the general public and is an example of new and collaborative work across the island of Ireland, which could be translated across other jurisdictions.

Abstract number: P2-179
Abstract type: Poster

Building a Palliative Care Network: The Role of the Social Media in Cameroon
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Introduction: Open day celebration (ODC) is a key awareness-raising event for institutions to advertise their care. The Bafousam Regional Hospital (BRH) is the reference hospital in the West Region of Cameroon and it sees cancer patients referred for supportive care and a cohort of more than 4000 HIV patients. The new palliative care (PC) unit of this hospital is the only one in the region and is not yet known by the general population.

Methods: Free screening campaign for the most frequent cancer in our area was organised on the 2013 ODC of the BRH. Patients were sensitised on the prevention of these pathologies via radio interventions (looped for one week) of different specialists: a gynecologist, a surgeon and a palliative care specialist. Patients who responded via radio invitation were screened for cervix, breast and prostate cancer carried out by professionals. Local radio and television (two) covered and broadcasted the 6 km city wide cancer and PC awareness walk organised in the morning of the ODC. Those who participated wore T-shirts and carried flyers with educational messages on cancer prevention and pain relief. A special educative workshop session on PC was organised in the evening of the ODC, for health care authorities and directors of the district hospitals of the region, as the first step to build a local PC network.

Results: 1183 persons participated during the screening for breast, cervix and prostate cancers while 255 subjects took part in the cancer and pain relief awareness walk. A register for patients with cancer was opened at the palliative care unit and most of them were referred for a first oncologist consultation before being referred back for supportive care.

Conclusion: Social media and ODC are powerful tools to advocate for PC and also to raise awareness in a given population on PC and its availability.

Abstract number: P2-180
Abstract type: Poster

Communication about Death and Dying – A Sociological Analysis of Institutionalized Palliative Care
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Background: Death and dying concern everyone, but literature and practical experience in a cantonal hospital in Switzerland show that communication about this issue is difficult and seems to have little intervention in the clinical daily routine. However, communication about death and dying is seen as important to develop a social as well as clinical culture, but there is a gap between ideal and reality. By finding reasons for communication difficulties, explanations from an individual psychological perspective don’t seem sufficient, they may be seen as topic of a larger sociological discourse.

Aim: This project shall help to understand the practical relevance of communication about death and dying and to capture interactive practice of communication in a cantonal hospital in Switzerland.

Methods: The project is designed as ethnography to explore the empirical field with various qualitative methods (triangulation). Grounded Theory is used for data collection and analysis. Qualitative interviews with palliative care professionals and associated stakeholders, participatory observations of palliative care consultations (including patients and if present next of kin) and reflection about palliative care consultations have been conducted. Data collection is still going on considering Grounded Theory approach of theoretical sampling. A couple of codes have been found in the data material. Key categories and further questions have been elaborated.

Results: 11 qualitative interviews with palliative care professionals and 3 with associated stakeholders have been conducted. One participatory observation of a consultation (whole consultation taped) and 20 reflections about palliative care consultations have been completed. Data collection is still going on considering Grounded Theory approach of theoretical sampling. A couple of codes have been found in the data material. Key categories and further questions have been elaborated.

Conclusion/discussion: In practice, addressing death and dying seems to be difficult for palliative care professionals. Acting in such specific situations makes high demands on them and high expectations often have to be scaled down.

Abstract number: P2-181
Abstract type: Poster

What Matters for Patients when Prognosis Is Uncertain? A Secondary Analysis of Qualitative Data
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Background: In our ageing population, an increasing number of people are living with complex advanced illness and an uncertain prognosis. Little is known about the effect of prognostic uncertainty on patient quality of life and patient priorities, or how patients cope with uncertain prognosis.

Aim: To understand patient experiences of living with an uncertain prognosis.

Methods: Qualitative secondary analysis of in-depth patient interviews; derived from 4 studies which investigated illness experience in patients with heart failure, chronic obstructive pulmonary disease (COPD), renal disease or cancer. Topic guides were assessed for comparability prior to analysis. We used purposive, maximum-variation sampling to select from the available transcripts, based on patients’ age and sex, as well as content relevant to uncertain prognosis. We undertook thematic analysis of interviews. One researcher coded the data with 10% independent cross-checking to increase rigour.

Results: Of 98 available interviews, 30 were purposively selected. These included patients with heart failure (n = 10), COPD (n = 4), renal disease (n = 10), and cancer (n = 6). 40% were female; median age was 75 years (range 43-93). Major themes relating to illness experience were the importance of staying independent, loss of control over health, peace and family support, poor understanding of illness, and differences between patient and healthcare professional priorities. Key patient priorities were appropriate communication, quality rather than quantity of life, and dealing with co-morbidities unrelated to the primary diagnosis. We developed a typology for patients’ responses to uncertain prognosis: contemplation of the future, practical planning, or disengaging.

Conclusion: Uncertain prognosis shapes illness experience for patients, and addressing patient priorities is important. We have developed a valuable typology of patient responses to uncertain prognosis to support this. This needs further testing.

Abstract number: P2-182
Abstract type: Poster

Finding the Words: Improving Conversations with Dying People & their Families
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Background: There is a clear need for precise & unambiguous communication which avoids mis-construed when talking to or about dying patients & their families. The distress caused by poor communication was highlighted in the Neuberger Review ‘More care, less pathway’ 2013, a government review into care of dying people in England, & the need for good, clear communication outlined in the new Priorities for Care included in the LACDP ‘One Chance to get it right’ response 2014. Aims: To enable all clinical & non clinical staff, working in community, hospital & care homes in a well circumscribed area of the north of England, who encounter dying patients & their families, to feel they are able to talk about death & dying openly & confidently with those in their care.

Method: During 2013 we compiled a list of commonly used words & phrases which could be mis-construed when talking to or about dying patients & constructed a list of useful alternatives. This has been included in the care of the dying training to more than 1600 individuals & printed on posters & business cards to be used as a handy reference in the workplace across care settings.

Results: The language used by & between professionals is changing across our organisation as evidenced through communications with staff who constantly remind each other & this has been recognised at the highest levels of the organisation. Even non-clinical staff are careful to use correct terminology at meetings. Audits of conversations documented show that clinical staff are documenting appropriate conversations.

Conclusion: Focusing awareness of the importance of clear communication has also raised awareness of death & dying in the Trust.
Pt-related preconditions encompass pts’ illness / prognosis understanding, coping, meaning in life, relation to family, prior experience with cancer and anti-cancer treatments, pt-perceived trust and experience with specific oncologist and treating team. General information is pt and decision independent and may occur routinely, including pt information leaflets supported by nurse or physician information. Interactive criteria include another pts’ pts addressed clinical benefit, expectations, timing of assessing response, or impact of side effects on quality of life. Implementing decision criteria in clinical care processes may require both preparation of preconditions, a background basis informed on pt-physician interaction. Further research explores relative importance of retrieved criteria and groups. Funding: Swiss Cancer League

Abstract number: P2-186

Abstract type: Poster

Advanced Cancer Patients’ Worries Related to End-of-Life and Perceived Communication with Health Care Professionals

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Advanced cancer patients (pts) face emotional and existential worries related to their approaching end of life (EoL). Addressing them is an essential palliative care (PC) intervention, but both pts and professionals (HCP) may collude with family. To assess pts worries related to EoL, pts’ self-perceived need to address them with a hcp, and the by pts’ recalled addressing of those by a hcp

The reported data is part of a larger observational study (268 adv cancer pts, defined PC needs, 74% ECOG 1+2), monthly collection of pt perceived needs/recalled delivery by hcp for 5 PC key interventions, demographics (adapted EAPC dataset), PC needs (IPQ, EQ5D), and quality indicators (QI, inappropriate anticancer treatment, aggressive EoL care, quality of dying).

For the key intervention “EoL preparation” patients were asked if they had 6 specific worries related to EoL (table 1), if they would have liked a hcp to address them, and if this had happened. The frequencies of the worries, need that the worry was addressed and recalled addressing by hcp is displayed in table 1.

Specific worry: % of patients that had this specific worry: % of patients with this worry that wanted this worry to be addressed by a hcp: % of patients with this worry that the worry was addressed: where it was addressed

<table>
<thead>
<tr>
<th>Specific worry</th>
<th>% of patients that had this specific worry</th>
<th>% of patients with this worry that wanted this worry to be addressed by a hcp</th>
<th>% of patients with this worry that the worry was addressed: where it was addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>The disease is spreading</td>
<td>62%</td>
<td>33%</td>
<td>60%</td>
</tr>
<tr>
<td>I might have suffering that cannot be relieved</td>
<td>48%</td>
<td>12%</td>
<td>55%</td>
</tr>
<tr>
<td>The bone tumor is located</td>
<td>49%</td>
<td>28%</td>
<td>52%</td>
</tr>
<tr>
<td>I am not prepared to cope with the situation</td>
<td>37%</td>
<td>35%</td>
<td>67%</td>
</tr>
<tr>
<td>I want to be assisted in the pain that I would like</td>
<td>9%</td>
<td>42%</td>
<td>56%</td>
</tr>
<tr>
<td>I feel there is unresolved business concerning material aspects</td>
<td>13%</td>
<td>50%</td>
<td>59%</td>
</tr>
</tbody>
</table>

Table 1

78% pts needed spiritual issues (e.g. meaning in life, inner peace) to be addressed by hcp, but only in 42% it happened. Analysis of the influence of demographics, institutions, spirituality, illness understanding, symptom burden and proximity to death on these worries and evolution over time is ongoing. EoL worries are frequent in Romanian cancer pts who frequently prefer not to discuss with hcp, maybe also caused by the fact that the hcp were not appropriately available.

Funding: SNF Grant (ZER02)-142226 / 1

Abstract number: P2-183

Abstract type: Poster

Palliative Care in Patients who Are Not Aware of their Diagnosis

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Aim: To highlight the difficulties in communication with patients and family members when they are not aware of the diagnosis and prognosis.

To emphasise the importance of raising the awareness of family members on the patients’ right of being informed on the diagnosis. To emphasise the importance of the cooperation between medical staff and the patient and their family members when they are aware of the diagnosis.

Methodology: Data was collected from “Mary Potter” Palliative Care Center for the period January 2004 – September 2014. It includes: – Information received from the patients’ family members during the assessment of the referral and also during their training at “Mary Potter” PC Center. – Information collected directly from patients.

Results: 1943 referral formularies are recorded for the period January 2004 – September 2014. 589 were referrals from pts living in urban areas and 1354 in rural areas. 1790 patients were not aware of their diagnosis (462 urban, 1238 rural). In all cases family members were barriers to telling the patients the truth of their diagnosis. Family members reflected significant lack of information on palliative care and its purpose. The patients who were aware of their diagnosis and prognosis had established a quite effective cooperation with the palliative care team with regard to the treatment of their symptoms. The absence of a law on the communication of the diagnosis represents a barrier for the communication and collaboration between health professionals and patients.

Conclusions: Being aware of the diagnosis and prognosis by the patient is essential to achieving the purpose of treatment in palliative care. The education of patients’ family members through trainings on palliative care facilitates the collaboration between the patients and care providers. Being aware of the diagnosis increases the reliability of the patient on the palliative care staff.

Abstract number: P2-184

Abstract type: Poster

Palliative Care Patient Perceptions and Experiences of Medicines Information Communication in a Community Pharmacy: A Grounded Theory Approach

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Background: Poor symptom management and harm from inappropriate medicines use in the community is well documented. Misunderstanding medicines use is most commonly caused by poor communication, especially between patient and professionals. On safe medicines use is a community pharmacist (CP) role. High risk medicines e.g. analgesics are used in palliative care patients. Little is known of palliative care patients’ communication experiences in a community pharmacy on using medicines safely.

Aim: To identify palliative care patient perspectives of communication barriers, facilitators and preferences for analgesics medicines information in community pharmacies.

Methods: A prospective study of face-to-face, recorded semi-structured interviews with a purposive sample of community based adult palliative care patients about experiences and preferences of obtaining information about medicines. The interview schedule, developed following literature review on barriers and facilitators to required medicines information exchange in community pharmacy, was peer-reviewed and piloted. Analysis of verbatim interview transcript data followed a grounded theory approach using constant comparison technique to identify factors involved in pharmacy based communication for palliative care patients.

Results: 31 participants. Communication with CPs about medicines was lacking. Adequate medicines information from contact with other health professionals was perceived by participants despite reporting needs around adverse impact of medicines on activities deemed important to patients. Lack of understanding of the CP role and reduced CP access as an unintended consequence of pharmacy medicines deliveries is revealed.

Discussion: Increasing pharmacist awareness about barriers to communication with palliative care patients may assist in improving access to medicines information support. The data indicate that CP communication appears to be only one influence on improved medicines understanding.

Abstract number: P2-185

Abstract type: Poster

Implementation of Distinct Categories of Decision Criteria for Chemotherapy in Palliative Intention (CPI) in Clinical Care Processes

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Decisions regarding anticancer treatment in advanced, incurable cancer patients (pts) merit acknowledgment of multiple factors, beyond tumor-related and toxicity-grading risk-benefit judgments informed by oncology clinical trials. Early specialist palliative care (PC) studies suggest the potential of multidimensional and -professional approaches, but implementation of DC applied by oncologist in routine cancer care is challenging. To develop DC for CPI applicable in routine clinical cancer care

Prio work (systematic literature review, interview guide, focus groups [4 FG, 15 pts; 2 FG, 17 physicians; 2 FG, 11 nurses], thematic qualitative data analysis, data reduction, Delphi consensus) retrieved 35 DC. 3 researchers independently characterised for each DC an appropriate group, then consensus defined them, the procedure was repeated until consensus.

Distinct groups include: 1. pts. pt. in pts’ live in pts’ pts, physician [3], relationship [10], hcp staff/system [3], family [3], 2. general information (cancer care [12], PC [3]) and 3. immediate interactive DC (12).
Abstract number: P2-187
Abstract type: Poster

Clinical Management and Care Planning of Patients with Locked-in Syndrome in Palliative Care

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Background: The Locked-in syndrome (LIS) is characterised by tetraplegia, aphasia and preservation of the level of consciousness, and it’s associated with a poor prognosis.

Aim: To reflect on the production of care in palliative care for patients with LIS in Brazil.

Methods: This study combined a qualitative literature review with case study. Male patient, 29 years, married, photographer, admitted to a hospice in São Paulo, detailed clinical and biographical history was collected with the family. The hypothesis was reviewed a reflective discussion about palliative approach in LIS was conducted.

Results and Discussion: The literature, the care of these patients in palliative care is still a relatively unexplored field, in Brazil, there are no published studies. The identification of post traumatic LIS is difficult and is subject to misdiagnosis, which could be avoided through the association of standard clinical examination, imaging tests and multimodal neurophysiological evaluation. It was observed that the access issues to the health services can be worsening factors.

Conclusion: With the yearly increase of the number of people, the incidence of the life threatening chronic diseases like cancer increased and the need for palliative care rises with time. Palliative care center (PCC) in Kuwait is the first stand center in the Middle East where patient care is integrated by a multidisciplinary team which aims at improving the quality of life for patients and their families.

Abstract number: P2-188
Abstract type: Poster

The Use of New Technologies and Social Networks to Spread the Philosophy of Palliative Care

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Background: To report on what we do and how we do it is essential to our future patients with oncological and non-oncological advanced diseases and their families. The utilisation of new technologies and the proper use of social networks bring us closer to society and make our work easier.

Aims: We want to get the Palliative Care Unit of our hospital (with over 21 years of activity) has a separated section on the website of the hospital, intended to raise awareness of the work done, expand the healthcare services and include palliative care within the portfolio of an Acute Care Hospital.

Methods: We created a dynamic graphic design, with appropriate texts, with general and specific information about the unit and the team. Entryways, necessary procedures and videos of our facilities were included. We opened a communication channel in real time in Facebook, Twitter, etc.

Results: Data obtained were extrapolated after the publication on the web, 35 days, go of two articles on current palliative care. We added, between visits, shared news and comments, an average of 121 daily records. By means of this tool we find a greater social sensitivity, improving of the experience of our patients at the hospital, and we could have also their opinion as a parameter for improved care.

Conclusions: To introduce ourselves as a group of interdisciplinary work, consultant, that provides continuous and coordinated care in different disciplines, helps the patient and his family to decide beforehand where and by whom he wants to be treated.

Abstract number: P2-189
Abstract type: Poster

Use of Interpreters in Palliative Care – A Practical Four Step Approach

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Background: Singapore is a multicultural city where numerous dialects are spoken. Communication in palliative care is difficult without a common language. Most healthcare professionals need to engage interpreters during some stage of their consultation. Many interpreters are not associated with health care and are employed solely for their language skills.

Objectives: To identify strategies for effective communication when using interpreters in palliative care consultations.

Method: Observation and reflective practice was used to identify strategies used to facilitate effective communication when using interpreters. Strategies were validated through discussion with professionals, including interpreters, from a variety of cultural and linguistic backgrounds.

Results: 4 steps: Basics, Exercise, Family conference and Debrief, contributed to effective communication. Basics ensure appropriate appearance and presentation of the interpreter. In the Exercise section, the interpreter translates a paragraph of information, with an emotive component. Although the health care provider is unaware of the accuracy of the information translated, this step provides the opportunity to look at facial expression, empathy, tone of voice, and the translation. The interpreter can then be asked to modify their approach if necessary. The interpreter is then informed of the information to be translated and given the opportunity to express their emotional response and comfort level with the task. The Family Conference, the interpreter is invited by a Debrief when the interpreter is able to reflect on the consultation.

Conclusion: This four-step approach is simple and easy to replicate with interpreters irrespective of their previous experience and training. The approach appears to improve communication, providing more control of the interpretation and maximises the available interpreter resource, particularly when interpreters are given a short Exercise in translation before the Family Conference.

Abstract number: P2-190
Abstract type: Poster

Communicate for a Mutual Understanding: A Study on Training Needs for Palliative Care Professionals

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Abstract number: P2-191
Abstract type: Poster

Biggest Palliative Care Center in the Middle East, Kuwait is Competing with Time

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The state of Kuwait is an Arab country in western Asia. As of 2013 Kuwait has population of 3.719 million and 1.185 of those people is Kuwaitis. With the yearly increase of the number of people, the incidence of the life threatening chronic diseases like cancer increased and the need for palliative care rises with time.

Palliative care center (PCC) in Kuwait is the first stand center in the Middle East where patient care is integrated by a multidisciplinary team which aims at improving the quality of life for patients and their families.

The center was opened on May 11, 2011, before this there wasn’t any palliative care unit in Kuwait.

The PCC consists of 92 beds in total, it started with 2 wards with a capacity of 14 beds for 2 years then became 4 wards with 28 beds capacity in the third year.

In the first year 40 patients admitted, 4 patients were seen in the outpatient clinic. The statistical numbers are dramatically increased from year to year. All patients were treated by a multidisciplinary team free of charge.

Cancer type distribution and the advanced patients to PCC was as follow: lung cancer 13.7%, head and neck cancer 12.33 %, colon cancer10.05% followed by many other type of cancer. In this paper we will present the details of the profile of a palliative care patient in Kuwait, the feedback and the future plan for palliative care in the region.
Kuwait Palliative Care Experience: A Small Country with a Successful Model in the Region Dr Iman Al Diriri

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Background: Many pain and palliative care initiatives are rapidly expanding around the world. Middle east is one of the regions where different models of such programs has been established over the last decade. Kuwait was one of the countries which realised early the importance of integrating palliative service into cancer care programs by establishing the first cancer pain clinic in the country in 1989.
Method: Different models of adult and pediatric pain and palliative care programs have been established over the last decade in the country. Services include an outpatient pain and palliative care service, a pain and palliative care consultation team for hospitalised cancer patients, a pediactric palliative home care service, a pediatric hospice, and recently a palliative care hospital.
Results: By using different models of care our aim to build a promising palliative care service was successfully achieved. Breaking multiple barriers at medical and institutional levels was essential to achieve such a progress. Our opioid consumption was significantly increased over the last decade, in the WHO report in 2010 Kuwait was leading the east middle east and gulf region in opioid consumption. Using pain and symptoms assessment tools, educational programs for medical professionals, implementing WHO and EAPC cancer pain guidelines, cooperating with leading centers in the world were some of the methods we used to achieve such a goal.
Conclusion: Kuwait managed to break different barriers and provide successful models of pain and palliative care by adapting the services which respond to patient’s needs and match the culture values. Kuwait model may help many countries in the region to develop their own program.

Collaborative Care – How Can It Be Accomplished?
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Abstract number: P2-193
Abstract type: Poster

Background, aims and goals: The Centre for Collaborative Palliative Care in Sweden started 2013, located at a midsize university. The overall aim of the Centre is that patients will experience good palliative care and family members will experience support before and after the time of death. This requires a solid palliative care development in collaboration with patients, family members, health care professionals, and researcher. The aim of the presentation is to describe the activity of the Centre.
Design, method, and approach: The Centre is led by two researchers and a strategic board consisting of leaders from the university, representatives from the county council and communities, patients, and family members. The Centre has an operative group of 16 researchers and clinicians. A collaborative group with patients and family members is participating in planning the work in the Centre. National and international networks within palliative care are also established.
Results and conclusion: The Centre has three main foci; education, clinical improvement and research. At the university, the Centre makes palliative care more visible in the nursing program and in courses at all levels. The improvement of the clinical practice is performed through offering education in palliative care to healthcare professionals and to implement good palliative care using a collaborative integrative learning process including families, health care professionals and researchers. Finally, the Centre conducts research projects to illuminate the meaning of a life with dignity when facing death from a patient, family member, family, and healthcare professional perspective and to develop and implement interventions to promote a life with dignity and dignity
With this unique Centre in which improvements of patients’ and families’ involvement and influence in the care are central, a well-functioning, sustainable care for all people can be realised.
Funding: The Kamprad Family Foundation.

Abstract number: P2-194
Abstract type: Poster

Organisation and Evaluation of General Palliative Care in Hospital – A Case Study
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Background: Hospitals have a responsibility to ensure that palliative care is provided to inpatients with illnesses they are expected to die from. Since 50% of the population dies in the hospitals, palliative care should be acknowledged and organised equally to other tasks in the hospital departments)
Conclusions: The networks have developed into forums where hospital care, primary care, municipal care, specialised palliative care and higher education meet. They also promote a professional attitude irrespective of the type of care and are supervised by a management team who not only exercise control but also offer support. The Network for Palliative Care is one of ten networks with participants from above mentioned caregivers. The aim of the Palliative Care Network is to increase and spread knowledge about palliative care so that the individual patient receives the best possible care irrespective of where the care is given.

Over the years participants have received continual in-service training via lectures, literature studies and individually designated courses. Mutual educational material has been compiled. National guidelines and recommended evidence based methods, for example, rating scales are continuously implemented. The routine and protocols are continuously developed and information on the transition to end of life care have been drawn up and a summarised version has been sent to all relevant caregivers. The body of knowledge acquired through the years has led the participants to act as palliative representatives outwardly and as a key resource within their own units. The network participants convey knowledge primarily to those caregivers who are closest to the patient. The educational material and the written routines are frequently used. Statistics from the Swedish National Register for palliative medicine are used in the evaluation of results. The six municipalities and two hospitals together have a coverage rate of 66–82% in the National Register. The result for individual questions is measured at the level of the individual unit.

Abstract number: P2-196
Abstract type: Poster

Dedicated Palliative Care Nursing in Denmark
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Background: We meet people in need of palliative care throughout the healthcare system and palliative care goes across specialties and sectors. Danish Association of Nurses in Palliative Care (FSP) was founded in 2006. FSP is a sub-group under Danish Nurses Organisation (DSN) and all active members of DSN can join the FSP.
FSP has 300 members.
FSP wants to develop the interdisciplinary palliative care at the basic level (home care and hospital departments) and on the specialised level (hospice and specialised palliative teams).
Aims:
To gather all nurses in palliative care
To disseminate evidence-based knowledge and visibility of nursing
To create uniform palliative skills at all levels
To be an active player in debate and to be involved in decisions about palliative care
Method: FSP has nine members of the board representing different geographical and professional backgrounds.
FSP in active in the making of several national clinical guidelines and educational programs.
Membership of DMCG-pal: FSP is represented by two members of the EAPC organising.
Membership of DanPall: FSP is represented in the DanPC groups and has been very active in the making of several national guidelines, curricula and educational programs.
Conclusion: FSP has moved from being an association focusing on the establishment and development of palliative care and to participate in the debate about education and values in the field of palliative care.
Abstract number: P2-197
Abstract type: Poster

Timing of Admissions to Specialist Palliative Care Units – A Service Evaluation
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Aim: A service evaluation of admissions to 3 specialist palliative care units (SPCU) assessing time of arrival & factors influencing arrival time.

Methods: A prospective review of all admissions to SPCU was performed during August/September 2013 & August 2014. On arrival to the ward, patient demographics, time of arrival, reason for admission, source of bed availability, mode of transport & performance status were recorded. Data were analysed using Microsoft Excel.

Results: ‘Late arrivals’ were defined as those arriving after 4pm based on a guide arrival time in units A&D.

<table>
<thead>
<tr>
<th>Categories</th>
<th>A (n=72)</th>
<th>B (n=26)</th>
<th>C (n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time of arrival</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;2pm</td>
<td>79%</td>
<td>66%</td>
<td>48%</td>
</tr>
<tr>
<td>2–4pm</td>
<td>21%</td>
<td>34%</td>
<td>52%</td>
</tr>
<tr>
<td>&gt;4pm</td>
<td>4%</td>
<td>3%</td>
<td>8%</td>
</tr>
<tr>
<td>Source of referral</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>42%</td>
<td>43%</td>
<td>54%</td>
</tr>
<tr>
<td>Daycare/OPD</td>
<td>16%</td>
<td>12%</td>
<td>3%</td>
</tr>
<tr>
<td>Hospice/Other</td>
<td>34%</td>
<td>37%</td>
<td>29%</td>
</tr>
<tr>
<td>Type of admission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of Life care</td>
<td>47%</td>
<td>46%</td>
<td>52%</td>
</tr>
<tr>
<td>Hospice/Other</td>
<td>47%</td>
<td>46%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Conclusions: More late arrivals in unit C than units A&D.

Discussion:

Discussion: Admission to a SPCU can be a time of distress for patients & their families. Patients who arrive ‘after hours’ will not be seen by the full multidisciplinary team & given a thorough holistic assessment until the following day. Recommendations to improve quality of care include implementing a guide arrival time for admissions, prioritisation of ambulance services for those being transferred to hospice, and giving patients advance notice of admission.

Conclusion: By implementing cost neutral recommendations, a higher proportion of patients could be admitted during core working hours. This will result in improved care for the patient and cost saving for the SPCU in reducing out of hours payments.

Abstract number: P2-198
Abstract type: Poster

Stakeholder Involvement in Health Technology Assessment Scope Development: Contrasting Views of Patients and Professionals about Issues Affecting the Organization and Development of Palliative Care Services
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Background: The INTEGRATE-HTA project is developing new methods to assess complex health technologies and applying these in a palliative care case study. Stakeholder involvement in Health Technology Assessment (HTA) is widely advocated to help ensure that results are useful to the end users. However, professionals, commissioners, patients and carers will have different concerns.

Aims: To identify stakeholder views of the key issues impacting on palliative care to assist with the HTA project scope development. This abstract focuses on the findings from England.

Design: Patients (n=20) and professional (n=34) stakeholders were engaged as ‘research partners’ in individual or group meetings lasting 45–105 minutes. An adapted version of the EU-NeHTA core model which guides HTA reporting and a scope diagram assisted face-to-face or telephone discussions. Thematic analysis identified key issues.

Results: Participants identified similar issues affecting the organisation and development of services. These included concern about public awareness of palliative care; the availability and accessibility of palliative care to various minority groups, staff education, training, support for carers and knowledge of the safety and harms of palliative care. Professionals queried what effectiveness in palliative care means whilst lay advisors wanted to know which elements of palliative care were effective. Professionals reported that improvements were needed to identify people with palliative care needs and co-ordinate services.

Conclusions: Having experienced the intended and unintended consequences of palliative care services, all stakeholders assisted patient-centred scope development by identifying important topics for HTA. Their early involvement will ensure that findings are useful to patients, families, carers, professionals and service commissioners.

The project is co-funded by the European Commission under the Seventh Framework Programme (Grant Agreement No. 300141).

Abstract number: P2-199
Abstract type: Poster

Outpatient Palliative and Hospice Care for Immigrants in Munich (Germany) – Integrating Multi-professional Service Providers
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Background: For immigrant populations, access to palliative care may be limited by communication deficits, lack of trans-cultural literacy, and individual preferences. In the Munich area, hospice, social welfare authorities, and health care providers have covered distinct aspects of palliative care issues so far. Here, an informal process of integrating these approaches is described.

Methods: During a first phase (2010–11), the nursing and psychosocial support team of Hospice Care DaSen was trained to provide end of life consultations for patients, families, and health care professionals with a focus on cultural and religious diversity. Main topics were symptom control, advance directives, and bereavement issues. Volunteers complemented the team. In a second phase of the project (2012–13), this care group then established a network with religious communities, municipal authorities, hospital discharge managers, general practitioners fluent in different languages, geriatric clinics, nursing homes, and funeral services. Moreover, working groups on immigration topics were actively contacted. Educational and public activities completed the program.

Results: Between 2010 and 2013, 688 patients were seen by the hospice team; among those, 111 (16%) had a migration background. The portion of patients from that sub-group rose from initially 9% (6) in 2010 to 44% (23) in 2013 which is close to their proportion within the entire population. Most patients were referred by hospital discharge managers, but sustainable support by their own communities was variable. In 2013, the program was regularly funded by public authorities.

Conclusion: Making hospice and palliative care services more accessible for immigrant populations in a municipal area is feasible. A next step towards a more sustained service implementation will be to explore specific needs and preferences regarding palliative and end-of-life care in this sub-group using qualitative interviews.

Abstract number: P2-200
Abstract type: Poster

Direct Access from Hospital to Hospice Cutting the Red Tape at End of Life When it Matters!
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With patient choice being the guiding factor and with just one chance to get it right, the provision of good end of life care is a necessity. However, many patients and their carers find themselves in acute hospitals at this time whether on acute units or in busy A and E’s. Hospices generally do not admit out of hours and have a referral process which can sometimes delay admission.

In a new initiative, a charitable local hospice is working with a large acute trust to cut the red tape and transfer imminently dying patients into hospice beds within hours. This not only reduces hospital deaths but increases access to hospice care. The rapid access beds can be admitted into directly by the Hospital Palliative Care Consultant, who upon assessment can phone the hospice at any time to transfer the patient and does not require a medico to accept the patient within the hospice setting. The Consultant completes a succinct medical clerking, drug chart and DNAR form within the hospital and then transfers the patient immediately. On admission to the hospice the emphasis is placed on nursing care and maintaining dignity, good end of life care and family support. The patient will be seen the next day by a medical professional for review.

This initiative has had a positive effect on patients and families; even when the patient has died within hours of admission to the hospice the family have felt this to be a good death, due to the excellent nursing care and the quieter, calmer environment. Effective and compassionate communication with family members is key at this time to ensure understanding of prognosis and the ethos of hospice care.

The hospital and hospice continue to work together to ensure excellent palliative care services for all patients within the local area, through identifying new ways of working together to increase and improve access to services and ensuring that patients have a choice in where they die.
Developing Home Based Palliative Care Service for Incurable Patients in the Capital of Moldova: Are There Any Limits?

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Abstract type: Poster

Methods:
1. There was a trend towards a reduced chance of successful discharge (p=0.108 Mann and data were extracted.
2. In October 2011 the domiciliary palliative care service for incurable non-cancer children was launched. In December 2013 the home-based palliative care service for incurable HIV/AIDS patients was established. There are also two additional palliative care services at home: for women, who underwent surgical interventions due to breast cancer and ovariectomy patients, when they become incurable.

Conclusions:
Despite the fact that the National Program in Palliative Care is in draft, the charity foundation for Public Health Angélu -Moldova still remains the only provider of qualitative domiciliary palliative care services for different categories of incurable patients in the country.

Delivering a New Model of Care to Support Residents in Nursing Homes

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Abstract type: Poster

Methods:
1. Conveyed an innovative model of care provision for improving EOLG in nursing homes through a case study which highlights its successful implementation in the Nursing homes within a local community. The service reports monthly against Key Performance Indicators which includes the monthly DD list, there was a trend towards a reduced chance of successful discharge (p=0.108 Mann and data were extracted.
2. Conveyed an innovative model of care provision for improving EOLG in nursing homes through a case study which highlights its successful implementation in the Nursing homes within a local community. The service reports monthly against Key Performance Indicators which includes the monthly DD list, there was a trend towards a reduced chance of successful discharge (p=0.108 Mann and data were extracted.
3. The education was set at foundation level to include Health Care Assistants (HCA), and carers to participate alongside the Registered Nurses (RN). Clinical Nurse Specialists (CNS) also developed a clinical round with nursing home staff. This was to identify those residents who were becoming more frail and showing signs of deterioration which may have indicated they were approaching the terminal phase. They provided role modelling and experiential learning at the bedside which helped to embed the theoretical educational sessions.
4. Regular attendance at Gold Standard Framework (GSF) meetings with the GP practices attached to the homes enabled multidisciplinary working amongst professionals in the community. This poster reflects an innovative integrated model of care for nursing homes in a local community to support staff in being able to recognise residents who are dying. It is underpinned by theoretical knowledge and clinical role modelling.

What Happens to People on the Delayed Discharge List of a Specialist Palliative Care Unit (SPCU)?

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Abstract type: Poster

Methods:
1. Delayed discharges from SPCU can prevent people being in their preferred place of care or prevent equitable use of beds for other needy patients if home discharge cannot be arranged, there is a drive to pursue discharge to care home.
2. Aim: There is very little published research on the prevalence of DD, or what happens to people who are delayed discharges from SPCU. This led us to audit our own experience.

Results:
1. Of 391 admissions, 21 patients were on the DD list. Data were available on 14 patients.8 patients on the DD list were transferred from the unit to another place of care, 6 died waiting. The mean number of days that patients were on the DD list was 21 (2 – 62). 35% of people (5/14) on the DD list lived alone and none were discharged back home if the palliative performance scale reduced in the home-based admission and being put on the DD list, there was a trend towards a reduced chance of successful discharge (p<0.108 Mann Whitney U test).
2. Delayed discharge from SPCU can prevent people being in their preferred place of care or prevent equitable use of beds for other needy patients if home discharge cannot be arranged, there is a drive to pursue discharge to care home. Aim: There is very little published research on the prevalence of DD, or what happens to people who are delayed discharges from SPCU. This led us to audit our own experience.

Conclusion:
As a team, we shall take these data on board and consider whether it is in patient’s and family’s best interests to begin a process of discharge to care home from the SPCU for people with an objective reduction in PPS since admission.

Neurological Palliative Care – A One-stop-Shop Approach

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Abstract type: Poster

Background:
1. The authors were aware that patients with non cancer diagnoses often need to access many different services and wanted to streamline their experience, whilst offering interventions that would be harder to obtain from other agencies, such as complementary and music therapy.
2. We incorporated a rehabilitative approach in order to offer practical solutions whilst using our specialist skills to facilitate excellent end of life care.
3. The aim was to introduce a model of care with a ‘one stop shop’ approach, which could be rolled out across a range of different disease groups, resulting in discrete, commendable services. The model brings together professionals from a range of services to implement early interventions to maximise independence within the parameters of the disease and avert crises.

Method:
1. We implemented a multidisciplinary Motor Neurone Disease group which met fortnightly at the hospice and was open to both patients and families. We brought together the multi-disciplinary team from the acute and community sectors, hospice team, alternative and voluntary sectors to support patients and carers.
2. Results: The qualitative feedback is that the group has created a safe environment in which to have open discussions about all aspects of the progression of the disease. It has resulted directly in integration of professional teams across organisational boundaries and increased partnership with other charities.
3. It has allowed us to test a model that we can develop across other disease groups.

Conclusion:
Providing a one stop shop for people with MND has improved quality of life and increased choice and preparation leading up to death.

Circle Team, an Innovative Palliative Care Collaboration in Primary Care. An Evaluation Study

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Abstract type: Poster

Methods:
1. A prospective evaluation study.
2. Aim: To support patients to die at their location of preference and ameliorate PC at home.
3. Patients with a life expectancy <12 months, identified with the ‘surprise question’ by PC professionals, were offered CT support. Patients supported by CT between Jan 2013–Dec 2013 enrolled in this study.
4. The CT collaborates through 2-weekly interdisciplinary consultation and 24/7 out of hours hospice consultation for patients, families and caregivers.
5. CT patients were registered in a database and a multidimensional patient record, to promote continuity of CT consultation.

Conclusion:
The delay in discharging patients from care home is about 1 month on average, making this an important practical consideration for our team and the patients and families we care for.
Starting a Hospital-based Palliative Care Program in Sub-Saharan Francophone Semi Urban Setting

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Objective: To organise a palliative care program is crucial for the effective follow-up and control of pain and other symptoms of this project. The aim is to organize and implement a system of primary care for people living with chronic pains in a hospital devoid of palliative care.

Methods: A strong and structured advocacy was made to the administration of the Regional Hospital of Balfoussam. Without morphology, we started psychological and supportive care to patients suffering from cancer and exacerbating pain in the different hospital services during a period of four months. First need for oral morphology was then made and presented to the administrative staff of the hospital through the presentation of the PC concept and its precepts. This was then reinforced by the presentation of the results of a cross-sectional study carried out in hospital need for palliative care. In the hospital, the need was also addressed to the chief nurses in the different services who were trained on the detection of patients needing palliative care in their services.

Results: Two people were sent on internship to the PC unit of the Regional Hospital Bambena on the use of morphology. Thereafter, a mobile unit of PC was created, in the hospital in July 2013. After one year, along with its creation, 34 patients were supported. These visits were also recorded to reassess the needs, continue care and provide psychological support for those who left the hospital, 5 condolence visits and many phone calls.

Conclusion: Creation of a successful system of care for patients in need of PC in a hospital setting is possible through innovative collaboration and organised advocacy.

How Should Care in the Last Days and Hours of Life Be Documented? Views of Healthcare Professionals in a Tertiary Cancer Centre

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Background: Following an onslaught of media criticism and the publication of the review ‘More Care, Less Pathway’, in July 2013, the Liverpool Care Pathway (LCP) was withdrawn from practice in July 2014. With no national replacement, it is the responsibility of individual institutions to develop new documentation and guidance for staff.

Aims: The purpose of this study was to ascertain the views of healthcare professionals prior to the development and implementation of a new end of life care document at a tertiary cancer centre.

Method: Two focus groups with a range of healthcare professionals from the cancer centre were held to explore key areas in relation to end of life care. They studied education, training, and the role of electronic documentation. A literature review then explored recommendations for best practice. Finally a questionnaire was developed, piloted and distributed to staff across the centre.

Results: The response rate was 29%. Of the respondents, 90% had used the LCP within the last 2 years and 77% felt it was not as should be discussed. 97% of healthcare professionals felt that end of life documentation should be multi-professional. 75% stated they would favour a similar format to the LCP and 50% did not want the new documentation to be electronic at this stage. 61% of staff had not received any training within the last two years and 78% believed the end of life care training should be mandatory for all staff.

Conclusion: Multi-professional documentation without an electronic format was the key request from clinical staff, although the majority felt that the LCP should not be replaced. Mandatory education and training in end of life care was seen as the main priority in order to develop skills and confidence amongst the workforce.

A Provision of Palliative Care Information for Patient and Caregiver in National Language – Project ‘Butterfly’

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Background: Positive aspects of palliative care in our country are not well recognised among professional in general population. Up until now, there was almost no written information available for public (general population) in our national language about palliative care.

Aims: To prepare written information about palliative care for patients and their caregivers in our national language.

Methods: A multi professional group involved in daily palliative care work have prepared a list of topics that could help patients and caregivers during palliative treatment. We have invited several professionals from different health institutions across the country to contribute their knowledge and experiences to the project.

Results: 42 professionals from 15 different health institutions (8 hospitals, several primary care providers and professors at medical school, Hospice) have been collaborating in the project. The majority of information provided had been written by physicians with several other professionals including: 12 nurses, 5 social workers, 2 psychologists, 2 spiritual providers, 1 physiotherapist. We have prepared 20 different topics that cover most common physical symptoms (pain, subcutaneous tumour, dyspnea, nausea/vomiting, delirium, fatigue, loss of appetite, constipation), nursing support (patients/patients), dysphagia, dementia, lymphedema, dry mouth), psychological problems (child/teenager close to palliative patient, self-care for caregivers, how to talk to a patient), social questions (home care, institutional care, how to deal with the need for palliative care before the end of life).

Conclusion: All 20 flyers were printed and distributed to all health institutions as a part of the World palliative care and hospice day 2014. For this purpose a new web page was designed www.paliativnaoskrba.si where all materials are published with some additional information. A project ‘Butterfly’ is one of the projects running under supervision of The European Palliative Care Academy.
Background: The physical and psychological effect of architecture on patients, relatives and staff is being studied all over the world. The results of these studies are applied to designs of hospices, hospitals and nursing homes in Denmark. However the focuses of the studies are of a great variety and they involve many different types of patients and settings. Studies involving palliative patients are limited and an overview is lacking.

Aims: The aim of this project is to ensure, that relevant knowledge regarding the staff, patients and relatives needs concerning the architecture in palliative care institutions is collected, communicated and in the end applied to the architecture of palliative care settings in Denmark.

Methods: Design guidelines are created on the basis of a literature review and qualitative studies of e.g. existing palliative care institutions. The review is grounded on evidence based knowledge about health care architecture and literature about the knowledge of architecture in palliative care settings.

Results: The design guidelines are sorted out in five themes:
1) privacy and social relations,
2) functionality,
3) light, sound, smell and air and temperature,
4) nature and
5) atmosphere.

Each principle consists of four parts; a review, specific opportunities for designing, an overview of how one principle affects the others and a catalog of architectural references related to palliative care and the specific guideline.

Discussion: The guidelines are constructed from the (limited) knowledge within this specific field. But whether these guidelines should be considered when selecting the studies? To what extent can conclusions from studies involving different groups of patients be transferred to the architecture of palliative care settings? And how can experience based knowledge or expert statements fill in the gap of evidence based knowledge?

Abstract number: P2-212
Abstract type: Poster

Improving Emergency Admissions in Palliative Cancer Pathways

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Background: Patients with advanced cancer are often admitted to hospital emergency departments. Aims: The main goal is to ensure equitable and coherent services to palliative cancer patients, patients and users experience high quality of services during emergency admission. Patients experience a long admission process in the emergency department, that the organisation, competence and quality of services are not satisfactory.

Design, methods and approach taken: Redesign method was used to analyse the emergency admission process in an acute department of a Norwegian hospital to hospitalisation in the oncology department. Data was also collected through semi-structured interviews of patients assessing their opinion about the admission process, next to medical data from hospital records indicating the amount of patients, when they arrive (time / day), their age and diagnostic background.

Results: The following improvement areas were identified: Changing the responsible physician from intern to resident to secure competence level. Development of a direct form for discharges from the oncology department to the emergency department, that contain latest discharge summaries, updated drug list, and their treatment plan, to facilitate the admission process with direct discharge to oncologic department. Patient should only encounter a team once and tell their story only one time. Intervention for pain management; an updated drug list must be in the patient’s electronic record, to ensure that patients receive their prescribed drugs at dosing time. Outcome measures are reduced pain-relief.

Conclusion/lessons learned: Emergency admissions may be experienced as stressful events for palliative patients and relatives. By improving simple procedures, redesign the current process and higher the level of expertise, we can improve the emergency admissions process for palliative cancer patients.

Abstract number: P2-213
Abstract type: Poster

Physician’s Perceptions about Palliative Care Specificities

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Background: In a region with 250 000 inhabitants there are no Palliative Care resources, despite the existence of a group of trained professionals and approved laws. According to literature, the barriers to Palliative Care organisation are lack of education of the physicians and of the knowing of the resources, not understanding the benefits of Palliative Care and team work not organised.

