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

Building Bridges

8 – 10 May 2015
Copenhagen, Denmark

www.eapc-2015.org
Foreword

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:

‘When you are weary, feeling small
When tears are in your eyes,
I will dry them all
I am on your side
When times get rough’

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

‘When evening falls so hard
I will comfort you
I’ll take your part
When darkness comes
And pain is all around’

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](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
Co-Chair of the Scientific Committee

Carlo Leget
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.
PL2 – Supporting family carers in palliative care: what are the main challenges?

Supporting family carers in palliative care: what are the main challenges?

Grande G.E.

University of Manchester, Nursing, Midwifery & Social Work, Manchester, United Kingdom

Presenting author email address: gunn.grande@manchester.ac.uk

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.
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:
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.

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.

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


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

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14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015
PL7.2 – Awarded Presentations

The Myeloma Patient Outcome Scale (MyPOS) – longitudinal validity and reliability of a measure of quality of life for clinical use in patients with multiple myeloma

Ramsenthaler C.1, Osborne T.R.1, de Wolf-Linder S.1, Siegert R.J.2, Gao W.1, Edmonds P.M.1, Schey S.A.4, Higginson I.J.1

1Cicely Saunders Institute, King’s College London, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom
2School of Public Health and Psychosocial Studies and School of Rehabilitation and Occupational Studies, Auckland University of Technology, Auckland, New Zealand
3King’s College Hospital, Department of Palliative Care, London, United Kingdom
4King’s College Hospital, Department of Haematological Medicine, London, United Kingdom

Presenting author email address: christina.ramsenthaler@kcl.ac.uk

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.
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 AIIHPC/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.
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
Debate: Hospices that provide comfort care only, undermine the palliative care commitment to individualised, goal-focused care

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

Chemny N.L.
Shaare 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 refused any treatment. He had a resolving cholangitis and was started 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. Incredulous, I called to speak with the physicians in the hospice, but my interview patients were 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 hampers 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. Psychological 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 Case against: Hospices that Provide Comfort Care Only, Undermine the Palliative Care Commitment to Individualized, Goal-Focused Care

Radbruch L.
University Bonn, Department of Palliative Medicine, Bonn, Germany

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 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 wish that he/she as a family care and there is a realistic chance to achieve that 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 neurone disease cannot be admitted unless respiratory support is available. All 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?

Vijver I.
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 only prolong dying of patients with severe dementia. It is possible to keep the patient comfortable without antibiotics, by antipyretic and analgesic administration. Effectiveness 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. Artificial saliva spray can help. Artificial saliva spray is also used 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 these 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 restrains of a patient who tries to remove the tube, loss of autonomy, 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 care and the dementia disease trajectory cannot be predicted well. Building bridges implies that we recognise sensitive issues and the specific contributions palliativists and dementia care specialists can make to optimise palliative care in dementia.
Assessing and managing breathlessness in palliative care

Abstract number: PS03.1
Abstract type: Parallel Session

Assessment of Breathlessness in Clinical Practice
Simon S.T.
University Hospital Cologne, Center for Palliative Medicine, Cologne, Germany
Presenting author email address: steffen.simon@uk-koeln.de

Breathlessness is a burdensome and prevalent symptom in many life-limiting diseases. The aim of this presentation is to provide an overview of the management of breathlessness in clinical practice including new developments and guideline recommendations. Methods: Systematic search of the literature and descriptive synthesis of study results and guideline recommendations. Results: The assessment of breathlessness in life-limiting diseases should be part of a comprehensive symptom assessment including different dimensions of breathlessness and other symptoms. A rigorous exploration of potential causes is essential. The gold standard of the subjective symptom breathlessness is self-assessment by the patient. However, proxy-assessment by carers or professionals is needed when self-assessment is not possible because of cognitive or physical impairment. Well validated uni/multidimensional measurement tools exist. Continuous and episodic breathlessness (including by exertion) should be differentiated to optimise the management strategy. New developments such as neuroimaging may routinely play a role in the future but not at present. Conclusions: Routine assessment of breathlessness should inform individual tailored management plans to improve symptom control in breathless patients.

Non-drug Approaches to the Management of Breathlessness
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. Drug treatments have an important role 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.

Drug Approaches to the Management of Breathlessness
Johnson M.
The University of Hull, Hull York Medical School, Hull, United Kingdom
Presenting author email address: mistam.johnson@hymsc.ac.uk

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. This presentation will provide an overview of 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 this group of drugs, but others will be addressed.

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
Houttekier D.
Vrije Universiteit Brussel (VUB) & Ghent University, End-of-Life Care Research Group, Brussels, Belgium

 Routinely collected databases offer the opportunity to monitor the quality of end-of-life care. Death certificate data The international place of death study (IPoD) 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. Analyses showed substantial variation in hospital death within and across countries in specific patient populations, e.g. in hospital death of people who died from dementia ranged from 2% in NL to 74% in KOR. Between-country variation in hospital death risk remained substantial after controlling for differences in patient and health care system characteristics, indicating room for improvement in many countries.

Healthcare claims data 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.

Measuring Quality in Palliative Care: Nationwide or Regional Implementation of Quality Indicators for Palliative Care. Feasibility and Potentials for Palliative Care Developments
Cumby D.C.
Flinders University, Palliative and Supportive Services, Adelaide, Australia

Patient reported point-of-care data collection is a fundamental building block of quality hospice/palliative care services. A number of initiatives are happening across the globe that have already demonstrated benefits from the patients’ point of view as well as from improved systems performance. The infrastructure for such initiatives can be modest and the ability to generate meaningful data need not be complex or expensive.