Aims: To analyse the hospital physicians and general practitioner’s perceptions regarding the specificities of Palliative Care.

Methods: A questionnaire was sent to physicians from three hospitals and seventeen primary health care centers and the difficulties faced with end of life were evaluated, taking into account aspects of Palliative Medicine and its importance at the bedside. The collected data were analysed with SPSS and both groups were compared.

Results: From the 308 physicians, 105 answered (34%) the questionnaire. There were 49 males, 44 females; 61 (58%) were from hospitals and 43 (41%) general practitioners. 45 (42.9%) had 51–60 years (median age 52). Only 21 (20%) attended any course on the matter previously.

At the attitude’s field, physicians had more difficulties in the suspension of ventilation and in the referral to another teams. At the communication’s field, most difficulties were in prognosis. Organised teams were considered as fundamental.

Discussion: Both groups showed interest and ability in team working, and was notorious the perception of importance of all chapters of Palliative Care in their training. The study allowed the identification of the physician’s needs and difficulties and subsequent studies may complement and extend these results in order to build future strategies in the region.

Conclusion: The author concludes that a network can be implemented with complementary teams, adapted to the region’s characteristics and supported on a comprehensive and structured training program to all physicians.

Abstract number: P2-214
Abstract type: Poster

A Network Model for the Future? Experiences from a Network of Physio- and Occupational Therapists as Part of a Multiprofessional Competence Network in Palliative Care

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Background: Interdisciplinary teamwork contributes to a holistic approach in palliative care. Both physio- and occupational therapists are important members of the team. However, the competence and knowledge in palliative care varies in this group, and there is limited knowledge among other professionals about their contribution in palliative care.

Aim: Increasing competence and engagement in palliative care among physio- and occupational therapists. Creating a platform for collaboration between health services and professions.

Method: An organised network of physio- and occupational therapists from different health services was established in 2007. The network, together with an existing network of nurses, established a multiprofessional competence network in palliative care in 2010. This also allows for other professions and is founded in the Norwegian guidelines for palliative care. The network groups have a common steering committee, are parts of a formal contract and have common strategy documents. The multiprofessional network arrange seminars annually, coordinates web information, newsletters, annual plans etc., and annual evaluations are conducted. The different networks are lead by separate executive groups who arrange seminars and have their own web information and competence plans.

Results: Experience from this network model and annual member evaluation indicates increased competence and engagement for palliative care among physio- and occupational therapists and a better collaboration between different services and professions as a result of the networking.

Conclusion: Increased competence, engagement and collaboration is likely to contribute to a higher quality of physio- and occupational therapy and should therefore contribute to better palliative care. This networking model has inspired other regions in Norway to start similar networks and may be a useful model also for other countries.

Abstract number: P2-215
Abstract type: Poster

Building Bridges – Palliative Care Beyond Borders

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Background: Globalisation doesn’t stop in patients who suffer from an end stage disease, such as cancer. The incessant reduction of travel costs inevitably rises the number of travellers. Therefore, palliative care professionals will have to deal with an increasing number of patients with advanced conditions travelling from all over the world. The different cultural background, that contain different languages, various beliefs and expectations can complicate the therapeutic relationship. These barriers may be further challenged in the event of a despaired repatriation for terminal care. The purpose of presenting this case report and its related literature review is to identify cultural, psychosocial, spiritual, financial and organisational aspects to facilitate international travel for patients with end stage diseases.

Case report and literature review: We report the case of a 47 years old Mongolian lady suffering from an end stage cervix carcinoma, who travelled to Switzerland, expecting to receive a curative treatment for her advanced neoplasia. The desire for immediate repatriation came up after several weeks of hospitalisation with the awareness about the absence of any potential cancer treatment. The overall issues which emerged during this successful repatriation have been the topic of our literature review. Cultural differences may be overcome through the involvement of cultural interpreters, who are able to discuss the patient’s expectations and allow the team to understand the various beliefs and rituals in end-of-life care. From an organisational point of view, thoughtful planning is mandatory, involving both administrative and healthcare aspects, assessing the travel risks accordingly.

Conclusion: There are many challenges in the repatriation of patients with an advanced illness, such as medical, cultural and organisational issues. These need to be addressed properly, in order to guarantee the best possible well being to the travelling patients.

Abstract number: P2-216
Abstract type: Poster

P2-211 On the Construction of Design Guidelines for the Architecture of Palliative Care Settings in Denmark

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1Poster Sessions (Poster Exhibition Set 2)
Patients in Palliative Care (PC) Reluctant to Benefit from Hospital Monitoring: What Type of Collaboration Can General Practitioners (GP) Expect?

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Could a palliative care network make bridges?

Objective: offer collegial sharing to GPs.

Methodology: Analysis of 5 cases encountered by our PC network in 2014.

Example: Two years after a breast cancer lumpectomy Mrs M was refusing any further treatment or investigations and was ready to sign a liability release to her GP. Her nurse seeking advice from our network about pain treatment because the patient seems embarrassed to call her GP.

Result: Problems experienced by the GP in the cases:
- A dilemma between a feeling of failure to meet someone's distress and the desire to respect the inherent dignity of patients who deserve the right to make their own choices at the end of their life, even if it is to refuse facing reality.
- The frustration of being refused well-being treatments.
- Patient's arguments for refusal can be of ambiguous nature.

The external position of the network allows standing back to make more appropriate decisions. The multidisciplinary dimension can widen the scope. The actions adopt an ethical approach and take into consideration the patients as well as the relatives and the GP and nursing staff.

Conclusion: How to provide collegial support to GPs in spite of geographical and time constraints?

The ethical approach is based on a hospital model in which actors share a workplace. The exchanges between peers are easier in a ‘medical’ structure, but not everyone can benefit from such an organisation.

The PC networks may take part to collegial exchanges when the patient doesn’t wish to be hospitalised. It might be interesting to carry out a survey among GPs to build an exchange scheme more adapted to their daily practice.

Supporting professional at home is essential as most patients wish to die at home. The integration of more and more patients to the hospital, together with crowded emergencies departments, is another incentive to develop proper homescare.

Abstract number: P-217
Abstract type: Poster

When Sociocultural Habits Re-humanize Patient Care: The Experiment of a ‘Wine Bar’ in a Palliative Care Unit

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In palliative medical practice, the question of how to take care and improve the quality of remaining life time is essential, restoring to the patient its human dimension also! It is also because palliative care tries to protect for the patient the simple habits of the life that ‘happy eating and drinking’ is at the centre of our concerns. To restore desire is a way of giving hope that tomorrow exists.

Aims: The first is to improve the quality of the end of the life of our patients and to respond to their desires, even when they are unfavoured by lack of means, family disagreements or sociological limitations. The second aim is to help the caregivers each day and to motivate the medical team with another way of taking care.

Methods: Once the purchase of the wine cupboard made, the symbolism of wine and food in an end of life situation was carried out by the nursing team, assisted by a socio-anthropologist who had already initiated a qualitative study on this subject. We established a data base with a questionnaire on the impact of this way of caring, concerning patient’s sensitivity, as that of their family and near ones, and of the nursing team.

Cooking workshops were created at the same time, arousing the curiosity of ‘all’. We can mention the intervention of another hospital center proposing the implementation of gastronomic workshops.

Conclusion: It shows that patients really appreciate this opportunity to taste a good wine and team explain the satisfaction, along with the pleasure of pleasing one another; the implication of the accompanying persons who find a meaning to this special moment that is the support of a seriously sick close relative to be able to give pleasure.

Conclusion: All in all this new generation of palliative care allows for pleasure. Sensorial experience is not only made through wines and food. We use all the sensorial dimensions: music, relaxation, essential oils, etc. ...

Abstract number: P-218
Abstract type: Poster

Telehospital for Nursing Home Residents: A Cost-effectiveness Review

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Background: Telemedicine is expected to effectively provide specialist care to nursing home residents. Hospice care is sparsely available in nursing homes, whose staff often lacks training. Telemedicine for palliative care, also known as telehospice, could be an efficient adjacent to regular care in nursing homes.

Aim: The aim was to review the cost-effectiveness and effectiveness rationales of combining the method – telemedicine, the setting – nursing homes, and the need - hospice care.

Methods: International and french databases (Medline, EBM Reviews, Cochrane, Web of Science, Scopus, Banque de données en santé publique, Cairn, France, Pascal, OpenGray, Google Scholar and DescIMeME) were searched for cost-effectiveness evaluations of the whole model. Combinations of its components (telehospice, telemedicine in nursing homes, and hospice care in nursing homes) were also searched for efficiency and effectiveness analyses.

Results: No publication evaluated the cost-effectiveness of the whole model. Some health systems have found telehospice efficent, but strong evaluations are missing. It was found acceptable, feasible, and effective in training staff and caring for patients. No cost-effectiveness study was found regarding telemedicine in nursing homes. It was found feasible at low cost, and effective in reducing hospital costs. Cost reduction was shown for chronic wounds and dementia management, staff training, and out-of-hours services.

Hospice care in nursing homes was proved efficient in the United States health system only. It was found effective in promoting home care planning and preventing hospitalisations. Staff training is effective only if followed by continuing support.

Conclusion: The efficiency of telehospice in nursing homes is suggested by the combination of its components’ efficiency and efficacy. A pilot project including a cost-effectiveness analysis should be performed before broader implementation.

Abstract number: P-219
Abstract type: Poster

What Factors Affect a Patient’s or Carer’s Decision to Attend a Hospice ‘Drop in Day’ Service and Having Attended What Factors Influence the Decision to Reattend

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Background: This report describes a piece of exploratory interpretative research relating to the evaluation of a ‘Hospice Drop in Day’

Aims: To explore what factors affect a patient’s or carer’s decision to attend a ‘Drop in Day’ service and having attended what factors influence the decision to reattend.

Methods: A feedback form was created and made available to those attending. 17 anonymous responses were received and this qualitative data was analysed using a grounded theory approach (Gibson, B., & Strauss, S., 1967).

Results: The identified motivating themes were: need for general support & social networking with similarly affected people, support another person, to access specialist advice, empathy, friendliness and cheerfulness of staff, enjoyment of the day, craft and therapy opportunities. Specific and general anxieties were dissipated before the first attendance. The theoretical statement is: ‘A fit for purpose’ Hospice Drop in Day provides an enjoyable networking experience where practical help and opportunities for creative expression are provided in an atmosphere of professional compassionate support.

Conclusion / Discussion: There were a variety of motivating factors to attend but provision of facilitated networking opportunities was most important. Careful recruitment and training of staff is required to allow the professional but compassionate atmosphere in the ‘Drop in Day’ to be created.

Services provided by volunteers such as art and other therapies are just as highly valued as those provided by paid staff.

The cost effectiveness of the ‘Drop in Day’ model makes it very attractive for Hospices in coping with ever increasing demands for services while resources remain limited. This research suggests factors which would make a ‘Drop in Day’ successful and can be used for any Hospice in development of this service. One would expect other Hospices to be interested in this research.

Abstract number: P-220
Abstracttype: Poster

Sustainable Hospice and Palliative Care Culture in Nursing Homes: Connecting Nursing Homes and Hospice Communities to Engage with their Nursing Homes Further Incentives will be Required

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Background: A large number of nursing homes (NHs) in the region of Aachen, Germany, have performed a process of implementing palliative care. There is an increasing discourse in Germany how and to what extent NHs can be part of ‘compassionate communities’ (A. Kelleher).

Aims: The participatory research study aims at answering the questions: Has palliative care culture been implemented sustainably in the participating NHs? To what extent do the palliative care processes enable the engagement in community care? To what extent has the research process itself fostered partnerships between the NHs and the community?

Methods: 10 nursing homes (NH) of 8 different providers volunteered to participate. A steering committee consisting of the NH managers identified relevant actors for palliative care culture within and outside each NH. Each NH nominated one or more interviewees, who carried out 39 qualitative problem-centered interviews and 5 focus groups representing 3 perspectives: Residents, relatives, professional cooperation partners and NH staff. The analysis was performed by the research team.

Results: All interview partners described attitudes of staff, explicit artefacts (E. Schein) and structural changes that are outcomes of a successfully implemented palliative care culture. Expansion into community care constitutes a major challenge both for NHs and for communities. It was disputed in the interviews that community care is the task of NHs. Conclusion / Discussion: Community palliative care culture and engagement in community care is becoming sustainability in the participating NHs. There is evidence that the participatory study itself contributed toward sustainability. NHs and communities are social systems that do not connect sufficiently. In order to encourage NHs to engage in community care and vice versa to encourage communities to engage with their nursing homes further incentives will be required.

Abstract number: P-221
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 2)
My Home Support A Collaboration between Housing and Hospice Care
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Pilot aim: To explore how housing support workers (HSW) could support patients and carers as part of the hospice’s Clinical Nurse Specialist (CNS) team. CNS capacity was being reduced by undertaking important albeit non-clinical activities. Additionally the service received ineligible referrals that were nonetheless judged to be at risk of crisis where an assessment could be beneficial. The housing sector partner seconded a HSW into the hospice’s First Contact Team. HSWs have valuable experience in supporting vulnerable clients and have knowledge of statutory and voluntary sector services, the hospice provided training on awareness of end of life care. The HSW makes contact with the patient and arranges a home visit to undertake a holistic assessment. The HSW supports the patient and their carers to access support including equipment, home adaptations, social care, benefit entitlements, in addition to liaising with healthcare professionals to organise GP reviews or District nursing support when required. Between November and the end of June 2014, the HSW has managed 31 cases.

The following indicators were evaluated via thematic analysis of case studies and clinical records by the partner organisations independently.

- Support people to remain at home for as long as possible at the end of life if they wish
- Analysis concluded that the service has a positive impact on this outcome.

- Reduction in inappropriate use of clinical time
- Analysis concluded that the service has an all-inclusive had a positive impact on this outcome

- Reduction in accidental death inquiries
- Analysis concluded that the service has an all-inclusive had a positive impact on this outcome

- Improved quality of life
- Analysis concluded that the service has a positive impact on this outcome

- Reduction in unplanned admissions/readmissions to hospice
- Detailed analysis of five specific cases where avoidance of admission was judged likely undertaken and accepted by commissioners. Concluded that the service has been important in avoiding admissions, reducing lengths of stay and improving home death in each case [results]
- Other key areas of learning: HSW support is acceptable to patients when they are not ready to accept hospice support: anecdotal evidence suggests that some patients avoid all health and care services whilst living in pain and/or on the edge of crisis. This service is demonstrating real value of integrated work with the housing sector utilising their knowledge and expertise in navigating services and support.

Reflection on the Development of a Complex Pain MDT Meeting within a Specialist Palliative Care Department
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Background: Pain is common in the setting of advanced malignant disease, for a small number of patients (10%) pain will be difficult to manage using the WHO analgesic ladder. 1 Local survey demonstrated an unmet need for this group of complex patients with persistent pain despite intensive specialist input. Palliative Care has had to tendency to work in relative isolation from other pain specialities and the development a local Complex Pain MDT has been important in generating a fully integrated strategy utilising all members’ expertise.

Approach: A Complex Pain MDT approach has been developed, involving Palliative Care Doctors, Clinical Nurse Specialists, Interventional Anæsthesists, Pharmacists, Occupational, Complementary and Physiotherapists. Patients meeting the referral criteria are discussed on a monthly basis in an open, reflective and educational forum to generate a management strategy utilising all members’ expertise.

Results: In the last 6 months 43 cases have been presented. Internal audit has demonstrated a number of positive outcomes. For example, a case series of patients undergoing interventional procedures e.g. intercostal blocks, with a focus on pain and quality of life measures has shown non-pharmacological pain control measures such as acupuncture. As well as newly established partnerships of joint-working between specialities e.g. neuro-rehabilitation.

Conclusion: The MDT approach has resulted in improved patient outcomes while also providing a regular opportunity for professional education and development. Along with these positive outcomes it has also highlighted a local deficit in psychosocial support which has been addressed by service improvement. The authors feel that the evolution of this Complex Pain MDT has provided a greater array of treatment options that should allow us to better meet the needs of our patients and could be used as a template for future services.


Developing Palliative Care Services in a Resource Limited Setting – It Is Possible!
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Aim: To foster palliative care services in two streets in Kibanga, Dar es Salaam Tanzania by forming palliative care teams and involving patient colleagues.

Design: Conducted two days introductory training on palliative care. Participants were selected from the community based on the known compassionate and caring attitude they have. Training was conducted in participant familiar language, Palliative care tool kit which is translated in Kiswahili was used and distributed to all participants. Home visiting was done to patients to cement classroom learning. The training used didactic lectures, role plays and sharing of lived experiences.

Results: The training was the genesis of palliative care services within the community. Palliative care teams have been formed and patients in need of palliative care are identified and cared holistically. Awareness has been created within the community on the needs of patients. Linkage is done and palliative care meetings are held once a month.

Conclusion: Palliative care services can be developed in resource limited setting by using a very minimal funds and available community resources. Building the capacity of the community to take care of their people is the only sustainable way of work which can effectively work in scaling up palliative care in the developing world where the demand of palliative care is huge.

The Integration of Municipal Emergency Medical Services to the End-of-Life Care at Home in Rural Areas
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Aims: To ensure that all people approaching death will receive good symptom management delivered into their homes regardless of where they live. This is challenging in the rural areas with long distances as there are no 24/7 district nursing care outside of city centres. If acute crisis could be resolved at home, unnecessary transfers of the fragile, dying patients to hospital could be prevented and the patient would be able to stay at home as per their wishes.

Methods: A local training program and protocols were developed to ensure and strengthen the pharmacists knowledge and vision of palliative and end-of-life care. Emergency medical protocols enable adequate symptom management also at home. To achieve this goal, all dying patients must have a written medical end-of-life-care plan available at home.

Results: The paramedics participated in interdisciplinary training course led by a palliative specialist doctor and nurse. This education included the most common palliative emergencies and their treatments, also not forgetting the holistic approach focusing on the patient and family. Protocols were developed in end-of life emergencies and needed medication. The importance of a carefully written care plan was emphasised in meetings with the local doctors and district nurses. The doctor on-call is available 24/7 by phone and the patient can be transferred into their local hospital by ambulance if required.

Conclusion: As the number of people receiving end-of-life care at home is increasing, our health care system must be ready to offer medical services and support to these patients wherever and whenever needed. Emergency medical services are available 24/7 also in the rural areas and should be integrated to the palliative care system promoting especially the end-of-life care given at home. When the management of life limiting illness is well-planned and organised, it can also be humanly good and economically sustainable.

The PATCH Service – Merging Oncology and Non-oncology to Provide anEqual and Expert Paediatric out of Hours Service
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The PATCH service (Paediatric Patient Advice by Telephone for Care at Home, Hospice and Hospital) is a specialist paediatric palliative care telephone advice service operating 24 hours a day, 7 days a week. The service started in 2010 for oncology patients and delivered a successful service over the following 3 years. In 2013 the PATCH service was developed further to cover non-oncology patients. The Paediatric Palliative Care Consultant who works across both Primary Treatment Centre (PTC) and Hospice observed an inequitable service for the two patient groups. Following review of an audit that took place for the oncology out of hours service the external professional service user feedback highlighted that they ‘wished’ there was a PATCH service for all their symptomatic/end of life patients and not just the oncology patients.

Government documents ‘Better Care Better Lives’ (DoH 2008) and ‘NHS Commissioning Board’ (2013) recommended that paediatric palliative care should provide a 24/7 on call service where possible for expert advice for children/ young people’s families and professionals involved in their care.

The PATCH team is funded and staffed equally between the PTC and the children’s hospice. The on call offers a two tier system which allows for a prescriber and senior practitioner to be available on all shifts.

The PATCH team have weekly multidisciplinary team meetings and teaching to share knowledge and discuss medical and nursing management of the current caseload. The number of referrals has seen an increase since the non-oncology patient group has joined. There has been positive feedback from families via audit to aid continued positive development of the service, the audit trail will continue to connect data to demonstrate that the PATCH service is as highly regarded by the non-oncology patient group as it has been by the oncology patient group in the previous audit.

Poster Sessions (Poster Exhibition Set 2) 219 14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015
Abstract number: P2-226
Abstract type: Poster

**Developing a Strategy for Advanced Care Planning: Choosing what Not to Do**

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**Background:** Advanced care planning (ACP) is the process of discussing and recording patient preferences around their choices for the future care and could potentially improve end of life care. Despite increasing evidence regarding ACP, uncertainty remains on the best way to do this. The regional network which is a virtual organisation comprised of commissioners, partners of specialist palliative care and end of life care services, patients and carers have appointed a clinical lead to guide this process.

**Aim:** To develop a comprehensive regional strategy for a system wide process to support community, hospital and hospice care and long term condition care and to facilitate and record shared conversations on standardised documentation. Training and public engagement are fundamental to promoting and maintaining change.

Abstract number: P2-227
Abstract type: Poster

**Bridging the Gap – How Research-ready Are Palliative Care Services in Sussex?**

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**Background:** The Sussex Palliative Care Research Specialty Group (SPCRSG), a regional UK research group was set up to promote palliative care (PC) research and increase recruitment in Sussex. However, the research needs and capabilities of organisations represented by the group were unknown.

**Aims:** 1) To identify factors that promote Sussex PC services to participate in research and barriers encountered 2) To understand research capabilities of services

**Methods:** A postal survey was sent to the clinical leads of all Sussex PC services. The 14 services included 7 independent hospices, 5 NHS hospital PC teams and 2 standalone community teams. Survey questions covered items related to service details, service research experience and capability, and barriers/factors promoting PC research. Collated results were analysed. Summary statistics used.

**Results:** The response rate was 100%. Within the 14 Sussex PC services, less than a quarter stated that they had been involved in PC research in the last year. Nearly 60% of services had research included in their business or strategic plans, but one third did not have a specific nominated research lead. Enthusiasm/motivation for potential research involvement was the most common factor cited to enable participation (7/14), as well as previous research experience (4/14). Time constraints were most commonly cited (10/14) as barriers to participation and lack of research experience (4/14). Access to a research nurse (6/14) and dedicated research time (4/14) were cited most commonly as helping services participate in future palliative care research.

**Conclusions:** There are unmet research needs for PC services across Sussex (regardless of whether services are voluntary sector or NHS services). These need to be addressed to establish research capability. Future directions involve inter-regional collaboration between other interested research networks and development of a local research infrastructure to support successful delivery.

Abstract number: P2-228
Abstract type: Poster

**Development of Continuous and Complete Palliative Care in Zagreb Improved by the Multidisciplinary and Interdisciplinary Approach and Teamwork**

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The aim of this study is to emphasise the improvement of palliative care development in Zagreb achieved by implementation of basic principles of palliative care. Multidisciplinary and interdisciplinary approach to palliative patients and their families as well and the service organisation contributed to the better quality of care and the growth of palliative care network.

Development of palliative care in Zagreb has started 20 years ago but only four years ago significant changes have started taking place. They were induced by the initiatives on the levels of the society: general public, professionals, local and national authorities. In the City of Zagreb three teams have developed their domiciliary palliative care activities and mutual collaboration, research based charity as a non government organisations (social worker and volunteers support patients and families), a project mobile team supported by the national health insurance (doctor and nurse provide symptom control) and a coordination centre for palliative care support (the best quality specialist plans care at home and coordinates palliative care teams and all the service providers and different health care levels). Even the teams are based in different organisational setting and team members meet different needs they work together as one broad team providing care for the same patients. Through continuous meetings, joint education and supervision team members accomplish personal and professional growth as individuals and within the team. In such a way the help to patients facing life threatening illnesses and their families is not just the sum of services but complete and continuous care. Despite the current growth palliative care development in Zagreb requires time and effort for more improvement and has a support of ‘Strategic Plan for Development of Palliative Care in Croatia 2014–2016’ issued by the Ministry of Health.

Abstract number: P2-229
Abstract type: Poster

**Developing a Primary Care Computer Record Search to Facilitate Identification of Patients with Palliative Care Needs**

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**Background:** Most palliative care in the United Kingdom spent much of their last year at home and could benefit from a palliative care approach during that period. However less than 30% of people with non-malignant disease are identified for such an approach before they die. The use of information technology currently in place in general practices provides an opportunity to systematically identify more people for a palliative care approach at an earlier stage than presently.

**Aim:** To develop a primary care electronic record search to identify patients with unmet palliative care needs.

**Methods:** A computer record search was developed and tested in fifteen general practices in two Scottish health boards. A sub-set of patients identified by the search were selected for further review and care planning by GPs. Quantitative and qualitative data were collected to assess the impact of the search on practice behaviour and attitudes towards the search among professionals and patients.

**Results:** The electronic record search successfully identified between 0.6 and 1.5% candidate patients, some of whom the practice reviewed and identified as having palliative care. Starting an Anticipatory Care Plan, and sharing it within Out of Hours services using a new national system which updates secondary care daily was the most common action GPs undertook for patient identified by the search.

**Conclusion:** Electronic searching of primary care records can identify a shortlist of patients to assess for palliative care needs. Regularly producing such lists at team meetings can increase the number of non-malignant patients with anticipatory care plans shared with secondary care. Computer searching for patients with advanced diseases in primary care and an electronic system for daily sharing of key information about such patients should be further explored.

Abstract number: P2-230
Abstract type: Poster

**Implementing a Dignity Care Intervention (DCI) for Individuals with Life-limiting Illness in a Community Setting in Ireland**

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**Background:** Evidence indicates that people at end of life fear loss of dignity more than anything else. What defines dignity for the individual patient and his or her family is unique. A central tenet of palliative care is to help people die with dignity. Whilst there has been an increase in emphasis on care in the community, there is lack of guidance on palliative care for vulnerable community healthcare professionals.

**Aim:** To implement a Dignity Care Intervention for individuals nearing the end of life in a community setting in Ireland.

**Methods:** The RIC Framework for Developing and Evaluating Complex Interventions was used for this multiphase mixed methods study.

**Phase 1: Contextualising the DCI tool using focus group interviews with user/carer representatives (n=10) and community nurses (n=18).** These explored the use and applicability of the tool for an Irish context.

**Phase 2: Educational programme for community nurses (n=94);**

**Phase 3: Implementation and evaluation of DCI in practice: 4 pilot sites, across rural and urban areas are implementing the DCI tool in practice.**

**Results:** Findings from Phase 1 identified issues such as reluctance to discuss feelings; having a desire to please other along with issues of communication within the patient and care context. Feedback from the educational sessions indicated an increase in confidence and competence for implementing the tool in practice. Realistic evaluation approach is ongoing including focus groups (n=4) and semi-structured interviews with patients and carers (n=20).

**Conclusion:** The complexity of implementing a tool in practice cannot be underestimated. Greater understanding of such issues will contribute to the future development of practice and subsequent improved care for patients approaching the end of life.
Integrated Community Palliative Consulting Care Team
the Active Care in Hungary

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Background: Cancer patients are seen in a variety of clinical settings. Many evidence describes that palliative care reduces the symptom problems, improve the quality of life. Some evidence describe that after the palliative consulting service the 51% of patient transferred to others hospice care. Our palliative care consult team is a group of dedicated health care professionals working together. Our services include both inpatient consultations and ambulatory care clinic visits.

Goal: We can help to the pain management and other physical and/or emotional symptoms, to facilitating support function, to helping patients and to navigating advanced care planning (home care, outpatient palliative care, inpatient palliative care). We aim to improve the quality of living and dying for patients and their families coping with challenging, advancing, or life threatening illness.

Methods: The palliative consulting care team – such as pilot program – started 2 years ago in the University of Pecs Clinical Center. In the team have 2 physian, 1 psychologist and 1 palliative nurse coordinator. The palliative nurse coordinator specialist is available 8:00-16:00, five days each week, and during the weekends answers the advice line as well as being available for face-to-face consultations in the clinical profile of 28 different departments.

Results: The total number of palliative care consulting was 450 cases. We found, that after the consultation, the families preferrence the home care better and that reduce the number of hospital admissions. The poster describes the experience, and the use of task of consultative care.

Conclusions: That consultations with a palliative care team are beneficial and enhance the patients’ discharge time increases.

Supporter: University of Pecs Clinical Center and Pecs-Baranya Hospice Foundation

Improving Palliative Care in North Wales

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The Betti Cadwaladr University Health Board (BCUHB) provides community palliative care to a population of nearly 700,000 people across an area of over 6,000 km². In seeking to address the emerging challenges of providing effective community palliative care across a largely rural area, a greater use of informatics has been advocated. Existing specialist palliative care services are delivered by small teams with accredited training which support the complex needs of patients, families, carers and healthcare professionals. As part of the wider Welsh Assembly Government (WAG) strategy ‘Developing Primary and Community Services’[2], we explored ways to improve efficiency in the delivery of this care. As well as improving the use of wireless technology through enhanced bandwidths at existing community hospitals, all community palliative care clinical staff were issued with the most suitable VPN-enabled hardware with an integrated video conferencing facility. Enhanced use of informatics sources is to optimise utilisation of specialist knowledge and skills by increasing time for patient contact and medical education. These telehealth solutions standardised professional working practice by optimising clinical record keeping and data input as well as reducing travel times. Consistent with the national programme ‘Together for Health – Delivering End of Life Care’[3], more efficient team working enhanced the quality of care given to patients and their families during palliative treatment. This was captured by the current ‘Want Great Care’ national survey.

This project was funded with £72,000 from the Welsh Assembly Government ‘Health Technology and TeleHealth Fund’.

(2) BCUHB: Health Technology and TeleHealth Fund ‘Developing Primary and Community Services – Project Initiation Document’ (2013)
(3) WAG ‘Together for Health – Delivering End of Life Care’ (2013)

Funding Initiatives for Palliative Care in Kenya: Building Support through Membership Schemes – A Case Study from KEHPCA

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Background: Kenya Hospices and Palliative Care Units (KEHPCA) is the overarching body that supports all aspects of Hospice and Palliative Care throughout Kenya. From its inception in 2007 it has supported the growth of palliative care from 14 providers to over 50 providers in the country, serving a population of over 40 million people. Like many other developing countries, Kenya is faced with an increasing number of patients faced with life limiting illnesses such as cancer, diabetes, HIV/AIDS, hypertension among others. Majority of these patients present late where cure is not possible and the only option is palliation hence the growth in the number of patients in the country in need of palliative care services.

Aim: To address sustainability in palliative care.

Methodology: KEHPCA is a non-profit organisation and the grant funding it receives is extremely generous but this is restricted to specific programs of work such as training and advocacy leaving a need to raise unrestricted funds. Funds raised from unrestricted funds helps KEHPCA in purchasing morphine and other pain relieving medicine for patients with life limiting illnesses, developing infrastructure, including a financial viability report.

To publicise our new service and make people to feel comfortable to have home treatment. The project will be completed in May of 2015 and we will be able to present all results at the EAPC 2015 Congress.
Abstract number: P2-236
Abstract type: Poster

‘Plus Sport la Vie’ Physical Activities (PA) Program for Patients with Cancer

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Background: Many studies indicate that physical activity (PA) can contribute to maintain physical function in patients with advanced and progressive disease, with a good impact in quality of life. Some physical and psychological symptoms can be improved (fatigue, sleep, mood, pain, alterations…). Improvement of survival length is shown in some study (High grade relapsing Gloma, ≥ 7 months).

Aims: Setting up an adapted PA program for patients with cancer during or after therapy: running, challenges, prospects.

Method: Introduction to the design of the project, activity sessions report since March 2013.

Results: ‘Plus Sport la Vie’ program is a tripartite agreement Marseille University Hospital–School of Medicine – Ligue contre le Cancer. It has been made for any patient regardless of the cancer treatment center, allowing an access to adapted physical activities per week taught by cancer specialist trainers. From adapted physical training in the Faculty of Medicine’s gymnasium and outside, in a natural park. Written and oral communications about this program have been performed. We created a sport and cancer association, resulting in a departmental broadcasting. It has funded a training ‘sport and cancer’ for a physical activity educator.

Discussion: Although PA prescription is now recommended at diagnosis of cancer, it is not often done. Many barriers to this practice have been identified, especially in cancer advanced stages coming from PA proposal, organisation, patients and physicians. This non-drug therapy is based on the only will of the patient. Developing psychological support, dietary counseling and link with therapeutic education program in association with PA are under study, as well as the development of research project.

Conclusion: Feedback from patients who participated in the program are very good, with improved fitness, reduced disease symptoms and treatment side effects, as studies made us hoping. Sustaining the program remains a priority.

Abstract number: P2-237
Abstract type: Poster

Municipal Institutions that Provided Special Palliative Care Programmes in Denmark

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Background: Research has shown that the number of Danish municipal institutions that provided special palliative care programmes (MISPC) has increased during recent years. The aim was to map and examine the characteristics of MISPC in Denmark.

Method: The research followed a mixed-method design combining quantitative questionnaires, mainly answered by directors of municipal health departments, directors of nursing homes and palliative nurses, with qualitative interviews with representatives from ten of the MISPC involved in the questionnaire.

Results: The research found that 40 institutions in 34 municipalities provided special palliative care programmes. Alone from 2012–2013 the number of the institutions increased by 43%. The establishment MISPC was based on a mixture of political, economic, geographical and professional grounds. Most of the institutions had of the institution included to ten beds and mostly housed elderly people with life-threatening diseases. The palliative care programme had a holistic perspective with focus on everyday life, activities and rehabilitation, symptom management and end of life care. The professionals working with palliative care, mostly included care-assistants, nurses, occupational therapists and physiotherapists. Only nine institutions had a physician attached and only one third of the institutions in the survey offered training in palliative care.

Conclusion: The research showed a difference in the composition of professions in MISPC compared to palliative institutions. MISPC’s focus on everyday life and rehabilitation may be caused by employment of more groups of therapists and social and health care workers, which could affect MISPC’s ability to provide palliative care and not offer outpatient palliative care services. Just as only few physicians attached to the institutions could add to the pressure on general practice.

Abstract number: P2-238
Abstract type: Poster

From Pioneers to Recognition – Developing Palliative Care in Sweden

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Background: The general development of palliative care in Sweden during the last decades has been positive in terms of official recognition, professional development, availability of services and professional competency.

Aim: To describe the development of PC in Sweden through the perspective of official and professional documents and activities.

Methods: Activities, documents and different initiatives related to PC development were collected through members of the board of directors of the National Council for Palliative Care (NRPV) and through the archives of the Council.

Results: The Swedish Society for Palliative Medicine (SFPM) was founded in 1997. A curriculum for education in Palliative Medicine, based on the UK and EAPC curricula, was published in 2004. NRPV was founded 2004 with economical support from the government, and consists of 11 professional PC national organisations. NRPV is responsible for the national PC conferences and publishes the Swedish palliative care periodical.

The Swedish register of Palliative Care was initiated in 2006 with the goal to collect data from all expected deaths in Sweden. Registry variables reflect quality indicators aiming at increasing quality of end of life-care. SPN – Swedish Palliative Care is the monthly electronic national newsletter reaches approx. 4000 e-mail addresses. A government recommendation 1995 listed patients in need for PC as the highest prioritised group for health care. Research was initiated in 2006 by the government and national directives for PC in 2013. Palliative medicine will become a medical subspecialty in 2015. APC is integrated in the official funding of health care.

Conclusions: There have been an increase in educational and official supportive activities, initiatives and documents in PC during the last decades. Next priority is education for professionals as well as equity of access to quality assured PC.
Background: Around half of all deaths in England occur in hospital, even though many like to die in their own place of care. It is recognised that health care professionals are required to respect patients wishes to achieve preferred place of death. We aimed to document the baseline quality of discharge documentation of those patients discharged home to die for end of Life Care.

Objectives: To check relevant pathways used effectively & patients who were discharged home for end of life care given appropriate medication, healthcare professionals are communicated to coordinate the support the patient/carer likely need.

Methodology: Retrospective case note review of 50 patients who were discharged home for end of Life Care. Patients were identified using referrals to Crisis Support Team. The following items were checked: Home to Die check list, discharge discharge (from medical notes entry), GP (District nurse informed, palliative care form completion, crisis medications prescribed, documentation of patient discharged home to die (for end of life care) in EDN, DNACPR for completed and communicated to GP, DNACPR sent with the patient.

Results: 27/30 had poor completion of Home to Die check list. 29/30 had poor completion of palliative care handover form. 18/30 discharged within 48 hours of decision to discharge. 9/30 patients had GP informed, 20/30 had District Nurses informed. 14/30 had evidence of medications review. 28/30 had crisis medications prescribed. Only 5/30 patients had clear documentation of Discharged Home to Die in their discharge letter. 23/30 had DNACPR form completed and communicated to relevant professionals. 10/30 patients had their DNACPR forms inappropriately left in their notes.

Conclusion: We found overall need for improvement in documentation and communication to community & district nurses and Palliative care team. We plan to update the discharge check list, EDN and educate the teams to improve the situation.

The Impact on Care for Cancer Patients of a Cancer Support Team in a University Hospital in Japan


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Aims: To evaluate the effects of a cancer support team in a university hospital.

Methods: We established a multidisciplinary cancer support team (palliative care physician, psychiatrist, nurse, pharmacist, medical social worker and physiotherapist) in April 2008. We analysed all cancer patients referred to the team during a period from 2008 to 2013.

Results: In the past 6 years, 2421 cancer patients were referred to the team. Approximately 40% of the patients were under treatment of chemotherapy and/or radiotherapy. The annual number of patients increased gradually. The median period of intervention was 17 days. The reasons for referrals were pain (39%), anxiety/depression (31.5%), insomnia (27%), delirium (5.9%), edema (3.7%), fatigue (2.2%), and nausea/vomiting (1.5%). The others were family support, drug administration guidance, and discharge support.

Discussion: The total number of referral is more than tripled in comparison with the average. The annual number of patients increased gradually. The median period of intervention was 17 days. The reasons for referrals were pain (39%), anxiety/depression (31.5%), insomnia (27%), delirium (5.9%), edema (3.7%), fatigue (2.2%), and nausea/vomiting (1.5%). The others were family support, drug administration guidance, and discharge support.

The Possibility to End Life at Home – A Measure of Good Palliative Health Care?

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Every individual has the right to be involved in the design of their well-being. Many critically ill patients state a desire to end their lives in their own homes. Both the patient and their families must experience that the situation is secure in order for a patient to be able to end their lives in their own homes. If not, hospital care or other in-patient care are the only options available. ASH-healthcare providers in Stockholm have a long common mission for advanced home care. This means that one can compare the operations (14 pcs) from different perspectives. The percentage of enrolled who die at home in relation to the total number of deaths in the home or in direct connection to ASH-healthcare varied in 2009 from 18%–64% between the various healthcare providers. The possibility for patients to have health care in the home at the early factors, such as family members’ willingness and energy to care for the patient at home, access to healthcare providers (ASH) and physical ability to adapt the home for the patients need. It also requires that healthcare providers provide support and wellbeing to the families in terms of feeling secure and well-cared for. This also involves offering fast access to healthcare providers both day and night. Perhaps the most important factor is the team’s (nurse, doctor, physiotherapists) expertise and ability to prevent unwanted outcomes by detecting the patient’s need for support and care initiatives in time if the above requirements are met, conditions are created to give the patient and their families the wished-for end of life care.
Service Redesign: Development of a 24/7 Triage Service

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24 hour seven day a week telephone advice has been provided by the hospice for several years. Calls outside traditional normal working hours were dealt with by nursing staff working within the inpatient unit of the hospice and were reported to cause a significant distraction from face to face patient contact. Patient and relative feedback indicated a wish to have a single point of contact for advice.

In response to this, a decision was taken to implement a dedicated advice and telephone support service for patients, relatives and health and social care workers. Several models of service delivery existed within the United Kingdom, usually led by nurses operating at an advanced practice level. No extra funding was available for a service development and the nursing establishment was reconfigured to enable the commencement of a 24/7 Triage Service. The service is staffed by Registered Nurses at a registered practitioner level.

In the first month of the service, without any formal publicity to the local community, 994 calls were handled and 124 patients were supported by the service. This represents a significant reconfiguration of activity. Initial feedback across the hospice service indicates a positive response with staff being freed up to concentrate on their patient care. Patients have offered feedback demonstrating a positive experience of their contact with the service. The nursing staff providing the service have found the experience positive and anticipate on-going professional development of skills in communicating and caring through telephone contact. The service has been implemented with minimal additional cost and utilising a lower grade of nurse than that commonly used in similar services and demonstrated the effective use of the hospice communication infrastructure including the electronic patient record. Formal evaluation will be undertaken at six months.

Abstract number: P2-248
Abstract type: Poster

Rehabilitation for People Living with Cancer

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Background: A growing body of evidence shows that many patients with advanced cancer disease have unmet PC needs at an early stage of their disease trajectory, and several studies indicate that these patients benefit from a PC intervention. It seems logical, that a PC intervention aiming at patients in earlier phases should be tailored differently than for end phase patients, and contain elements of rehabilitation. We developed and established an out patient service ‘Rehabilitation for people living with cancer’ which opened in January 2014 at a national cancer centre.

Aim: Our overall aim is to improve patients perception of health and quality of life.

Methods: We based the development of the service on
- Studies of symptoms and needs in the population
- Reviewing relevant literature
- Reviewing clinical guidelines
- Studying best clinical practice
- Our own expertise and experience as a specialist palliative care team

During the first year we continuously evaluated the service with patients, and implemented changes according to their feedback.

Referral criteria: Advanced cancer disease, complex symptomatology and suitable performance status. Patients were seen by doctor and nurse and screened with EORTC–QLQ-C30 before and after the 12-weeks intervention, and presented at our multi professional team meeting.

Possible interventions: Physical exercise in small groups, Educational programmes in groups for patients and relatives addressing physical symptoms, social, existential, and psychological issues. Dietary advice, individual consultations by psychologist, O&O, dietitian, doctor, nurse, physiotherapist etc.

Results: Details of the service and of all referred patients and results from pre- and post EORTC–QLQ-C30 screening of the first 50 patients who completed the programme will be presented.

Discussion: This is a description of a pioneer- and pilot project. Further research is needed and a RCT of the service starts up December 2014.

Abstract number: P2-249
Abstract type: Poster

An Interdisciplinary Assessment Tool

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A so-called S-analysis supports the interdisciplinary collaboration in a hospice. In this way we work in every aspect is grounded in the knowledge of the patient and the patient's participation, wants and needs. The intention is that the patients experiences that he or she is seen as a human with own thoughts and choices in the last part of life.

To fulfill the hospice philosophy, data was collected in dialogue with each patient regarding
- Our own expertise and experience as a specialist palliative care team
- The patient's participation, wants and needs. The intention is that the patient experiences that he or she is seen as a human with own thoughts and choices in the last part of life.

In the hospice context we exploit a broad variety of tanatological items where needed. All professional groups contribute with their knowledge to illuminate the patient's 5 status. We find, that the S-analysis when conducted interdisciplinarily is a valuable tool which helps us to set the direction for the specific palliative initiatives, each patient can benefit from.

An oral presentation will illustrate and broaden this more closely.

Abstract number: P2-250
Abstract type: Poster

Cooperation between Nurses and Medical Carers and Other Specialists in Hospices, Nursing Homes and Long Term Care Units in Poland (Pilot Study)

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Background: Real collaboration, not merely simultaneous work of different specialists, allows to improve patients quality of life efficiently. Cooperation between nurses and medical carers, who work close to patients, is of a great importance.

This applies not only to palliative care units, but also long-term care and nursing homes, where people who need palliative approach may stay.

Aim: We aimed to define the characteristics of cooperation between nurses and medical carers in different places of care. In addition we assessed the specificity of multidisciplinary approach in the hospice care and verified applicability of questionnaire for further research.

Method: Diagnostic survey was implemented. Anonymous questionnaire was sent to randomly selected hospices, nursing homes and long-term care units in Poland - one in each district (48 places in total). 136 questionnaires were returned (35% medical care practitioners, 65% nurses) from 16 units.

Results: 91% responded cooperated with more than 3 specialists while performing their duties. Almost equal number of participants wanted to be satisfied with the scope of their duties, as to have too wide one. Analysis of open questions showed that 36% of participants indicated atmosphere in the workplace as important factor of satisfaction with cooperation, followed by organisational aspects (30%) and communication in the team (17%).

In hospices, more respondents (91%) cooperated with physicians and psychologists.

Conclusion: Hospices differ from nursing homes and medical care units in many aspects of team work. Most participants indicated atmosphere as factor of good cooperation, which is difficult to operationalise. It is necessary to search for methods of providing high level of inter-professional cooperation in different settings of care.

Abstract number: P2-251
Abstract type: Poster

Knowledge and Attitudes of Palliative Care Teams of Oncology Centers in Mexico

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Aim: The aim was to analyse the degree of knowledge and attitudes of PCE and post-training through a survey before and after your workout shape evolution, measuring the degree of progress to the academic activity.

Diagnostic survey was implemented. Anonymous questionnaire was sent to 44 surveys PCE and the level of basic knowledge of practitioners, 65% nurses) from 16 units.

Results: 91% respondents cooperated with more than 3 specialists while performing their duties. Almost equal number of participants wanted to be satisfied with the scope of their duties, as to have too wide one. Analysis of open questions showed that 36% of participants indicated atmosphere in the workplace as important factor of satisfaction with cooperation, followed by organisational aspects (30%) and communication in the team (17%).

In hospices, more respondents (91%) cooperated with physicians and psychologists.

Conclusion: Hospices differ from nursing homes and medical care units in many aspects of team work. Most participants indicated atmosphere as factor of good cooperation, which is difficult to operationalise. It is necessary to search for methods of providing high level of inter-professional cooperation in different settings of care.

Abstract number: P2-252
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 2)
Increasing the Number of Legal Oral Morphine Prescribers in a Resource Limited Setting

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Background: The number of cancer cases especially in low and middle income countries is estimated to double by 2030. In 2009, 200,000 South Africans died with moderate to severe pain (Wilma 2012) and according to Mermans, more than 200,000 Ugandan patients are in need of pain control and yet access to morphine prescribers still remains a challenge. Aims: 1. To equip clinical officers (Medicine Diploma graduates) with the knowledge and skills to prescribe morphine for pain management and to help in integrating palliative care services into the existing health services structure. 2. To train clinical officers in providing appropriate palliative care services to patients after doing a thorough pain and symptom assessment 3. To develop the competencies of clinical officers in prescribing morphine and adherence to the necessary legal requirements and practice.

Methods: Students were randomly selected from various parts of the country and subjected to class teaching for four weeks and thereafter taken for a two weeks clinical placement in various Hospices and Hospital palliative care units to translate the class theory into practice.

Results: A total number of eighty Clinical Officers were trained and equipped with impeccable knowledge on pain assessment and morphine prescription in accordance with national and international guidelines.

Conclusion: The training of clinical officers and other health professional that are the primary contacts for the majority of palliative care patients need to be supported and funded by all partners. Countries need to integrate palliative care into their main stream health care services as well as training curricula for paramedics and other health professionals and to stock oral Liquid Morphine at all levels of health care. Other countries can emulate this example to amend their laws to allow specially trained Clinical Officers and Nurses to prescribe oral liquid morphine for palliative care pain management.

Abstract number: P:2-56
Abstract type: Poster

Pretending to be Dying
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Introduction: The benefits of online learning and patient simulation have been extensively studied. These technologies solve a myriad of dilemmas inherent in the Australian context. The tenants of Palliative Medicine: excellent symptom control and communication, optimisation of quality of life, patient-centred decision making and utilisation of the multidisciplinary team are increasingly being seen as vital skills for all doctors regardless of their area of practice. But how do students feel about digitised learning in the palliative care context?

Aim and design: To explore the reactions of final year medicine students to patient scenarios presented in video format and to concepts of simulated patients in the teaching of Palliative Medicine. Three focus groups (n=22) were provided with a copy of an online-learning package. They were asked to respond to a series of questions in free text. Thematic analysis was used to analyse the data.

Points for discussion: This preliminary work indicates that students have specific concerns regarding use on line and simulated patients in the Palliative Medicine context. They expressed a strong recognition of the importance of confronting the issues inherent in palliative care and felt that the digital environment both protected and buffered them from this experience. Students expressed a wish for palliative care to be different from other areas of training and to provide ‘real patient’ and ‘real educator’ interaction in a way that they perceived as lacking elsewhere. The students felt unable to ‘suspend their disbelief’ and effectively respond to actors portraying terminal illness and dying patients. When asked for their preferred teaching method the majority of respondents indicated ‘bedside teaching’. This work runs counter to the bulk of current work in this area and poses an important question for further studies and for the Palliative Care community.

No additional funding was utilised for this project.
Mobile information technologies, including tablets and apps, are becoming ubiquitous in today's health care environments. In addition to accessing patient information at the point of care, they also present exciting platforms and opportunities to support just-in-time learning. Peer-reviewed learning and End-of-Life Care (EOLC) courseware and training materials produced nationally for use across Canada and abroad provide a framework for a suite of products for mobile devices and desktop computers that support distributed learning and clinical decision making at the point of care. New e-learning apps will be demonstrated including ‘Doodles’, ‘Snippets’, and ‘MindMaps’. Doodles are short (1 to 3 minute-long) YouTube-type videos that combine voice-over narration with animated sketching to provide dynamic presentations, as ‘Who provides palliative care?’ and ‘Better Early than Late’. Snippets are short online modules (2–5 minutes long) on various topics such as, ‘Discussing opioid side effects’, often with short videos to demonstrate techniques. MindMaps draw upon cognitive psychology research on how people store information. The interactive maps (available as a website and as apps) use a trunk-branch-twig format to provide essential clinical tips on the essentials to providing Palliative and End-of-Life Care. These include tips on pain and symptom management, communication, psycho-social and spiritual care. Upon completion of the workshop participants will:

- Gain an understanding of the Learning Management System (LMS) that supports e-learning apps
- Learn how to access just-in-time teaching/learning e-resources to support best practice bedside care
- Be invited to recommend future Palliative care training e-learning topics. These resources support just-in-time learning across the learning continuum, from undergraduate, to postgraduate and professional development, across different disciplines, and mainly at the point of care.

Abstract number: P2-258
Abstract type: Poster

How End of Life Care Facilitators within an Acute Health Trust have Improved End of Life Care through Different Styles of Education

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Aim: To improve end of life care through education and training for all health care professionals working within the Trust ensuring that all patients nearing the end of life and their families feel that they have not been cared for 'luck' but is evidence based and delivered with care and compassion.

Method: The end of life facilitators in conjunction with the specialist palliative care team have implemented a number of different styles in education and training to meet the needs of all health care professionals working within an acute trust. These range from formal teaching sessions/study days to bespoke one to one adhoc clinical based training. To raise the profile of the educational opportunities on offer, awareness stands and e-learning packages have been implemented.

Results: All education provided has been well evaluated and so far 3688 HCP have attended or completed EOLC education over a 2 year period. This has had a positive impact on patient care particularly medication prescribing, documenting preferred place of care and the importance of communication with patients and those who are important to them. Conclusion: The aim of the role was to improve education and training for all health care professionals. The implementation of the facilitator’s role within the acute hospital trust has significantly raised the awareness of the need for end of life care education. However there are some inconsistencies in certain areas and the challenge in releasing staff to attend education remains a problem. End of life facilitators continue to develop innovative approaches to address these issues and will continue to raise the profile of end of life care through education.

Abstract number: P2-259
Abstract type: Poster

Implementation and Evaluation of a Four-year Integrated Palliative and End-of-Life Care Curriculum for Medical Students

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Background: Graduating medical students do not consistently feel competent to provide palliative care. We created, implemented, and evaluated a four-year medical student curriculum in palliative and end-of-life (eol) care.

Aims: - Create and implement a longitudinal, integrated curriculum to promote the acquisition of primary palliative and eol care competencies.
- Evaluate the effectiveness of the curriculum with a multi-method approach.

Methods: Learning objectives were defined for each curricular component which included seminars; standardised patient and interprofessional workshops; hospice experiences; communication and reflection exercise on clerkships, online interactive modules. A multi-method curriculum evaluation included: analysis of student written reflections and questionnaires; graduating student surveys; demonstration of students’ competency in palliative care with a newly created observed structured clinical examination (OSCE).

Results: Content on experiential components demonstrated meaningful engagement in the learning, with recognition of the complexity of patients’ reactions to dying and the value of the clinicians’ presence and the interprofessional team. Graduating students indicated that they have gained many important skills in the palliative care OSCE.

Conclusions: This effective curriculum is distinguished by these key features: - Employs longitudinal, developmentally appropriate, integrated learning - Utilises many different curricular teaching methods - Emphasizes experiential, skill building activities - Focuses on student self-reflection - Incorporates interprofessional learning and faculty - Includes spiritual and cultural aspects of care

- Utilises online, blended learning

With defined modalities and educational tools, components of our proven curriculum can be adapted for use in existing curricula.

Abstract number: P2-260
Abstract type: Poster

One Chance to Teach it Right: A Response to One Chance to Get it Right

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Background: One Chance to Get it Right, 2014 outlines 5 Priorities of Care for Dying People in England, highlighting the need for education to deliver high quality care. An integrated specialist palliative care service with designated education team, supports community, hospital & care homes within a well-curriculum described area in the North of England. We describe the educational response to this new guidance.

Aims: To provide local priorities of care training to all staff involved.

Method: A training package, developed to outline the 5 priorities of care for dying patients, is delivered by a team, within specialist palliative care services, to any staff – health care assistant to consultant, therapist to GP, cleaner to chief executive, across community, hospital & care homes. Strong Trust Executive Board & Clinical Commissioning Group leadership ensures staff are released for training.

Training emphasises the need for clear communication. Further education & support is delivered to reinforce learning following recent changes to the Individualised Plan for Care for Patients thought likely to be Dying. All who receive training are given a colourful handout & certificate of training. Supporting posters are displayed throughout the hospital, community, offices & care homes. Business cards have been developed to remind staff of useful terminology for speaking to patients & families.

Results: In the first 3 months training has been delivered training to 1696 individuals – 723 hospital, 392 community & 484 care home staff. We have visited & trained GPs in 76% of local GP surgeries. Training has been well received with a surge of enthusiasm & pride for the end of life care given locally.

Conclusion: A large-scale education drive has enabled delivery of Care of the Dying Training to large numbers of staff in a short period. This has made staff aware of their duties & responsibilities & generated a renewed culture where clinical & non-clinical staff strive for excellent care.

Abstract number: P2-261
Abstract type: Poster

What Are the Educational Needs of Palliative Medicine Trainees in the Assessment and Management of Pain in Patients with Dementia?

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Background: Pain in patients with dementia (PwD) is often poorly recognised and treated. Although specialist palliative care services are increasingly becoming involved in the care of PwD, little is known about the training needs of palliative medicine doctors in this area.

Aims: To assess palliative medicine trainees perceptions of their current skills in the assessment/management of pain in PwD and their perceived educational needs.

Methods: An electronic survey was sent to Palliative Medicine trainees with a national training number in the United Kingdom registered with the Association of Palliative Medicine (n=204, response rate 23%). Quantitative data was analysed using IBM SPSS Statistics Version 20 and content analysis was used for qualitative data.

Results: Median confidence scores (1–10 scale) for assessing/managing pain in PwD were 6 (IQR 5–8) and 6 (IQR 6–8) respectively. However, only 46% of trainees had received training on assessment, and only 26% having had training on management, of pain in this patient group. An awareness of pain assessment tools for PwD was not associated with higher perceived confidence in the assessment of pain, and only half of those indicating an awareness of tools had actually used them in practice. Factors shown to have an association with higher confidence levels were:

- the length of palliative medicine experience – for management of pain
- previous experience specifically in elderly medicine and the frequency of contact with PwD
- previous experience working with those with dementia

Conclusions: Palliative medicine trainees have moderate-high confidence in assessing and managing pain in PwD but relatively low levels of training specifically in this area and on the use of pain assessment tools.

Trainees expressed a desire for further training, preferably in a study day setting. Further work is required to determine the content of educational modules and to explore the potential benefits of cross-specialty training days.
European Palliative Care Academy (EUPACA) – Leadership Course

Frech Georg, K., Kofman J.2, Mosac D., Krakowiak P.4, Krajnik M.5,6 , Mitrea N.3, Gil Higues E.1, Monleon Just M.1, Cid C., García Adrados S., Sales T.T., Saez E., Barcelò Escotó M.3, Pita A.2, Fernández Gómez C.3, Ecobas M.4

Aims: The European Palliative Care Academy-Leadership Course is an innovative trans-continental postgraduate educational program in palliative care (PC). Participants are trained for future leadership positions to advance PC provision across Europe. The program takes place over 1.5 years and comprises one course each year in each of the four European academic institutions in addition to an ‘Observation Week’ at a chosen institution. Methods: By means of an online survey needs were assessed to inform the content and delivery of the programme prior to its commencement. 194 European PC professionals shared their views. Based on these findings, a steering committee comprising partner institution professionals determined course content and structure. They selected 20 participants according to previously determined criteria. Course evaluation was conducted by standardised questionnaires as well as an external evaluator.

Results: The needs analysis indicated that the course should be in English and divided into single week modules, run in each of the four countries. The modules comprise Personal Development, Project Management, Teamwork, Research Methods, Advocacy and Local Best Practice of each host country. The participants of the current program include 7 professions from 14 countries in eastern and western Europe (50%). The 20 participants with their personal projects have already ensured that the first course has enriched PC in Europe. Both internal and external evaluations support the aims of each programme has been well received.

Conclusion: The needs analysis identified a lack of postgraduate training opportunities to promote leadership in PC across Europe. The evaluation illustrated that course structure, organisation, and delivery were well below for the achievement of the learning objectives. The results of the evaluations will be used to make necessary amendments for successive intakes. In order to secure long-term sustainability of the programme, further funding partners are being sought.

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Abstract type: Poster

Madrid Training Program: Building Blocks to Bridge Clinical Knowledge and Understandability

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Background: Considered a right and a duty, professional development is a commitment shared between organisation and professionals. We set to Promote Training, Research, Development and Innovation to ‘Adaptative professional, volunteers and carers’ education for which a central training program was developed framed within a model of knowledge management that comprises one courses and professional development supported by competences improvement.

Methods: Descriptive, retrospective and quantitative 6 year period study for a 4 level training program to develop, analysing the qualitative changes in care provision and recruiting number of professionals trained from each of the disciplines involved in End of Life Care.

Results: Four level fully interdisciplinary program now in place. Places to attend are sought after a 6 day course in, and most independent units and health centers encourage their professionals to attend a) Basic: 20 hours 20 editions attended by over 2000 students b) Intermediate: 40hours 8 editions attended by 240 students c) Consolidation level: 15 hours/ 5 weeks, 2 editions, 30 students d) Advanced: 8 hours 16 study days, over 500 students.

Expert: 8 hours 4 Study Days, 120 students Disciplines: Doctors, Nurses, Nursing Auxiliaries, Social Workers, Pastoral Care Workers, Psychologists, Physiotherapists, Occupational Therapists and Emergency Care. A detailed summary of topics taught, budget available and time.

Conclusion / Discussion: Changes have been observed: more integral focus on PC approach, relationship establishment in professional care, better supported improvement communication skills round patient and family related to holistic assessment, ethically focused advanced care planning and bereavement, Preferred Place of Care Death, discomforted and reduction in complaints.

Abstract number: P2-264

Abstract type: Poster

Planning for the Future: Increasing the Advance Care Planning Confidence of District Nurses

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Aim: The project is a small scale study of the knowledge, skills and confidence of district nurses to engage in advance care planning (ACP) conversations with palliative patients at home. A teaching package was delivered to discuss advance care planning and a tool designed to support and documents these conversations to improve communication. This was followed by an evaluation of project and its implications.

Background: The End of Life Strategy (NHS, 2008) identified the lack of open discussion between health and social care staff, those approaching the end of life and those who care for them, as one of the key barriers to the delivery of good care. The key finding of this review supports the evidence that ACP should be integrated at end-of-life discussions and that good communication is the cornerstone of a therapeutic relationship with the patient and their family. ACP is a process which enhances quality of life, therapeutic communication and value patients autonomy.

Method: Quantitative data was collected using questionnaires and auditing current practice. The delivery of an advance care plan presentation and introduction of a documentation tool was initiated followed by post analysis and evaluation of its impact in the advance care planning process.

Results: The initial data identified the district nurses had neither received training and or had reduced confidence in implementing the principles of advance care plan communication. Following the project the data revealed the positive impact the tool and support training provided had on the district nurses approach to advance care planning. DNs recorded number of patients had been given an ACP pack increased form 30% – 70%, those with ACP discussion from 20% – 70%, those whose wishes & preferences were reviewed increased from 30%–90% those with other items from 0-10% patient & carer wishes reviewed in last days 45%–100%.

Conclusion: All aspects of ACP discussion & documentation had improved considerably.

Abstract number: P2-265

Abstract type: Poster

Community of Practice: Developing a Cross-Border Community of Learning for End of Life Care

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Background: It was planned to make community & hospital Band 6 nurses within the Trust responsible for End of Life Care. In order to prepare them for and support them in this new role they formed a Community of Practice led by Specialist Palliative Care Services.

Aims: To improve the quality & experience of End of Life Care for all patients & families, across the trust.

Method: Gained support from Director of Nursing & Trust board to drive this 11 month initiative. These influential Band 6 nurses leaders from all areas of the KO joined together to assess gaps in knowledge, meet frequently to learn, enthuse, support one another with ideas, share good practice, and encourage the promotion of good End of Life Care within their own work areas. All undertook the End of Life Skill Set Challenge development programme and are auditing End of Life practice within their own areas. They have celebrated their successes at the end of the year.

Results: The programme will be completed by the end of the calendar year. Achievements to date include audit of spiritual needs assessment with a resulting development of a Spiritual Care Plan for use across the Trust, improved working relationships between hospital & community staff, audits spanning every aspect of End of Life care from medication to conversations about dying. This presentation will include the number of staff who complete the End of Life Kit Skills Challenge, a summary of the End of Life audit results, qualitative & quantitative feedback from participants undertaken independently by local university staff.

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Abstract type: Poster

Evaluation of Palliative Care Education in Japanese Pharmacy Students

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Background: Palliative care education for pharmacy students and pharmacists is now developing in Japan. We initiated lectures about palliative care pharmacy therapeutics for undergraduate pharmacy students in Hokkaido Pharmaceutical University from 2010, and took the lead in palliative care student education nationwide. Our prior study showed significant increase in knowledge about palliative care just after the lectures among the students.

Aims: Our aims of this study are to estimate the long-term changes in knowledge about palliative care in pharmacy students through lectures and clinical trainings and evaluate the efficacy of our educational program.

Method: Our palliative Care program consisted of essential 15 lectures for 5 grade pharmacy students. We followed pharmacy students who took palliative care lectures until they finish clinical training about 18 month later. We compared scores of Palliative Care Knowledge Test (PCKT) which include 20 questions at all lecture courses, and current self-assessment of palliative care knowledge and their practice.

Results: The mean total score of PCKT was 9.4±2.6 (standard deviation) (SD) 3.3 to 10.8 (SD 2.4) among 87 students, but it was not statistically significant. More than 90% of students answered correctly for questions about philosophy of palliative care. However, even after lectures and clinical trainings a 20% or the score was decreased from before lectures among some questions about (dyspnea), (psychiatric problems (delirium)), and [gastrointestinal symptoms (nutrition)] before palliative care lectures and after clinical trainings.

Discussion: The mean total score of PCKT was 9.4±2.6 (standard deviation) (3.3 to 10.8 (SD 2.4) among 87 students, but it was not statistically significant. More than 90% of students answered correctly for questions about philosophy of palliative care. However, even after lectures and clinical trainings a 20% or the score was decreased from before lectures among some questions about (dyspnea), (psychiatric problems (delirium)), and [gastrointestinal symptoms (nutrition)] before palliative care lectures and after clinical trainings.
Physician Trainees’ Perceptions of Palliative Care Education and Training – An Illuminative Evaluation

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Abstract number: P2-267
Abstract type: Poster

Background: In the UK most palliative care occurs in acute hospital settings, delivered by non-specialist physician trainees including Core Medical Trainees (CMTs). Most have not received specific postgraduate palliative care training. Little is known about physician trainees’ perceptions of palliative training.

Methods: This unprecedented study takes a social constructivist approach informed by illuminative evaluation methodology. Eleven semi-structured interviews with CMTs in a UK University hospital were undertaken between May–June 2014. Content analysis of interview transcripts generated themes. Respondent validation and investigator reflexivity ensured reliability. Ethical approval was granted.

Aims were to describe trainees satisfaction with training, perceptions of good and bad learning experiences, and confidence levels in curriculum palliative competencies.

Results: trainees felt training was lacking, satisfaction was low, but comparable to other curriculum areas. Experiential, informal learning provided most training opportunities and was a feature of good learning experiences. Interaction with hospital palliative care teams, senior physicians and experience in certain specialties was important.

Greater clinical experience positively correlated with trainees’ perceived confidence in curriculum competencies. Most confidence was expressed in pain and symptom management, completing death certificates, referring to the coroner, and discussing resuscitation status. Least confidence was expressed with: advance care planning, assessment and management of psychological and spiritual needs, agitation anxiety and depression, knowledge of spiritual care services. Findings are supported by the wider literature and may be applied to other Western healthcare settings.

Conclusion: Future educational interventions should be targeted towards areas of least confidence. Consideration should be given to mandatory attachments to palliative care specialists for physician trainees.

New Colleagues – Former Students. Spreading Palliative Care Knowledge among Nursing Students

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Abstract number: P2-268
Abstract type: Poster

Background: Our aim was to prepare nursing students to care for dying patients during their clinical practice and also create a good learning environment. We wanted a supportive environment that enabled safety and strength to the students in engage in existential dialogue and solve problems with patients in end of life care. A pedagogical project was initiated in a palliative care unit in Stockholm, with funding’s from the county council and the aim to spread palliative care knowledge. Focus was on high quality clinical practice, both theoretical and practical, in the palliative learning environment.

Method: We choose to collaborate with two universities profiled in higher nursing education in palliative care. The nursing students had a four week clinical practice in our unit in the fifth semester of their education while they also attended a university course in palliative care. Further the direct patient care the students attended a theoretical day with lectures by different palliative care team members, primarily nurses. The lecturers addressed reality based patient cases, severe symptoms of terminally ill, existential support, bereavement and teamwork. Daily reflection was an important learning aspect and in the end of practice the students participated in a one hour semi-structured reflection, led by a nurse, where they were able to express difficulties, and reflect on expectations for their clinical practice in palliative care.

Results: The student evaluations were very positive, regarding learning, learning environment and an increased awareness for palliative care.

Conclusion: Our aim to offer a clinical practice in integration with direct patient care, theory and reflection has turned out to be a success, both for the students and the nurses – both the tutors and their colleagues. The work to spread palliative care knowledge continues, and the greatest success of all is that a number of former students are now our colleagues.

Inter-professional Education in Palliative Care. Educating across Sectors in Palliative Care

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Abstract number: P2-269
Abstract type: Poster

In 2011, the Ministry of Health recommended that the education standards for palliative care be raised to a higher level for all basic professional groups.

Due to the increased costs for continuing education, few institutions or hospitals can afford to send only a few of their staff members to educational enrichment courses. The education programmes offered are based on one specific profession.

Aims: Constructing an education model in which (1) the courses become a shared experience for different inter-professional participants, and (2) that the courses become a shared experience for different inter-professional participants, and (3) that the courses become a shared experience for different inter-professional participants, and (4) that the courses become a shared experience for different inter-professional participants. The education topics are chosen by the participants beforehand according to their specific needs. The courses are for free.

Results: 20–40 people attend each course. The duration of the courses varies from 2–3 hours to a full project day. Among the first year of the project 536 have participated in the education programme: Hospital doctors, general practitioners, nurses, home helpers and physiotherapists. There are 250 participants for autumn 2014, 140 district nurses, and all...
Palliative Care (PC) Education and Its Importance in Providing a Quality Service

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Goal: To present the work of Mary Potter team over the years being made on the continuing education of healthcare professionals on PC; Highlight the positive impact of the education on the daily life of patients and nurses To provide a clear view of the method used for the education; To show the plans regarding the future organisation of these trainings, to discover the impact of the education of healthcare providers on the quality of life for all the patients in need

Methodology: For this presentation we have used Data gathered in Mary Potter PC center which provides PC education for healthcare professionals from the entire country; Questionnaires filled by participants of the residential courses before and after training; Reports and notes left in the book of impressions; Training programs; Information collected from patients and their caregivers.

Results: Since 2007 Mary Potter PC center has organised trainings in different formats lasting 1 day, 2 days and 5 days (residential courses, for physicians, nurses, social workers and psychologists from the entire country). All the training were recognised and accredited by the National Center for Continuing Health Education. The trainings were positively evaluated for the organisation, topics selected, methods applied to deliver the information and the overall importance of the trainings. The practical experience has been assessed as the most valuable experience of this activity. Indirect beneficiaries in this trainings are patients who are being modestly provided with PC from healthcare professionals trained in MP center. The effect of education/training in basic PC of medical staff and integration of PC into CICS at the hospitals of Georgia. The obtained results confirm the importance of education/training in basic PC of medical staff of CICS physicians and nurses evaluating their knowledge and skills necessary for conducting of adequate PC.

The second study has shown that more than 70% of needs and attitudes towards the care of patients’ family and more severely, of the patient him/herself. The first study has evidenced that more than 84% of medical staff working in CICS do not have adequate knowledge and skills needed neither to deliver quality PC for patients nor to communicate effectively with patients and their families. The second study has shown that more than 70% of needs and attitudes towards the care of these cohorts, recognising the limited terms of their life, is consistent with the 3rd and 4th levels of A. Maloum pyramid of needs. It was suggested, that such needs and attitudes should be maximally taken into account by medical staff even when the adequate communication is implicated or impossible due to the patient’s health state in CICS. The obtained results confirm the importance of education/training in basic PC of medical professionals, working in CICS.

The EAPC Steering Group on Medical Education and Training, (www.mcpcil.org.uk/media/24441/eapc%2015.pdf), a new Taskforce project will seek to use the work of previous EAPC Taskforces on the care of the dying, and the findings from the International consensus to develop a multiprofessional and societal curriculum in care of the dying. The aim is to develop a competency based multiprofessional and societal curriculum for care of the dying in the last hours or days of life. International consensus to develop a multiprofessional and societal curriculum in care of the dying is required to effectively provide education and training to manage the challenges posed by the projected increased morbidity and mortality in Europe and beyond. The development of a multiprofessional curriculum is a necessary step towards the development of new tasks for the 5G-MET.

The teaching syllabus is organised around three core concepts: care philosophy; clinical situations, management; and personal work. Additionally, training contents are recently focused on chronic advanced patients and end of life care.

Mainly of the students of the last 3 editions did not work exclusively in PC services. They seek to improve their clinical knowledge in regards to symptoms control and to develop better skills as for emotional issues of PC delivery. Their level of satisfaction was 4 out of 5.

Conclusions/discussion: Advanced training and education helps professionals to improve their clinical skills and knowledge for advanced chronic care. The learning outcomes obtained at the Master of PC, based on case report methodology, are the foundation for professional accreditation and advanced career development in the context of PC.

Advanced Training in Palliative Care: 15 Years of Experience in Catalonia (Spain)

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Background: Advanced training and education in palliative care (PC) is essential for the development of high quality PC delivery. The Catalan Institute of Oncology launched the first Master in PC in 1998. Ten editions have already been completed. The Master is offered by the University of Vic in collaboration with University of Barcelona (Barcelona, Spain).

Aims: Describe the qualitative results and evolution of advanced training in Palliative care in Catalonia at its 15 years of implementation

Methods: The structure and contents evolution of the master are revised and the participants` professional background, work place, experience, and satisfaction degree in regards to the master are described.

Results: More than 400 professionals, 60% physicians and 40% nurses, from diverse settings hospital, home support teams and socio-health units have been trained by the master. The master started as modules of 42 academic credits and, since 2010, into subjects and 60 European Credits Transfer System to adapt to the European regulation for superior education.

The teaching syllabus is organised around three core concepts: care philosophy; clinical situations, management; and personal work. Additionally, training contents are recently focused on chronic advanced patients and end of life care.

Mainly of the students of the last 3 editions did not work exclusively in PC services. They seek to improve their clinical knowledge in regards to symptoms control and to develop better skills as for emotional issues of PC delivery. Their level of satisfaction was 4 out of 5.

Conclusions/discussion: Advanced training and education helps professionals to improve their clinical skills and knowledge for advanced chronic care. The learning outcomes obtained at the Master of PC, based on case report methodology, are the foundation for professional accreditation and advanced career development in the context of PC.
Abstract number: P2-277
Abstract type: Poster

Patients and Families Information Needs Regarding Palliative Care
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Background: In Romania, due to cultural particularities and slow development of palliative care, the family plays a major role in the care process at end of life. The Romanian Palliative Care Strategy has as first level of care in the strategy education and support for care. To implement the strategy in our area an Information & Education Center in Palliative Care for Patients and Families has been set up. The center offers: weekly self-care courses, personal counseling, online and printed materials.

Aim: To identify the aspects of palliative care on which patients and families would like to receive information and the preferred ways to receive information.

Method: A prospective cross-sectional survey, using a purposely developed, face to face administered questionnaire with 20 items. The questionnaire was piloted on patients and family members in day care (aka Cornbach=0.77). After adjusting it was made available to all patients and family members attending our day center and outpatient clinic during July-September 2014.

Results: From 73 distributed questionnaires, 67 persons responded (91.78%). Among them, 89.6% were patients and 19.4% family members, women 71.6%, men 28.4%; main age group was 40 to 59 years old. The main information needs identified: modalities to offer emotional support 66.7%; methods to cope with stress and anxiety 59.7%; evaluation and prognosis of the disease 55.2%; treatment options 55.2%; pain treatment 50.7% and information related to communication, life style, nutrition, care and social rights. The preferred ways for information were: counseling/meetings with a health care professional 70.1%, group meetings with patients that have the same diagnosis 41.8%, printed information materials (brochures, books) 34.3% and less the internet.

Conclusions: Direct communication by professionals, psycho-emotional aspects of care, existing treatment options and pain therapy are priority issues for respondents in our study.

Abstract number: P2-278
Abstract type: Poster

Constructing Professional Development in Hospice Rookies. How Do We Measure Growth?
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Aims: The aim of this work is to ensure that newly appointed hospice staff can develop the skills to deliver specialist palliative care and demonstrate professional development. Approach taken: It is wise for voluntary sector hospices to demonstrate to financial and service commissioners that the care provision is value for money, specialist and delivered by a competent workforce.

Results: Newly qualified staff experienced staff new to palliative care and those wishing to advance to senior positions, need development programmes to support the changing demographic of the dying in England.

Systems to measure professional growth are integral to the design of new development programmes. The concept of ‘70/20/10’ (Jennings, 2013) suggests that most professional learning takes place on the job. Options to demonstrate professional growth include the use of knowledge audits before and after learning opportunities, coaching records, feedback on observed practice, reflective writing, learning contracts and assessment of clinical correspondence.

Conclusion: The main objectives of this activity were: hearing and sharing stories of people who are sometimes invisible in hospitals and health institutions; decrease the hierarchical distance between top-level professionals and those without technical training; provide students the experience of collecting life histories and production of narratives.

P2-279
Abstract number: P2-279
Abstract type: Poster

‘Learning at the Coalface’ – Evaluating Graduate Medical Students Experiences Following Placement at an In-Patient Specialist Palliative Care Unit
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Limited exposure to dying patients & those with advanced incurable illness has been highlighted as a potential limitation of undergraduate medical curricula. Optimal symptom management within this patient cohort & provision of end of life care has also been identified as an ongoing learning need by newly qualified doctors.

We sought to use a mixed-methods study of graduate medical students following placement at an in-patient hospice unit with view to informing further educational input & curricular development.

At placement conclusion, attending 3rd/4th year medical students were invited to complete questionnaires rating aspects of their experience on 5-item Likert scale with additional qualitative feedback sought in narrative format. Quantitative data was subsequently analysed independently & grouped into broad themes.

Conclusion: This study examines primarily pre/post-effects within a single cohort. Due to average study the quality the reported findings in this review are to be seen as indicators at most. Nevertheless, this review makes evident that without attending one’s own beliefs and needs, addressing spirituality in patients will not be forthcoming. It also demonstrates that spiritual care training may help to challenge the spiritual vacuum in health care institutions.
Background: Accessing ongoing postgraduate education continues to be a challenge for some nurses working in rural areas despite proliferation of online courses being developed in recent years. In some regional and remote locations internet access may still be unreliable or unpredictable. Low staffing levels at rural health services can contribute to nurses not being able to have access to such resources. And the cost of travel can be prohibitive in attending education programs at metropolitan centres.

Aim: This study evaluated a three day face to face short course in palliative care tailored to the needs of rural nurses and facilitated in two regional communities in 2013.

Methods: A mixed qualitative and quantitative study. Pre and post course questionnaires were completed by the attending nurses. The questions were structured on a five point Likert scale recording the level of knowledge of 11 different aspects of palliative care provision. The completion questionnaires were analysed using SPSS version 21 to obtain p values. The course content was assessed using a survey employing a 1–10 scale with 1 being the least favourable and 10 being the most favourable. These results were collated using descriptive analysis and additional comments grouped into common themes.

Results: Sixteen nurses with a range of qualifications from midwives, registered nurses to care workers attended the short course. Confidence levels (p < 0.001) ranged from 4.398 pre course to 8.207 post course in knowledge base. The course content was rated between 6– 10 by all the nurses in range of topics covered, applicability to workplace, comprehensiveness and resources utilised within the course delivery.

Conclusion: Providing face to face education is an accessible and affordable mode of professional development for rural nurses. Into the future training institutions need to aspire to providing mixed delivery modes of education and consider taking some programs to rural and remote centres.

Abstract number: P2-283
Abstract type: Poster

Reported Impact of Commissioning Community-based End-of-Life Care Education: A Qualitative Inquiry
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Background: In England, Clinical Commissioning Groups commissions’ delivery of end-of-life care education programmes for community based nurses and social service providers to enhance the skills of the workforce to deliver higher quality end-of-life care. However, little is known about how this educational programme impacts in terms of its quality (valuing palliative care and confidence around delivery of EOLCs), scope and impact on service users (patients and families who use the service).

Aim: To explore and critically examine stakeholders’ views and perceptions concerning the community-based end-of-life care education.

Methods: With relevant approvals, in total of 11 in depth, semi-structured interviews and one focus group (n=3) were conducted with providers who had delivered (community palliative education team and hospice based palliative education teams) or received (community based district nursing staff and ambulance services) this end-of-life care education. Transcribed Interviews were analysed by using framework analysis.

Findings: Clinical practitioners and educational providers were highly positive about the existing end-of-life care education provision. Focused education on facilitating choice was a need for rural nurses. Into the future training institutions need to aspire to providing mixed delivery modes of education and consider taking some programs to rural and remote centres.

Abstract number: P2-284
Abstract type: Poster

Evaluation of High-fidelity Simulation Training in Delivering Palliative Care Education to Final Year Medical Students – A Pilot Study
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Introduction: Established evidence suggests that most newly qualified doctors feel insufficiently prepared to provide end-of-life care. A problem facing medical students is the very little hands on training received in dealing with the dying. Simulation has been extensively used in teaching the management of acutely ill patients. Its use in delivering palliative care education, however, has never previously been assessed at an undergraduate level in the UK.

Methods: Final year University of Birmingham medical students (n=13) on placement at Good Hope Hospital were randomly allocated to a group that had a day of simulation teaching (n=6) and a group that received a ‘standard’ palliative lecture followed 10 days later by a day of simulation teaching (n=7). Each student participated in a simulation scenario individually. Pre and post session questionnaires with free text responses and visual analogue scales (VAS: 0–10) assessing self-reported confidence across a range of palliative care competencies were collected and analysed.

Results: Only 25% of the level of knowledge was previously received sufficient palliative care teaching. Post-simulation, mean self-reported confidence levels across all sampled palliative care competencies as assessed by VAS had improved. Additionally, the lecture groups self-reported confidence increased further still following simulation than it had following the lecture. Students rated the simulation as a very useful technique, particularly valuing the hands-on practical experience in end-of-life communication skills and pharmacological symptom control.

Conclusion: The innovative use of undergraduate palliative care simulation has the potential to foster effective learning in a more realistic yet safe and controlled environment, where direct feedback may be given on management of a simulated patient scenario. This confers several advantages over more traditional methods. A larger study is required to further evaluate our initial findings.

Abstract number: P2-285
Abstract type: Poster

Building Bridges of Knowledge “Palliative Care” – A Collaborative Project between Hospice and Nursing Homes
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A study of the palliative care on the municipal level draws attention to the fact that social and healthcare assistants (SHA) lack knowledge about palliative care. Only a small group of the terminally ill and dying needs specialised care at the hospice, which underlines the importance of maintaining a certain quality in the least palliative care in the municipal level.

Aim: To transfer knowledge and experience from the hospice sector to the nursing homes.

Purpose: To enhance the knowledge and qualifications within palliative care of the SHA.

Method: A qualitative study. 40 SHA participated in a course about palliative care where skilled personnel from Hospice taught. An assessment of the course was made with a response rate at 67.5%. Data was obtained from the municipal care system on the 25 citizens who died 6 months prior, during and after the course at the nursing homes taking part of the study.

Results: The assessment showed that the SHA: Have strengthened their palliative qualifications by an enhanced understanding of and knowledge about relief and prevention of suffering Express good conditions for reflection in the workplace, while other express dissatisfaction Use work methods that can strengthen the quality of the palliative care, ex a palliative detection schedule and a communications tool Are better at documenting observations Can estimate the need for involving a nurse or doctor Have improved the collaboration with the relatives

Conclusion: The SHA professional and palliative qualifications have been strengthened and they are qualified and confident in their work. The progress is backed up by good support from leaders and through preparation of municipal palliative guidelines. This help the implementation of tools, a reflective framework, improved documentation and a continuous focus on strengthening the collaboration with relatives and colleagues. This is a prerequisite for developing the quality of the palliative patient care.

Abstract number: P2-286
Abstract type: Poster

Using the European Association of Palliative Care Educational Competencies to Develop an Online Academic Award in Cancer and Palliative Care
Stevens E.1, Mikkilä S., Witherspoon 1,2
1University of the West of Scotland, School of Health, Nursing and Midwifery, Paisley, United Kingdom, 2NHS Greater Glasgow & Clyde, Glasgow, United Kingdom

Background: Palliative care is provided in many settings and as such members of the care team need the knowledge and skills to enable them to provide optimal palliative care within their role. The European Association for Palliative Care White Paper provides 10 core competencies to help educators, service providers and professionals to indicate the knowledge and skills that are required in order to provide such care. In addition the guidance recommends the development of structured inter professional education programmes, which are defined by the level of responsibility the professional has within their service.

Aims: This presentation discusses how one university utilised the EAPC competencies to develop a new, multi-professional Masters level award in cancer and palliative care.

Design: The EAPC competencies were mapped by the palliative care academic team to the priorities and ethos of palliative care. The resulting methodology contained the requisite information. The content of the modules of learning namely, Contemporary Issues in Cancer and Palliative Care, Advancing Communication, Symptoms in Advanced Disease and Psychosocial Concerns was then developed taking into account the academic level of delivery. Finally the pedagogy was developed to ensure it was commensurate with the level of qualification and the online delivery methodology.

Results: This programme of study is now delivered fully online and is available to all members of the multi-professional team who work a cancer or palliative care setting where a core part of their role is caring for such people and their families.

Conclusion: The programme is in its infancy but indications from stakeholders involved in its development and current students is that it meets the needs of cancer and palliative care providers as well as individual clinicians working at a more senior level.
Evaluation of Multi-medical Staff Education for Death Related Care in Rural Areas

Tran K.V., Kawamura M., Abe Y., Kidowaki A., Mishima K., Nishimoto T.*
*KKi Sapporo Medical Center, Sapporo, Japan; *Sapporo City University Nursing Course, Sapporo, Japan; *Asahikawa Medical College, Palliative Medicine, Asahikawa, Japan; *Palliative Clinic Eniwa, Eniwa, Japan; *Teine Keijinkai Hospital, Palliative Medicine, Sapporo, Japan; *Hokkaido Gakuen University, Sapporo, Japan

Background and aims: Palliative care is generally accepted in Japan due in large part to government initiatives during the past ten years. However, a large number of medical institutions in rural communities do not take advantage of palliative care due to a lack of resources and the unclear roles of physicians. This study aimed to teach rural medical professionals about the benefits of using palliative care in EOL treatment by starting a dialog through workshops and meetings.

Methods:
1. Two rural areas, Hokkaido were selected for their relatively distant location from the prefectural capital of Sapporo.
2. Organised health service: a public health center in community A, a hospital established by a town in community B.
3. Conducted two 2 hour open workshops in two different contexts: a conference room and a cafe.
4. Distributed written questionnaires after the workshops and meetings.

Results: The workshops held in a conference room, attracted 89 subjects in A and 43 in B. The workshop held in a cafe, attracted 37 practitioners in A in 38 in B. 85.9% participants from A answered the questionnaire while 100% of participants from B answered the questionnaire.

The majority of the participants were satisfied with the workshops. They stated that they were willing to learn more about how to care for the terminally ill and their families. Over 80% of attendants requested more information and materials about EOL care using palliative care. Participants in both communities stated that communication between medical professionals and patients is a barrier in the dying of dying patients. Allied health professionals such as caregivers expressed interest in palliative care training but time constraints do not allow them for additional training.

Discussion: Several points were made: 1. Palliative care was widely recognized by medical professionals and allied health professionals interested in palliative care needs to be provided.

Abstract number: P2-288
Abstract type: Poster

Improving Quality of Living and Dying for People with Dementia Following the Gold Standards Framework Dementia Care Training Programme

Thomas K., Stobbart-Rowlands M.
The Gold Standards Framework Centre, Shrewsbury, United Kingdom

Background: The importance of End of Life care for people with dementia is increasingly recognised. Evidence that people with dementia are at greater risk of inappropriate hospitalisation and interventions, and that hospital admissions can be detrimental with an increase in morbidity and mortality (double the non-dementia rate). In addition they suffer poorer quality of life sometimes during hospital admissions, due to severe disorientation, distress and anxiety, sometimes leading to behavioural issues, which are often a communication of their distress. In addition, care for people with dementia on a hospital ward poses particular problems for hospital staff, sometimes leading to inappropriate use of psychotropic medication and sedatives. The Programme was supported by a DH grant.

Aims: To improve
1. Awareness of the impact on the person and their families and person-centred care.
2. Communication and Advance Care Planning with people with dementia.
3. Assessment and management of pain and distress in people with dementia.
4. Outcomes with living and dying in their usual place of residence and reduced hospital admissions.

Method: Evaluation includes before and after measures, both quantitative and qualitative. We report on the outcomes of above (100%[M5]) learners in different settings and disciplines.

Conclusion: The programme shows improvements in staff confidence in caring for people with dementia towards the end of their life, and in the four key areas of improving outcomes, and has also shown that staff are able to better identify deterioration in a person with dementia as they approach the end of their life. The programme has proven to effect the whole organisation and all care homes staff, changing the ethos and attitudes within the organisation. This work is helping to put UK Government policy into practice.

[M5]Check numbers

Abstract number: P2-289
Abstract type: Poster

The Heart of Gold Projects – GSF Improving Area-wide Integrated Cross Boundary Care End of Life Care

Thomas K., Armstrong-Wilson J., Edgar C.
Gold Standards Framework, Shrewsbury, United Kingdom

Background: In response to the growing challenges of the ageing populations and whole system area wide care one of the key factors is to develop an integrated cross boundary care approach to meet the needs of the population. GSF can be part of the solution in developing such integrated care by developing a common ‘vocabulary’ of care for all people in any setting with any condition in the final year or so of life. GSF is widely used in the UK in primary care, care homes, hospitals, domiciliary care and hospices. By working together to a common plan, GSF can help be a vehicle for improvement with patients at the heart of care, as ‘gold patient’ or VIPs, receiving gold standard care.

Aim: To use GSF programmes in different settings, to develop an integrated whole system approach, with patients at the heart of care– the ‘heart of gold’ projects. GSF improves the early identification, Advance Care Planning discussions and coordination of care reducing unnecessary hospital admissions.

Method: The GSF Foundation Sites in Integrated Cross Boundary care include training in a number of settings, ‘better together’ workshops plus individual and collective evaluations. More detailed evaluations are developing as such as the Delphi database, plus practical and qualitative measures.

Results: Findings from the current areas are presented, showing the value of a synergistic approach in whole system care.

Conclusion: Significant improvements are being seen across whole areas by using GSF as a vehicle for better coordinated care across different settings. ‘Gold patients’ and their families feel reassured that there is support available, and that they have a say in their care planning. Additional benefits include improved confidence of staff and pride in this area of work and ‘cultural change in care, especially for the frail elderly. Such a model is just developing in the UK, but early signs are encouraging.

Abstract number: P2-290
Abstract type: Poster

Palliative Medicine – From 2014 a ‘Field of Competence’ for Medical Specialists in Denmark

Danish Association for Palliative Medicine, Copenhagen, Denmark

Background: The Danish Association for Palliative Medicine (DSPaM) was established in 2001, and in 2003 we establish The Nordic Specialist Course in Palliative Medicine (NSCPM) in collaboration with our Nordic colleagues. The Danish Curriculum in Palliative Medicine (PM) was revised in 2013, when Palliative Medicine was classified as a ‘Field of Competence’ (FOC) in the national organisation for all medical associations (UJS). DSPaM has the responsibility for defining the theoretical and clinical demands for obtaining the title ‘Field of Competence Specialist in Palliative Medicine’ (FOCPiM), and for acknowledging the specialists. DSPaM has 145 members. Thirtyseven Danish doctors have passed the NSCPM to this date.

Aim: To describe the first application- and acknowledgement procedures and details about the physicians who applied and those who obtained the title FOCPiM in the first application round.

Methods: Demands for FOCPiM:
Full specialist training in relevant specialty
NSCPM or similar theoretical course in PM
2 years of clinical work in specialist palliative care (as defined by DSPaM)
Minimum 1 year with consultant colleague
Minimum 1 year with in-patient care
The dead line for application was October 1st 2014
Results: 39 doctors applied in the first round, 16 men, 23 women. Mean age 56 years (range: 42 – 81). Specialties: Anesthesiology 16, General Medicine 14, Oncology 4, Other 4. None. Theoretical course: NSCPM 24, Cardiff Diploma in PM 4, MSc in PC 1. 24 doctors were acknowledged as FOCPiM, 3 had a conditional acknowledgement (insufficient clinical training). 11 were rejected, 1 was uncertain.

Discussion: The possibility to apply for FOCPiM continues in the ‘transition phase’, until we have a detailed training programme including a log book and classification of the specialist palliative care units in the training programme. In the future we hope to have time limited training positions in palliative medicine.

Abstract number: P2-291
Abstract type: Poster

Core Curriculum and Guidelines for the Basic Education of the Physiotherapist in Palliative Care, Published by Società Italiana di Cure Palliative

Società Italiana di Cure Palliative, Brescia, Italy; *Società Italiana di Cure Palliative, Firenze, Italy; *Società Italiana di Cure Palliative, Milano, Italy; *Società Italiana di Cure Palliative, Roma, Italy; *Società Italiana di Cure Palliative, Bologna, Italy; *Società Italiana di Cure Palliative, Torino, Italy

The Società Italiana di Cure Palliative (SICP) has published the Core Curriculum for Physiotherapists in Palliative Care (2013) to define the skills and educational requirements necessary for the consolidation and improvement of palliative care. It is a tool intended for decision-makers with the purpose of defining educational policies in accordance with the prime objectives proposed by the SICP. The Guidelines for the Basic Education of Physiotherapists in Palliative Care, published by the SICP at the end of 2014, derives from the core curriculum and sets forth a specific educational program for providing appropriate knowledge in palliative care to students of the degree course in Physiotherapy.

Both documents are set out in tables that specify the effective nature of the skills and knowledge which are distinguished by the field of action:
• Ability to assess patients and their families
• Ability to take care of patients
• Ability to take care of patients and their families as a physiotherapist
• Ability to take care of families in various care settings
• Ability to work in a team
• Ability to coordinate a physiotherapy service
• Ability to deal with ethical and legal issues
• Ability to carry out research
• Ability to instruct

The knowledge and skills necessary for practicing physiotherapy in PC are extremely complex and regard various training contexts. It is required that an adequate education may be achieved through:
• The addition of specific studies to already existing educational programs
• The introduction of a specific course of Physiotherapy in Palliative Care
• The introduction of specific training

The importance of the content and the specific nature of the educational targets should stimulate appropriate reflection concerning the role and responsibilities of the trainers.
Motivations of Outpatients to Complete their Advance Directives

Poster 5. Zumwald C., Meyer Kouakou L.

Community Palliative Care Unit, Division of Primary Care, Carouge, Switzerland, 1mad, Geneva, Switzerland, 2Yalucry Medicine, Geneva, Switzerland

Context: Despite the presence of advance directives (AD) in the health law in the Canton of Geneva for many years, the number of patients who completed their ADs law.

Aims: Identify factors influencing the writing of DA in outpatients. Describe the current involvement of medical and nursing staff in supporting patients to write AD.

Method: On clinic dates, patients who completed their AD and received homecare. One other was completed by the nurse and the physician (GP) in charge of the patients at home.

Results: 14 patients of a total of 233 that received home care had completed AD. 34 accepted to participate and had no cognitive impairment. 7 patients were encouraged to fill AD by their GP, 4 by health professionals. 15 patients preferred to complete an existing questionnaire. 14 completed AD alone, mostly driven by their own motivation and they faced little difficulties. However 17 patients highlighted that more involvement of their GP would have been important. Main motivations of patients to complete AD were the onset of a severe disease with complications and the importance of not burden their relatives. Main cited items were: resuscitation, fear of suffering having his life extended. 1/21 nurses that completed the survey systematically asked the patients if they completed AD, 2 supported the patients to complete AD. 4/16 physicians that completed the survey systematically asked the patients if they completed AD.

Conclusion: Motivations of the minority of patients that completed their AD are very individual. The completion of AD are seldom triggered by the health professionals in charge of them. To promote the completion of AD but we should be very creative and find other ways to promote shared decision making.

Palliative Care and Quality of Life in the New Italian Code of Medical Ethics

Cipolloni G., del Bon P., Buzzi E.M., Conti A.

Fondazione Campiliano - Domus Salmuri, Palliative Care Unit, Brescia, Italy, 1University of Brescia, Department of Surgery, Radiology and Public Health, Public Health and Humanities Section, Brescia, Italy

A brief analysis of the most significant provisions of the new Italian Code of medical ethics reveals the centrality of the ethical principles of beneficence, respect of autonomy, proportionality of care in the doctor – patient relationship.

In general, the application of these principles results in particular attention to promote the wellbeing and the quality of life of the patient, taken as a whole in his/her global dimension as a whole. This is clearly stated in Section 3 of the Code according to which duties of the physician are the protection of life and psycho-physical health, the treatment of pain, and the relief of suffering, respecting the freedom and the dignity of the person.

The authors therefore analyze the code as a living will. The most prevalent dementias were: 104 (55%) Alzheimer’s Disease, 37 (19.57%) Vascular Dementia and 20 (10.58%) Lewy Body Dementia. Severity of the dementia was evaluated using the Global Deterioration Scale (GDS) which was registered in 151 (79.89%) of the patients with ACP. Of these, 91 (60.26%) had a GDS of 7 and 51 (33.77%) a GDS of 6. Do not resuscitate (DNR) orders were present in 109 patients (57.57%) and in 110 patients (58.2%) there were orders not to be admitted to the Intensive Care Unit in the event of medical complications.

Conclusions: ACP is registered in the majority of patients. The most frequent types of ACP are DNR orders and do not to admit the ICU. Patients with ACP have more advanced disease. During the last 2 years there has been an increase in ACP registered in the case histories.
Medicine continues to fail to deal humanely with dying people. Mainstream health-care has a problem acknowledging death as a natural outcome and Early critical commentary on the development of palliative care gave warning that palliative care, no differences were detected between the two groups. On the other hand differences were present during hospital admission, 19 patients being identified de novo in the ACP group and in 2 in the no ACP group. ACP was agreed with the patient in 11 cases (12%) and with the family in 66 cases (71.7%). In 12 (13%) intensive therapy on the ward was indicated. In 75 (81.5%) there were Do-Not-Resuscitate (DNR) orders in the event of cardiac arrest and in 76 (82.6%) orders not to be resuscitate (DNR) orders in the event of cardiac arrest and in 76 (82.6%) orders not to be admitted to the Intensive Care Unit (ICU) in the event of medical complications. In 65 patients (70.7%) the decision was to prioritise comfort in the event of poor clinical course. Conclusion: ACP is registered in 50% of the patients in the AGU. Dementia and a low Barthel Index are present. ACP is usually agreed with the family. The most frequent ACP are DNR, do not admit de ICU and give priority to comfort.

Abstract number: P2-298
Abstract type: Poster

Ultime Time of Life

Chazot I., Chvatofic G., Prechot M.
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Background: When reaching the terminal stage of the cancerous disease, many patients ask the question about the time that remains to live: “how long do you give me, doctor?” Aim: From these questioning, our reflexion concerns this ultimate time: what about this? This time has questioned philosophers for a long time. So difficult to define, this limited time which separates these formulated questions and the death of the patient; an uncertain time for the patient, his family, the doctors and the nurses who accompany him. The High Authority of Health as well as the French Society of Accompaniment and Palliative Care insist that this time should not be neglected. What are the particularities for this temporality: non-cognitive of a life which cannot go on or greater value of every moment? How to live this time, alone, of course, but also surrounded by the nursing staff and close relatives whose course of life continues?

Method: From these questions and having consulted the literature, we led fourteen semi-managed interviews with cancer patients in one palliative care unit. What about this time? Does the initial question (how long?), persists?

Results: The qualitative analysis of the words allowed to better characterise this time. The patients also described the resources which allow to continue to live in such a process of mourning. This uncertain time is marked by heterogeneity: with sad words alternating with nonsense of a life which cannot go on or greater value of every moment? How to live this time, alone, of course, but also surrounded by the nursing staff and close relatives whose course of life continues?

Conclusion: Obviously, this study does not erase the aporetic character of this ultimate temporality! But our work shows that the ultimate time is one of a new temporality which having no capacity to extend or to gain in length, would gain in ‘width’ or would dilate.

Abstract number: P2-299
Abstract type: Poster

Palliative Care Values

Wood S.
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The UK has a well-established Palliative Care service that grew out of the hospice movement of the 1950s. It is pioneering and evangelising, serving as a role model to other countries it has largely failed. This failure is significant for countries other than the UK, since many countries, Denmark included, have been seeking to follow the UK’s lead. This paper draws upon the work of an earlier project, the first scrutiny of the ethics of palliative care in Europe, it also draws upon more recent bioethical research that is examining critically the values of palliative care within the UK and other European countries where hospice and palliative care are evolving. The method is empirically informed bioethics and drawn upon expert testimony, conceptual analysis, official and media documents. The results indicate: Early ethical commentary on the development of palliative care gave warning that palliative care would be under pressure from medicalisation, and from the managerialism that went hand in hand with mainstream health care. The unsolved ethical dilemmas can compromise the quality of end-of-life (EOL) care and cause real distress in the healthcare team. Despite extensive theoretical reflection, guidelines and protocols, the ethical dilemmas continue to negatively affect patients and professionals as well as informal caregivers. The main problem might be that the most common approaches are proposed as purely logical procedures which, although rigorous in terms of methodology, fail to grasp the human good of the patient at the EOL. Abundant literature covers the many advantages of the narrative approach, however, until now, very little has been explored about how the narrative approach can contribute to the problem of ethical dilemmas in palliative care (PC) and EOL decision-making. Aim: To show how the narrative approach constitutes a useful, and even necessary tool, for the analysis and resolution of the ethical dilemmas that arise in EOL.

Methods: Epistemological and moral analysis of the contribution of the patient’s narrative to crucial dilemmas of PC. Three clinical scenarios are shown. Results: The scenarios will be on: a) refusal of treatments, b) palliative sedation, and c) goals of care. The patient’s narrative does not consist in a mere sequence of events, but it captures the intelligible content of situations and expresses the moral/existential content of events which we observe on the external level. Therefore it should opportunistically integrate the most common methods of ethical dilemma analysis. Advance care planning (ACP) and shared decision-making (SDM) models partially assume a narrative approach and can take further advantage of a more explicit reference to the narrative approach. Conclusion: The logical and narrative knowledge are two complementary aspects of the ethical clinical judgment. In a multidisciplinary team, the PC consultant plays a crucial role in facilitating the resolution of ethical dilemmas and fostering ACP and SDM models of care.

Abstract number: P2-301
Abstract type: Poster

Cabrera M., Herranz S., Sales P.
Parc Tauli University Hospital, CSS Albada Health Center, Sabadell, Spain

Objective: To study the Advanced Care Planning (ACP) among elderly offering better care in accordance with their needs and preferences.

Methods: A prospective study of 188 patients admitted to the AGU of whom 92 (48.9%) had ACP. Barthel Index prior to admission in the AGU group showed severe or complete dependence (Barthel < 35 or < 20) in 41 patients (45.1% of the AGU group), whilst there were 16 patients (16.6%) in the group without ACP increasing on admission to 59 (64.9%) and 29 patients (30.2%) respectively. Dementia predominated in the group with ACP (37 patients: 19.7%) compared with 19 in the no ACP group (10.1%). With regard to identification prior to admission of patients with advanced chronic diseases and conditions in need of palliative care, no differences were detected between the two groups. On the other hand differences were present during hospital admission, 19 patients being identified de novo in the ACP group and in 2 in the no ACP group. ACP was agreed with the patient in 11 cases (12%) and with the family in 66 cases (71.7%). In 12 (13%) intensive therapy on the ward was indicated. In 75 (81.5%) there were Do-Not-Resuscitate (DNR) orders in the event of cardiac arrest and in 76 (82.6%) orders not to be admitted to the Intensive Care Unit (ICU) in the event of medical complications. In 65 patients (70.7%) the decision was to prioritise comfort in the event of poor clinical course. Conclusion: ACP is registered in 50% of the patients in the AGU. Dementia and a low Barthel Index are present. ACP is usually agreed with the family. The most frequent ACP are DNR, do not admit de ICU and give priority to comfort.

Abstract number: P2-298
Abstract type: Poster

Narrative as a Contributing Factor in Solutions to Ethical Dilemmas of End-of-Life and Palliative Care

Consentino N.1, Centeno C.2
1) University of Navarra, ICS, Programa ATLANTES, Pamplona, Spain, 2) University Campus Bio-Medico of Rome, PAST, Rome, Italy

Background: The unsolved ethical dilemmas can compromise the quality of end-of-life (EOL) care and cause real distress in the healthcare team. Despite extensive theoretical reflection, guidelines and protocols, the ethical dilemmas continue to negatively affect patients and professionals as well as informal caregivers. The main problem might be that the most common approaches are proposed as purely logical procedures which, although rigorous in terms of methodology, fail to grasp the human good of the patient at the EOL. Abundant literature covers the many advantages of the narrative approach, however, until now, very little has been explored about how the narrative approach can contribute to the problem of ethical dilemmas in palliative care (PC) and EOL decision-making. Aim: To show how the narrative approach constitutes a useful, and even necessary tool, for the analysis and resolution of the ethical dilemmas that arise in EOL.

Methods: Epistemological and moral analysis of the contribution of the patient’s narrative to crucial dilemmas of PC. Three clinical scenarios are shown. Results: The scenarios will be on: a) refusal of treatments, b) palliative sedation, and c) goals of care. The patient’s narrative does not consist in a mere sequence of events, but it captures the intelligible content of situations and expresses the moral/existential content of events which we observe on the external level. Therefore it should opportunistically integrate the most common methods of ethical dilemma analysis. Advance care planning (ACP) and shared decision-making (SDM) models partially assume a narrative approach and can take further advantage of a more explicit reference to the narrative approach. Conclusion: The logical and narrative knowledge are two complementary aspects of the ethical clinical judgment. In a multidisciplinary team, the PC consultant plays a crucial role in facilitating the resolution of ethical dilemmas and fostering ACP and SDM models of care.
**Poster Sessions (Poster Exhibition Set 2)**

**Abstract number:** P2-302  
**Abstract type:** Poster  
**What Do Proxies Direct In Advance?**

*In der Schmitten J.,* **Poster**  
*1, Jox R.,** **Poster**  
**Background:** In Europe there are an ageing population structure and the cause is an increased life expectancy. This means that older persons’ likelihood will be confronted with their own family member’s serious illness. Older parents are as a result of growing aged population at the risk that they may have to follow their adult child in a severe illness and even to their death.

**Aim:** A study to investigate how it is feeling being a parent to an adult child with a serious illness.

**Method:** The A qualitative design with mixed methods to gain a deeper understanding. It was done through qualitative data, collected by in-depth interviews and a questionnaire.

**Result:** The result showed that a common sense was that it is very special to have an adult child and they are doing activities to achieve the happiness. The elder are made possible, with the redemptive nature of the frustrations and the possible to increase of the health. The elder would have a problem of the health and the illness but the elder are not interested to talk about the elder people's health and the illness.

**Conclusion:** This study is not the objective of this significant and mysterious time which is agony. In the long term, this approach would aim at considering a comprehensive approach of the patient in the end of life, and the attendance of the family caregivers taking into account the cognitive state of the frail elderly patients.

**Abstract number:** P2-303  
**Abstract type:** Poster  
**Functional Dependency of Patients at the End of Life and Overburdening of Caregivers: Cognitive State of Patient as a Modulator Variable**

*Barreto Martín J.P.,* **Poster**  
*Soto Rubio A.,** **Poster**  
**Background:** In Europe there are an ageing population structure and the cause is an increased life expectancy. This means that older persons’ likelihood will be confronted with their own family member’s serious illness. Older parents are as a result of growing aged population at the risk that they may have to follow their adult child in a severe illness and even to their death.

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**Abstract number:** P2-304  
**Abstract type:** Poster  
**How Is It Being a Parent to an Adult Child with a Seriously Ill Disease?**

*Benkel L.,* **Poster**  
*Molander U.,** **Poster**  
**Background:** In Europe there are an ageing population structure and the cause is an increased life expectancy. This means that older persons’ likelihood will be confronted with their own family member’s serious illness. Older parents are as a result of growing aged population at the risk that they may have to follow their adult child in a severe illness and even to their death.

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**Abstract number:** P2-305  
**Abstract type:** Poster  
**Information to Family Members and Other Loved Ones – Being Updated Facilitates In-patient Palliative Care**

*Bjørnmyr C.,* **Poster**  
*Benkel L.,** **Poster**  
*Carling L.,** **Poster**  
*Molander U.,** **Poster**

**Background:** In Europe there are an ageing population structure and the cause is an increased life expectancy. This means that older persons’ likelihood will be confronted with their own family member’s serious illness. Older parents are as a result of growing aged population at the risk that they may have to follow their adult child in a severe illness and even to their death.

**Aim:** A study to investigate how it is feeling being a parent to an adult child with a serious illness.

**Method:** The A qualitative design with mixed methods to gain a deeper understanding. It was done through qualitative data, collected by in-depth interviews and a questionnaire.

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**Conclusion:** This study is not the objective of this significant and mysterious time which is agony. In the long term, this approach would aim at considering a comprehensive approach of the patient in the end of life, and the attendance of the family caregivers taking into account the cognitive state of the frail elderly patients.
The Influence of Life Experiences with People at the End of Life on Attitudes towards Death and Dying

Background: Relatives are usually expected to care of the dying family members. It provokes many emotions and difficult situations. There are many factors that can affect our attitudes towards caring for dying persons, such as personal experiences with death at the end of life.

Aim: The aim of this study was to collect data on relation between the experience of a relative’s end-of-life in the past and attitudes towards death and dying at present.

Methods: Fifty four family members of deceased people participated in the study. Most of them was witness to the death of grandparents (40%) or parents (39%). 78% of respondents claimed that they took a direct part in caring for the dying close relatives. Self-constructed questionnaire containing 28 items related to the dimensions of the study has been used to examine any relationships between bereaved family members experiences and some factors that form said attitudes.

Results: Majority of respondents declared that if it was possible to turn back time they would have the Coaches and Coordinator rejoin the project. However they were not sure whether they would care of terminally ill relative at home again. Faced with the idea of their own death respondents were afraid of leaving behind their family. They felt fear of dying rather than of death itself. There exist factors that impact mentioned attitudes, i.e. age, religiosity, the feeling of fulfillment, family support.

Conclusions: The previous experience of relative’s death, as well as taking care of them shapes attitudes towards death and dying – both one’s own and other people.

Abstract number: P2-308

Abstract type: Poster

Caregiver Coach Service: A Volunteer Service Aimed at Maintaining the Wellbeing of Family Caregivers


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Background: Family caregivers (FCGs) often experience decreased wellbeing while providing care and in bereavement. Clinicians often do not have time to focus on FCGs, leaving FCGs at risk for problems if their needs for support are not identified and attended to. Volunteers may have a role to play in supporting FCGs, but the literature indicates that they are not trained to focus on FCGs’ own wellbeing.

Aim: To implement and formatively evaluate a volunteer service to coach FCGs of people at the end of life to maintain their own wellbeing in the patient’s last months and in early bereavement.

Methods: Study design was informed by the participatory Fourth Generation Evaluation methodology (Guba and Lincoln 1989). Data were collected from FCGs (n=21), volunteers (n=13), their coordinator, and referring clinicians, as well as the service database; via various means, including interviews, reflective notes and time logs. Concurrent content analysis and descriptive statistics are being used for ongoing formative evaluation.

Results: The format of the Coach training program was revised: didactic presentations were eliminated and replaced by discussion of assigned reading and case studies. To date, all FCGs reported benefits from the service; several noted that they had difficulty envisioning the handling of relatives with psychiatric diseases on a Palliative Care Unit – Is Primary Caregivers’ Satisfaction with Home Palliative Care of Patients with Cancer Associated with Caregiving Outcomes?

Liakopoulos I., Kanatzakis S., Lemonidou C., Katsaragakis S., Limouzou E., Ioannou E., Tzirikoglou D., Patraki E.

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Background: The caregivers satisfaction consists an important quality of palliative care indicator. The aim of this study was to describe the primary caregivers’ satisfaction with home palliative care of patients with cancer and to explore the association of their satisfaction with caregiving outcomes.

Methods: The study took place at the only Palliative Care service providing home care to adult cancer patients in Greece. Eighty two (N=82) primary caregivers of newly - admitted patients, during the 2nd to 3rd week of care completed a demographic and clinical form, (a) the Faculty of Nursing, Centre on Aging, Victoria, BC, Canada, 11 Jewish General Hospital, Social Work, Montreal, QC, Canada

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Abstract number: P2-309

Abstract type: Poster

Family Members Education at ASIH in Palliative Care

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Background: We were part of a study that was conducted in 2013 about family invention within home hospice care under the name “Palliative care, active allinove and support” The objective of the study was to ascertain if education could make the family member feel more secure in the roll as carer. Our experience as those who had the classes was that the family member did feel more secure and we wanted to continue the education and meetings for family members.

Aims: To give family members of palliative patients increased knowledge about palliative care, different strategies, including medical, spiritual and psychological, about the treatment progression of disease, and how to care for patients. This to make them feel more secure in their roll as a carer giver of a palliative patient.

Method: Family members of patients who from palliative care were invited to three meetings. At the first meeting a doctor talks about disease progression, medical treatment, useful strategies when the end is near and about the process of dying. At the second meeting a nurse talks about the way life changes, how to make daily life easier through strategies such as closeness, nutrition, hygiene and adaptive equipment. At the third meeting a counselor talks about normal psychological defenses, the family’s relationships and how the home hospice counselor can help. Every meeting started and ended with a nurse to help create group togetherness, to lead discussion and end with a relaxation technique. An evaluation was given to the participants at the last meeting to be able to improve the meetings.

Results: The evaluations show that the family members were satisfied with the meetings, that they had better understanding and that it was supportive to meet other family members in the same situation.

Conclusion: We saw that the family members has gained greater sense of security, a greater knowledge and a better understanding of what services we in home hospice care offer.

Abstract number: P2-310

Abstract type: Poster

Is Primary Caregivers’ Satisfaction with Home Palliative Care of Patients with Cancer Associated with Caregiving Outcomes?

Background: The caregivers satisfaction consists an important quality of palliative care indicator. The aim of this study was to describe the primary caregivers’ satisfaction with home palliative care of patients with cancer and to explore the association of their satisfaction with caregiving outcomes.

Methods: The study took place at the only Palliative Care service providing home care to adult cancer patients in Greece. Eighty two (N=82) primary caregivers of newly - admitted patients, during the 2nd to 3rd week of care completed a demographic and clinical form, (a) the Famcare Scale, a 20-five point Likert type items instrument divided into 4 subscales (Information, Availability of care, Psychosocial, and Physical patient care), (b) the Bakas Caregiving Outcomes Scale.

Results: Most of the caregivers were females (74.7%), their mean age was 55±15.5 years old and were patient’s spouses (42.7%). The patients’ mean age was 68±6.17 years old, and their mean Palliative Performance Status was 46.7±18.3 (0–100). The caregivers reported a high satisfaction with the home palliative care of patients’ (Mean Total (4.7±0.4) and Psychosocial (4.8±0.4), Information (4.7±0.4), Availability of Care (4.6±0.3), and Physical Care (4,6±0,4) subscales satisfaction scores). Additionally, the caregivers reported good adaptional caregiving outcomes (58.0±15.8 (15–105) that were not associated with total satisfaction (r=0.05, p=0.411, N=82) and subscales scores (p>0.070). Moreover the Multiple Linear Regression Analysis revealed that none of the examined patient’s and caregivers demographic and clinical characteristics was recognised as an independent factor of caregivers’ satisfaction.

Conclusion: This study is the first exploring the satisfaction of caregivers with home palliative care of cancer patients in Greece. Despite that caregivers were very satisfied with patients’ care, further investigation is needed to explore other factors associated with their satisfaction.

Abstract number: P2-311

Abstract type: Poster

Handling of Relatives with Psychiatric Diseases on a Palliative Care Unit – Experience of the Nurses

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Aims: Relatives with psychiatric diseases are a challenge for Palliative Care teams. Since the patients are seriously ill and therefore they might lose their partner, the relatives are frequently also in a crisis. Furthermore, the relatives are not in their familiar environment and the physicians who normally control the psychiatric disease don’t have frequent access to their patients. The nursing stuff of Palliative Care units has frequently no experience in the care of relatives with psychiatric diseases.

Methods: We have used a non-standardised interview to evaluate the difficulties and challenges the interaction with relatives who suffer from a psychiatric disease causes for the nurses.

Results: Eight nurses participated in the interviews. All described that the care for relatives with psychiatric diseases has been experienced as a severe crisis for the Palliative Care team, especially the nurses. As a severe burden have been identified the missing knowledge of the disease and the disturbed behavior, especially during night time. Furthermore, being responsible not only for the patient but for the whole family is described as a constant challenge, especially, if medication for the relatives has been in need because of a psychiatric crisis.

Conclusion: There is a high burden for nurses caring for relatives with psychiatric diseases on a Palliative Care Unit. Especially during night time when access to physicians might be limited, the burden increases. Based on these experiences we will develop systematical strategies for the handling of relatives with psychiatric diseases on a Palliative Care Unit.
Abstract number: P2-312
Abstract type: Poster

The Design & Dignity Project: Transforming End of Life Care in Hospitals, One Room at a Time

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Aim: To describe the outputs of the Design & Dignity Project. Phase 1

The goal of the Design & Dignity Project is to transform the way hospital spaces are designed for people at the end of life and their families by awarding €1.5m in capital grants to hospitals in Ireland.

Approach: Public hospitals in Ireland were invited to submit applications for grants to renovate areas used in end of life and bereavement care. Hospitals were supported with architectural advice from the awarding body during the application stage. Qualitative and quantitative data submitted by hospitals was analysed by the awarding body.

Results: 11 hospitals were awarded grants for the renovation of family rooms, mortuaries, gardens and bereavement suites in emergency departments. Before and after photographs powerfully illustrate the positive improvement made to the physical environment. National and international media coverage was secured to demonstrate the value of the project. A freely-available style book for hospital staff and architects was developed based on learning from phase 1. Further funding for the Design & Dignity Project was secured and phase 2 of the project was initiated in 2014.

Lessons learned: Through the Design & Dignity Project clattered rooms and dreary facilities are transformed into tranquil spaces where families gather to be with each other and their deceased family member. Testimonials from hospital staff, patients and families illustrate the enormous impact the renovated spaces have on their end of life and bereavement journey.

Learning from phase 1 informed modifications to phase 2. This involved a revised application process to increase the qualitative and quantitative data submitted by hospitals to the awarding body. An increased level of architectural support was made available to hospitals during the application stage. Design guidelines based on evidence from phase 1 have been adopted by the main national health care provider.

Abstract number: P2-313
Abstract type: Poster

Palliative Care Needs of Family Carers: A Literature Review

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Aim: The aim of this piece of work was to establish, from the literature, the current situation for family carers providing care to a dying loved one and provide some direction for working with them.

Design: A review of the literature was carried out by searching key terms on the databases CINAHL and PubMed, searching academic journals and non-academic grey literature websites. 121 Articles retrieved were assessed for relevance and information was synthesised by the author to form prominent themes. The themes to emerge are ‘General Support’, ‘Psychological Distress’, and ‘Decision Making’.

Results: The literature indicates the following:
1. Family caring provides end of life care are often undervalued and underrepresented in the literature.
2. Family carers require support in the form of information, respite care and financial assistance.
3. Family carers experience high amounts of isolation and are found to experience significant losses upon death of their loved one and/or on transition to a continuing care setting.
4. Clarity in the decision-making processes at the end of life is required, and the extent of responsibility family members have in this area.
5. Family carers were found to enjoy the caring role and when adequately supported experienced more positive bereavement outcomes.

Conclusion: Although the palliative care approach addresses the needs of family carers as well as the person with life-limiting disease, the needs of the carer are not routinely acknowledged. Health care agencies need to provide greater direction and support to family carers so that they can fulfill their caring role with confidence, this will be done with the development of learning modules that family carers caring for a loved one at the end of life and learning modules that family carers can access.

Abstract number: P2-314
Abstract type: Poster

How Do Terminally Ill Patients Face Death? An Overdeterminalization of Their Network

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Background: Studies exploring close network of terminally ill patients have primarily focused on perspectives of relatives. How do terminally ill patients experience relationship to his or her relatives? Empirical knowledge is scarce on how comfort of relatives can strengthen dignity and identity of patients.

Aim: To acquire a differentiated understanding of how and to which extent comfort from terminally ill patients’ network support them in their effort to manage life and changes brought by disease.

Method: A qualitative study was conducted with individuals in-depth interviews with six terminally ill cancer patients. The interviews were based on patients’ life stories to obtain a more detailed in-depth understanding. Qualitative and quantitative theory analysis of interviews were transcribed, coded and main themes were extracted.

Results: The study showed that terminally ill patients experience three different types of comfort. ‘The active comfort’ supports terminally ill patient’s identity through social activities as close to patient’s values and lifestyle as possible. The passive comfort’ is a phenomenon where relatives giving comfort take on the role of a co-suffering feeling sorry for the patient and displaying sympathy characterised by sentimentality. ‘The comfort as drive’ is the kind of comfort patients get from fellow patients. In this situation the personal problem is transformed into a universal problem as it is not unique but general to the entire group. This kind of comfort has a supportive identity-creating effect similar to ‘active comfort’.

Conclusion: This qualitative study comprising interviews with six terminally ill patients showed that they experienced three different types of comfort: ‘active comfort’, ‘passive comfort’ and ‘comfort as drive’. The results emphasise an individual approach to comfort and more knowledge is needed on how professionals can support the interaction between the patient and the relatives.

Abstract number: P2-315
Abstract type: Poster

Teenagers Reasoning about their Parent’s Recent Death

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Background: Teenagers are greatly influenced by a parent’s illness and death.

Aim: To explore how teenagers reasoning about their parent’s recent death and their life without the parent.

Methods: The study has a descriptive- interpretive design using qualitative content analysis.

Results: Importantly, all teenagers appreciated to participate in the interviews. It was somewhat painful to be reminded but still a great relief to talk about the death of the parent and their own life without the parent. Some of them had not earlier talked more in depth about this to anyone while others had open communications in their families. All teenagers showed up for a second interview indicating a wish for continued conversation. Most of them talked in detail about the days around and the exact day and hour of their parent’s death. All expressed a wish to be included and present despite their own sorrow and feelings of helplessness when watching their parent suffer from pain or other symptoms. Some of them considered the hard part to be after the parent’s death while others considered the opposite. Unselfishly, they felt that death had relieved the parent from suffer and a life with severe illness. They seemed to at least partly have adapted to a life without the parent, expressing life is back on track, and mostly they could look forward in life. It was very important to remain a teenager living an ordinary life in school with friends. Health professionals should take on the responsibility and initiate conversations with teenagers during these traumatic life events.

Abstract number: P2-316
Abstract type: Poster

Using a Self Completed Checklist to Assess and Manage the Needs of the Carers of People with Advanced Cancer in General Practice: A Randomised Controlled Trial

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Aims: The carers of patients with advanced cancer have specific health and psychosocial needs, often not addressed. We assessed whether GPs could meet these needs if they are self-directed by the carer.

Methods: Prospective randomised controlled trial. Intervention was a self-reported checklist completed by the carer followed by a carer-GP consultation, at baseline and at three, six and nine months. All GPs were included. Data was compared with a control group of patients with advanced cancer.

Results: N=392. No significant differences were detected between groups in either the number or intensity of needs. Compared with controls, participants with baseline clinical anxiety showed improved mental wellbeing (p=0.027), and those with baseline clinical depression developed anxiety more slowly (p=0.044). Physical wellbeing improved for people not anxiou (p=0.040). Those caring for patients with AKPS >60 had improved mental wellbeing (p=0.022), but carers of people with AKPS < 60 had more physical needs (p=0.037), and more psychological and emotional needs (p=0.036) compared to controls. Hospital parking, impacts on working and other activities and balancing personal and patient needs remained highest needs over time. Making decisions about the future, and concern over cancer coming back became more important with time.

Conclusion: This intervention did not influence the number or intensity of needs reported by carers of people with advanced cancer. The intervention had limited positive effects in people with pre-existing clinical anxiety and depression. It reduced physical needs in people who did not have clinical anxiety. It had negative effects on people caring for the people most severely affected by advanced cancer, possibly by drawing attention to the significant impacts of caring for such severely ill individuals.
Effects and Meanings for Patients when their Family Caregiver Participate in a Psycho-Educational Intervention during Ongoing Palliative Care

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Background: Patients receiving palliative care often have great need for support and practical assistance from their family members who becomes central in providing the care. Studies show that family members feel more prepared, competent and rewarded in relation to their caregiver role when receiving sufficient support. However it is not known whether and how this actually affects their care of the patients.

Aim: To explore the effects and meanings for patients when their family caregiver participate in a psycho-educational intervention during ongoing palliative care.

Method: An interpretative descriptive design was chosen and qualitative interviews were conducted with eleven patients whose family members had participated in a psycho-educational intervention. All the patients received specialised palliative homecare. The interviews were analysed with qualitative content analysis.

Results: Most patients expressed thoughts about being a burden to their family members and therefore felt relieved by their participation in the intervention. To all patients it was of importance that their family member was supported and had someone to talk with about their feeling and the situation. They felt reassured that their family members were given an opportunity to increase their possibilities to handle the difficult situation. None of the patients disapproved of the family member participation and they didn’t worry concerning what was said about their process of illness or anything about their situation. Patients sensed that their family member were more prepared and with a different approach at home that could be due to increased medical knowledge, even if no effects of the care were seen.

Conclusion: Patients did benefit from the intervention and felt relieved as their family members got supported and a chance to prepare for the situation. Nevertheless, they couldn’t see any effects on the actual care in their present situation.

Abstract number: P2-318
Abstract type: Poster

Elaboration of a Psychosocial Attention Manual for Caregivers of Patients with Palliative Needs

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Introduction: It is essential to take care of oneself, in order properly take care of others. When an advanced disease affects a person, the consequences go far beyond that person, affecting the whole family. Then, it is irrevocable to have the right tools to properly manage the situation.

Objectives: Our goal is to provide a guide for the caregiver that will increase awareness of the importance of self-care. We want to shine a humanistic and encouraging point of view of what is taking care for a patient who is a close relative, through the experience of professionals and with the important help of caregivers who wanted to collaborate with their testimonies to provide a realistic point of view to this work.

Methodology: A bibliographical review of psychosocial care for patients with palliative needs was carried out. We have verified the necessity of developing a manual to provide caregivers guidelines, tools and strategies for dealing with various scenarios that happen during the care of a person having an advance disease. We counted on the testimonies of caregivers so that their real emotions and experiences are expressed.

Results: After reviewing the bibliographical and the direct care-day care we have verified that caregivers that are aware of self-care are more suitable and experience less emotional breakdown.

Conclusions: This manual will serve as a tool capable of representing the psychosocial needs of caregivers and families with patients with advanced disease. It will provide the adequate resources to facilitate their psychosocial and emotional wellbeing. The first edition has 3000 copies.

Abstract number: P2-319
Abstract type: Poster

Self-care Practice Ability Program: Practical Program for Caregivers in Palliative Care

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Variables of well-being and exhaustion are generally related to family caregivers in palliative care (PCI). Few studies which focus specifically on interventions aimed at their treatment – a practical preventive interventions to enhance the internal/external resources of the patients and families. To create a program named Self-care Practice Ability Program (SPA Program) to increase the well-being and reduce exhaustion of the caregivers by combining skills training and complementary therapies. The SPA Program had 3 six-hour modules (Practical, Emotional, and Relational), unfolded in 4 steps, in a period of 3 months: 1 – the participants (P) signed the informed consent and filled out a scale to identify the module to be addressed by the team; 2 – P filled out the Zarit scale and the Personal Wellbeing Index; 3 – P receive satisfaction questionnaires; 4 – Repetition of step 1 and 2.
Cronica: oncologic PC caregivers; > 18 years; verbal and writing comprehension of Portuguese of patients who finalize the course.
In 2013 a PCI Service (in Oporto) treated 461 patients, 85% of whom had an oncologic diagnosis (follow up median=17 days). The P who addressed the Practical module (N=4)

Abstract number: P2-320
Abstract type: Poster

Sleep among Bereaved Caregivers of Patients Admitted to Hospice: A 1-Year Longitudinal Pilot Study

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Background and aims: Caring for a dying family member is known to interfere with sleep, yet little is known about bereaved caregivers. This pilot study aimed to describe the sleep of partners and other family caregivers during the first year after a hospice patient’s death.

Methods: The pilot study used a longitudinal, descriptive, comparative design. Participants included primary family caregivers of patients admitted to a hospice in Norway. Caregiver sleep was measured subjectively with the Pittsburgh Sleep Quality Index (PSQI) and objectively using wrist actigraphy over 1 year. Data were collected at four different times: during the hospice stay, and at 6 and 12 months after the patient’s death.

Results: Sixteen family caregivers (10 partners and 6 other family members) completed the 1-year protocol without difficulty. Sleep quality and quantity were comparable over time, and at each assessment, approximately half of the sample had poor sleep quality, both by self-report and objective measures. However, the sleep trajectories differed significantly over time, with older caregivers (>65 years) having significantly longer sleep durations than younger caregivers (<65 years). Furthermore, sleep quality also differed over time depending on the caregiver’s relationship to the patient, with partner caregivers having significantly worse sleep quality than other family caregivers over time.

Conclusion: Findings demonstrate feasibility of the longitudinal study protocol and indicate that sleep problems are common for caregivers and continue into the bereavement period, particularly for partner caregivers. The caregiver’s relationship to the patient may be an important factor to consider in future studies.

Source of funding: The study was supported by Lovisenberg Diakonale University College and Lovisenberg Diakonale Hospital.

Abstract number: P2-321
Abstract type: Poster

Team Support for Parents with Cancer who Have Young Children

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Background and aim: Parents who are diagnosed cancer have much psychological distress and several problems for family, especially children. Palliative care teams support for patients, their partner and children. We always have conference with primary medical staff before patients’ support. We report support needs of parents with cancer who have young children through consultation to our team.

Methods: We study retrospectively medical electronic records of support by palliative care team for parents who have young children (under 20 years) about patients’ demography, support needs, interviews and activities.

Results: 60 patients (m/f 27/33, ave. 43yo) requested to our team from April 2013 to October 2014. Average age of children (108) was 9. Support was offered by a certified nurse and a hospital play staff of our team. Eleven patients were supported with their partner and 22 cases were application from partners. Eleven cases needed to support children directly. Parents’ major concern was how to tell about parent’s diagnosis to their children including poor prognosis. One case was requested as bereavement care for children just after the parent died. Primary nurses also have worry about patients’ distress and needed advices from our team about family support.

Conclusion: A certified nurse and a hospital play staff offer support for cancer patients who have young children. It should be realized one of important supports in oncology. Further study should needed to effective support by team to reduce their distress.
Background: Diagnosis of cancer has a significant impact not only on patient, but also on their caregivers. In Italy more or less 92% family caregivers are often responsible for providing support to advanced cancer patients. However, evidence suggests that caregivers receive limited information and help to support them for such a role.

Aim: The aim of this study was to identify which family caregivers’ characteristics could be associated with a better competence in taking care of end-of-life home cancer patients.

Methods: A structured interview measuring caregiver’s competence in giving basic and specific care and in communicating patients’ needs to health professionals, was administered to a sample of 166 caregivers caring for advanced cancer patients who were assisted by a palliative home care team. The differences between categorical variables were tested by x2 analysis and the correlation between continuous variables was tested using the Pearson correlation coefficient.

Results: 149 family caregivers (89.8%) were able to provide basic care, 131 (78.9%) specific care and 140 (84.3%) were able to communicate patients’ needs to health professionals. Older caregivers seemed to have more difficulties in providing specific care no matter their degree of kinship (p = ,008). Caregivers with lower education tended to have lower communication competence (p = ,02). Therefore, significant correlations were found between competence in reporting patients’ needs and competence in providing basic care (p<.001) or competence in providing specific care (p<.001).

Conclusion: These results show that older caregivers should require a more intensive support in order to provide a more accurate and complete care to advanced cancer patients. Moreover, health professionals should acquire a set of knowledge and skills to improve communication with caregivers having a different social and cultural background.

Abstract number: P2-323
Abstract type: Poster

Exploring Carers’ Experiences of Supporting a Patient with Palliative Heart Failure: A Mixed Methods Study

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Aims: This paper presents preliminary findings and methodological challenges of conducting a study exploring the impact of being an informal carer for a person with palliative heart failure on carer quality of life and factors influential to carers’ perceptions of caring.

Method: The study is a 2 phase sequential mixed methods study. A sample of carers was recruited from Heart Failure Nurses (HFNS) caseloads in UK rural and urban settings. Carers were invited to complete the Family Quality of Life (FAMQOL) questionnaire, a tool developed for carers of heart failure patients. Participants were also asked to provide contact details if they are willing to be interviewed.

Analysis: Questionnaire data was entered onto SPSS and analysed for correlations between variables. Interviews were analysed using Interpretive Phenomenological Analysis which recognises the centrality of the researcher in exploring and interpreting the participants’ beliefs and descriptive dialogues of being a carer.

Results: 120 questionnaires were distributed to HFNS, each nurse being given 20 questionnaires. A third of carers who returned the completed questionnaires agreed to participate in an interview. Initial response rate was good but questionnaire returns gradually decreased over a few weeks. It transpired that due to the nature of the service delivery, on average each nurse distributed 5 questionnaires during a three month period. The author of the FAMQOL tool reported similar issues in the USA when using HFNS as gate keepers to carers.

Conclusion: The study highlights important methodological considerations for recruiting carers. As the intention was to begin the analysis of the questionnaires prior to commencing the second phase of the study, the researcher was compelled to consider how integration was maintained and how to improve access to carers for research. Reflections and recommendations addressing these methodological challenges will be critically discussed in the paper.
Abstract number: P2-326
Abstract type: Poster

**International Palliative Care Network Conference: Free Participation and Access**

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**Aims or goal of the work:** To promote the free exchange of knowledge amongst palliative care professionals across the globe.

**Design, methods and approach taken:** An annual online conference is hosted on the Palliative Care Network (PCN) community website. A theme decided by an international planning committee leads to experts in the field being invited to present lectures. In addition, abstracts are invited to be submitted for both lectures and a poster exhibition. All disciplines are included and awards are sponsored for the poster exhibition by various organisations and a publication. All materials are prepared on power point to ensure easy participation and access. The conference enjoys the endorsement of various organisations internationally and has been held under the auspices of the European Association of Palliative Care.

**Results:** The International Palliative Care Network Conference (PCN) hosts the works of palliative care professionals from across the globe and enables the free exchange of knowledge. Based on feedback, this has lead to changes in perceptions, knowledge base, policies and practices across the globe. Some of the feedback received is:

* ‘This will improve teaching of the medical students as the information has improved my knowledge very much’ Africa
* ‘The lecture series on the models has allowed me to reframe the current work I am doing on a statewide model of care’ Australia
* ‘I had no prior experience in hospice and palliative care. I was very impressed. I will more quickly identify patients I can refer for PC consults’ USA
* ‘We can study the trend of palliative care in the world’ Japan

**Conclusion / lessons learned:** PCN is an effective avenue for the exchange of information amongst palliative care professionals across the globe. This is a no cost and high impact initiative for participants.

Abstract number: P2-327
Abstract type: Poster

**Preliminary Findings from the Stakeholder Advisory Panel Meetings with Experts and Families in a Project Health Technology Assessment – INTEGRATE in Poland**

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**Introduction:** The aim of the HTA-INTEGRATE project is to find the best model of palliative care using stakeholder advisory panels (SAPs) in several European countries involving experts and patients from the palliative care field.

**Methods:** Two SAPs panels were held in Poland including experts and patient families. Meeting involved at least 8 participants in each group. Meeting were organised in September 2013 and in June 2014. Each meeting took 3 h. Two moderators led the discussion.

**Results:** The meetings were highly appreciated by both experts and families as it was possible to discuss all important issues in views of participants that were important for Polish situation in palliative care. Several problems were identified by both experts and families. Experts indicated insufficient funding from the National Health Fund for palliative care and especially inadequate allocation of existing resources. Families identified several weaknesses and strengths of palliative care services. Among weaknesses families indicated problems in communication with medical staff, limited availability in case of emergencies, limited availability of palliative care in rural areas, gaps in education of families that care for patients at home. Among strengths the surveyed listed good quality of palliative care services, medical and psychosocial support, availability of rehabilitation at home.

**Conclusions:** Using the HTA-INTEGRATE SAPs meetings allowed to identify several strengths and limitations of palliative care in Poland. It may serve as a base for the improvement in organisation, resources allocation and quality of care for palliative care services in Poland.

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**Medical sociology**

Abstract number: P2-328
Abstract type: Poster

**Dying in Prison: A New Form of Shameful Death**

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**Aims or goal of the work:** In the last decade the number of older men in prisons, in both the UK and many European countries, has increased sharply, leading to a rise in anticipated deaths in prison. This paper draws together sociological scholarship around contemporary dying and the rapid growth in prison populations with early scooping work from the ‘both sides of the fence’ study of prison dying, to propose that dying in prison is an important new form of shameful death.

**Design, methods and approach taken:** Increases in the prison population have been theorised by Wacquant as flowing from political change, and correlate with the extent to which countries have embraced neoliberalism. In its simplest form, neoliberalism is a set of ideas associated with economic policies aimed at reducing government spending and enhancing the role of the private sector. Locating recent change in prison dying within Wacquant’s theoretical framework and using data from discussions with staff providing palliative care in prisons, we theorised that aspects of neoliberalism shape prison dying. We then explored the damaging and protective mechanisms involved.

**Results:** Neoliberal prison policies have multiple implications for prison dying, one of which is the new shameful death. In prison death, shame attaches to the person as well as to place, raising questions about practical and discursive resources available to protect the self at the end of life. Reductions in prison resources consistent with such policies compound the indignities of prison dying.

**Conclusion:** The nature of these population and policy shifts mean challenges for prison staff as well as having consequences for prisoners. Staff draw on universalist discourses undermined by ethical practices, which serve to protect both staff and prisoners. However, political and policy decisions shaped by neoliberalism threaten further resource reductions and undermine protective discourses, so impact negatively on prison dying.

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**Poster Sessions (Poster Exhibition Set 2)**

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14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015 240
Habitually Unaware of Palliative Care Applying Health Promotion Methodology to Reach out to Populations

Abstract type: Poster

Abstract number: P2-330

Reasons for, Appropriateness and Avoidability of End-of-Life Hospital Admissions: Results of a Survey among Family Physicians

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Background: The acute hospital setting is considered not to be an ideal place for final care or as a place of death. However, many patients are being admitted to an acute hospital setting at the end of life and die there subsequently.

Aims: To examine the reasons for end-of-life hospital admissions, whether they are considered appropriate or avoidable and what made them appropriate or could have avoided them as according to the family physicians (FP).

Methods: A retrospective survey was used among FPs concerning the last hospital admission of their patients that died on an acute ward of university hospital in Belgium (January 2014 to August 2014). Only patients that died non-suddenly were included in the analysis. Descriptive analysis was used.

Results: 233 completed questionnaires were received (response rate 65.1%); of those 76.7% died non-suddenly (N=178). The most frequent medical reason necessitating the end-of-life hospital admission was treatment for a specific symptom, while other non-medical factors were also considered to have influenced the decision whether or not to admit (e.g. family was convinced that care was better in the hospital). Only 12 (7.0% of all cases) were considered to be appropriate according to the FP, while 84.9% was appropriate. Medical reasons were most frequently reported as the most important reason that made the admission appropriate and 52.2% of all potentially avoidable end-of-life hospital admissions could have been avoided by informing the patient earlier about his/her life expectancy or by providing more adequate support to family caregivers.

Conclusions: Only a minority of all end-of-life hospital admissions were considered to be inappropriate or avoidable by family physicians. This might indicate that the acute hospital setting might be the most adequate setting at the end of life in these circumstances and that the potential to actually avoid them may be limited in the present Belgian health care system.

Abstract number: P2-331

Staff’s Understandings of Cross-cultural Interaction in End-of-Life Care: A Focus Group Study

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Background: There is evidence of poorer quality of health care among people from ethnic minorities in the context of end-of-life care (EOLC). Even though staff members’ understandings of cross-cultural interactions may influence the individual’s and the team’s actual care of dying patients from ethnic minorities and their families, there is relatively scarce knowledge about this.

Aims: To explore staff members’ understandings of cross-cultural interactions from the perspective of EOLC.

Methods: Staff in end-of-life care professionals were recruited from eleven health care units that provided EOLC. The focus group interviews were analysed using qualitative content analysis.

Results: Staff expressed concern about their ability to provide equal EOLC to people with ethno-cultural backgrounds that are different from their own. Differences in ways of handling the EOL process were talked about in terms of the challenges they pose: communication, emotional expressions and pain, families/relatives, and knowledge. The informants’ expressed that it was vital that they as care professionals have knowledge about ethno-cultural minorities, and also about how to communicate with patients and families who have such backgrounds. The staff members’ understandings also conveyed that cross-cultural interactions bring about uncertainty, stress, feelings of not doing a good job and being mistrusted in their professional role. When the staff discussed the identified challenges, they tended to focus on patients with ethnic minority backgrounds irrespective of their specific ethno-cultural backgrounds, and to compare those patients with patients of the ethnic majority. Limited experience of cross-cultural interactions did not hinder staff to have understandings of such meetings.

Conclusions: Important aspects of staff’s understandings of cross-cultural interaction during EOLC were identified, which have implications for clinical practice and the need of a process perspective in future research.

Abstract number: P2-332

Applying Health Promotion Methodology to Reach out to Populations Genuinely in Need of Palliative Care

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Background: Large proportions of European populations have complex needs and yet, they are unaware of the availability of services and what made their responses to these needs Health Promotion approaches can promote changes to facilitate social progression by education people.

Aim: To apply Health Promotion divulgative methodology to extend PC philosophy, knowledge, and understanding.

To work at municipal level to achieve much needed social penetration of the PC concepts.

Approach: Working closely with local Health, Health Promotion and Social professionals to organise workshops and informative talks, we identified areas of interest, potential work and further developments. Initially, general chats of the history of PC and developments were offered, followed by question and answer sessions. From these, more focused sessions were organised. Particularly significant was the request to move the programme to a distant Nursing Home, distant from main stream Health facilities. The successful afternoon came from a well attended event including professionals, residents and a large group of relatives who came in specially.

Results: Analysis of social impact measured three years later in terms of PC activity in the area, home and nursing home deaths. Trends identified in the sessions were closely related to those commonly associated with Health Promotion: leadership, empowerment and communication.

Discussion and conclusion: This initiative has changed the End of Life experience, interest and professional courses and debates in this locality. We intend to extend it to other areas as it is very cost-effective and has an important impact on social understanding of PC philosophy. End of Life Care could change substantially supported by a Health Promotion approach.
Research Priority Setting in Palliative and End of Life Care: The James Lind Alliance Approach Consulting Patients, Carers and Clinicians

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View s in Health Technology Assessment Scope Development

Poster

Abstract type: Poster

Abstract number: P-233

Abstract text

Trends and Characteristics of Inpatient Palliative Care for Cancer Patients in Taiwan from 2000 to 2010: A Nationally Wide Study

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Inpatient palliative care (IPC) is the main stream of hospice care in Taiwan, however the trends of IPC and characteristics of IPC have never been well explored.

Aims: To investigate the trends of IPC and characteristics of patients receiving IPC in Taiwan 2000 to 2010.

Methods: This study was a secondary data analysis by analysing the National Health Insurance Database (NHIRD) comprising anonymised secondary data from patient registries and claims data of the Taiwan NHF Program. We identified subjects diagnosed with the leading cancers, including hepatic, colorectal, gynecological, breast, lung, and esophageal cancer by ICD-9-CM code in the registry of catastrophic illness. Patients with multiple cancers were excluded. Income levels, residence urbanisation, comorbidities, hospitals levels and teaching status of the hospitals were identified. Compound annual growth rates (CAGR) and trends of IPC, and patient characteristics were presented.

Descriptive statistics were presented.

Results: A total of 44,232 patients had IPC, the majority of patients were male (59.1%), and the mean age of cancer diagnosis was 62.86 ± 14.53 years and that for the first IPC was 64.58 ± 14.24 years. Majority of the patients had a middle income (45.4%), lived in the urban area (60.3%), hospitalized in teaching hospitals (65.4%) and regional hospitals (46.2%). The total CAGR of IPC was 15%, and the CAGR in non-teaching and teaching hospitals were 34.6% and 13.3%, respectively. The CAGR of IPC in tertiary, regional and local hospitals was 13.4%, 17.4%, and 25.0%. The trends of IPC for different hospital teaching status, and hospital accreditation levels were significantly different (P < 0.0001).

Conclusion: There were increasing trends of IPC in Taiwan during 2000 to 2010, and different patient characteristics, including age at cancer diagnosis, income level, residence urbanisation and different hospital characteristics of IPC were noticed.

Implementation Advance Care Planning Across a Healthcare System: Identifying Local Barriers and Facilitators


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Advance Care Planning (ACP) is a process of reflection and communication of a person’s future preferences. Promotion of ACP is a priority for many healthcare systems. However, it is not guaranteed that a person’s appointed power of attorney is known and is made at the appropriate time. Further, the uptake of ACP has not reached the expected level.

Aims: To understand local barriers and facilitators to the uptake of ACP in the Alberta region.

Methods: This project was part of a larger study funded by the Alberta Strategic Clinical Networks (SCNs)—teams tasked with implementing transformational innovation in healthcare. The survey was based on published literature on barriers and facilitators to ACP and on the niche Theoretical Domains Framework patient stories in healthcare provider behavior in the uptake of best practices.

Results: Fifty-one of 88 SCN members (58%) completed the survey. Insufficient public
**Evaluation of the Efficacy of Psychosocial Teams' Intervention: A Randomized, Open, Controlled, Multi-centred Phase III Study**

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**Background:** The Program for the Comprehensive Care of Persons with Advanced Diseases from la Caixa Foundation (PCCPAD-CF) has implemented psychosocial teams that offer support in regards to emotional, spiritual and social issues and contribute to patients' integral care.

**Aims:** To evaluate the efficacy of the psychosocial teams' intervention on levels of emotional distress in patients with advanced disease and emotional distress as measured by the Detection of Emotional Distress (DED) scale, being moderate (DED<9) or severe (DED≥18).

**Methods:** A randomised, open, controlled, multi-centred, phase III study. 80 subjects (candidates to be included in the PCCPAD-CF, being ≥ 18 years old and giving informed consent) are randomised in a 1:1 ratio to Arm A: psychosocial intervention every 3 days (days +2 and +4) or a period of 7 days in combination with conventional intervention or Arm B: conventional intervention.

Psychosocial intervention consists of addressing patient's emotional distress through psychotherapeutic techniques depending on each patient's needs. Conventional intervention consists of non-specific psychosocial intervention offered by healthcare professionals. DED scale is administered to all enrolled subjects at days +2 and +6. Method of statistical analysis: Primary efficacy endpoint is the proportion of subjects with DED<9 at 7 days after completed intervention. Test 2 for two proportions will be used to determine if hypothesis difference between population proportions differs significantly from that observed in the samples. An interim analysis of data will occur when reached half the planned recruitment (40 subjects).

**Results:** Recruitment is currently ongoing (11.2% completed by October 2014). Results from the interim analysis are expected to be available in June 2015.

**Conclusion:** Evaluation of efficacy of psychosocial teams' intervention within PCCPAD-CF has been designed and implemented.

**Abstract number:** P2-340

**Abstract type:** Poster

**The Cost of Palliative Care in Breast, Colorectal and Prostate Cancer**

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**Aims:** To explore the resource use and cost of palliative treatment among breast (BCa), colorectal (CRC) and prostate cancer (PCa) patients.

**Methods:** Patients in palliative care were recruited from the Helsinki University Hospital's Department of Oncology and from a local hospice (Terhokoti). Resource use, demographics and cost data at the time of death were extracted from patients' electronic medical records, and a self-administered questionnaire. Costs were divided into 1) direct health care costs (HCC), i.e., medication and in- and out-patient costs, 2) productivity costs, i.e., the value of days absent from work due to cancer, and 3) informal care costs, i.e., care given free by family or friends. Time dependency of HCC was explored by dividing them into two-week periods in the last 12 weeks of life.

**Results:** Of the 70 patients in the study, 61% were females, the median age was 70 (35–87), 13 had BCa, 33 had CRC, and 24 had PCa. The mean duration of palliative treatment was 179 days: 59 in BCa, 181 in CRC, and 239 in PCa, respectively.

**Conclusion:** A study to evaluate efficacy of psychosocial teams' intervention within PCCPAD-CF has been designed and implemented.

**Abstract number:** P2-341

**Abstract type:** Poster

**Because Trust and Justice Matter: Perceptions of Health Professionals Providing Palliative Care in Primary Care Services**

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**Background:** Organisations' true sustainable advantage is to its people. Health professionals are key players in providing quality patient-centred care. Their perceptions of the structure and processes of the workplace may affect their performance and quality of care. Trust and procedural justice are core features in healthcare organisations. Studying these variables is relevant to evaluate micro, meso and macros-outcomes in health services research and evaluation.

**Aims:** To analyse the relationship between two organisational contextual factors (trust and procedural justice) and psychological empowerment among professionals providing generalist palliative care in primary care settings.

**Methods:** As part of a large multicenter survey study, a random sample of 299 professionals (nurses and physicians) providing primary palliative care in two Spanish regions was drawn. Three pre-validated scales were used to measure trust, procedural justice and professional empowerment. The Trustworthiness, the Procedural Fairness and the Psychological Empowerment Questionnaires. Multiple regression analyses were performed to study the hypothesis of trust and procedural justice being positively associated with psychological empowerment.

**Results:** As hypothesised, both trust (β =1.64, p<.05) and procedural justice (β =-2.29, p<.05) in the workplace were significantly and positively associated with perceptions of psychological empowerment in health professionals from primary palliative home care services.

**Conclusions:** Based on these findings, recommendations can be made to ensure that health care managers and professionals leading primary care teams facilitate the implementation and delivery of palliative care by promoting trustworthiness and fairness in their teams. These are critical to create conditions (trust within teams and fairness of formal decision-making policies) that facilitate teamwork and promote empowerment in primary care settings, contributing to the quality of care provided.

**Abstract number:** P2-342

**Abstract type:** Poster

**Burnout in Palliative and Intensive Care Units: Does it Make a Difference?**

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**Background:** Repeated contact with dying and death is a major burnout risk factor. Hence, professionals working in palliative and intensive care are at special risk.

**Aims:** To identify and compare burnout levels and its related factors among professionals working in palliative and intensive care units in Portugal.

**Methods:** Multicenter quantitative, comparative study. The Maslach Burnout Inventory was used. Data was collected together with a questionnaire of socio-demographic and profession-related variables, and a questionnaire of work-related experiences in the week and day prior to completion. 392 professionals participated in this study, 92 worked in palliative care units (PCUs) and 300 in intensive care units (ICUs). Univariate and multivariate logistic regression analyses were performed. OR sideelong with 95% CI were calculated. Results: While 25% of the professionals working in ICUs exhibited burnout, only 3% of those working in PCUs exhibited this syndrome. Univariate logistic regression analysis showed that burnout was inversely associated with working in PCUs (OR = 0.41, 95% CI: 0.224–0.785 95%). When controlling for other variables (e.g., professionals’ socio-demographic characteristics, post-graduated education in intensive/palliative care, work-related experiences), differences remained significant (OR = 0.36, 161–0.975 95%). Higher levels of burnout in ICUs were related to being a nurse (OR = 1.849, 95%CI 1.029–3.321) and experiencing conflicts (e.g., conflicts in the work context) increase the risk of developing burnout among professionals providing end-of-life care. These findings suggest the need to further implement conflict management strategies in these settings, helping professionals to cope with high-demanding situations associated to providing end-of-life care.

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**Abstract number:** P2-346  
**Abstract type:** Poster

**National Perspectives on Dying and Bereavement – Ireland 2004 and 2014**  
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**Background:** Policy/service developments benefit from being planned relative to people's views – their current opinion & future concerns. Over the last decade international and Irish surveys have engaged with the public about end of life. This study aims to examine the contemporary knowledge, attitudes and behaviour of Irish people with respect to death and bereavement. Comparisons with baseline data from 2004 & UK data will be made.

**Method:** A questionnaire was designed based on Irish and UK surveys. Research ethics approval for a survey process was obtained. Adults from the republic of Ireland were randomly sampled to participate in an omnibus telephone survey. A telephone survey was conducted with a representative sample (n=4891) during May 2014.

**Analysis:** Frequencies & descriptive statistics were generated, comparison by region, gender, age and class was conducted.

**Results:** 57% felt there was not enough discussion about death & dying (up from 51%). Dying at home was the preference of 74% (up from 67%) & most do not believe their preference will be available for them (53% up from 45%)

**Conclusion:** There is appetite for discussion but still limited action around end of life plans though over half have recently been bereaved. Preferences are more strongly stated than in 2004. These trends will be discussed relative to changes in Ireland between 2004 & 14.

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**Abstract number:** P2-345  
**Abstract type:** Poster

**The Ordkal Model: Establishment of an Integrated Oncology and Palliative Care Outpatient Clinic to Improve Collaboration and Care – Who Are The Patients?**  
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**Background:** Integration of palliative care into oncology may improve quality of life for patients and family members, increase patients’ time spent at home, and reduce aggressive end-of-life treatment. An integrated outpatient palliative care clinic was established at a local hospital (Orkdal) in Mid-Norway in 2012.

**Aims:** The Orkdal Model aims to develop, implement and evaluate an integrated model of palliative care cancer care. It consists of a standardised care pathway coordinating care within specialists- and community care, and between the two levels; an educational program for healthcare providers; and information on palliative care to patients, their family, and the general public. The present study aimed for describing the patient population.

**Methods:** All patients visiting the Orkdal oncology outpatient clinic from October 2013 to July 2014 were eligible. Data regarding socio-demographics, cancer disease and subjective symptoms were collected by the EAPC Basic Dataset. Numerical rating scales from 0 to 10 were used for symptom assessment.

**Results:** 119 patients participated. Mean age was 67. Fifty-one percent were females. Stage of disease was: metastatic 62%, locally advanced 14% and local 19%. The three most prevalent cancer groups were female breast cancer vs. 19.3%, prostate cancer and lung cancer vs. 17.8%. Treatment intention was: curative 30% and palliative 66%. Mean Karnofsky performance status was 84%. 101 patients had more than one registration. 31 patients died in the study period; among these 33% died at home. Average intensity across were: pain 16%, dephlegminal death well being 2.46.

**Conclusion:** An integrated model to improve palliative cancer care is developed. Data from patient, family members and healthcare providers will be collected prospectively and compared with the present data and with a control population. The model may be applied in other regions and for other chronic diseases.

**Funders:** The Central Norway Regional Health Authority and the Norwegian Directorate of Health.
To determine the effectiveness of formal case conferences between General Practitioners occurs 4 times a year in 15 hospitals of Japan, 245 of these conferences were conducted between 2011 and 2012. In this study, we aimed to analyze the content of these conferences conducted to promote end of life care.

Methods: After obtaining ethical approval from Hofstra Northwell School of Medicine Institutional Review Board, we invited 21 General Practitioners to review the content of these conferences. These General Practitioners were from 15 hospitals across Japan.

Results: A total of 3572 entries were collected from 21 General Practitioners across 15 hospitals, and the results were analyzed. The most common topics discussed in these conferences were end of life care (54.6%), pain management (35.6%), communication with patients and caregivers (24.7%), and advance care planning (20.5%).

Conclusion: These case conferences are an effective tool for General Practitioners to discuss and prepare for end of life care. However, more emphasis needs to be placed on communication and advance care planning to improve care quality.
Treat. Treat… Treat: The Philosophical Divergences of End of Life Care in Critical Care Units

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Abstract number: P2-353
Abstract type: Poster

Background: Around 52% deaths in the UK occur within a hospital setting, with a significant proportion of these being in critical care settings. Specifically, 15% to 36% of patients admitted into an intensive care will die. Despite the implementation of clinical guidelines such as the Liverpool care pathway (LCP), facilitating end of life care in critical care settings remains a challenge for critical care practitioners.

Aim: This study aimed to explore experiences, challenges and practices of critical care practitioners in delivering end of life care in critical care settings since the discontinuation of LCP.

Methodology: A qualitative exploratory design was used. After full ethics approval, semi-structured interviews were conducted with fourteen critical care practitioners from two acute NHS trust hospitals in England.

Findings: Framework analysis revealed five key themes of philosophical divergences in end of life care in the critical care setting. These themes included distinctive patients, defying setting, divergent dying trajectories, feeling useless and new directions. The themes explored how the nature of critical illnesses, trajectory of death, patient characteristics, and new directions challenged the delivery of end of life care in critical care settings. Participants’ described unique challenges of defying the philosophy of critical care and changing contexts from treatment to palliation infusing a feeling of uselessness in delivering quality end of life care.

Conclusion: This study found that the creative philosophy of critical care and the rapid end of life trajectory often negates the ‘negotiation of a natural death’ in critical settings.

Educational interventions both in pre and post registration health care practice need to be developed to tackle these philosophical divergences of care delivery in critical care settings.

Abstract number: P2-354
Abstract type: Poster

Communication, Interaction and Coping of Cleaning Staff with Seriously Ill and Dying Patients

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Background: Although the palliative care team traditionally consists of professionals specialised in this field (e.g., physicians, nurses, psychologists, social workers), other professional groups within the hospital (e.g., receptionists, secretaries, cleaning staff) often have frequent contact with patients and may help to improve the overall care of patients.

Aim: We were interested in how cleaning staff (CS) communicate and interact with seriously ill and dying patients. In addition, we investigated how CS cope with the situation of death and dying and whether there is a need for additional support to deal with this aspect of their work.

Methods: A sequential mixed methods design was chosen. At a large university clinic in Germany, CS and cleaning management staff were recruited for interviews and focus group discussions.

Findings: In total, 120 questionnaires were returned. About half of participants indicated that patients talk with them every day, on average for 1–3 minutes. Among the most common topics of conversation included weather and family, patients also discussed their illness and, occasionally, thoughts regarding death. When patients addressed illness and death, CS often felt uncomfortable and helpless.

Conclusions: Cleaning staff perceive that they have an important role in the clinic – not only to clean but also to support patients. Likewise, patients seem to appreciate being able to speak openly with CS. Still, it appears that CS may benefit from additional training in how to communicate with patients about sensitive issues such as illness and death.

Abstract number: P2-355
Abstract type: Poster

Describing the Content of ‘Early’ Specialised Palliative Care (SPC) in the Danish Palliative Care Trial (DanPaCT) – Which Interventions were Initiated and for Which Symptoms and Problems?

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Background: It is now often recommended that patients should be referred to SPC at an earlier time in their disease trajectory than what has traditionally been the case. However, little is known about what early SPC consists of.

Aims: The aim of this study was to describe the content of early SPC in DanPaCT.

Methods: DanPaCT investigates whether patients with metastatic cancer, who reported palliative needs in a screening, would benefit from being referred to early SPC. Patients were either randomised to standard oncologic treatment or standard oncologic treatment plus SPC (the intervention group). For patients in the intervention group the medical records for the eight weeks of the trial were coded based on a coding scheme to describe the interventions given. In the coding scheme each coding consisted of an action (e.g. an intervention) attached to a symptom or problem and to a profession.

Results: The results from 44 of the 145 patients, who were randomised to the intervention group show that 37 (84%) of these patients received at least one intervention. In total 183 interventions were given to the 37 patients (mean = 5 per patient; range 1 to 22). Of the 183 interventions 58% were medical prescriptions, 20% were therapeutic conversations, and 7% were referrals to other specialists. Of the 37 patients who received at least one intervention, 54% of the patients were given an intervention at least once for pain, 38% for financial difficulties, 30% for emotional function and 22% for constipation.

Discussion/conclusion: Early SPC consist of medical treatments in more than half of the interventions given, and the symptom that was most often treated was pain. We discuss the challenges of coding the psychosocial content of the interventions. Some patients (16%) never received any intervention from SPC.
Challenges in Preparing Advance Directives and Advance Care Planning for Dementia Patients: Summary of Issues for Policy Discussion in Japan

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Background: Decision making for dementia patients is a global problem. In some countries, including England, preparing advance directives (ADs) and/or advance care planning (ACP) before one loses the capacity to do so in 2006. Since then, the number of palliative terminal beds and the provision of palliative care in hospices (n = 41) Central Bureau of Statistics: mortality statistics of people with chronic illness (not sudden death)

Quantitative: Retrospective study: semi-structured interviews with survivors (n = 20) Analyses: Chi-square test; the Spearman Rank Correlation Coefficient Qualitative: Open and axial coding, using a repetitive process. Results: The gap between desire to die at home and reality has decreased in the last 10 years. The current gap seems to be partly due to different definitions of ‘home’. Those in the last phase of life attached more importance to ‘feeling at home’ than ‘being at home’. Feeling in control about dying was more of a relational process of sense making than an individual act. Dialogue and sense making about the meaning of dying preceded and were considered more important than decision-making.

Conclusion: The process leading to the realisation of the place of death is not linear but complex. Decisions can change over time. Professionals should attach more importance in realising the wishes of patients than influencing their decision-making. Relational care requires dialogue of sense making between all participants in the dying process.

The survey was financially supported by VPTZ Nederland

Access to Opioid Medicines: A Methodological Framework for Analysing Policy Barriers

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Background: The World Health Organization (WHO) defines the principle of ‘balance’ in controlled substances policies to ensure that opioid medicines are available for patient care while preventing their abuse. However, national policies often strongly emphasise control and restriction, thereby interfering with the medical availability of opioids.

Aims: To develop a methodological framework for the systematic analysis of policy barriers to accessing opioid medicines in twelve European countries.

Methods: Data for qualitative action research were collected throughout the Access To Opioid Medication in Europe (ATOME) project in collaboration with national country teams. Documents developed during the project, such as protocols of national problem analyses, strategic action planning worksheets, and minutes of national ATOME conferences were analysed using qualitative content analysis. A category system was developed based on the literature, public health models, and WHO policy guidelines, and validated by experts from pharmaceutical policy. The identified policy barriers were sent to the national teams for verification.

Results: Four major categories of barriers were defined: (1) policy and regulation; (2) financial and economic aspects; (3) knowledge and education; and (4) social awareness.

Within each category, a hierarchy of sub-categories was identified including specific barriers to accessing opioid medicines for pain relief, palliative care, and treatment of opioid dependence.

Conclusion: The methodology provided a useful framework for the analysis of policy barriers. Regular communication with country teams helped to create ownership of the resulting recommendations. Limitations were that ‘thickness’ of data depended on the commitment of national key contacts, and consensus on the impact of barriers was not always reached. To ensure that the identified barriers validly represent a country’s situation, dialogue with a broader range of stakeholders would be necessary.

Poster Sessions (Poster Exhibition Set 2)
**Who Are Demanding Changes in the Russian Public Agenda?**

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**Abstract number:** P2-361  
**Abstract type:** Poster

**Abstract:**

**Background:** For many years, the problem of inadequate pain relief was denied by the Russian Ministry of Health, despite the low level of opioid consumption for medical and research purposes: 204 ME mg/capita. The problem moved into the public agenda this year when the State Duma [Congress] passed on the first hearing proposed changes to the existing law on narcotic drugs, the government held a meeting concerning the problems of accessibility of opioids in various regions of the country.

**Aim:** Identification of Russian agenda builders who demanded change.

**Methods:** The analysis of information: social and professional media: newspapers, press releases, TV, radio, and identification of the sources that promoted change.

**Results:** Media exposure of the suicide of Admiral Apanasenko and the criminal convictions of Doctor Khomukayev were catalysts in altering the public’s attention to access of opioids and made people sensitive to the issue. Russian Association for Palliative Medicine representatives did not comment on the issue. Physicians, who are governmental employees in Russia, failed to be open about their opinions. As a consequence, only a small group of palliative care advocates had the opportunity to provide indisputable facts to the media that helped the Russian public and policy makers understand the size of the problem. Assistance from Human Rights Watch and the European Association for Palliative Care gave confidence to these advocates of their rightness.

**Conclusion:** In the current political environment, the role of the professional medical community was minimal. Assistance from international organisations was a necessity. Mass media exposure critically modified the dynamics of the policy-making process. At a time when the democratic institutions in Russia do not work properly, a World Health Organization investigation on the availability of opioid for pain relief is vital.

**Abstract number:** P2-362  
**Abstract type:** Poster

**Building Bridges with the General Public: Palliative Care and Media**

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**Aim:** The aim of this presentation is to highlight the importance of working with media, to overview possible ways of engaging with the general public and to provide an example of a successful online public campaign, including challenges with its realisation.

**Design, methods and approach taken:** Thinkaboutdeath.org is an online campaign offering an opportunity to contemplate one’s last wishes and to create a list of last wishes, which can be shared via social media with friends and family. It was developed by a hospice Cesta domu, based in Prague, the Czech Republic, with the creative agency MediaArti. After the success of the initial Czech version (Mojesmrct.cz), the EAPC granted their auspices for developing an international version in English.

**Results:** In the first four weeks of the campaign, more than 20,000 users visited the website, 7,500 of them engaged in the core part focused on creating a list of your last wishes. Average session duration is 13 minutes, which can be considered as a major success with regard to the usual web traffic. 40% of visitors are between 25–45 years of age, 29% are older than 45.

All types of media, both local and international, have published stories about the campaign, the usual web traffic. 40% of visitors are between 25–45 years of age, 29% are older than 45.

**Conclusion / lesson learned:** Working with media is crucial in developing a relationship between professional community and the general public, consisting also of future patients and their relatives. Assistance from international organisations was a necessity. Mass media exposure critically modified the dynamics of the policy-making process. At a time when the democratic institutions in Russia do not work properly, a World Health Organization investigation on the availability of opioid for pain relief is vital.
Poster Sessions (Poster Exhibition Set 2)

Abstract number: P2-365
Abstract type: Poster

Ten-year Trends in the Risk of Hospital Death for Conditions Needing Palliative Care: A Death Certificate Study

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Background: Most people die in hospital despite a preference to die at home. Understanding trends and factors is key but most evidence is from regions where palliative care is well-established.

Aims: To examine the risk of hospital death for conditions needing palliative care over a 10-year period in deaths within Sweden.

Methods: Death certificate study of all 1,041,596 deaths of residents aged ≥18 years (2003–12, Portugal). Criteria for palliative care need were cause of death (ICD 10 codes cancer, heart and cerebrovascular, renal, liver, respiratory or neuropsychological diseases, dementia阿尔zheimer/senility, or HIV/AIDS. For this study, we tracked trends and factors associated with dying in hospital using multivariate logistic regression.

Results: 736,454 (70.7%) of deaths met the criteria for needing palliative care. 51.2% men, median age 80, heart and cerebrovascular diseases (43.8%), cancer (32.2%), 61.8% of these deaths occurred in hospital, 36.8% of which outside the patient’s municipality of residence. The risk of dying in hospital increased by year (AOR 1.04, 95%CI 1.04–1.04), with age- and gender-standardised percentages rising from 56.3% in 2003 to 66.7% in 2012. Odds were higher for the married and those dying from HIV/AIDS (3.18, 2.91–3.48), renal (1.57, 1.51–1.63), liver (1.49, 1.45–1.55) or respiratory diseases (1.45, 1.43–1.48) versus cancer. Odds were lower for heart and cerebrovascular (0.48, 0.48–0.49) and neurodegenerative (0.41, 0.40–0.44) diseases, dementia/阿尔zheimer’s/senility (0.13, 0.13–0.13), and for older people.

Conclusions: We found an upward trend of hospital death and higher risk for the married. Results that are opposite to countries where palliative care is well-established. In addition, there is wide variation in the risk of hospital death among patients with non-malignant conditions. This clinical heterogeneity requires attention from care, policy and research.

Funding: Calouste Gulbenkian Foundation.

Abstract number: P2-367
Abstract type: Poster


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Background: Place of death, with home reported to be the most desirable place, is considered to be one important aspect of quality of care at the end of life. Sweden, until now, lacks population-based studies that not only examine place of death, but also what factors that may influence where people die.

Objectives: The objectives were to examine place of death in Sweden and associations between place of death and diagnosis, personal characteristics, geographical and sociocultural factors.

Design and methods: This study, being part of the International Place of Death (IPoD) project, was based on all deaths in Sweden 2012 (n = 918.74). Data was derived from death certificates and registry-based registers. Place of death and other variables were assessed using the Death Anxiety Scale. Binary logistic regressions were performed to examine factors associated with dying in hospital, at home and in nursing homes.

Results: Of all deaths in 2012, 42.1% died in hospital, 17.8% at home and 38.1% in nursing homes. Being married and having higher education increased the likelihood of dying at home, whereas living in an urban area decreased the likelihood of dying at home. Being old, and dying from dementia increased the likelihood of dying in nursing home. In fact, the majority of individuals ≥90 years (61.9%), and with dementia (89.8%) died in nursing home, while most (74.5%) children 0–17 years died in hospital.

Discussion and conclusions: In Sweden, people who are to be in need of palliative care continue to die in hospital, and many old individuals die in nursing homes. While dying in hospital has been associated with risk of futile treatment, previous studies also lack of palliative care and lack of care. The geographical and sociocultural distribution of place of death call for further attention. As the Swedish national guidelines for palliative care were launched in 2012, these results provide important baseline information to evaluate its effects.

Abstract number: P2-368
Abstract type: Poster

Common Attributes of Patients with Advanced Chronic Disease who Would Benefit from Palliative / Hospice Care

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Aim: To establish the characteristics of patients who could benefit from early access to palliative / hospice services, we identified the attributes of patients commonly hospitalised / re-hospitalised with renal failure, sepsis, congestive heart failure, chronic obstructive pulmonary disease and pneumonia.

Methods: We conducted a retrospective analysis of the US Center for Medicare and Medicaid Service (CMS) data for patients living in central and southeast Ohio (approximately 500,000 Medicare beneficiaries). We identified index hospitalisations for each of these five conditions, described co-morbid conditions using Agency for Healthcare Research & Quality clinical classifications of physical conditions, and evaluated the characteristics of patients with a risk of dying within six months. The resultant models for each of the five conditions had significant and different covariates.

Results: The adjusted odds ratios of eight attributes were common to these five conditions, and associated with a risk of dying within six months, including: Congestive heart failure without hypertension, odds ratio 1.347–1.507 Respiratory failure with insufficiency or arrest (adult), odds ratio 1.295–1.689 Chronic renal failure, odds ratio 1.172–1.441 Chronic ulcer of skin, odds ratio 1.46–2.268 Secondary malignancies, odds ratio 5.115–7.068 Nutritional deficiencies, odds ratio 1.915–2.205 Delirium, odds ratio 1.329–1.893 Discharge to a Skilled Nursing Facility, odds ratio 1.483–2.152

Conclusions: These eight attributes that are associated with an increased risk of six-month mortality after discharge from a hospital, and common across these five chronic conditions, can be used to identify patients who could benefit from early referral to palliative and hospice care services earlier, and measure the timely utilisation of these services within a population of patients at risk of dying within six months.

Spirituality

Abstract number: P2-369
Abstract type: Poster

Pastoral Care of the Dying: What Pastoral and Religious Support Is Offered to Dying People by Clergy? A Pilot Study among Ordained Clergy in Lambeth and Southwark, South East London

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Abstract number: P2-370
Abstract type: Poster

Innovation in Cancer Management Spiritual Care and Changes in Receptor Gene Expression in Breast Cancer Patients

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Breast cancer is the most common cancer in females in Iran and in most of the developed countries. Behavioral and clinical studies have shown that having chronic stress and impaired mental and spiritual condition of each individual predispose several types of cancer including breast cancer. Research results showed that religious and spiritual factors correlate with indices of physical conditions such as heart disease, cancer and death. Also, there is a confirmed relation between psychiatric conditions and changes in receptor gene expression in depression and anxiety social dysfunction. Different studies demonstrated the role of spiritual factors in occurrence and progression of cancer. They affected cells by their various types of receptors. In accordance with our previous studies, the most effective genes in psychiatric conditions and thus physical conditions are Dopamin and Serotonin receptors. Accordingly, the study was conducted to evaluate effects and spiritual therapy on changes in Dopamine and Serotonin receptor gene expressions in breast cancer patients and hence, determine specific gene receptors to be held responsible.
90 female volunteers, were selected to run the study. It was observed that D82D-DELRI in intervention group PBMC decreased compared to the control group and lower than those of healthy individuals. Moreover, real-time PCR data indicated significant promotion in expression of SH3TAR and SH2TAR in PBMC in breast cancer. Our results indicated significant reduction in expression of SH3TAR and SH2TAR in intervention group compared with the control group but there were no findings exchange in comparison with healthy samples. The findings were of great significance in prevention and treatment of cancer because they revealed the possibility of using other types of treatments such as spiritual interventions apart from conventional medical treatments.

Abstract number: P:2-371
Abstract type: Poster

Sustaining Hope and Life Courage – The Impact of Care
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Background and aims: In the Western World ovarian cancer is the leading cause of death from a gynaecological malignancy. Consequently, women with ovarian cancer can have palliative needs right from the beginning of their treatment. In this study we explored embodied experiences of comfort and discomfort as they develop during the final diagnosis of ovarian cancer and the commencement of treatment.

Methods: The study took place in a Danish regional hospital for surgical treatment of gynaecological cancer. A number of nineteen qualitative research interviews were conducted. By applying a phenomenological-hermetic text interpretation methodology, the findings were systematically identified, put into meaning-structures, interpreted, and critically discussed.

Results: The women were hoping for survival, but also, if this was not possible, for dying with dignity and a minimum of suffering. To possess life courage seemed crucial in order to go on living, even though life was tough, and at the same time prepare for dying even though life was wonderful. The empirical material constituted this main theme: ‘Hope and life courage are created in the interplay between body and mind.’ These findings dealt with personal intentions, actions, reflections, and experiences in relation to the following subthemes: ‘Experiencing discomfort,’ ‘The impact of care’ and ‘Comfort and hope.’

Conclusions: The newly diagnosed and commence the treatment of a serious or late-stage cancer disease represents a period of time in life in which both hope and despair are present. Depending of the character of the disease intentions of patient involvement and shared decision making may be put under pressure during diagnoses and commencement of treatment, and whether a free treatment choice is an option can be questioned. Symptom relief represents a well-known and hope-enhancing strategy in palliative care. However, less emphasis has been put on this aspect in the beginning of the patient pathway.

Abstract number: P:2-372
Abstract type: Poster

Palliative Care Training on the Spiritual Dimension: A Pilot in Teaching Hospitals in the Netherlands (SPIRIT-NL)
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Background: In the Netherlands, palliative care (PC) is not a medical specialisation and non academic teaching hospitals do not have PC units. In these hospitals, PC is integrated into the care of the patients. In the last years, the development of multidisciplinary teams has been considered a way to improve the quality of both. The purpose of the baseline audit was to assess the benchmark for spiritual assessment and delivery of spiritual care in those thought likely to be dying.

Method: The method employed for baseline and post-intervention audits was to visit hospitalwards and review a random selection of 20 individualised plans for the care of those thought likely to be dying.

Results: Spiritual assessment improved from 70% patients to 85% & 45% families to 50% from first audit to second
- Identified spiritual needs improved from 40% patients to 55% & 35% families to 45%
- 64% of those who requested pastoral support are documented as having received it compared to 50% previously
- 30% of all patients received pastoral support whether or not the identified need was documented; compared to 20% previously
- 60% of patients had a daily review of spiritual needs, compared to 50% previously.

Conclusion: Between audits visibility and accessibility of the Chaplaincy and Spiritual Care Service was increased in the introduction of posters and a chaplain doing a weekly ward round with the End of Life Facilitator.

Abstract number: P:2-373
Abstract type: Poster

Improving Spiritual Support: Audit of the Assessment of Spiritual Needs and Delivery of Spiritual Care in those Thought Likely to be Dying
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Background and aims: As good spiritual care begins with good spiritual assessment on two occasions the documentation of those considered sick enough to be dying was audited, particularly in relation to the assessment and provision of spiritual care. The aim was to improve the quality of both.

Method: The purpose of the baseline audit was to:
- Assess a benchmark for spiritual assessment and delivery
- Offer action points for improvement

The audit cycle was completed to measure improvement following intervention.

Results:
- Spiritual assessment improved from 70% patients to 85% & 45% families to 50% from first audit to second
- Identified spiritual needs improved from 40% patients to 55% & 35% families to 45%
- 64% of those who requested pastoral support are documented as having received it compared to 50% previously
- 30% of all patients received pastoral support whether or not the identified need was documented; compared to 20% previously
- 60% of patients had a daily review of spiritual needs, compared to 50% previously.

Conclusion: Between audits visibility and accessibility of the Chaplaincy and Spiritual Care Service was increased in the introduction of posters and a chaplain doing a weekly ward round with the End of Life Facilitator.

Abstract number: P:2-374
Abstract type: Poster

‘Becoming Small together Around the Big Questions’ – An Inquiry into how Philosophical Counselling and Socratic Dialogues and Communities of Wonder on Hospices Can Strengthen the Existential and Spiritual Care in Palliative Work
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In the contemporary research on existential and spiritual care in palliative work focus has mainly been on psychological and pastoral, approaches, and to some extent also on aesthetic approaches. When ‘spirituality’ is described as what gives people balance when finding meaning in the existential challenges of life (Wight, 2005) it is surprising how little research there has been on the relevance of the practice of philosophising and philoso phising dialogues, and especially the discipline of philosophical counselling, in palliative care. Based on a three-year phenomenological-oriented action research project on a Danish Hospice this paper describes how and why especially an existential-phenomenological and action-oriented research design was chosen and how this inquiry and cooperation (and co-creation) between the researcher and the nurses as ‘wonder-driven co-inquires’ came out. The result of this action research project was partly on the methodological level a development of a kind of ‘wonder lab’, where the nurses through different forms of phenomenological writings and Socratic wonderments upon their written narratives of spiritual and existential moments in palliative care came up with some evocative and insightful insider-descriptions (or ‘phenomenological snapshots’) of these fragile and volatile but deeply meaningful life experiences and moments. On the other part some important research findings was also that the hospice nurses indeed were able to approach existential and spiritual questions and themes and situations in a more open sensitive and wondrous way than before, and that the ability to ‘stand in the openness’ in so-called Sociocentric Communities of Wonder also had an influence on the way they developed a new language and modes of being in dialogues around existential and spiritual issues or situations. This gave the nurses a new and more symmetrical and wondrous relation of being-with-the-other in spiritual care.

Abstract number: P:2-375
Abstract type: Poster

The trial runs in two rounds, the results of the first group and part of the results of the second group of pilots will be presented at the conference.

Discussion: Developing multidisciplinary SC in PC care requires joint commitment of healthcare chaplains, management, physicians and nursing staff.

Poster Sessions (Poster Exhibition Set 2)
Poster Sessions (Poster Exhibition Set 2)

Abstract number: P2-375
Abstract type: Poster

Nurses Exploring the Spirituality of their Patients: An Observational Pilot Study in Palliative Care

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Background: Nurses have to give attention to all four dimensions of the patients they care for: physical, psychological, social and spiritual. Exploring the spirituality apparently isn’t always easy. Nurses at the oncology department of a large university hospital in the Netherlands, are acquainted with the three questions of the Mount Vernon Cancer Network (MVCN) which might help them to explore the spiritual dimension of their palliative care patients.

Aims: This observational pilot study aimed at getting insight in how and if nurses recognise and take advantage of situations in daily care to talk about spirituality with their patients. Furthermore we want to find out whether the MVCN questions is part of this exploration.

Methods: The clinical spiritual care of the participating hospice nurses was video recorded along with several nurses in their daily work (3-6 shifts). Due to this part observation technique, in which she wears a doctor’s white coat, the care situation remains as natural as possible. The consultant is well-known and esteemed at the department.

Results: The study is currently in progress and will be completed and analysed for the start of the conference. Therefore, no results are yet available. Results that will be presented focus on the following aspects:

(1) care situations in which nurses (might) interact with their patients about spirituality,
(2) whether or not the MVCN questions play a role in that situations,
(3) barriers and facilitators experienced by nurses regarding discussing spirituality with their patients.

Conclusion / Discussion: In order to support nurses in exploring the spiritual dimension of their patients, it is necessary to know what they do already in daily practice and what hinders or facilitates them. The results of our study will generate more insight in these processes. This study might help to complete and integrative nursing care for people in the last phase of their life.

Abstract number: P2-376
Abstract type: Poster

How Do Palliative Care Doctors Ask Cancer Patients about Spirituality? A Qualitative Study

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Research indicates that patients would like their doctors to ask them about spirituality but it is not clear how such conversations are currently conducted. As spiritual care is a recognised domain of palliative care, we aimed to discover how palliative care doctors currently ask their patients about spirituality, the impact of such discussions and what factors contribute to success.

This study used grounded theory methodology to explore the ways doctors discuss the topic of spirituality with their patients. Semi-structured interviews were conducted with 20 doctors in Australia and New Zealand who were involved in palliative care practice. They were asked to describe their usual practice and their views on facilitating factors and barriers as well as the impact of spiritual discussion on patient care. Snowballing was used to identify a wide range of perspectives. Interviews were transcribed verbatim, subjected to line-by-line coding and analysed for unifying themes.

Respondents provided spiritual enquiry as a process over time which needs to be sensitive to individual patient needs. The doctor’s own spirituality and self-care is critical to its successful practice. Spiritual discussion in palliative care can enrich relationships between the doctor, patient and their family, and is an important and effective intervention which can improve patient care by reducing symptom distress and supporting acceptance of approaching death. Facilitating factors and barriers to discussion are described. Skills improve over time but can be taught.

This sample of doctors describe discussion of spirituality with palliative care patients as a delicate process which needs to be aware of individual patient needs, but which can improve job satisfaction and patient care. Results of this qualitative study suggest that introduction of training in spiritual discussion into palliative medicine teaching programmes would promote development of proficiency and improve care.

Abstract number: P2-377
Abstract type: Poster

Hospice Philosophy in Practice – Spiritual Care in a Hospice Setting

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Spiritual care is today seen as an integral part of palliative care within the Danish National Health Service. From international research we know hospice practitioners find it difficult to articulate the nature of spiritual care related to dying persons, especially in the hospice setting. spiritual care is today seen as an integral part of palliative care. In Denmark we do not have much research on spiritual care and as Denmark is known as a rather secular society the question about the nature of spiritual care is important to clarify.

The aim of this study is to explore the practice of providing spiritual care as seen from the perspective of nurses working within a Danish hospice setting. A secondary aim is to place this understanding within the secular, individualised society of a contemporary Westernised Westernised Danish society.

The method used in this research is phenomenological and hermeneutic and utilizes philosophical practice as a tool for enabling hospice nurses to articulate and reflect upon their experiences of delivering spiritual care to dying persons. Existential phenomeno-phenomenological theory is used as an analytical framework.

Results: The nurses tend to look retrospectively to meaningful aspects of their patients’ lives more than gazing towards the possibility of a hope for an afterlife. Spiritual care is also associated with the concept of ‘hope’ which is itself complex and has ethical, aesthetic and metaphysical dimensions commonly expressed in terms of ‘love’, ‘pleasure’ and ‘faith’ all of which are rendered significant in terms of the lives of the patients.

The nurses identified good spiritual care with perceptive and attentive care because what counts as ‘spiritual’ for a particular patient is very individual to them. Concluding spiritual care appears as a broad and challenging concept which requires us to ask: what is the difference between spiritual care and care?
Social care and social work

Abstract number: P2-382
Abstract type: Poster

'A Museum with you'. Pictures from Movies in a Hospice

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A professor of history of cinema was admitted and died in our hospice in spring 2014. In his letter to his family and the hospice he collaborated with the National Museum of Cinema of our city and published several books and manuscripts on this topic. During his stay in the ward he actively collaborated with this institution moving his office into the hospice. Due to his determination and the quality of care received he could actively work until the last days of his life. In his will he desired to have a permanent exposition of pictures from notorious movies to be shown in our hospice ward. The exposed pictures are mostly from Italian famous movies from the sets. They were selected by the patient together with the hospice personnel excluding joyous scenes or those with nude actors or too sad to be displayed. The pictures are nice and pleasant and are showing a deep evocative impact on our admitted patients and their relatives. They work as a relational bridge between the guests and the professionals helping in breaking the barriers and inducing narrative. Using an oblique and narrative approach this post mortem evocative impact was studied by the staff. Themes like 'remembering' and sharing positive images from the past, 'allowing emotions breathing spaces that move the death and dying away for a moment', together with deep stories give evidence of the importance of sharing personal history of the patient and not only the final phase emerged from this study. As a preliminary result we conclude that this experience is helping both patients, their families and the hospice staff in easing difficult relationships and maintaining pain and peaceful end of life experience of the patient who made this possible.

Abstract number: P2-383
Abstract type: Poster

Professional Competencies of Social Workers in Palliative Care Specialized Services – The Romanian Experience

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Background: In Romania the competencies for Social Workers (SW) in palliative care have gained recently interest due to participation in the EAPC SW taskforce. In 2012 translation of Canadian Competencies in Palliative Care (PC) and adaptation to Romanian context by an expert panel established the Romanian competencies for SW in PC. 6 domains were defined: advocacy, patient and family support, research and education, information exchange, interdisciplinary team and self reflectve practice covering 10 competencies.

Aim: To determine beneficiaries perspective on importance of the competencies in the 2 domains target on them: advocacy and patient and family support (with 4 sub-areas of expertise: situation assessment, decision making, care planning, and provision of resources).

Method: Patients survey (outpatients and day care PC services) using a purposely designed self administered questionnaire, with 21 questions with answers on a Likert scale, July – August 2014.

Results: Out of 69 questionnaire distributed, 61 completed questionnaire returned (RR=88,6). Respondents were predominant women 77%, from urban area 82%, with over a year of care in the hospice 70,5%, main age group 44–65 years 54,1%. In ‘advocacy’ domain: 96.7% appreciated as extremely important for the SW to demonstrate the capability to support and promote the patient’s and family’s case. In ‘support for the patient and family’ domain: 95% saw extremely important for the SW to demonstrate the ability to accurately assess the general situation of the patient and the family; 73.7% for the SW to be pro-active and time-efficient in decision making; 44.2% for the SW to demonstrate the ability of ‘planning the care’. 55.7% for the SW to effectively intervene in ‘providing resources’. Simultaneously the patient and the family are relying on the social worker for representation, global assessment, support in finding solutions, counseling, advice and guidance.

Social Needs for Adult Patients with Cancer

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Background: Palliative Care includes holistic care, addressing needs in all four domains: physical, emotional, social and spiritual. In resource poor settings, social needs, especially financial needs, can be overwhelming and social workers roles are shaped by these needs. Aim: To identify social care needs of patients with cancer who are enrolled in hospice program.

Method: Research in two stages: first semi-structured interviews with patients in hospice care to develop themes for the questionnaire, second a cross sectional survey of hospice patients with the special developed questionnaire.

Results: 12 hospice patients (5 women, 7 men) with performance status ECOG 1=2, 2=2, 3=8 were interviewed. Themes identified were: impact of the disease, symptom burden, information concerning the disease, work and life, financial impact, changes in relationships, most difficult moments in disease trajectory, relationship with God and church. Build on the results a survey with 70 questions was designed. Survey: 323 patients responded to the questionnaire (out of 400, RR=81,25%). Respondents were women 177 (54,8%), men 142 (44%), urban 249 (77,1%), rural 55 (18,3%). 42.5% of respondents were the main financial supporters of the family. Income was insufficient to provide medication in the case 53,3% of respondents, for basic needs like food in 44,6% cases and home maintenance payments 55,7%. 34.6% received financial support from different sources. In networking sphere 86.6% of cases had good relationships with family and 12% had problems in the relationship family. 66.1% received emotional support from family.

Conclusions: Social workers are indispensable in evaluation and intervention for cancer patients in hospice care to enact additional social benefits for beneficiaries, to provide comfort, financial security and hence the quality of life of patients with incurable diseases.

Poster Sessions (Poster Exhibition Set 2)
Poster Sessions (Poster Exhibition Set 2)

Psychology and psychiatry

Abstract number: P2-385
Abstract type: Poster

Perceptions of the Mother’s Role, Spouse’s Role, Parent-child Relationship & Opposite Sex Relationship in Breast Cancer Women with Mastectomy and Healthy Women

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Purpose: The purpose of this study was to compare the perceptions of mother role, spouse role, parent-child relationship and opposite sex relationship in breast cancer women with mastectomy and healthy women.

Method: In this qualitative study 26 breast cancer women with mastectomy who referred to Shohada-e-Tajrish hospital were chosen from available samples and they were compared to 26 healthy women by using the Apperception Test which constructed by researcher.

Findings: In positive perceptions of mother’s role, spouse’s role and opposite sex relationship and negative perception of mother’s role, spouse’s role and vague perception of mother’s role, Spouse’s role and opposite sex relationship existed a significant difference in the two groups.

Conclusion: The Qualitative analysis of 520 short stories showed, in perception of mother role, women with mastectomy were more emotionally involved with their children, they also had higher intellectual concerns about their children and had supportive role towards their children. In perception of spouse’s role, physical weakness to perform the role of a wife, and the decline in intimate marital relationships were a clear cut reason for the decrease in quality of marital intimate relationship, fear of losing their spouse and families tearing apart. In parent-child relationship two different aspects of relationship was seen; one was a dependant role, the other one was a relationship based on exclusion of children for not being dependant which was seen in women with mastectomy. In terms of the relationship with the opposite sex, there were changes in sexual orientation, steering away and getting into a relationship with the opposite sex especially for women with mastectomy, who were either divorced, widowed or single.

Keywords: Breast Cancer, Mastectomy, Perceptiion, Mother Role, Spouse’s Role, Parent-Child Relationship, Opposite Sex Relationship

Abstract number: P2-386
Abstract type: Poster

Predictive Factors Influencing the Illness Perception and Quality of Life in Iranian Breast Cancer Patients

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Illness perception (IP) and quality of life (QoL) are two important issues considering the breast cancer management. An attempt was made to examine the predictive variables influencing the illness perception and their impacts on quality of life in cancer patients. The key predictors adapted from some previous studies such as life satisfaction, perceived social support, self-esteem, hope, optimism, and spiritual well being were taken into account. We found out the direct or indirect effects and also their magnitude on IP & QoL. Our sample included 200 female volunteers suffering from breast cancer applying exclusion criteria. The data was collected via various questionnaires. The obtained data was statistically analyzed by means of path analysis & structural equation modeling.

The results revealed, of the six predictors, the spiritual well being and social support had direct effects on QoL and IP respectively. The only path has significant indirect correlation with IP was social support. Spiritual well being has the second significant direct effect on QoL. Self-esteem has the third rank in both direct effects on QoL and IP.

In conclusion, here in Iran and maybe in other religious communities, spiritual intervention is an effective strategy for raising quality of life and also, social support helps women suffering from breast cancer experience better understanding and coping strategies.

Abstract number: P2-387
Abstract type: Poster

Clinical Interventions Regarding Meaning in Life for Patients with Advanced Disease: A Systematic Review

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Background: Research shows that the presence of meaning in life (MiL) improves both spiritual wellbeing (SWB) and quality of life (QoL) in patients with advanced disease.

Although several interventions for improving MiL have been described, a critical synthesis in order to compare them has yet to be conducted.

Aims: To carry out a systematic review of the literature on interventions for promoting MiL among end-of-life patients.

Methods: A systematic review and synthesis was conducted in accordance with the REALIST and Meta-narrative Evidence Synthesis (RAMESES) protocol. The selected studies were evaluated using the CASP and the CONSORT statement.

Results: The search strategy retrieved 1229 articles, of which 12 fulfilled the inclusion criteria. These 12 papers described 9 different interventions, 6 of which were accompanied by an evaluation of outcome measures (see table below).

Conclusion: Despite the growing interest in MiL interventions as part of end of life care there is limited empirical evidence regarding their effectiveness. Studies that have examined the possible benefits tend to measure related outcomes (such as SWB and QoL) rather than use specific instruments to assess MiL.

Abstract number: P2-388
Abstract type: Poster

Prevalence of Delirium in Hospitalized Patients in a Palliative Care Unit

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Introduction: Delirium is a common neuropsychiatric syndrome in patients who are in palliative care units. The palliative care patient’s increases vulnerability by having a serious illness and advanced, polypharmacy, among others. The diagnosis is clinical and can be undiagnosed as easily, confused with other conditions attributable to the underlying disease and drug effects. In the literature there are reports on the prevalence in palliative care units, ranging from 28 to 48% at the time of admission and up to 90% in the last days of life. This frequency is unknown in the population of our palliative care unit.

Objective: Determine the prevalence of delirium in the Oncological Palliative Care Unit.

Methods: 66 patients at the time of hospital admission were evaluated in the Palliative Care Unit of the National Cancer Institute by CAM (Confusion Assessment Method) and registering its main socio-demographic data.

Results: We evaluated 66 patients, of whom 36 (54.5%) were female; the average age was 50.22 years (SD 18.99). Of all patients, 21 (31.8%) met diagnostic criteria for delirium; of these 56.5% were hypoactive, hyperactive 4.3% and 39.1% mixed.

Conclusions: The population in our palliative care unit behaves in the range reported in the literature, with 38.9% of the population with delirium and hypoactive type is more prevalent.

Abstract number: P2-389
Abstract type: Poster

The Role of Psychologists for Prevention Syndrome Professional Burnout of Hospice Workers

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Introduction: A characteristic feature of palliative care establishments is hard work. Highly qualified medical professionals may not always be good hospice workers. Qualifications and professional skills must be on par with the ability to empathise. In addition, there is a dissonance between time spent at work and the self-energy end result. Such constant intense physical and psycho-emotional cost creates prerequisites for the development of burnout syndrome.

Purpose: Show the role of the psychologist and opportunities to create a collective of professional burnout syndrome prevention.

Methods: Psychologist observed for 29 medical workers in Ivano – Frankivsk Hospice and the dynamics of the team, carried an analysis of interpersonal relationships and communication with patients and analysis of the various claims and causes of dismissal from work.

The main results: Ivano-Frankivsk hospice has The Collective System of prevention of professional burnout syndrome, which is used in different ways:

1. Personal psychological characteristics are taken into account during the hiring.
2. All employees adhere to provisions about the conservation status and psychological comfort.
3. Conducted training on personal emotional stability and self-regulation skills.
4. We use a variety of adaptive capacity microclimate group: discussion and sharing individual problem solving, Room psychological relief, optimisation of conditions and the nature of work processes, an informal team meetings.
5. Psychologist conducts regular monitoring and analysis of the physical and mental state of the staff.

Conclusion: There is now a huge most important resource in Hospice – a team of people with special composition of the soul and persistent opinions in mercy to patients, and support each other in solving problems.

Poster Sessions (Poster Exhibition Set 2)
Background: Psychological distress in patients receiving palliative care is under-recognised and under-treated. Health care professionals are poor at detecting distress, and patients are sometimes reluctant to discuss psychological concerns unless a standardised questionnaire or systematic questioning is used.

Aims: To assess the levels and sources of distress reported by a population of patients receiving specialist palliative care in a hospice in Patient Unit (IPU), and to assess the prevalence of likely psychological morbidity (anxiety and depression) among this patient population, using standardised assessment tools.

Methods: Upon admission to the IPU every patient meeting the inclusion criteria was given the opportunity to complete the Distress Thermometer (DT) and Problem List (PL), and the Hospital Anxiety and Depression Scale (HADS). Medical and demographic information was also recorded.

Results: Data was collected for 44 patients admitted over a two month period. 52% of patients were male, 88% had malignant disease and 11% were admitted primarily for other offers (hostile/distant-dominant). Relatives were not aware and did not address the needs of the patient in terms of the Maslow’s hierarchy of needs concept.

Conclusions: The prevalence of possible anxiety or depression reported here is high. Since patients nearing death often experience distress that is not well characterised by the traditional conceptualisations of anxiety and depression, there is a need to consider broader psychological dimensions of suffering. The DT may be useful for identifying broader sources of distress which may benefit from intervention.

Abstract number: P2-391
Abstract type: Poster

*I Searched for Unconditional Love for my Whole Life!*: Relationships of Palliative Patients – Attachment Strategies, Interpersonal Impact (II) and Social Correspondence (SC)

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Background: In times of vulnerability experiencing SC leads to feelings of protection and calmness. Based on II, people receive supportive or distancing resonance. Early attachment experience lead to strategies (secure vs. insecure) to secure SC. Confrontation with the own death causes distress which triggers these strategies. We attempt to bridge a gap between attachment needs and attachment oriented support for palliative patients by analysing II as mediator between attachment strategies and quality of SC.

Method: 5 secure and 3 insecure attached patients were included from a palliative care unit. It was measured with the Impact Message Inventory and SC was rated by a systemic psychologist after a stay of 10 days.

Results:

Secure patients’ communication with family was mutual and frankly. The illness was referred to with appropriate emotions. Patients seemed open, attentive and cooperative; problem-solving strategies for terminal phase could be developed. It was friendly dominant or friendly. Quality of SC was stable and strong.

Insecure patients could be divided into 2 groups: avoidant patients neglected to acknowledge own needs. They seemed rational busy not talking about feelings. Ambivalent patients displayed extensive need for closeness and could hardly satisfy their attachment needs. Both appeared distant and inhibited in interpersonal contact. Support offer was not noticed (hostile/distant-submissive) or perceived as patronising continuously demanding other offers (hostile/distant-dominant). Relative were not aware and did not address the needs of the patient. None of the interaction was mutual supportive and often accompanied by psychological distress.

Discussion: Secure and insecure attached patients differ in their II and the quality of SC. Training for health professionals could help to sensitise for specific attachment strategies to reduce psychological distress and enhance quality of life in terminal phase especially for insecure attached patients.

Abstract number: P2-392
Abstract type: Poster

The Need for Social Contact during the Dying

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Background: The social contact need and its saturation during five stages of dying by E. Kübler-Ross stage model is mentioned only in general in the professional literature. The goal of research has been set as follows: to discover how the patient’s needs of social contact are changing during the particular stages of dying in terms of the Maslow’s hierarchy of needs concept.

Methods: The survey has been taken over the medicare staff in the hospices (121) and in the hospital facilities specialised for long term ill patients (94). Two research questions have been posed and a questionnaire of 30 relevant questions have been completed.

Results: The total of 215 a questionnaire have been collected. The data have been consired from both facilities as the whole and as parts well. The answers from both facility types seem to be fully comparable. More significant differences between two data samples have been commented. The differences are caused by the different medicare approach in considered medicare facility types. On the basis of the computed results and chi-squared tests it has been stated that there is the statistically significant dependence between the stages of dying by E. Kübler-Ross, patient’s needs of social contact and its fulfillment; and a hierarchy of the individual patient’s needs by A. H. Maslow.

Conclusions: Taking in account above mentioned results of quantitative and qualitative aspects concerning the social contact needs of the dying patient the conclusion has been made, that the social contact needs in various stages of dying by E. Kübler-Ross differ and that there is a dependence between the patient’s needs in terms of the Maslow’s hierarchy of needs and the stage of illness. We have discovered that the needs of social contact are highly accentuated in the terminal stage of illness.

Abstract number: P2-393
Abstract type: Poster

Utilization of a Needs-based Psychological Intervention in Specialized Palliative Care (SPC). Preliminary Results from the Intervention Arm in a Randomized Controlled Trial

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Background: The utilisation of psychological interventions among patients with cancer and their caregivers in palliative care is scarcely studied. Planning of targeted care would benefit from evidence on determinants of the utilisation of psychological interventions.

Aims: This study investigates the characteristics of patients and caregivers utilizing a needs-based psychological intervention in a randomised controlled trial (RCT) of SPC and how they relate to the frequency of sessions received.

Methods: Data stem from patients in the intervention arm in an RCT of SPC at home. Data include numerical of psychological needs assessments and intervention sessions received, and characteristics of patients and caregivers (age, diagnosis, time since diagnosis, patient-caregiver relationship). The study is ongoing, and results will include associations with quality of life (EORTC-QLQ-C30&SF-36), distress (SCL-92), and caregiver burden (Zarit Burden Interview).

Results: To date, 18 patients’ (mean age 68) who received the psychological intervention have died after a mean of 3 months (range 0.8–9.5) in the RCT. Of 14 participating caregivers (mean age 66), twelve were spouses, one a sibling, and one a close friend. Patients were diagnosed on average 17 months (range 2–76) before inclusion, with lung (n=7), gastrointestinal (n=4), gynaecological (n=3), brain (n=2), and other (n=2) tumours. Patients and caregivers received an average of 1 intervention session per month (total range 1–9), as well as a psychological needs assessment on average every 2.5 months, and 10 of 14 caregivers received one or two sessions during bereavement.

Discussion: This study sheds light on the utilisation of psychological intervention in palliative care and patient and caregiver characteristics that may predict utilisation. The findings can aid in planning and implementing future needs-based psychological services. The study is supported by the Danish Cancer Society and the Tryg foundation.
Negative Emotions as Predictors of Cancer Patients' Functioning

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Background: Contemporary medicine, and especially oncology, attaches great importance to the effectiveness of therapy and good symptom control. Despite many observations suggesting a link between the emotional state of the patient and the quality of life, the care for the mentally well-being of the patient is unfortunately often marginalised.

Aim of the study: The aim of the present study was to assess the impact of negative emotions (anxiety, depression) on the quality of life and functional status of patients with cancer.

Material and methods: The study included 50 women and 72 men (mean age 57 years) with a diagnosis of cancer suffering from cancer pain for at least three months and a stable pain care clinic in oncology hospital. Patients' functioning was measured using the Quality of Life Questionnaire (QL-C-38). Anxiety and depression were measured using Modified Hospital Anxiety and Depression Scale (HADS-M). The results were statistically analysed. The relations were evaluated using the tau-b Kendall correlation coefficient.

Results: The results show that the lower the severity of depression and anxiety, the better patients' functioning in all measured areas (physical, roles, emotional, cognitive and social) was reported. Anxiety proved to be the stronger determinant of patients' functioning with the correlation coefficient of -0.324, -0.234, -0.491, -0.480, -0.425.

Conclusions: The results indicate that minimisation of negative emotions, especially anxiety, improved their physical, emotional and social functioning both. It shows that it is important to provide psychosocial support together with medical treatment at each stage of the disease to ensure the highest possible quality of life.

Funding: The study was funded with Institute’s research budget.

Abstract number: P2-395
Abstract type: Poster

Successful Use of Dexmedetomidine Continuous Subcutaneous Infusion (CSCI) to Prevent Terminal Sedation in a Severely Depressed Person

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Background: Patients suffering of a severe psychiatric disorder can experience a dramatic confusional, fearful, obsessional state when the dying process starts and become unable to take regular antidepressant and antipsychotic oral medication. Dexmedetomidine, an α2 adrenergic agonist, used for sedation and analgesia, allows a conscious sedation and no the ‘symptomatic storm’ arising in stressful situations.

Aim: The aim of this case report is to assess whether continuous subcutaneous infusion (CSCI) of Dexmedetomidine could be safely and effectively used to support a patient in severe existential distress facing death.

Methods: Noted were:
- Diagnosis at referral
- Preexisting antidepressive, antipsychotic, anxiolytic drugs
- Other current medication
- Follow up
- Outcome

Special attention was given to the skin site.

Results: A 73 year old lady, diagnosed 15 months previously of metastatic lung cancer, was admitted to an inpatient palliative care unit in severe existential distress 12 days before she died. She was treated for a long standing bipolar depression with a daily dose of Lithium 800 mg, Venlafaxine 225 mg, Trazodone 150 mg. She was also on Flupentixol 20 mg 3 weekly injections. Dexmedetomidine was started as a CSCI 9 days before the died at a dose of 300 µg/24 h, increased next day to 400 µg/24 h (0.3 µg/kg per h). No significant change noted in blood pressure or heart rate. The subcutaneous access remained intact for the 9 days without any local irritations.

Although the patient required additional breakthrough doses of midazolam + phenobarbital she experienced increasing periods where she was restless, more orientated and could share very meaningful moments with family.

Conclusion: The patient’s aim was to find peace after a life-long struggle with depression and in- and outpatients with incurable cancer, with no or limited antineoplastic treatment. In and outpatients with incurable cancer, with no or limited antineoplastic treatment.

Abstract number: P2-396
Abstract type: Poster

‘Rémanceur’: Portraits in Palliative Care

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Aims: To offer to patients a representation of themselves distinct from the one associated with the disease

Methods: Patients’ graphic studio portraits were taken in palliative care units (using make-up, lighting, and photo editing). A paper print and a digital medium were handed over to the patients. Their feelings were collected after handing them over the final portraits. 10 patients took part to 4 sessions.

Results: For most of them, the experience was a good one. It helped some of them to retrieve a positive representation of themselves at least the disease. A visitor asked to wish to share these pictures with their family.

One person was disturbed by her evolution (achaecia). A supervision by a psychologist seemed therefore to be necessary. We do know that two portraits were used during the funeral, but we didn’t ask anybody to describe their feelings about that.

Discussion: Contemporary communications techniques force upon us using representation criteria close to perfection. Where has the patient to stand in relation to his disease? Is the horror aroused by the view of a tumor enough to prevent smoking cigarettes?

It is acceptable to take pictures of patients in a palliative care unit? Would it be more decent to use this approach just for curative patients? The aesthetic approach cannot be considered as invasive as the use of a scalpel blade but raises the question of voyeurism. Preventing ourselves from taking portraits comes to stigmatising patients. We can’t help thinking of caregivers being unconsciously affected by various symbolic representations (pathology, medical imaging, and biology).

In a world in which the self-image is used for social integration these portraits allow patients to see themselves from a different viewpoint. The camera captures pictures to keep them in our memory. This work contributes to self-esteem. It completes the healthcare process and make it more creative.

Abstract number: P2-397
Abstract type: Poster

Need for Psycho-oncological-Social-care of Oncological Inpatients: A Pilot Survey Using Hornheider Questionnaires

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Aim and object: The aim of this survey was to identify psycho-oncological and psycho-social needs of routine inpatient care of oncological patients.

Material and Methods: A total of 200 oncological inpatients patients underwent the paper-based Hornheider questionnaire, a validated instrument to identify the need of psycho-oncological and psycho-social care at first contact. Hornheider scores ≤4 were considered to indicate psycho-oncological and psycho-social need.

Results: Overall, 149 patients returned complete questionnaires (75%, 68 women and 81 men, 74 ≥65 years and 75 < 65 years). Hornheider scores ≤4, indicating psycho-oncological and psycho-social need in 49 patients, i.e. in 32.9%. Psycho-oncological and psycho-social need did not differ significantly between women and men (30.0% vs. 34.6%, p=0.175) but was significantly higher in patients < 65 years than in those ≥65 years (41.3% vs. 24.3%, p=0.027).

Discussion: The results of this pilot project show that almost a third of oncological inpatients are in need of psycho-oncological and psycho-social support. This in particular holds true for older patients.

Research methodology

Abstract number: P2-398
Abstract type: Poster

Status on the DOMUS Study: A Randomized Clinical Trial of Accelerated Transition from Oncological Treatment to Palliative Care at Home

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Background: Specialised Palliative Care (SPC) focuses on improving care for patients with incurable diseases and their families, which includes the opportunity to make their own choice of place of care and ultimately place of death.

Aim: The DOMUS study investigates whether an accelerated transition from oncological treatment to SPC enriched a psychological intervention at home for patients with incurable cancer results in more patients reaching their preferred place of care and death.

Method: DOMUS is a RCT with an allocation ratio of 1:1. The planned sample size is 340 adult in- and outpatients with incurable cancer, with no or limited antineoplastic treatment options, and EOCG Performance status 2–4 at a comprehensive cancer center. Patients are randomly assigned either to:
- a) standard care plus SPC enriched with a standardised psychological intervention for patients and caregivers at home or
- b) standard care alone.

The patients are followed for six month and several symptoms, psychological and treatment variables are assessed.

Results: 7299 patients have been screened since June 2013 and by 1st September 2014, 78 were included (43 female and 35 male, mean age = 68 years). The majority had cancer in the respiratory, digestive, reproductive, or central nervous systems. 11 concluded (8 intervention gr., 3 control gr.), 36 deceased during the study period (17 intervention gr., 19 control gr.), seven had dropped out (2 intervention gr., 5 control gr.) and 24 are still being followed. The slow inclusion of patients has required measures to optimise study development. The main obstacles for adequate recruitment of patients are strict inclusion criteria and patients’ refusal to participate. Therefore, the inclusion criterion of ECOG Performance status 2–4 has been reduced, which may implicate earlier intervention and an analysis of reasons for refusal is ongoing. The changes have been reported to clinicaltrials.gov.

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The Attitudes and Experiences of General Practitioners towards Nurse Independent Prescribing of the Clinical Nurse Specialist in Palliative Care in the Community

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Background: Nurse Independent Prescribing (NIP) has been reported to enhance patient care and may prove beneficial to the practice of palliative care in the community. Clinical Nurse Specialists (CNSs) are key workers in the delivery of specialist palliative care and often working autonomously and in the community setting where medical prescribing is the key responsibility of the General Practitioner (GP). However, many GPs see palliative care patients infrequently, thus CNSs are arguably better positioned to respond quickly to the need of these patients due to their considerable expertise and close contact with them. There is little evidence on the attitudes of GPs towards NIP in palliative care in the community, particularly in Wales.

Aim: The aim of the study was to interview GPs in order to explore views and experiences of NIP in palliative care. The purpose was to identify barriers, benefits and support available and as a result inform future practice.

Method: Semi-structured interviews exploring attitudes towards NIP were undertaken with ten GPs in a locality in Wales. The interviews were audio recorded and transcribed verbatim. Data were analysed using thematic analysis.

Results: Four major themes were generated from the analysis of the interviews: (i) impact of nurse prescribing; (ii) prescribing practices; (iii) communication; (iv) education. GPs attitudes towards NIP were positive, with advantages to patient care identified including saving CNSs’ and patients’ time, greater autonomy for the CNS and being of benefit to working relationship.

Conclusions: NIP is an evolving area of clinical practice enhancing the nursing role. The research has given insight into the supportive views of GPs. Effective collaborative working is fundamental to successful implementation of NIP in palliative care.

Abstract number: P2-400
Abstract type: Poster

Factors Associated with Attraction in a Multicenter Longitudinal Observational Study of Patients with Advanced Cancer

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Background: Attraction is a common problem in longitudinal observational studies in palliative care. Few studies have identified factors associated with patient dropout in observational studies.

Aims: To identify patient characteristics at enrollment associated with attrition in a longitudinal observational study.

Methods: Patients with advanced cancer enrolled onto a multisite longitudinal observational study in five countries (Jordan, Brazil, Chile, Korea and India) to examine the changes in symptom profile among outpatients. Follow-up assessments were planned between 2 and 5 weeks after enrollment. We compared baseline characteristics among patients who returned for follow-up visit and those who dropped out of the study. Results: Between 344 and 396 patients with advanced cancer were enrolled. Mean age was 57-years-old (range 22–92) and 41% were female. Attrition rate was 33%, with significant variation among different countries (rates between 22% and 39%; p<0.02). In univariate analysis, baseline predictors for patient attrition included Delirium Assessment Relaxation (MDAS) (OR 1.23 per point, p < .01), Karnofsky Performance Status (KPS) (OR 1.55 per 10 point decrease, p< .01), Edmonton Symptom Assessment Scale (ESAS) total physical symptoms (OR 1.05 per point, p= .01) and (log) time to referral in months (OR 0.89 per log increase, p<0.03). In multivariate analysis, independent predictors of attrition were MDAS (OR 1.1 per point, p=0.02), ESAS total physical symptoms (OR 1.02 per point, p<0.01) and KPS (OR 1.05 per 10 point decrease, p= .01). After adjusting for baseline characteristics, there were no differences in attrition rates among participating countries.

Conclusion: Advanced cancer patients with cognitive failure, increased physical symptoms and poorer performance status were more likely to dropout of our longitudinal observational study. These results have implications for data interpretation and future study design.

Abstract number: P2-401
Abstract type: Poster

How Research Governance Challenges Ethnography in Palliative Care

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Context: Ethnography is a key approach in medical anthropology and sociology. It seeks to understand people’s experiences, logics and conceptions of illness over long periods of time in study settings with participants and exploit a range of techniques, notably observation and interview. It is marked by a high degree of flexibility and increasingly used to study end of life care. Use in such settings may be threatened by regulatory systems of ethical governance which take clinical trials or biomedical testing as the paradigm case. Aim: To examine the application of research governance to ethnographic research in the UK and Wales.

Method: Critical reflection on governance processes undergone in the setup of a 1 year ethnography of choice for people with brain tumours. Reflection focuses on assumptions embedded in documents required for ethical approval and their subsequent review in multiple correspondence and a meeting with a research ethics committee.

Results: Constructions of research, researcher, participant and risk governance are based on assumptions derived from models of clinical trials or biomedical testing. These tend to frame research as burden, reinforce asymmetrical power relations between researcher and researched and imply a particular model of informed consent. Study design, instruments and implementation are required, including detailed specification of time spent with participants, full delineation of risk, and a minimum 24-hours between requests to participate and written consent.

Conclusion: Key assumptions embedded in governance conflict with those assumed by ethnography. This complicates how ethnographic research is practiced, risking disruption of researcher-participant relationships and extending the burden of research. This is keenly felt in palliative care settings where participants, presumed highly vulnerable, are subject to greater protection and where research relationships are key to producing quality data.

Abstract number: P2-402
Abstract type: Poster

End-of-Life Care Research with Bereaved Informal Caregivers – Analysis of Recruitment Strategy and Participation Rate

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Background: Research in end-of-life care seems to be a ‘minefield’ of ethical issues due to the vulnerability of the patients and caregivers. This analysis aims to elaborate on recruitment strategies and participation rates when involving bereaved informal caregivers as participants.

Methods: From July 2012 and Nov 2013, informal caregivers of deceased inpatients from two German PCUs were invited to participate in a questionnaire validation study of the ‘Quality of Dying and Death’ (QODD). They were called by a trained research worker in the fourth week after the close one’s death and latest until the 16th week. In case they refused momentarily, they were asked whether the researchers may recall at a later time point. In case of immediate consent, they took part in a planned face-to-face to interview at the PCU or in their private home.

Results: 226 participants out of 297 eligible cases were enclosed in the study, participation rate 76.1%. The majority was female (61.1%), middle age (mean 55.6 years). The average time between patients’ death and caregivers’ interview was 57.3 days (range 26–176). The mean duration of interview was 39.1 minutes (range 10–165). The mean burden was 2.5 (range 0–10). 71.5% reported low to moderate burden (0–4) and 7% indicated severe burden (8–10) on a numerical rating scale.

Considering study conduction, the time point was perceived rather well chosen (n=13), but some considered it too early (n=5) or too late (n=1). Coming back to the PCU was perceived rather difficult (n=14) and some evaluated the opportunity to participated by phone (n=1), in a couple of caregivers (n=1) or in private home (n=3) as valuable.

Conclusions: Evidence from this project shown, that ethical concerns against end-of-life research on sensitive issues with bereaved family caregivers are somehow unjustified. The method used can be recommended to other researcher and clinicians, but staffing issues have to be taken into account.

Abstract number: P2-403
Abstract type: Poster

Overcoming Challenges in Conducting an International Mixed Methods Study in Investigated Palliative Care

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Background: Conducting an international, mixed methods study in integrated palliative care (IPC) demands that many challenges are well prepared for. These include differences in national ethics regulations, language and cultural contexts and ensuring uniformity of study procedures that are responsive to local practice. Agreed methods to overcome challenges in international palliative care research are absent.

Aims: To discuss methods used to overcome challenges faced in conducting an international mixed methods study exploring best practice in IPC in European countries.

Methods: We developed an action plan including uniform study protocols, questionnaires and interview guides to ensure overall consistency of data collection. An English coding book was developed to support qualitative analysis. Two training workshops were organised in between regular project meetings. Monthly Skype meetings were held to facilitate communication. A Google drive log was used to record researcher findings.

Results: Study protocols were adjusted to national ethics regulations and questionnaires were translated. An online database was developed according to Good Clinical Practice. Findings were iteratively incorporated into the interview guides. Study procedures were sometimes adjusted to local context and the core of no local changes remained unchanged. Training workshops, Google drive log and Skype meetings were invaluable for developing a uniform understanding of the research aims. This enhanced cross-cultural communication and the study aims is essential. An international platform is useful to discuss and overcome challenges faced in IPC research.

Funding: EU FP7 grant #335555
Volunteering

Voluntary Terminal Care by Specialized Volunteers in Nursing Homes

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Background: At the end of their lives, elderly people in nursing homes – just like anyone else – may have a need for someone with a listening ear and open heart to support them. When the social network has diminished, and staff has little time for providing personal attention, specialised volunteers can play a significant role in supporting the resident and their family.

Aims: The aim of this project was to sensitise staff to noticing the resident might die in the near future, teach them how to raise this issue and how they can be of importance to the resident ‘when nothing can be done anymore’, teach them how to share the care with family members and specialised volunteers, and including specialised volunteering in the nursing homes’ policy and regulations.

Methods: A collaboration of volunteer palliative care services and nursing homes in two cities in the Netherlands, supported by national organisations for nursing homes and palliative care volunteering. The project entailed developing instruments and courses to help staff recognising and discussing end of life issues and organisng informal care (family members and volunteering), developing a training course for the volunteers on dealing with dementia and working in a nursing home setting, and developing policy within the nursing homes around palliative care and collaboration with specialised volunteers.

Results: an atmosphere where end of life issues are much earlier recognised and discussed - ‘care for the carers’ who are more open about their own emotions and needs - high satisfaction of residents and their families (88,0% on a 10-point-scale) and staff (98,0% with the support of the volunteers)

Conclusion / lessons learned: The collaboration between specialist voluntary palliative care services and nursing homes is of great value in enhancing the atmosphere around end of life issues and supporting residents and their families.

Funding: Fonds NutsOhra (NL).

Abstract number: P2-408
Abstract type: Poster

Ensuring the Voice of the User/Carer for Palliative Care Research

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Background: Public and Patient Involvement (PPI) in research has received significant attention in recent years. There are clear examples of good practice guidelines yet questions exist regarding what user involvement in research actually means. A core theme of the work of a research Network was to ensure meaningful involvement of users, carers. Aims: To ensure meaningful involvement of users, carers and communities in the development and delivery of palliative care research in Ireland.

Methods: A Forum entitled ‘Voices 4 Care’ was established comprising of user/carers and citizens with an interest from across the island of Ireland. Two key stages were undertaken: Phase 1: A ‘think tank’ event was undertaken with key stakeholders to address aspects such as role and function; membership; marketing and key messages and culture and structures for Forum.

Phase 2: A workshop was undertaken with Forum members addressing questions around public and patient involvement in research. This focussed on: challenges; skills & knowledge and strategies to develop involvement in research.

Results: Key messages from the user/carers were: they offered a common sense/open perspective that would be of clear value to researchers. Secondly they possessed significant personal experience that would be rich resource for researchers. The key challenges included the need for training; issues with language and jargon and a clear need to have ongoing engagement across the project not just a tokenistic approach.

Conclusions / lessons learned: User/carer involvement offers significant challenges and yet benefits to not only palliative care researchers but the wider palliative care community. Strategies for recruitment, retention, learning and ongoing engagement require consideration. There are however clear benefits not only for the research community but to overall palliative care policy, practice and education.
Cancer

Abstract number: P2-410
Abstract type: Poster

Outcome after Palliative Percutaneous Transhepatic Drainage in Malignant Biliary Obstruction

Abstract number: P2-411
Abstract type: Poster

What is Known about the Experience and Outcome of Cancer Treatment in People with Dementia: A Systematic Review

Abstract number: P2-412
Abstract type: Poster

Using Erdostone to Regulate the Tissue Response of Radiotherapy in the Intestine, an Experimental Study on Rat

Abstract number: P2-413
Abstract type: Poster

Relationships between Spiritual Well-being and Symptoms in Advanced Cancer Patients

Abstract number: P2-414
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 2)

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015
General Self-efficacy as a Predictor of Psychological Adjustment of Cancer Patients

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Background: Theories and research results indicate that attitude toward disease that patients demonstrate is associated with the effectiveness of patients’ coping with cancer and negative consequence of the disease, i.e., pain, lower well-being, and changes in life caused by disease. General self-efficacy is associated with patient’s belief to be able to control their every day life and behavior.

Aim of the study: The aim of the present study was to assess the psychological adjustment to disease in patients treated for different types of cancer.

Methods: A multicentre prospective observational study was undertaken between January 2013 & September 2014. Eligible patients met the following key criteria: - > 18 years of age, advanced incurable cancer & Eastern Cooperative Oncology Group (ECOG) performance status 1-4. The following information was collected at baseline: cancer type & stage, details of chemotherapy/ radiotherapy, drug history, co-morbidities, clinician predicted survival, response have been validated for prognostication in advanced cancer and these have been combined in prognostic tools. A systematic review by this group has concluded that although numerous prognostic tools exist comparison of these has not been done. A prospective study examining key prognostic factors alone, and in combination as prognostic tools would enable comparison and identification of the most predictive prognostic markers in advanced cancer.

Aims: To assess all prognostic factors & tools, which have been shown to predict survival in advanced cancer.

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Background: If age of cancer patients affects the quality of end-of-life (EOL) care has been insufficiently studied.

Aim: To explore age differences in the quality of EOL care delivered to patients with cancer in Sweden, using a population-based approach.

Methods: All adult patients reported to the Swedish Register of Palliative Care to have died from cancer (n = 36,297) were categorized in five age-groups: 18–39 y (G1, n = 341), 40–59 y (G2, n = 3017), 60–74 y (G3, n = 10,126), 75–84 y (G4, n = 8,393) or ≥ 85 y of age (G5, n = 9,099). Odds ratios (ORs) with 95% confidence intervals were calculated using the oldest group as reference.

Results: Young patients were more often informed about imminent death, ORs 3.85 (G1), 2.24 (G2), 1.74 (G3), 1.4 (G4). Families of young patients were more often informed, with ORs 2.55 (G1), 1.87 (G2), 1.52 (G3), and 1.25 (G4), and more likely to be offered bereavement support, ORs 4.56 (G1), 2.33 (G2), 1.65 (G3), 1.33 (G4). External competence was more often sought in the care of young patients, ORs 4.33 (G1), 2.82 (G2), 2.37 (G3), 1.93 (G4). Parenteral fluid therapy during the last 24 hours was more common in young patients with ORs 2.61 (G1), 1.95 (G2), 1.71 (G3), 1.29 (G4). Prescriptions as needed (PRN) with regard to anxiety or nausea were more common in young patients, with ORs 3.79 (G1), 2.69 (G2), 1.66 (G3, 1.25 (G4), and 3.63 (G5), respectively. Parenteral pain assessment was less frequent in young patients, ORs 1.61 (G1), 1.45 (G2), 1.37 (G3). Severe pain (ORs 2.5–3.7 of G1–G4), breathlessness (OR 2.2–3.7 for G1–G4) and anxiety (OR 3.7–4.3 for G1–G4) were more frequent in young patients.

Conclusion: Age impacts on several quality aspects of EOL care for cancer patients in Sweden. The differences in relation with symptoms need to be recognised.

Funding: The executive committee of the National Quality Registries in Sweden.

Abstract number: P2-420
Abstract type: Poster

Phoenix RETRO: A Retrospective Study of Chemotherapy in Palliative Intent (CPI) in Patients with Advanced Cancer with a Reduced Performance Status (PS) on an Accredited Integrated Palliative Care (PC) Unit

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Background: Patients with advanced cancer often suffer from a decline in physical function, which is reflected in a reduced PS. The benefit of CPI in patients with reduced PS (≤2) remains untested although it is a common practice. Aim: Our aim was to analyse in a retrospective review our current practice, experiences and outcomes of CPI in patients with PS2/3 at a PC unit in a tertiary cancer centre.

Methods: Charts of cancer patient with advanced cancer (PS2/3) with newly started CPI (excepted tumours: H/HCT/CT 50%) were analysed in the years 2012–14. CPI-Livedata: Average 250 patients/year, death rate 48%, mean hospitalisation 11 days. Charts were selected based on pharmacy order forms. Variables extracted encompass patients, disease, CPI dosing and monitoring data, especially Systemic pain assessment was done, and parents/informed consent was signed in common patients, ORs 1.61 (G1), 1.45 (G2), 1.37 (G3). Severe pain (ORs 2.5–3.7 of G1–G4), breathlessness (OR 2.2–3.7 for G1–G4) and anxiety (OR 3.7–4.3 for G1–G4) were more frequent in young patients.

Conclusion: Age impacts on several quality aspects of EOL care for cancer patients in Sweden. The differences in relation with symptoms need to be recognised.

Funding: The executive committee of the National Quality Registries in Sweden.

Abstract number: P2-420
Abstract type: Poster

Renal Failure in Patients with Advanced Cancer Sent to Palliative Care

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Background: Palliative patients may have strong hope, even hope for a cure, despite awareness of prognosis. This hope features prominently and positively affects their quality of life. Healthcare practitioners hope for some of the same. It is difficult to quantify the extent of renal complications associated with malignancy which is reflected in a reduced PS. The benefit of CPI in patients with reduced PS (≥2) remains untested although it is a common practice.

Methods: CPI and KI-PCC variable analysis is in progress.

Results: Patients may have a number of hopes at the same time. Also, they may hope for (re)covery and, at the same time, make preparations for imminent death. Hope has a function, it cannot be forsaken and it benefits so much from it. Hope can spring from many sources and can evolve over time in the disease or as a result of influencing internal or external factors. If there are fewer potent sources to tap into, people create hope themselves, if necessary against the facts. Self-created hopes take more effort to maintain. Hope is a thought construct which is cherished, nurtured and protected against threats. Hope can vary in strength, and that strength is not determined by chances, but by need.

Conclusions: A better understanding of the process of hope, its dynamics, and its meaning and function will lead to better psychosocial support for palliative care patients with cancer. Unrealistic hope in well-informed patients is rarely due to lack of insight into their own situation, denial or misunderstood information. Healthcare practitioners convey many messages that affect the hope of the patient.

Abstract number: P2-424
Abstract type: Poster

Contrast in Palliative Care Patients Profile Admitted for at a University Hospital versus Hospice

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Background: The National Cancer Institute. Patient records outside curative cancer treatment for the first time referred to palliative care in the period July–December 2012. The glomerular filtration rate was calculated with the MDRD (Modification of Diet in Renal Disease) with 4 variables and Cockcroft-Gault, they were analysed comparatively. We studied 380 patients, of which on 188 were sent to CPI and 192 were given drugs with glomerular filtration rate cave variables. Using both, equations was observed that patients with a GFR < 60 ml/min, corresponding to carriers of any gastrointestinal cancer. With the relationship the BUN/ creatinine ratio 36.7% h patients, had hypovolemia secondary to loss of extracellular space by reduced intake or excess loss and bleeding. The appropriate water management of patients can slow the progression of chronic kidney disease morbidity initially slowing and therefore better quality of life for the patient.

Abstract number: P2-422
Abstract type: Poster

Care Needs in Cancer at the End of-Life for Recipients Study (CaNERS)

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Background: Unmet healthcare needs can have adverse consequences in patients with advanced cancer. Systematic identification of moderate or severe unmet needs is thus important so that gaps in service provision can highlighted and addressed. Hence, we used the 59-item Cancer Need Assessment Tool (CNAT) in a cross-sectional study to identify the unmet healthcare needs of patients with advanced cancer in Singapore.

Methods: Post-institutional review board approval, eligible inpatients and outpatients were enrolled. The inclusion criteria was patients diagnosed to have metastatic solid cancers no longer undergoing curative treatment with intact cognition. The CNAT was administered with the help of an interviewer, to assess 7 domains of unmet need namely Information education, Psychosocial, Healthcare staff, Physical symptoms, Hospital facilities/services, Spiritual/terminal support and Practical support. Unmet need was rated as nil, mild, moderate or severe.

Results: Altogether, 7,13 patients and outpatients with advanced cancer were surveyed. The median age of all study subjects was 60 years and an outpatient: hospitalised inpatient ratio of 1.36. Breast, colon and lung cancers were the commonest cancer types. Only 39.9% of all study subjects received palliative care at the time of the survey. Of all subject, 16.1% (n = 28) were moderate and severe overall unmet need affecting multiple domains. The highest percentage of moderate or severe scores was in the ‘Information and education’ domain in those with moderate or severe overall unmet need. Malay ethnicity was significantly observed to be associated with moderate or severe overall unmet need with ethnic differences in the percentage of moderate or severe scores for specific CNAT domains and items.

Conclusions: Significant unmet need occurs in the minority of patients with advanced cancer with Malay (minor) ethnicity as a possible risk factor in Singapore.

Abstract number: P2-423
Abstract type: Poster

Hope Dies Last... A Qualitative Study into the Meaning of Hope for People with Cancer in the Palliative Phase

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Background: Palliative patients may have strong hope, even hope for a cure, despite awareness of prognosis. This hope features prominently and positively affects their relation with quality of life. Healthcare practitioners hope for some of the same. It is difficult to quantify the extent of renal complications associated with malignancy which is reflected in a reduced PS. The benefit of CPI in patients with reduced PS (≥2) remains untested although it is a common practice. Aim: To explore the meaning of hope amongst patients with cancer in the palliative phase of their illness.

Design: A secondary analysis was made of interview data (n=80) obtained in a series of studies in the Netherlands and Flanders on living with cancer with a short life expectancy (between 3 and 12 months). The interviews were transcribed and thematically analysed.

Results: Patients may have a number of hopes at the same time. Also, they may hope (for recovery) and, at the same time, make preparations for imminent death. Hope has a function, it cannot be forsaken and it benefits so much from it. Hope can spring from many sources and can evolve over time in the disease or as a result of influencing internal or external factors. If there are fewer potent sources to tap into, people create hope themselves, if necessary against the facts. Self-created hope takes more effort to maintain. Hope is a thought construct which is cherished, nurtured and protected against threats. Hope can vary in strength, and that strength is not determined by chances, but by need.

Conclusions: A better understanding of the process of hope, its dynamics, and its meaning and function will lead to better psychosocial support for palliative care patients with cancer. Unrealistic hope in well-informed patients is rarely due to lack of insight into their own situation, denial or misunderstood information. Healthcare practitioners convey many messages that affect the hope of the patient.

Abstract number: P2-424
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 2)
Disparities in Hospitalized Cancer Patients Receiving Palliative Care Consultation

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Background: Racial disparities in healthcare are documented among minority groups. As a result, minorities are diagnosed with advanced cancer and have inferior outcomes which lead to increased suffering. Little is known, however, about disparities in access to and outcomes of patients receiving specialty palliative care (PC).

Aims: Evaluate outcomes among hospitalized minority patients (black and Hispanic) with cancer receiving PC consultation.

Methods: We used data from the Palliative Care for Cancer Patients (PC4C) study, a multisite observational study of the effect of inpatient PC on patient outcomes and utilization among cancer patients. We compared patient samples to patients receiving care from established, interdisciplinary teams. Univariate analyses and multiple regression analyses compared differences in outcomes among minority and non-minority patients.

Results: 183 (19%) patients received PC. Of those, 166 (20%) were minorities and 418 (72%) non-minorities. Mean days to PC was 4.4 vs. 3.2 in non-minorities and minorities, respectively (p=0.65). At baseline, minorities reported a higher burden of symptoms on the condensed Memorial Symptom Assessment Scale (CMSAS). Similarly, they were less likely to have discussed their wishes with their doctor (p=0.04), less likely to have completed a living will (p=0.01), or have a proxy (p=0.01); had no difference in pain but were less likely to be taking pain medications (p=0.001) or report relief from pain medications (p=0.03). After PC all CMSAS symptoms improved for minority patients (except worry; p=0.03). Additionally, after PC, there were no significant differences among minorities with respect to discussing wishes (p=0.27), DNR completion (p=0.72), proxy assignment (p=0.22) and taking pain medications (p=0.22) when compared to non-minorities.

Conclusions: There were associations with improvements in symptom control and discussions of care goals among minority patients who have worse baseline health assessments.

Poster Abstract: P2-426

Abstract type: Poster

Last Month of Life – How Often Are Patients Over-treated?

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Background: In the last month of life (LMoL) one of the major goals of management shifts from curing to healing as emerging symptoms worsen the quality of life (QoL). Methods such as specific anticancer treatment (ST) are discouraged in this period as they provide no additional benefit and lead to toxic adverse effects. In 2009 we evaluated how many patients (P) were treated with at least one cycle of ST in the LMoL. As results were not encouraging many educational events and workshops were organised in order to further educate doctors on this topic.

Aim: To re-evaluate the situation after three years.

Methods: Data from 363 P who died at our institution in 2012 was retrospectively collected and compared with results from 2009 for the rates of use of ST (chemotherapy (Cht) and target therapy (TT)) and initiation of a new line of ST. The association between over-treatment and P age, WHO performance status (PS) and chemosensitivity of tumour (lymphoma, small cell lung cancer, germ cell tumours, breast, bladder, ovarian, head & neck, colorectal cancer, gastrointestinal stromal tumour) was evaluated using Chi-square test.

Results: Median age at the time of death was 61 years (range 22 – 87), 176 P (48.8%) were diagnosed with the chemosensitive cancers and 167 P (46.3%) were in PS 3 or 4. In the LMoL 124 P (33.7%) received ST in 2012 as compared with 110 P (39%) in 2009. In the LMoL, a new line of ST was initiated in 52 P (14.6%) in 2012 and 49 P (17.5%) in 2009. We found no statistically significant association between over-treatment and age (comparing younger and older than 70 years old) (p=0.4), chemosensitivity of the tumor (p=0.4) or PS (p=0.3).

Conclusions: We found a negligible difference in the rate of use of ST between 2009 and 2012. We need to implement further efforts in physician recognition of end-of-life period and appropriate decision making about discontinuing futile treatments.

Poster Abstract: P2-427

Abstract type: Poster

Mechanisms that Contribute to the Tendency to Continue Chemotherapy in Patients with Advanced Cancer. Qualitative Observations in the Clinical Setting

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Background: Many patients receive aggressive treatment shortly before death, although this is often seen as unfavourable practice. Aim: Describe mechanisms that contribute to the tendency to continue chemotherapy in patients with advanced cancer.

Methods: Qualitative observations at an outpatient oncology clinic of a university hospital. 28 patients with advanced cancer and their physicians were included.

Results: We uncovered four mechanisms:

1) ‘presenting the full therapy sets the standard’ patients seemed to base their justification for continuing chemotherapy on the ‘standard’ therapy with the maximum number of cycles as presented by the physician at the start of the treatment.

2) ‘focus on standard evaluation moments hampers evaluation of care goals’ whether or not to continue the treatment regimen with a new cycle of chemotherapy was mostly only considered at standard evaluation moments. The need for ST and the timing of evaluation was not discussed in these tests;

3) ‘opening question guides towards focus on symptoms’ most patients gave an update of their physical symptoms or treatment side effects in answer to the opening question ‘How are you doing?’ Physicians consequently discussed how to deal with this at length, which often took up most of the consultation.

4) ‘treatment is perceived as the only option’ patients mostly wanted to continue with chemotherapy because they did not want to give up or felt that they had to try every option the physician offered. Physicians also often seemed to focus on treatment as the only option.

Conclusion: The mechanisms seem to be a result of working in a routine manner combined with a lack of reflection on care goals throughout the visits. Discussing care goals more regularly with the patient, facilitated by using standard evaluation moments, a lack of knowledge, might help counter the mechanisms and enable a more well-considered decision. This could be either stopping or continuing chemotherapy.

Poster Abstract: P2-428

The Pelican Study: Patient Experience of Living with Cancer-associated thrombosis

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Background: The management of cancer associated thrombosis (CAT) in the palliative setting poses many challenges to clinicians. Whilst the management of CAT is well established, its impact on the patient’s quality of life (QoL) is not fully understood. Additionally, venous thromboembolism (VTE) QoL tools in current use were developed for the non-cancer population and may be of limited use in the cancer setting.

Aim: To evaluate the experiences of patients with CAT, to identify key unmet needs and evaluate the utility of (VTE) QoL tools in the context of the cancer journey.

Method: 20 patients were recruited from two hospitals in South Wales. A two part qualitative interview consisted of semi-structured interviews to explore the effect CAT has on QoL, and cognitive interviews to assess currently available QoL questionnaires and their relevance to cancer patients. Framework analysis was applied to the semi-structured interviews. Both deductive and inductive analyses were used to analyse the cognitive interviews.

Results: Major themes emerging from the semi structured interviews included a lack of knowledge of VTE symptoms causing significant patient anxiety and treatment, a lack of knowledge of VTE risk with cancer and cancer treatment and a lack of information and support during and post diagnosis prior to referral to a specialised CAT clinic. VTE QoL tools were found to be inadequate since the experience of cancer and VTE are enmeshed.

Conclusion: More information and support is needed for both cancer patients and their health providers. QoL questionnaires specifically for use with CAT patients need developing.

Funder: Leo Pharma, Denmark.
Beck Inventory for Depression-8 and other measure of symptom burden. Mplus was used to fit 2- and 3-correlated factor models using unweighted least squares estimation. Symptoms were then delineated under the factor labels affective, cognitive, and sickness behavior (3-factor model) and sickness behavior and negative affectivity (2-factor model). Results: Fit statistics for the 3-factor model were: χ²(186) = 273.624, p < 0.01, RMSEA = 0.049. Standardised factor loadings were generally high. The standardised factor loadings were: 0.47 for agitation (39), 0.47 for anxiety (38), and 0.54 for depression (39). Support for a sickness behavior factor was also observed in the 2-factor model (χ²(188) = 278.129, p < 0.01, RMSEA = 0.048, CFI = 0.947). Conclusion: Both factor models provide initial psychometric support for the unique construct of sickness behavior in a sample of patients with advanced cancer. Results also support the notion that the demarcation of other factors is less salient. Symptom clusters are recognised as a research priority that may elucidate neurobiological underpinnings and thereby improve treatment outcomes. Factor correlations with other measures of distress are presented and clinical implications are discussed.

Non-cancer

Abstract number: P2-432 Abstract type: Poster

Dignity Therapy: A Supportive Psychological Intervention for People with Motor Neurone Disease and their Family Carers

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Background: There are calls to explore psychological interventions to reduce distress in Motor Neurone Disease (MND) patients and their family carers (FCS). Dignity Therapy (DT) is a short term psychotherapy intervention shown to alleviate distress for people with life limiting illnesses.

Objectives: To assess the acceptability, feasibility and effectiveness of DT to reduce distress in people with MND and their FCS.

Methods: Clients of the MND association in Western Australia were invited to participate in 2011-13. The study used a repeated measures design pre and post-intervention.

Acceptability and feasibility were assessed using participant ratings of the helpfulness of the intervention across several domains and time and resources required. Effectiveness measures for patients included: dignity-related distress, hopefulness and spiritual wellbeing; and those for FCS included: burden, hopefulness, anxiety and depression.

Results: 27 patients and 18 FCS completed the intervention. DT was well accepted, including by patients who required assisted communication devices. There were no significant differences in all outcome measures for both groups. However, the high satisfaction and endorsement of DT suggests it has influenced various important aspects of end of life experience such as helping them attend to unfinished business and made them feel they were still themselves. FCS overwhelmingly agreed the DT document is and will continue to be a source of comfort, and they would recommend DT to others in the same situation.

Conclusions: This is the first DT study to focus on MND and home-based caregiving. The therapy needs to be offered earlier. Results established the importance of narrative and generativity for patients with MND and may open the door for other neurodegenerative conditions. (Funded by an Australian Research Council Linkage Grant and the MND Association of Western Australia).

Abstract number: P2-434 Abstract type: Poster

Symptoms and Palliative Care Needs of Patients with Fibrotic Interstitial Lung Disease: A Systematic Literature Review

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Background: Interstitial lung disease includes a diverse number of disorders in which pulmonary fibrosis are the final common pathways of lung damage. Idiopathic pulmonary fibrosis is the most common subset of Idiopathic Interstitial Pneumonias. It is a specific form of chronic, progressive fibrosing interstitial pneumonia of unknown cause with limited and often unsuccessful treatment options. Research has shown this disease negatively affects the quality of life of patients and caregivers, and only a small number of patients with PF-ILD have benefited from palliative care services. Little is known about the needs of this population.

Aims: To determine from existing studies the prevalence of symptoms and those for FCs included burden, hopefulness, anxiety and depression.

Methods: Comprehensive searches of MEDLINE, Cochane clinical trials database, EMBASE, Science Citation Index Expanded, pre-MEDLINE, CINHAL and PSYCINFO for clinical studies where the target population were adults with progressive idiopathic Fibrotic Interstitial Lung Disease and for whom assessment of the prevalence and incidence of symptoms and prevalence of symptoms and those for FCs included burden, hopefulness, anxiety and depression (10–49%). The heterogeneity of studies limit their comparability, but patients with PF-ILD and other chronic conditions have similar complaints regarding symptoms. Further research is needed in order to better characterise these findings.

Abstract number: P2-430 Abstract type: Poster

Incidence of Diabetes Induced by High-dose Glucocorticoid Therapy in Cancer Patients

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Abstract number: P2-431 Abstract type: Poster

Integration of Palliative Care in Patients with Cancer in Europe. Where Do We Stand and What Are the Challenges?

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Abstract number: P2-433 Abstract type: Poster

Deconstructing Depressive Symptoms in Advanced Cancer: Is ‘Sickness Behavior’ a factor?

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Abstract number: P2-432 Abstract type: Poster

Reversing clinical depression in patients with cancer is a priority that exhibits a robust relationship with inflammation. Although sickness behavior and depression share overlapping symptoms, their relationship is unclear and complicated by the presence of a unknown. In contrast, sickness behavior is a symptom cluster that exhibits a robust relationship with inflammation. Although sickness behavior and depression share overlapping symptoms, their relationship is unclear and complicated by the presence of a unknown. In contrast, sickness behavior is a symptom cluster that exhibits a robust relationship with inflammation. Although sickness behavior and depression share overlapping symptoms, their relationship is unclear and complicated by the presence of an unknown.
Abstract number: P2-435
Abstract type: Poster

**Dialysis or Conservative Management in Chronic Kidney Disease (Stage 5)? Evaluation of Patients in a Tertiary Hospital who Started Dialysis in 2012**

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**Abstract type:**

**Background:** Studies suggest that in elderly patients with Stage 5, Chronic Kidney Disease (CKD-5) the survival benefit with dialysis can be lost if there is high comorbidity and low performance status and thus Conservative Management (CM) can be a valid option.

**Aims:** To describe hospitalised patients who started dialysis in a tertiary hospital in 2012: to determine mortality predictors, and to identify patients who could benefit from CM.

**Methods:** We retrospectively examined the data from hospitalised CKD-5 patients, who were followed over a 23-month period. Patient data included their Karnofsky Performance Status (KPS), Mean follow-up was 12.66 months; 35% died, 47% during their first hospitalisation.

**Results:** Mortality was associated with age 75+ (p < 0.001), KPS 50 (p = 0.01); cancer, and dementia (CDMS) (p = 0.01), ECI 5 (p = 0.05), COC (p = 0.05), heart failure (HF) (p = 0.02), coronary artery disease (p = 0.03), arhythmia (p = 0.01), and CKDEPI (p = 0.01). Mortality predictors in a Cox-regression model were: 75+ (HR 3.7; p = 0.003), HF (HR 1.9; p = 0.03), CDMS (HR 3.7; p = 0.003), and CKDEPI (HR 1.7; p = 0.003). The 75+ patients (n = 11) who were referred early to Nephrology with HF and KPS 50, and met standard CM criteria benefited less with dialysis: 6 died and 1 recovered renal function.

**Conclusions:** CD and KPS status were useful in predicting mortality. Dialysis use and mortality may be considered reduced by applying CM criteria. In an outpatient renal clinic setting could identify robust CM criteria in frail elderly patients with high comorbidity.

**Abstract number:** P2-436
**Abstract type:** Poster

**Variation in Quality of Palliative Care Provided to Patients with Cancer, Chronic Organ Failure, Old Age or Dementia: The Views from Bereaved Relatives**


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**Background:** There is a recognised need for palliative care for patients with non-malignant diseases, like chronic heart failure or dementia. However, the often unpredictable illness trajectories of people with conditions other than cancer may hamper provision of high-quality palliative care.

**Aim:** The aim is to compare the quality of care in the last week of life of patients with cancer, organ failure and frailty, as experienced by bereaved relatives.

**Methods:** An existing dataset of 408 bereaved relatives was analysed to determine the differences in the quality of care for three groups of patients; cancer, organ failure and frailty. Data had been collected with the validated questionnaire Consumer Quality Index Palliative Care for bereaved relatives. Multilevel analysis, logistic regression and linear regression were used to calculate differences between groups.

**Results:** Differences existed regarding the perceived quality of care as received by the patient in the last week of life. Bereaved relatives of patients with organ failure (n = 64) and with frailty (n = 182) both reported more negative experiences regarding expertise of the healthcare professionals involved, respectively OR 9.5995 CI 1.6–52.49 and OR 4.5995 CI 1.9–19.1. Furthermore, patients with frailty had less frequent access to a counsellor of spiritual problems compared patients with cancer (n = 215); 0.5495 CI 1.4–20.8, as experienced by their bereaved relatives. The bereaved relatives' rating of quality of the care in the last week of the patient's life was significantly lower in the frailty group compared to the cancer group (p = 0.01). No significant differences were found between the three groups regarding psychiatric care for the patient.

**Conclusion:** The quality of care as perceived by bereaved relatives differs between patients with cancer, organ failure and frailty. Overall, bereaved relatives of cancer patients have more positive experiences regarding the care for the patient in the last week of life.

**Abstract number:** P2-437
**Abstract type:** Poster

**PROLONG: Identification of Patients with COPD with a Poor Prognosis and Implementation of Proactive Palliative Care**


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**Abstract type:**

**Background:** Proactive palliative care is not yet common practice for patients with COPD. Important barriers are that relative high proportion of patients with poor prognosis and the organisation of proactive palliative care dedicated to the COPD patient. Recently a set of indicators has been developed to identify those patients with COPD hospitalised for an acute exacerbation who are at risk for poor palliative care quality and mortality. Only after identification of these patients with poor prognosis a multi disciplinary approach to proactive palliative care with support of a specialised palliative care team can be initiated.

**Aims:** To 1) assess the discriminating power of the proposed set of indicators (indicator study) and 2) to assess the effects of proactive palliative care for qualifying patients with COPD on the wellbeing of these patients and their relatives (intervention study).

**Methods:** The PROLONG study is a prospective cluster controlled trial in which 6 hospitals participate. Three hospitals are selected for the intervention condition based on the presence of a specialised palliative care team. The study population consists of patients with COPD and their main informal caregivers. Patients are included during hospitalisation for an acute exacerbation. All patients in the study receive standard care (usual care). Besides, patients in the intervention condition who meet two or more of the criteria of the set of indicators receive additionally regular consultations with a specialised palliative care team.

**Results:** The primary outcome measure is death for any cause (indicator study) and change in quality of life three months after inclusion (intervention study). Preliminary findings are presented during the EAPC 2015.

**Discussion:** The PROLONG study results may lead to better understanding of the conditions to start and the effectiveness of proactive palliative care for patients with COPD.

**Source of funding:** ZonMw, the Netherlands.

**Abstract number:** P2-438
**Abstract type:** Poster

**Quality in End of Life for Dying Stroke Patients**

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**Background and purpose:** Stroke causes suffering in patients, but there is limited information on the quality of palliative care for patients dying from stroke. A large-scale palliative research has centered on patients suffering from cancer. The aim of this study was to examine the quality of palliative care during the last week in life for patients dying from stroke in terms of symptoms, and communication and compare the results with those who died from cancer.

**Method:** A retrospective comparative registry study was performed using data from a Swedish national quality register for end-of life care. Data from 1626 patients deceased from stroke were compared with data from 1626 matched patients dead from cancer. Binary logistic regression analyses and odds ratio were calculated.

**Results:** All six assessed symptoms were reported by the health care staff as being present during the last week of life in the stroke group with 63% having death rattles, 52% pain, 26% anxiety, 18% dyspnea, 11% confusion and 10% nausea. Compared to the cancer group, it was significantly more often unknown to the reporting health care staff who died of cancer in the patients in the stroke group had presence of the studied symptoms and if the place of death corresponded with latest expressed wish of the patient. In addition, the stroke patients and their relatives had significantly lower odds to achieve informative communication about transition to end-of-life care and the family members to be offered bereavement follow up.

**Conclusion:** This study indicates inequalities in the quality of palliative care depending on diagnosis, and unmet needs during the last week of life of patients dying from stroke. The findings have implications for clinical practice and the need of health care staff to pay more attention to the quality of the palliative care situation of the dying stroke patient.
Abstract number: P2-440
Abstract type: Poster

The Role of a Palliative-Focused Outpatient Intervention for Patients with End-stage Lung Disease Awaiting Transplant

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Background: Patients with end-stage lung disease (ESLD) awaiting lung transplant suffer from a complex array of burdensome symptoms. There is a paucity of research exploring the impact of an outpatient palliative care (OPC) service for this population.

Aims: Our novel study was designed to explore the impact of an OPC intervention on symptoms for patients with ESLD awaiting transplant, as well as to provide further support for the role of OPC in the non-malignant setting.

Methods: 115 patients awaiting lung transplant were referred to the OPC from December 1st, 2011 to March 1st, 2014. Patient demographics, diagnoses, reason(s) for referral to the OPC, palliative care performance score (PPS) at time of consultation, PC interventions performed, and Edmonton Symptom Assessment System (ESAS) scores were evaluated. Of the initial 115 referrals, 65 patients completed ESAS scores for both the initial consult and follow-up. Using paired t-tests, changes in symptom scores were assessed.

Results: 50.4% of patients were male. The most common diagnosis was interstitial lung disease (65.2%), followed by COPD (12.2%) and other (22.6%). Over 93% of patients had a PPS in the transition zone (60–40) at time of consult. The initiation of opioids for relief of breathlessness was the most common intervention performed. Changes in symptom scores after referral were: pain -0.5 (P< 0.12), tiredness -0.5 (P< 0.16), nausea -0.2 (P< 0.47), depression +0.3 (P< 0.44), anxiety -0.3 (P< 0.4), drowsiness -0.3 (P< 0.4), appetite -0.3 (P< 0.4), wellbeing -0.1 (P< 0.74), shortness of breath +0.2 (P< 0.56), constipation 0.0 (P,0.70), sleep -1.7 (P < 0.0001), and cough -0.7 (P< 0.03).

Conclusion: The initial consult by the OPC team achieved significant improvements in sleep.

No official funding received.

Abstract number: P2-441
Abstract type: Poster

Perceptions of Healthcare Professionals Regarding the Transition to a Palliative Approach to Care in Advanced Heart Failure

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Background: National and international consensus guidelines recommend a palliative care approach in heart failure when it is not been well managed and clinicians find it hard to identify when a transition to palliative care should occur.

Aims: To explore health care professionals’ perceptions of decision making and communication regarding the transition to a palliative approach to care in heart failure.

Methods: [description, data collection, analysis] Qualitative focus groups were conducted with a broad range of health care professionals with experience of caring for patients with heart failure and palliative care needs from cardiology, primary care and specialist palliative care. A topic guide was used. Groups were recorded and verbatim transcribed. Data were analysed using a thematic framework according to suitability. Identification and group dynamics were noted and used to help understand the themes emerging from the data.

Results: Seven focus groups with clinicians were conducted and major themes and quotes are presented in the table.

Cardiology
Primary care
Specialist palliative care

Recognition of transition to palliative care

‘I don’t think everyone knows the exact kind of patients’

‘We have for heart failure you don’t have such a clear message from the specialist’

The heart failure nurses are outstanding and pessimist that connection between hospital, hospice and community, they just got buried or it was wasted.

Comparison with cancer

‘since you’re diagnosed with cancer people expect you to do well, whereas many heart failure patients do not expect to die very soon’

‘It’s very streamlined, oncology, palliative, Macmillan’

The heart failure, oncology patients, respiratory patients, get eight visits’ (to day hospice of cancer patients)

Importance of integrated palliative care

‘...I don’t even look at the weight chart, at the blood pressure, we mess about with the drugs and we don’t actually deal with what the patients have a problem with’

‘Important of heart failure nurses being supportive and positive for patients’ tangible feeling of relief’

‘Two-way process, learning from each other’

Conclusion/discussion: The data support an integrated approach to a palliative care in heart failure and the pivotal role of the heart failure nurse specialist or other key worker to university care.

No official funding received.

Abstract number: P2-442
Abstract type: Poster

Bridging Disciplinary and Professional Gaps: Psychologist as Key Worker within MND

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Background: Our centre was established as national tertiary unit in 2006, has cared for some 800 MND patients and families: many travel for several hours. As a high resolution centre, coordination must be excellent.

Aims: To establish the role of the team psychologist in a metropolitan MND unit as the professional to streamline highly complex expert care, offering care, support and advice underpinned by research. To offer a person centered model of care balancing life expectancy and difficulty in treatment adherence.

Methods: Retrospective descriptive study from 7 years data from comprehensive database, register and management registry, expert opinion and important research: national and international guidelines and protocols. Showcase the Psychologist Key Worker (PKW) role as guide from diagnosis through multidisciplinary and experimental treatments, surgery, ventilation, Palliative Care and Care management in their geographical area through to death and bereavement care.

Results: 751 patients included. 37.5% were men and 42.5% women. 45% were from this region, 54% from other regions and 1% from abroad.

The two psychologists offered a total 3.285 interventions as key worker while offering their input as team psychologists. Key worker interventions have multiplied by a factor of 14. Currently 349 patients remain in our books (54%) have died, of which 29.5% died in our unit, 16% in hospital, 12.5% in their own home, 0.5% in other institutions and 0.5% in the ambulance. The analysis of the trends show a strong component of Alleviated anticipated suffering and Reduced feelings of lack of control and unsafety, reported by patients and families.

Reduced number of unnecessary admissions and re-admissions.

Conclusion: PKW underpins the MND Care Process, negotiating the health system offering high quality response to global care, structuring it within a short time. The model offers good planning and coordination of care promoting quality of care and reducing expensive fragmented care.

Financial Implications for People Dying with Advanced Dementia in Care Homes in England

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Background: The Care Act 2014 framework enables a local authority to decide how much to change the care but this is not a simple one. Meeting a person’s care and support needs. The overarching principle is that people should only be required to pay what they can afford.

Aims: To explore financial dimensions of well-being among people dying with advanced dementia in care homes in England.

Methods: Using data of weekly charges levied by 10 care homes across Greater London and the guidelines for financial assessment, we synthesise the findings to provide a view of residents’ financial well-being.

Results: Across 10 care homes, the mean charge for weekly stay is £174 (std dev £163). In our sample of 70 residents (median age 85, % female 79%, % White British/Irish, FAST score 7a–7c 66%, 7d–72 33%), almost 4% are fully funded by the local authority for their stay at a care home, indicating that savings and assets they hold are under the threshold of £23,350 as set out by the Care Act financial assessment guidelines. A quarter of residents are partially funded by the local authority with a weekly mean personal contribution of £316 (std dev £201). This corresponds to their average personal net worth of around £47,000, which is still below that of a typical UK pensioner. Only 1 patient paid full charges out-of-pocket, indicating above national average personal wealth.

Conclusion: While average pensioner incomes have risen significantly in real terms in the past decade, the real value of the majority of patients dying with advanced dementia in care homes across Greater London are in the lowest 10% of pensioner population. On average, they are unlikely to be home-owners, have occupational pension, sizeable net savings or investments. With rates of dementia set to increase, government policy needs to address challenges for future funding of care.

Source of funding: Marie Curie Cancer Care (grant ref. MCCC-FPR-11-U) administered in partnership with Cancer Research UK

Poster Sessions (Poster Exhibition Set 2)
Patient-reported Outcomes in Primary and Acute Settings in South Africa: The IMPAQ Study

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Background: The burden of progressive illness (particularly NCDs) falls greatest in low and middle income countries, where to date research has focused on HIV and cancer patients. This novel study aimed to measure longitudinal patient-reported outcomes and health service use among COPD/heart failure patient in South Africa.

Methods: Consecutive patients with stage III/IV CHF or V/VI COPD breathlessness were invited to participate. Each gave self-report data using the POS (Palliative Outcome Scale), with worst scores (0-5). Each completed 4 monthly time points. The analysis determined:

1) Worse items at baseline;
2) score changes over time using non-parametric matched score analysis performed between first/last timepoints;
3) Descriptive health service; 4) Determined associations between POS total score and service use.

Results: N=104 recruited, 78% CHF, 26% both CHF & COPD. Mean KPS=61.2 (SD=7.6).

1) Worst problems: sharing feelings, life worthwhile, being at peace, advice to plan (all median=2).
2) The following items showed score worsening over time: sharing feelings (p=0.020), life worthwhile (p=0.014), at peace (p=0.001); help and advice to plan (p=0.001). Around a quarter of the sample reported worsened pain, symptom and worry scores.
3) Over 4 months, there were n=662 primary care contacts, n=525 outpatients, n=567 other HCN, and n=902 hospital admissions.
4) Baseline total POS score associated with more outpatient visits (p=0.021) and a trend for more admissions (p=0.078).

Conclusion: The results confirm multidimensional burden related to palliative-care related problems among people with chronic disease in primary care, and a high level of service use. These data have been used for a quality improvement plan, including data-driven training, clinical mentorship and repeated outcome measurement.

Abstract number: P2-445
Abstract type: Poster

Non-malignant Referrals to an Irish Hospital Specialist Palliative Medicine Service – The Rising Tide

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Aim: Analysis of the trend of non-cancer referrals to the Specialist Palliative Medicine Service (SPMS) at St. Vincent’s University Hospital between 2009 and 2012.

Methods: Approval was granted from the Clinical Audit Department. The electronic Palliative Care Database was used to identify all patients with a non-cancer diagnosis referred to the SPMS during 2009 and 2012. Data was collected from patients’ medical and hospital’s administrative systems.

Results: The number of individual patients without cancer referred to the SPMS rose from 92 in 2009 (22% of referrals) to 221 in 2012 (35.6% of referrals). End of life care was the most common reason for referral in 2009 (55.4%, n=51) while symptom control was the most common reason for referrals in 2012 (78.7%, n=174) (p=0.000). 2012 saw a marked increase in referrals of patients with neurological conditions such as motor neurone disease, stroke, dementia and, as respiratory conditions, particularly cystic fibrosis. New non-malignant conditions referred in 2012 included cerebral palsy (1.4%, n=3) and Parkinson’s disease (2.3%, n=5). While there was no record of fentanyl use by continuous subcutaneous infusions in 2009, it was the opioid of choice in 5% of the 2012 sample (p=0.03).

Conclusions: There is an increasing recognition that palliative care services should be accessible on the basis of need rather than diagnosis. Our service is adapting to accommodate a marked increase in the number of non-malignant referrals, as well as a broadening of conditions referred and is working to promote a shared-care model of timely referral, focusing on enhancing quality of life and not primarily focused on end-of-life life.

Keywords: Non-malignant, palliative medicine, referral patterns, symptoms, end-of-life

Abstract number: P2-446
Abstract type: Poster

Managing Parkinson’s Disease in the Last Days of Life – A Guide for Clinicians

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Aim: To provide health professionals with guidelines for the management of Parkinson’s disease in the last days of life.

Methods: A literature review was undertaken to examine evidence for the use of anti-parkinsonian medications in the last days of life. This includes information on dose and formulation of medications given orally, via enteral feeding tubes as well as transdermal and subcutaneous drugs. Advice for symptom control issues specific to this patient group is also included. Flow charts have been produced to simplify the initiation of the rotigotine transdermal patch depending on previously used anti-parkinsonian drug doses. Contact links to a network of local specialists in Parkinson’s disease and palliative care are included.

Conclusion: This comprehensive and practically useful new clinical guidance provides an excellent resource for health professionals treating a patient group with often complex needs. Pilot implementation is taking place in a University teaching hospital with additional plans for adoption across two hospice sites, with the intention that this work will evolve to become wider regional guidance.

Abstract number: P2-447
Abstract type: Poster

Interventions Involving Patient-centred Care in Chronic Heart Failure – A Systematic Review

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Background: Chronic heart failure (CHF) is a progressive life-limiting condition with a considerable disease burden and poor quality of life complicated by unaddressed communication needs. Prognosis is difficult to predict and treatment decisions are complex. Patient-centred care (PCC) recognises the external and internal factors affecting individual patient as person and enables patients to play an informed, active role in decision-making about their goals of care, but the best way to achieve this in clinical settings and PCC intervention outcomes are unclear.

Aims: To identify PCC interventions and outcomes for patients with CHF.

Methods: Searches were undertaken in Medline, Embase, PsycINFO, Cinahl, Aissa, the Cochrane Library, clinicalgovs. gov, journals and in citations for studies that examined PCC interventions in patients with CHF staged II to IV using the New York Heart Association (NYHA) classification. Study quality was assessed using the Down and Black appraisal tools for randomised and non-randomised studies and a narrative synthesis was undertaken.

Results: Of 12,280 studies, 10 eligible studies were identified. PCC interventions focused on collaborative goal setting between staff and patients, although considerable variation in interventions was found. Core elements included patient motivation, patient-identified goals and trust between staff and patients. Four interventions emphasised the need for improved communication to identify barriers to patients taking a more active role in their care. An overall trend towards improved health-related quality of life, reduced symptom burden, reduced readmission rates and enhanced patient engagement was evident.

Conclusion: PCC interventions with patient motivation, patient-identified goals and trust between staff and patients lead to improved outcomes and processes for patients with CHF. More studies are needed to further determine the core ingredients of effective PCC interventions.

Abstract number: P2-448
Abstract type: Poster

Palliative Care for Patients with Non-cancer or Particular Conditions in the Netherlands

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Aim: The aim of this study was to gain insight into what topics are considered as priorities for improving the quality of palliative care for patients with non-oncological disease such as stroke, COPD, dementia or heart failure or patients with a psychiatric disorder or mental disability by professionals in the Netherlands.

Method: A digital survey was developed and widely disseminated among professionals involved in one of the six target groups mentioned above. The questions concerned the extent to which certain challenges of improvement were recognised and which remedial actions deserved priority.

For each target group a top three of desired developments was drawn. Results were compared between different sectors of healthcare and professional groups.

Results: The survey yielded 1,184 usable responses. Of the respondents, 40% work in the sector of primary care, 25% in hospital, 20% in nursing homes and 4% in a hospice. One third is employed as a consultant in palliative care or in a hospice but their response did not differ significantly from the rest. Three quarters of the respondents consider improving palliative care for non-oncological groups as needed.

By target group specific priorities were identified. Most frequently mentioned improvements were:

• To actively disseminate existing guidelines, methodologies, and services,
• To foster regional (transmural) cooperation,
• To educate health care providers in hospices and consultants in palliative care with regard to non-oncological disease.

Conclusion: There is support and potential for enhancing palliative care for patients with non-oncological or particular conditions. In our study the six target groups differ in stage of development with respect to palliative care. Therefore, each target group requires a specific approach to improve palliative care.
An Examination of Prognostic Factors Including the Systemic Inflammatory Response in Patients with Heart Failure

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Background: Due to the varied trajectories that exist in heart failure as patients conditions decline, it is important that optimal risk stratification of patients occurs. Improved prognostic methods are to achieve this.

Aim: The study compares validated prognostic factors (i.e. age, male gender, New York Heart Association classification, ejection fraction, N-terminal pro-brain natriuretic peptide (NT-proBNP), atrial fibrillation, and haematological markers) with an inflammation-based score combining CRP and Albumin (modified Glasgow Prognostic Score – mGPS), in patients with heart failure (HF).

Methods: A prospective open label observational study was conducted in a tertiary cardiac centre based in the United Kingdom between July 2005 and July 2007. Patients were recruited consecutively and met the following key criteria: over 18 years, LV systolic dysfunction or preserved systolic function but clinical diagnosis of heart failure. Key prognostic markers were examined and the relationship between these and survival was examined using Kaplan–Meier and Cox regression methods.

Results: Data were available on 127 patients. The median survival (IQR) was 48.7 months (16.2–92.1). The median EF (IQR) was 38.0 (26.0–51.0) demonstrating that the majority of patients had left ventricular systolic dysfunction. Forty-eight percent of patients had a NYHA functional classification of 3. On univariate survival analysis, age (p=0.002), NT-proBNP (p=0.043), and mGPS (p<0.001) were significantly associated with survival. On multivariate survival analysis, the most highly predictive factors were age (HR 1.64, p=0.001) and mGPS (HR 1.62, p<0.001).

Conclusion: An inflammation-based score, the mGPS, predicts survival in cardiac failure, is readily available to all heart failure teams and could be useful in risk stratifying and guiding therapy strategies for these patients.

Health-related Concerns of Young Adults with Life Threatening Non Cancer Conditions, a Need for Palliative Care?

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Background: There are increasing numbers of younger people living with a chronic condition. Chronic disease has been highlighted as a priority (NHS Outcomes Framework), and quality of life in long term conditions is one of five key areas in the NHS Mandate. Disease complications mean frequent hospital visits and patients often die in hospital, however palliative care involvement is limited.

Aims: To explore awareness of, attitudes to, and preferences for palliative care services including advance care planning among young adults with chronic disease.

Method: In-depth qualitative interviews with young adults from three disease groups; cystic fibrosis, sickle cell disease, and chronic kidney disease. Participants were purposively selected by sex, age and disease stage. Interviews were recorded, transcribed verbatim, and coded using a constant comparative approach until data saturation.

Results: 17 interviews (10 men), median age 34 years (range 24–50 years), revealed consistent participant preference for palliative care involvement to address physical symptoms, psychological distress and the challenge of advance care planning. Themes included:

i) the importance of symptom control, expressed alongside the limitations of current symptom management,
ii) major social and psychological support needs, often unaddressed, with reluctance to further burden family and friends, and
iii) limitations in current scope to plan ahead for future care, with an overt and expressed need for advance planning.

Conclusion: This work highlights the need to address the health-related concerns of young adults with life threatening non cancer conditions. Emphasis needs to focus on planning for the future if we are to improve the quality of life for these young adults, and deliver care that meets patient choice and preference. One key challenge is to understand how advance care planning can be applied successfully in this cohort of young adults.

The Palliative Care Needs of People with Young Onset Dementia: A Literature Review

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Aim: This piece of work was carried out to explore the palliative care needs of people with young onset dementia and inform the development of guidance documents that are being prepared.

Design: A review of the literature was carried out by searching key terms on the databases CINAHL, and PubMed, searching academic journals and non-academic grey literature websites. Articles retrieved were assessed for relevance and information was synthesised by identifying prominent themes. The themes to emerge are: ‘Diagnosis’, ‘Impact on family’, ‘Services’ and ‘Quality of life’.

Results: The literature indicates the following:

There is a research and practice gap regarding the palliative care needs of this group. Receiving a timely diagnosis and engaging in advanced care planning are of crucial importance.

Family members/carers are impacted financially, socially and emotionally by taking on a caring role and experience ambiguous loss throughout the caring role. Services accessed are largely inefficient and inadequate at meeting peoples’ needs. Living with young onset dementia impacts on quality of life but caution must be taken in reaching negative assumptions.

Conclusion: People are living and dying with young onset dementia and numbers look set to rise in the coming years. This review identified very few pieces of research about this topic thus signifying the need for further exploration via the use of a case study. This is important so as to inform society, policy makers and service providers about the needs of people with young onset dementia.
Deactivation of an Implantable Cardiopulmonary Defibrillator (ICD) – How Do Professionals Decide?


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Background: The therapeutic benefit of an Implantable Cardiopulmonary Defibrillator (ICD) during the last stage of any illness remains uncertain. International guidelines recommend professionals discuss deactivation with patients, but literature suggests this rarely occurs. Aim: To identify factors that impact on professional judgement regarding deactivation of an ICD at end of life.

Methods: This involved two phases: 1. Systematic narrative review of 19 empirical studies on patients’ perceptions of deactivation. Phase 2: Semi-structured interviews with patients (n=62), carers (n=16), and professional focus groups (n=7). Data were combined to identify and conceptualise factors affecting decision making

Results: Nine factors (studies) were identified. Majority of patients included within the published studies and interviews were male (gender), median age 64 years (age) and lived with a family member (social support). Qualitative showed that many patients’ were reluctant to engage in a discussion through their illness until almost their death (49 year female). Frequent shocks prompted patients to consider deactivation and was viewed by professionals as indicative of a discussion. Professionals mentioned numerous of hospital admissions as a sign of clinical deterioration Ethical and legal considerations dominated in clarifying treatment intent. Patients felt ill equipped (e.g. ‘woe has the right to make the decision for you who is not medically trained’ (60 year male). Despite being elderly with deteriorating health future symptoms (heart failure severity) patients anticipated surviving more than 10 years. Many professionals felt that unless patients had a cancer diagnosis (de- morbidity) they were less likely to engage in a discussion.

Conclusion: It was postulated that the nine implicit factors identified affect professional decision making about ICD deactivation at the end of life. These have been developed into a web-linked professional factorial survey.

Abstract number: P2-454
Abstract type: Poster

Palliative Care for People with Chronic Obstructive Pulmonary Disease is a Neglected Area in Primary Healthcare

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Background: Patients with chronic obstructive pulmonary disease (COPD) are underserviced in the primary sector and receive less palliative care than patients with other diseases with comparable symptoms and prognoses. Aim: To examine health professionals’ reflections, experiences and considerations on palliative care for people with COPD in primary healthcare.

Methods: In the period August—September 2014, 66 health professionals (nurses, assistants and helpers) participated in a 120-minute group interview. Ten group interviews with 3–8 participants were completed. The health professionals were invited from eleven healthcare districts in Denmark and the interviews were analysed descriptively. Five major questions were discussed during the interviews: what is palliation and who needs palliative care; what are the challenges working with COPD sufferers; how do you identify palliative care needs; do you initiate discussions with patients about the future; and are you able to respond to patients’ palliative needs?

Results: The participants expressed vague definitions of palliative care services to patients suffering from COPD; revealed urgent need for knowledge; and thought it was difficult to find the right time for serious conversations about future life concerns related to COPD. The participants considered good relations and clear agreements to be important for the patients’ confidence but felt unable to help and support the patients during crisis of breathlessness and anxiety.

Conclusion / Discussion: Palliative care for people with COPD is a neglected area. Primary health professionals are eager to learn about COPD and how to manage palliation, relieve symptoms and communicate.

Abstract number: P2-455
Abstract type: Poster

Bode Index as Screening Tool for Referring COPD Patients to Palliative Care

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Aim: To assess the utility of Bode Index to detect COPD patients needing palliative care interventions.

Methods: This is part of a larger study between the Respiratory Department and the Palliative Care Department attending the outpatients COPD clinic aim were to take part after informed consent. Two independent blind assessments were done by pulmonologists and palliative care physicians. At the COPD clinic, a part from the routine global respiratory assessment including assessment by Bode score. The questionnaire was completed by the Modified Medical Research Council Scale and Body Mass Index to perform the BODE Index. At the PCT, a global assessment was developed including: Edmonton Assessment system was completed, functional assessment by Palliative Performance Scale and Psycho-social situation: Statistics: Descriptive analysis by central tendency measures and frequencies and correlation and comparative analysis was performed by non-parametric tests. Spearman correlation was used and Classification and Regression Tree (CART) was use to establish the best BODE index level for palliative care referral.

Results: 50 patients were included, 2 patients were excluded because missing data. Mean age was 72.1, male 66%. Mean number of symptoms was 5. The median of symptoms’ intensity was 3. Dyspnoea was the most important symptom. PPS median was 70. BODE average was 3.1. We identified 20 patients with BOD index ≥5 (3.94 p<0.01). BODE index more than 5 can identify patients needing palliative care intervention either as outpatients or at home.

Conclusion: BODE Index can be use by pulmonologists to refer patients to palliative care teams.

Abstract number: P2-456
Abstract type: Poster

Physical Symptoms and Comfort in People with Advanced Dementia: A Longitudinal Cohort Study

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Background: People with advanced dementia often have poorly managed physical symptoms and need better quality care at the end of life. Aim: To describe symptoms in people with advanced dementia and inform development of a complex intervention to improve care.

Methods: Longitudinal cohort study of people with advanced dementia (Functional Assessment Staging Scale ≥6) with assessments at study entry and every month for 9 months or until death. Tools included: Bedford Alzheimer Nursing Scale (BANS), Chalfon Co-morbidity and Waterlow Scores, Pain Assessment Evaluation in Advanced Dementia Scale (PAINAD), Cohen–Mansfield Agitation Inventory (CMAI), Symptom Management at the End of Life in Dementia (SM-EOLD), Comfort Assessment in Dying with Dementia Scale (CAD-EOLD) and Quality of Life in Advanced Dementia (QUALID).

Results: We recruited 85 participants (93% residing in a care homes, 79% female, median age 85 years, 79% white British, median assessment visits 6 per person). At first visit median BANS score was 21, 38% were high risk and 53% at very high risk of pressure sores, 42% had difficulty swallowing, 76% needed assistance with eating, 34% had weight loss and 27% were afebrile for most of the day. 14% had excess respiratory secretions and 13% had breathing problems. On the PAINAD 51% had pain at rest and 68% at movement, increasing to 61% and 100% respectively at last visit. CMAI scores increased from median of 41 to 51 during the study. QUALID scores were median 23 at baseline to 30 at final visit showing reduced Del. Median SMEOLD_ll was 33 at baseline rising to 40 at last visit. 26 participants died during follow up with a median CAD-EOLD score of 37.

Conclusion: Our population was frail and at high risk of pressure sores. Pain was common; this, clinically significant agitation, and quality of life worsened over time. As well as defining symptom trajectory these data inform the development of a complex intervention and highlight which symptoms should be considered.

Abstract number: P2-457
Abstract type: Poster

Re-engineering Dialysis: The Role of Palliative Medicine

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Background: End-stage renal disease (ESRD) is a life limiting illness with significant morbidity. Half are unable to participate in decision making at the end of life. Advanced care planning (ACP) is critical in this population. We sought to determine the impact of routine palliative medicine (PM) consultation on patients with ESRD.

Aims: 1. Determine the feasibility of embedding PM consultations in the HD unit during HD runs. 2. Determine impact of PM consultation on ACP.

Methods: Adults receiving HD at a single HD unit were considered eligible. Patients were excluded if they declined consultation. All consultations occurred during the patient’s HD run over a 6-month intervention period. MedRec records were reviewed for documentation of advance directive, code status and GOC discussion before and after PM intervention. Pre and post analysis was done using McNemar’s test.

Results: 10 patients were eligible. 11 patients were included for PM consultation. One patient not seen was hospitalised and unavailable but was included in the analysis. Prior to PM intervention 66 patients were full code, 21 had an unknown code status and 5 were DNR. After intervention: 75 patients were full code, 1 had an unknown code status and 16 were DNR. Prior to intervention, 3 patients had documented GOC discussion in their medical record. Following intervention, GOC documentation rose to 54. The number of patients with an advanced directive on file increased from 38 to 42.

Conclusion: PM consultations during HD were well received by patients. The prevalence of advanced directives did not increase with embedded PM consultation. The frequency of GOC documentation and clarification of code status increased significantly. Embedded PM consultation is effective in improving ACP in the ESRD population.

PrePostP-value

GOC documentation, yes13(39%)42(92%)*0.005

Advanced directives, yes18(54%)42(92%)*0.005

GOC discussion, yes3(9%)54(92%)*0.005

* denote statistical significance.
Palliative care for older people

Abstract number: P2-458
Abstract type: Poster

Putting the EAPC White Paper on Dementia into Practice – Development of a Practice Guideline

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Background: Dementia is a progressive degenerative disorder causing severe cognitive impairment, behavioural disturbances, and loss of ability to perform activities of daily living. The median survival time from onset of dementia to death is 4.1 years for men and 4.6 years for women. Significant needs presented in the literature for other palliative patient groups without dementia. The ZULIDAD study is the most comprehensive study on nursing home residents with advanced dementia in Switzerland.

Methods: The ZULIDAD study consists of three complementary parts: ZULIDAD-A, ZULIDAD-B and ZULIDAD Round Table. Based on the Resident Assessment Instrument – Minimum Data Set (RA-I-MOS), ZULIDAD-A prospectively collects health status and mortality data from residents (n=20000+) of several hundred nursing homes in Switzerland. ZULIDAD-B is an in-depth prospective study of nursing home residents with advanced dementia (n=150) who live in eight nursing homes in Switzerland. Participants of ZULIDAD-B are followed for three years or until their death from two perspectives including their family members and professional caregivers who are asked to fill questionnaires about satisfaction with care, quality of life and advanced directives. The ZULIDAD Round Table consisting of representatives of three relevant stakeholder groups (family members, professionals and researchers) serves as a supervising instrument during the entire course of ZULIDAD as well as an instrument for disseminating the study results of ZULIDAD-A and B.

Results: First results from the baseline assessment of the ZULIDAD-B study as well as from the Round Table ZULIDAD will be presented.

Conclusions: The ZULIDAD study is the most comprehensive study on nursing home residents with advanced dementia in Switzerland. It will provide patients, families, and health care professionals with unique data on which to base their care decisions.

Abstract number: P2-461
Abstract type: Poster

Bridges to Advance Directives – Readiness to Sign, among the Elderly

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Background: In the 2005 the Israel Knesset passed the ‘Dying Patient Law’, which includes the Advance Medical Directives (AD) form, by which the individual makes known his/her wishes regarding treatment, or withholding of treatment, at the terminal stages.

Aim: To explore factors that increase or decrease readiness to sign AD.

Methods: Lectures on the subject were given before 747 old people, in residential care and the community (2011-2013). 396 subjects (mean age 78.2 ± 8.9, 75.8% females) filled in validated questionnaires that included socio-demographic factors, knowledge, attitudes, choice of treatment and quality of life.

Findings: 1. 256 (76.2%) were ready to sign AD, including 97 (28.9%) who had already signed.

2. Factors predicting readiness to sign by regression analysis: participation in lectures (OR-1.7, p=0.001), previous discussion of subject (OR-1.9, p=0.002), arguments for signing (OR-2.4, p<0.001) and arguments against (OR-0.245, p<0.001).

3. 60%– 81% wanted to forgo life-saving treatments and invasive therapies, while only 17%– 25% wanted to forgo palliative treatments during terminal stages.

4. 51.7% decide for themselves to fill AD forms, while only 24.1% thought that health care professionals could influence them.

5. 44% wanted to forgo life-saving treatments during terminal stages, so as to reduce unnecessary suffering. This study showed that most subjects were willing to sign AD forms and that provision of reliable information through lectures and discussions with family and professional staff, tend to increase willingness to sign.

Conclusions: AD are intended to give patients informed control over treatment during terminal stages, so as to reduce unnecessary suffering. This study showed that most subjects were willing to sign AD forms and that provision of reliable information through lectures and discussions with family and professional staff, tend to increase willingness to sign. The patient should be the first to be consulted over signing AD and others, such as relatives and health professionals, should also be involved.

Abstract number: P2-462
Abstract type: Poster

Needs of People with Severe Dementia – The Priority of Personhood

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Background: An increasing number of people affected by dementia is expected worldwide. There is rare empirical evidence about needs of people with severe dementia especially at the end of life.

Aims: The study aims to identify the needs of people with severe dementia living in residential care in Germany.

Methods: A qualitative study using a grounded theory approach was conducted. Participative observation of residents and group discussions with family members and health professionals were chosen for data collection.

Results: Observation of 30 residents, eight group discussions and three interviews with health professionals and family members were performed. Analysis showed a variety of different needs which had a unique appearance to each resident. Related to individual personality, identified needs had a specific level of significance in each resident. Residents used a variety of verbal and nonverbal means of communication such as single words, bodily tension, moving head, moaning or sounding to express their needs. Examples of identified needs were psychological needs, eg - absence of pain - to move and being moved - social isolation, eg - minimised external stimuli - to interact with someone - religious needs - to express religiosity - to take part in religious rituals.

Discussion: People with severe dementia had a variety of needs which were familiar to some needs presented in the literature for other palliative patient groups without dementia. The study stressed the demands for individual person centered care as basis for caring strategies and fulfilling the needs of people with severe dementia. It will be important to train health professionals and increase sensibility for expression of needs and for the complexity and individuality of needs to find ways to meet them suitable to each resident.

The study is funded by the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (BMFSFJ3011S0700).

Poster Sessions (Poster Exhibition Set 2)
P2-463

Abstract type: Poster

Predictors of Tube Feeding in End Stage Dementia, in European Long Term Care Facilities

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Background: Feeding illness is common in Long Term Care Facilities (LTCFs), and is usually provided by formal care providers. Aims of the study were to identify the predictors for tube feeding (TF), and to compare TF practices among LTCFs.

Methods: Data originates from the EU-funded SHIELD database, collected from 70 LTCFs across 9 different countries. The sample was filtered to include LTCFs with at least 100 residents.

Results: Of the 41,516 LTCF residents, 701 residents were 65 years or older and fulfilled the criteria for end stage dementia. Dementia stages, severe cognitive impairment, and end stage dementia (Cognitive Performance Scale 5–6) were independent predictors for TF. Of the care interventions only number of physician's visits was associated with TF. Care provider's presence was significantly correlated with TF.

Conclusion: Dementia stages, severe cognitive impairment, and end stage dementia are significant predictors for TF. Future studies should involve qualitative research to explore the TF practice and its consequences.

P2-464

Abstract type: Poster

Self-management Support Interventions for Informal Caregivers of People with Dementia: A Systematic Meta Review

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Background: Informal caregivers of people with dementia are increasingly burdened. Aims: To synthesise evidence from previous systematic reviews on self-management support interventions for informal caregivers of people with dementia.

Methods: This systematic meta-review followed the PRISMA Statement. Searches were conducted in PubMed, Cochrane Library, Embase, and PsycINFO. A two-step selection was performed: (1) screening based on titles/abstracts and (2) screening based on full text. Methodological quality was assessed by the Quality Assessment Checklist for reviews. Interventions were grouped using an earlier developed categorisation of self-management, covering 5 intervention targets: (1) collaboration between palliative care and geriatric care; (2) screening based on full text. Methodological quality was assessed by the Quality Assessment Checklist for reviews. Interventions were grouped using an earlier developed categorisation of self-management, covering 5 intervention targets: (3) maintaining an active lifestyle, (4) techniques to cope with memory changes and (5) information about dementia.

Results: 10 systematic reviews were included. Strong evidence exists for self-management support interventions focusing on relationship in relieving caregiver burden. There is moderate evidence that self-management support interventions targeting psychological wellbeing contribute to a reduction of depressive symptoms. Last, strong evidence was found that interventions targeting ‘information about dementia’ increase wellbeing, and moderate evidence was found for a decrease of depression.

Conclusion: This meta-review indicates that self-management support interventions by health care professionals have positive effects on various outcomes of informal caregivers of people with dementia.

P2-465

Abstract type: Poster

Mapping Palliative Care Provision in Long Term Care Facilities for Older People in Europe: Outcomes of the EAPC Task Force

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Background: Older people are increasingly living in long term care facilities (LTCFs) due to aging populations and growth in non-cancer related care. Palliative care (PC) is well organised in many countries and provision diverse, but PC in LTCFs is a recent development. Comparison of the effectiveness of Palliative Care for Elderly people in LTCFs in Europe (PACE) is an international study on the state of current provision. Aims: To map provision of PC in LTCFs in Europe. Methods: Extending an earlier EAPC LTC taskforce from 13 to 29 countries, a mapping survey was sent to key country informants from PC, long term and geriatric care settings between April and August 2014. LTCF demographic data, PC activities and current practices are collated and key components identified. Data were analysed using a coding template for LTCF funding and organisation, resident populations, regulation and training, and PC practices and innovative approaches to provision. Results: Data show differing PC provision for 23/29 countries. Reported initiatives illustrate cross country provision, with limited regional organisation level initiatives in Central and Eastern European countries. Relevant national policy level PC developments are reported, with limited focus on LTCF provision. Conclusions: There are challenges for LTCFs in providing PC, with complex funding, organisational partnerships, regulatory frameworks and policy directives shaping delivery and care provision. Comparison across Europe is difficult owing to varying levels of data available by country. All countries have systems of regulation to ensure minimum standards for quality care in LTCFs. The intended focus of PC interventions or developments are often patient and family focused. Other benefits can be seen for individual staff, teams and organisations. Evidence remains limited with few rigorous evaluations of such developments.

P2-466

Abstract type: Poster

Inter-disciplinary Perspectives on Palliative Care Provision for Older People: Barriers and Facilitators

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Background: In September 2013, the Marzouza Foundation, EAPC, and the EUGAMS launched a manifesto: ‘Palliative Care for Older People in the European Union’. The aim was to raise the profile of the needs of older people for palliative care and assist policy makers and organisations to improve palliative care for older people in Europe. Subsequently, a working group was established to work with key stakeholders. Aims: To identify: (1) collaboration between palliative care and geriatric care (2) barriers and facilitators to on-going collaboration.

Methods: A descriptive exploratory study was undertaken. Four discussion groups were held: two groups at each organisation’s annual conference. Analysis was undertaken using an open coding template to identify key issues under pre-determined themes.

Results: Thirty three participants (24 women and 9 men), from 18 countries worldwide, participated. The following disciplines and backgrounds were represented: medicine, nursing, policy and research in geriatrics and gerontology, palliative care and primary care. Examples of collaboration were identified in clinical care, education, policy, research and leadership and organisational structures. Collaboration often relied on the individual clinician as the driving force for the service. Barriers and facilitators identified concerned different understandings of palliative care, funding models for care; availability of geriatric and or palliative care specialists in care settings; role of geriatricians in palliative care teams and inter-disciplinary education opportunities.

Conclusions: Whilst barriers to collaboration exist, examples of innovative collaborations drawing upon personal and service expertise exist across Europe.

P2-467

Abstract type: Poster

Qualitative Study on the Perception of Hospice Nurses in Relation to the Palliative Sedation in Adult Cancer Patients

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Context: Palliative sedation (PS) is the subject of many extensive medical and ethical debates regarding end of life decisions. Nurses are important participants in the conduct and use of this practice, but despite this, only 9 articles that investigate the nursing experience in the field of palliative sedation were found in the last 10 years. Objective: To explore and describe the knowledge, perceptions and experiences the nurses have within the Hospice of PS. Methods: Face to face interview from the article ‘Nurses’ Perception of Palliative Sedation in a Scottish Hospice: An Exploratory Study’ (CL Zinn et all, 2012 Jul.), a group study of 19 nurses from 7 Hospice’s in Milan. All the data collected was organised through a system of categorisation of data, through the use of concept maps. Results: The group interviewed, all female, average age 40 years, average length of service of 17.5 years, and in palliative care 8 years. All nurses have described PS as an indispensable and important method to accompany the terminally ill to a peaceful death with dignity, creating conditions of peace and tranquility. More than 80% of respondents did not report discord in the use of PS, as this is seen as the end result of a process of sharing between the team, patients and caregivers. The group involved is aware that PS does not affect the survival times of patients and the practice, only when it considers it truly necessary. Respondents expressed the need of having to periodically discuss and share with the team, ethical situations more complex in order to share and resolve inner conflicts unleashed from a subject as painful as the end of life. Conclusions: PS is looked upon as a fundamental practice. There is a need for more training on palliative care not only in environments such as Hospice, but also in all hospital departments to ensure a peaceful death to all terminally ill patients.
Contact with hospital outpatient services and 20.6% with community palliative care. 42% were transferred to ED for a diverse array of acute problems. Very few were definitively managed in the ED and most resulted in a hospital admission. 32% of residents had an admission in the last month of life, compared to 8.1% to 10.8% in the five months before this. Factors associated with lower odds of ED transfer include contact with an out of hours GP (OR 0.65; p<0.000), advance care planning (OR 0.68; p<0.000) and teaching hospital (OR 0.706; p=0.008). Factors associated with higher odds of ED transfer include younger age (OR 0.982; p<0.002), males (OR 1.31 p<0.011), dementia (OR 1.291 p<0.042), heart disease (OR 1.28 p<0.016) and feeding tube (OR 2.27 p<0.001).

Discussion: NH residents are at high risk of hospital admission once transferred to an ED. Health care service use increases in the last months of life. Interventions supporting the use of anticipatory prescribing and ACNs by GPs and NH staff are likely to reduce ED transfers towards the end of life.

Abstract number: P-2471
Abstract type: Poster

Breast Cancer Survivors Aged 60 and over Thrive with Dragonboat Paddling
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Background: In recent years, Breast Cancer Survivor (BCS) Dragonboat teams have organised to provide the opportunity for women diagnosed with breast cancer to engage in competitive paddling, an active upper body sport requiring training and regular off and on the water practices. An Internet survey was initiated which received responses from 749 women participating in BCS teams in the United States, Canada, England, Australia, New Zealand, and South Africa. Women 60-86 were 46 % of the survey respondents.

Aims: The goal of this study was to have the breast cancer survivors who paddle describe the personal impact of paddling as an active, upper body aerobic activity on their lives after cancer treatment and how participation in a BCS team has affected their lives as cancer survivors.

Methods: BCS teams were contacted using E-mail and sent a letter explaining the research study, including a ‘url’ which provided access to the informed Consent and survey document. Accepting the informed Consent and completing the Qualification Survey and created a private, individual data record. The only identifying data collected was a birth date. Results: Women 60–86 reported: 99% began to dragonboat paddle after their cancer diagnosis; 89% paddle 2-times a week or more. Palliative benefits of paddling were: increased fitness 98%, feel better 92%; healthier 89%; stronger 89%; energised 88%; happier 83%. They said they would continue to paddle to: Keep physically active, 87%; Maintain a healthy lifestyle, 81%; Have the support of friends and the team, 85%.

Conclusions: For older women, dragonboat paddling provides an active, beneficial life style. For many it is a new opportunity to engage in a competitive Team sport. Team members of all ages support each other to deal with challenges of life after cancer, illustrating the potential of dragonboating as a beneficial support program.

Abstract number: P-2472
Abstract type: Poster

Comparing Circumstances of End-of-Life Care for Older People Living at Home and in a Residential Home in the Netherlands via a Mortality Follow-back Study
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Background: Due to the growing proportion of older people, their place of residence and place of care at the end of life is becoming increasingly important.

Aim: To compare circumstances of end-of-life care and transitions between care settings in the last three months of life among older people in residential homes and home settings in the Netherlands.

Methods: Using a nationwide representative mortality follow-back study, we identified patients of 74 participating GP practices who died non-suddenly over the age of 65 in 2011 and 2012. Patients whose longest place of residence in the last year of life had been a home setting (own home or a relative’s home) or a residential home were included (n=498).

Specialist nursing homes were excluded.

Results: Home settings and residential homes cater to different populations of older people: those in residential homes are older (87 versus 81), more likely to be female (63% versus 43%), more likely to have dementia (25% versus 54%). While there were no differences in treatment goals or communication about end-of-life care, those living in a residential home were more likely to have received palliative care from a GP than those living at home (56% versus 53%).

Conclusion: Despite similar treatment goals, older people living at home are at risk of a lower quality of end of life and death than those living in a residential home. Measures should be taken to ensure that patients in different living situations receive appropriate end-of-life care.

Main funding source: EU Seventh Framework Programme (FP7/2007-2013, grant number 266497).
**Hospice and Palliative Care in Long Term Care Settings: The Relatives’ Perceptions of Sustainability**

**Background:** There is growing recognition in Europe that hospice and palliative care in long term care settings are relevant approaches for delivering good quality care for people living and dying in these institutions. Many innovative projects have been developed also in Germany seeking perspectives with high commitment during the past 15 years. Therefore it is necessary to find out factors supporting the sustainability of these projects. **Aims:** The aims of the presented paper here is to highlight insights from the perspectives of relatives of people living and dying in long term care settings. As hospice and palliative care include the whole family as relevant care system we asked relatives, how they perceived the sustainability of these efforts. **Methods:** A qualitative study based on a participatory approach was conducted. With support by management of long term care settings we organised four focus groups in different and thoroughly sampled nursing homes in Germany that have a long tradition of hospice and palliative care. The setting varied concerning place, provider organisation and composition of participants. Analysis of data was processed inductively on individual and interdisciplinary basis. **Results:** From the perspective of relatives the following themes are key for sustainability of hospice and palliative care: 1) nursing homes as places; 2) inbetween living and dying; 3) Understanding and feeling understood in multicultural contexts; 3) Communication culture between staff and relatives; 4) Structural and organisational background; 5) Conflicts of care; 6) Grief and joy at the same time. **Conclusion:** Based on these insights we conclude: Central aspects concerning sustainability of hospice and palliative care in long term care settings encompass the role that long term care settings play in society, the question how communication culture can be developed and the relation between living and dying. The project is funded by the Robert Bosch Stiftung, Stuttgart.

**Depression and Neuropsychological Functioning in Inpatient Palliative Cancer Care**

**Abstract number:** P2-475  
**Abstract type:** Poster  
**Background:** Depressed older adults tend to present with poorer executive function than non-depressed. However, to date no research has explored this relationship in inpatient palliative cancer care. This study explores the relationship between neuropsychological (NP) functioning and depression/anxiety in patients with terminal cancer.

**Aim:** This study investigates the numbers of people dying in care homes (nursing & residential) comparing those who were residents and those who were not by age, gender, cause of death and geographical location. **Method:** Data from deaths extracted from ONS Mortality Data. To determine if a person dying in a care home was a resident, place of residence at death certificate was matched to ONS Communal Establishment database. If the postcode matched, it was inferred this person was a resident of a care home. **Results:** Approximately 1.5% of care home deaths is increasing with many admitted near the end of their life after discharge from hospital. **Conclusion:** The population in England is ageing with people living longer and care homes are the place of death for an increasing number of people. The increase in non-resident care home deaths may reflect that more people are living alone and unable to maintain themselves at home at the end of their lives. With more people with complex conditions transferred in to a care home setting near the end of their life, care homes must be adequately resourced to enable people to die comfortably as in the Dutch model of care. Further study could examine that difference adults between gender and whether different genders of people or gender and palliative care treatment. **References:** 1. www.sueryder.org/~/media/Files/About-us/A-Time-and-a-Place-Sue-Ryder.aspx

**Care Home Deaths: A Comparison between Residents and Non-residents**

**Abstract number:** P2-477  
**Abstract type:** Poster  
**Aim:** The difference in numbers of people dying in care homes (nursing & residential) comparing those who were residents and those who were not by age, gender, cause of death and geographical location. **Method:** Data from deaths extracted from ONS Mortality Data. To determine if a person dying in a care home was a resident, place of residence at death certificate was matched to ONS Communal Establishment database. If the postcode matched, it was inferred this person was a resident of a care home. **Results:** Approximately 1.5% of care home deaths is increasing with many admitted near the end of their life after discharge from hospital. **Conclusion:** The population in England is ageing with people living longer and care homes are the place of death for an increasing number of people. The increase in non-resident care home deaths may reflect that more people are living alone and unable to maintain themselves at home at the end of their lives. With more people with complex conditions transferred in to a care home setting near the end of their life, care homes must be adequately resourced to enable people to die comfortably as in the Dutch model of care. Further study could examine if difference adults between gender and whether different genders of people died in care homes. **References:** 1. www.sueryder.org/~/media/Files/About-us/A-Time-and-a-Place-Sue-Ryder.aspx
Abstract number: P2-478
Abstract type: Poster
Researching Non-kin-Care Relationships in End-of-Life care – Methodological Challenges
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Background and aim: The percentage of people living in a single household in western societies has increased in the last decades. Many of them have no family nearby and do have palliative care needs, e.g. frail older people. Non-kin-carers play an essential role to support these individual’s preferences for staying at home, even until death. However, non-kin-carers usually are not considered in research. In a study which aimed at getting insight into non-kin-care relationships of older people living alone at the end of life, substantial methodological and ethical challenges emerged worldwide to be discussed.

Method: A qualitative design included narrative interviews in retrospect with non-kin-carers (n=13) aged between 52 and 84 years. As part of the case study approach, additional interviews with selected health professionals (n=8) were conducted. A research diary was kept and discussed throughout the study. In retrospect of this study we reflected upon methodological challenges and issues in a focus group discussion with an interdisciplinary team of researchers (n=5).

Results: As non-kin-care does not take place within organisations, access is difficult. People often suppose their engagement as private and some do not consider themselves as carers. An open call for participation is therefore useless. The retrospective design implied that the caring process had finished. Therefore health professionals or legal attorneys often had lost touch with the non-kin-carers, except for specialist palliative care services that provided support with bereavement. Regarding research ethics, approaching non-kin-carers is demanding, since there relationships mostly have no legal status and data protection issues prohibit research.

Conclusion: Research of informal caregiving in palliative care will have to go beyond families. This requires research designs with ‘mixed recruitment approaches’ and thorough reflection of challenges in order to enhance good quality of research.

Abstract number: P2-479
Abstract withdrawn

Abstract number: P2-480
Abstract type: Poster
The Experience of Teenagers and Young Adults (TYAs) Having Cancer Treatment in an Adult Setting: A Systematic Review of the Literature
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Background: Every year, 2,200 teenagers and young adults (TYAs) aged 15–24 are diagnosed with cancer in the UK. Best practice guidelines recommend that TYAs with cancer be treated on specialist adolescent units, of which there are now 27 in the UK. These units are considered to provide clinical and psycho-social benefit to young people. However, the majority of TYAs with cancer (70%) actually have their cancer treatment at their local hospital or at cancer centres along with adult patients of all ages, and do not receive the recommended age-appropriate care provided on specialist units.

Aim: To undertake a systematic review of the literature to discover what is known about the experience of teenagers and young adults who received any cancer treatment in an adult setting.

Methods: A systematic search was conducted in May 2014 of five major electronic databases: Academic Search Complete, CINAHL, PsychINFO, PubMed and Scopus. Meta-synthesis was used to integrate the results.

Results: Based on strict eligibility criteria, 14 studies (4 quantitative, 9 qualitative and 1 meta-synthesis) were identified reporting primary data about the TYA experience of cancer treatment in an adult setting.

Conclusion/discussion: Synthesis of the 14 papers suggests that TYAs find adult units isolating, boring, distressing and undignified. They are generally not critical of the medical/cancer care they received, but find the psycho-social care to be lacking. TYAs report that staff working in adult settings do not know how to relate to younger people and the ward routines can feel inflexible and inappropriate. They also report that adult units lack any leisure space or facilities for friends and family to stay. TYAs miss having peer contact and can find being amongst older patients distressing and can reinforce the fear of death. Findings from the majority of studies suggest that a specialist TYA unit would be the preferred place of care for TYAs with cancer.

Abstract number: P2-481
Abstract type: Poster
Use of Dronabinol in Children: A Cross-national Survey
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Background: Despite a myriad of studies and case reports in different fields of medicine documenting beneficial effects of dronabinol in adults (e.g. in multiple sclerosis), little is known about the impact of dronabinol to alleviate burdening symptoms in children. Moreover it is to date quite unclear to which extent pediatric patients have access to dronabinol.

Methods: We contacted 317 pediatric institutions in Germany, Switzerland and Austria (27% questionnaire return rate) using a 17 item questionnaire send via email.

Results: 39 out of 85 responding institutions (46%) declared dronabinol use. Most commonly treated symptoms were: spasticity, pain and loss of appetite. 87% of the respondents used daily dosages between 0.25–0.75 mg/kg/day. Again 87% of the respondents reported on minor adverse effects (dizziness, agitation, slightly reddened eyes). Major obstacles for dronabinol use are cost coverage problems with the health insurance and a general lack of information concerning indications and dosages for children.

Conclusions: A substantial number of pediatric institutions use dronabinol to treat various symptoms in children. The vast majority report about clinically relevant effects. Nevertheless there are many uncertainties with respect to indications, dosing and cost coverage. Clinical trials helping to establish dosage regimens for children would be as essential as trials focusing on specific indications.

Abstract number: P2-482
Abstract type: Poster
Pediatric End-of-Life Care in the Home Care Setting: Creating and Balancing Family’s Lifeworld
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Aims: This study explored the parental experiences and needs during their child’s end-of-life (EOL) care in the home care setting. The patient’s characteristics, and current provision were described, and influencing system factors for the EOL care were determined.

Background: Parents experiencing their child’s end-of-life care at home face a most existential and challenging time. Their experiences/needs are influenced by system factors on different system levels (material, health care, family, and individual levels). Little is known about parent’s experiences/needs and the influencing system factors for child’s EOL care at home.

Methods: This study used the nationwide survey ‘Paediatric End-of-Life Care Needs in Switzerland’ used a concurrent qualitative embedded mixed methods design. It included 46 families, whose child (0–18y) died in the years 2011–2012. Ten parents were included in semi-structured interviews, analysed by thematic analysis. Patient’s characteristics were obtained from patient’s medical charts and parental experiences/needs through the parental questionnaire (n=46). Appropriate descriptive statistics and logistic regressions with generalised estimation equations were computed.

Results: Parents experienced enormous effort by creating a family’s unique lifeworld, and balancing it with the challenges of the outside world during child’s EOL care at home. They were supported in child’s EOL care by professionals (community care 50%, clinicians 50% pediatric palliative care (PPC) teams 28%). Influencing factors for child’s EOL care at home were found to be the parental readiness, child’s diagnosis, and sociodemographic factors. The access to EOL services correlated with proximity of the treating center.

Discussion: Individual-tailored EOL care with flexible approach (eg. a hospital-based PPC team), is needed in order to fulfill the needs of the child and family. Practical help in house holding was a major need of mothers.
Specialized Paediatric Palliative Home Care in Germany – Different Models of Service Provision

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Background and aims: Since 2007, the children's right to specialised paediatric palliative care (SPPHC) became law in Germany. According to estimates, a nationwide comprehensive SPPHC is possible by the implementation of about 30 regional teams. To date, 23 of these teams exist within the country. Their design differs depending on regional geography, healthcare structures and resources. The aim of our study was to compare different SPPHC teams in terms of formation and service provision.

Methods: Examination of 3 different SPPHC teams concerning their structure, regional conditions, and characteristics of service provision in 2012 and 2013. The documentation of SPPHC was conducted using a similar online data base.

Results:
- Regional geography:
  1. Territorial State,
  2. City state,
  3. Densely populated area.
- Team structure:
  1. 5 regional specialist teams with a common central office providing coordination and administration.
  2. Central specialist team providing medical and nursing home care, coordination and administration, supported by 2 paediatric home nursing teams and 4 specialised physicians from surrounding hospitals.
  3. Regional specialist team based at an oncology department of university clinic.

Catchment area:
- 1) 48,000 km²,
- 2) 1,200 km²,
- 3) 5,000 km²

Start of service provision:
- 1) 4/2010,
- 2) 6/2011;
- 3) 1/2010.

Number of patients (2012 + 2013):
- 1) 69 + 66,
- 2) 25 + 63,
- 3) 37 + 42.

Conclusion: Different regional models were implemented to comply with the legal right to SPPHC in Germany. Their design depends on regional conditions.

Abstract number: P2-483
Abstract type: Poster

Creative Officer – Apply within Evaluation in a Children’s Hospice

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Recent evaluations of arts projects at a children’s hospice indicate that activities developed in-house by experienced specialists and practitioners are often more attuned to the needs and aspirations of children and young people (cyp) with life limiting conditions and their siblings than those led by visiting companies. This paper explores the application and evaluation process of a theoretical model PREPARE (Sturge and Aaro, 2012) to design, implement and evaluate activities in this setting.

The model: PREPARE, model, founded on the work of community music therapy practitioners, is based on seven principles:
- Encouraging participation and inclusion, Ecological-based on existing relationships,
- Promotes performance as an approach to development, Is activist – addressing problems and influencing change, Is reflective through evaluation, Ethical – responsive and responsible,

Method: The model is used as a template for discussion and enables the aims and expected outcomes to meet the needs, abilities and development opportunities of life-limited children and young people. The PREPARE principles, embedded throughout the project and are driven by the interest, skills and aspirations of cyp. This was used with an arts project in a children’s hospice, initiated by a young person, designed and developed by the other cyp in the hospice and produced with support from an artist, staff and volunteers.

Results: Young people, some with profound disabilities, through full participation produced pieces of art, sculpture, animated stories and short animated film. They saw change through increased confidence and skills, uncovered hidden talents and were rewarded by the positive response to their art exhibition held in a prestigious venue and subsequently at an international conference in Canada.

Conclusion: Using this model provides a systematic approach to creative activities in the hospice setting and ensures maximum empowerment and benefit for all those who take part.

Abstract number: P2-484
Abstract type: Poster

Bridging the Gap for Young People in Transition between Children's and Adults Services

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Aims: A UK wide Transition Taskforce was established to lead a coordinated strategic approach to providing and developing care and multi-agency support for young people with life-limiting conditions making the transition to adulthood.

Approach: Former activity relating to the transition between children’s and adult services has tended to focus on the ‘jump’ from children’s services and the Taskforce is now working with adult services to support them to match this with a ‘pull’ to ensure that young people make a successful transition to adult care and are able to live as independently as they wish and achieve their aspirations. The Taskforce works at 4 levels in order to achieve its aims:
- Nationally, to coordinate the overall work, develop materials, share information, create national collaborations and links, and to oversee the development of regional action groups;
- Regionally, through Regional Action Groups, to identify needs in their area, promote regional collaboration and identify organisations that can promote the development of services;
- Locally, to develop collaboration between organisations that will lead to the provision of facilities and services to support individually; and
- Individually, to work with young people to listen to their views and to ensure that young persons’ needs and preferences are used.

Results: Regional Action Groups are established in six regions of England and in Scotland, Wales and Northern Ireland. Evaluation of the project has so far highlighted four areas where further focus is needed: Opportunities for young people to gain employment, Collaboration between health, social care and education providers, Adapting existing environments to accommodate the needs of young people; Communication within and between teams.

Conclusion: This whole systems approach to improving outcomes for young adults in transition to adult services is a powerful and effective method, worthy of consideration in other countries.

Abstract number: P2-486
Abstract type: Poster

Development and Validation of the APCA African Children’s Palliative Outcome Scale (C-POS)

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Background: Assessing the outcomes of palliative care in children has been hampered by the lack of outcome measures. Thus an outcome tool was developed for use in children for clinical practice, audit & research.

Aim: To develop & validate the APCA African Children’s POS in sub-Saharan Africa, utilising a collaborative approach.

Method: A literature review was conducted & the tool developed in 3 phases:
1) Development & piloting of an initial tool in 4 sites across 3 countries (Kenya, Ug & SA) utilising both quantitative & qualitative data collection.
2) Revision of tool & assessment of its utility, including acceptability in practice, feasibility & face validity. 198 children recruited across Ug, Kenya, SA & Zimbabwe. Qualitative interviews were also held.
3) Revision & validation of the C-POS, establishing face, content & construct validity, reliability & acceptability. 302 children recruited (Ug, Kenya & SA) & 61 in-depth & cognitive interviews conducted.

The tool was finalised in September 2014.

Results: The C-POS is a multi-dimensional outcome tool with 14 questions, 9 aimed at the child (completed by child or proxy) & 5 at their carer. In the final validation phase, mean age for child respondents was 12 (SD= 4.9). Cronbach’s alpha was 0.38 (child) & 0.56 (proxy) indicating expected moderate internal consistency. For construct validity (C-POS-PedsQL Kendall’s coefficient of concordance were low-moderate as expected (0.41–0.51). Good test-retest reliability was seen with high correlation Kendall’s coefficient for all items (0.67–0.88). Median time to complete at final visit was 5 mins (child), 10 mins (proxy) & 13 mins (child). Good responsiveness to change was seen & interviews showed POS items mapped well onto identified needs with good interpretation (n=61).

Conclusion: The APCA African C-POS is a valid & reliable tool & its development is an important step forward in the measurement of outcomes in children’s palliative care.
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