Examples include a number of tools with the common theme being patient reported symptoms and performance status. These can be linked with other important issues such as place of care, transitions of care and place of care at the time of death. Examples of the initiatives include the Carolinas Program, Cancer Care Ontario, California and the Palliative Care Outcomes Collaborative (PCOC) in Australia. All of these programs are designed to minimise the impact on clinicians’ time and maximise the quality and level of data that can be collected against performance of the palliative care services. Without such measures, it is difficult to gauge the performance of services. With these data, systematic service improvement can be achievable, even in small, poorly resourced services.

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?
Kellishaw 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

Fennungsplassen S.
UT MD Anderson Cancer Center, Houston, TX, United States

Presenting author email address: syenna@mdanderson.org

Objectives of the presentation: To provide a brief update on sleep disorders among advanced cancer patients. This includes discussion of the available data regarding their diagnosis, treatment and follow-up, highlighting the unique aspects pertaining to advance cancer patients.

Background: Advanced cancer patients often experience one or multiple psychological symptoms (eg, sleep disorders, anxiety and depression) and physical symptoms (eg, pain, loss of appetite, fatigue, sleep disturbances). These symptoms are a result of co-morbidities, a severe illness affecting multiple systems (eg, immune, neurotransmitter, hormonal and circadian rhythm dysregulation), and powerful treatment with potential severe side effects. Sleep disturbance is frequent and usually underdiagnosed despite its significant impact on quality of life. At the conclusion of this presentation the participants will be able to understand the complexity involved in the diagnosis and the complex interventions needed to successfully alleviate distressing symptoms in most cases a routine comprehensive assessment and an interdisciplinary approach to patient care and structured management plan should be adapted to the available resources.

PS06

Implementation of advance care planning

Abstract number: PS06.1
Abstract type: Parallel Session

Implementation of Advance Care Planning in Daily Practice

Hamner BJ.
Gundersen Health System, La Crosse, WI, United States

Presenting author email address: bjhamner@gundersenhealth.org

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

Abstract number: PS07.1
Abstract type: Parallel Session

Implementing Patient Reported Outcome Measures (PROMs) in Clinical Practice: Guidance and Experiences

Bausewin C, van Vliet L, Murtagh FEM
1Munich University Hospital, Munich, Germany, 2King’s College London, Cicely Saunders Institute, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom

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 implement and use them in clinical care. In this parallel session, organised with strong inputs from the Taskforce on Patient Reported Outcome Measures, we aim to help bridge the gap 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 (4 presentations, with each presenter being the first author on one of them):
1. Prof Dr Claudia Bausewin – 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 Liesbeth 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 Murtagh – 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.

Economic Evaluation of Palliative Care - Challenging, but Feasible

Abstract number: PS08.3
Abstract type: Parallel Session

Economic Evaluation in Palliative Care Economical Evaluations

Normand C
1Trinity College Dublin, Health Policy and Management, Dublin, Ireland, 2All Ireland Institute of Hospice & Palliative Care, Dublin, Ireland

Presenting author email address: charles.normand@tcd.ie

There are two main reasons why it is now important to develop evidence on cost-effectiveness in palliative care: to reduce waste in the increasingly competitive environment of health care financing, and to make better decisions in how palliative care resources are used. While there are challenges in measuring costs and outcomes in many areas of health care, these can present in more extreme ways in palliative care. Drawing on evidence from the Economic Evaluation of Palliative Care study, JARE 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 funder. 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.
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

Farquhar M.1, Preston N.1, Ewing G.1
1University of Cambridge, Public Health & Primary Care, Cambridge, United Kingdom.

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. Our group has been leading a programme of research to improve recruitment including 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 and benefits some experience 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 ‘direct care team’, whereas community-based research nurses cannot necessarily access patient notes in primary care. The compelling 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 a 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 and end of life care studies via health care professionals. Thus it will contribute to the debate on best practice in patient recruitment to palliative and end of life care research.

PS10
Examining trends in place of death: methods, results and meaning

Abstract number: PS10.1
Abstract type: Parallel Session

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

Gates G
King’s College London, Cicely Saunders Institute, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom

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 research on 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 countries (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.
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 63.4% to 63.0%), though not in people living alone (increase from 62.0% to 65.5%). In Belgium (1.1%), the Netherlands (1.2%), 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.

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

Froggatt K.
Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom

Patient and public involvement (PPI) in research is promoted in UK policy and by research bodies. The benefits of PPI in research are noted in respect to the focus 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 are 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

Timm H.
University of Southern Denmark, Knowledge Centre of Rehabilitation and Palliative Care, Copenhagen, Denmark

Presenting author email address: timm@uds.dk

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 that 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-people’-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:

1) 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-people 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 palliative care on their member’s websites.

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

Hegedus K.
Semmelweis University, Institute of Behavioral Sciences, Budapest, Hungary

Background: In 2011, after 20 year 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 Psychology Information, Ovid, MEDLINE, Help the Hospices databases for articles published between 1980 and 2014.

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, and 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. In Europe 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.

PS12 Paediatric palliative care: moving forward

Abstract number: PS12.1
Abstract type: Parallel Session

Barriers and Facilitators to Responsive Respite in Children’s Palliative Care

Ling J.
EAPC, Dublin, Ireland

Presenting author email address: julie.ling@eapcnet.eu

Aims: Respite is an integral part of children’s palliative care and aims to provide a break from the routine of caring for parents. There is a dearth of evidence regarding the frequency, location and type of respite provided although evidence suggests this respite provision varies according to the child’s age, diagnosis, geographical location and the family’s capacity to meet the child’s care needs. This research aims to identify the barriers and facilitators in the provision of respite to children with life-limiting conditions and their families.

Methods: Utilising multiple longitudinal qualitative case study design the respite needs and experiences of parents caring for a child with a life-limiting condition were explored. Multiple in-depth interviews were undertaken with parents who were identified by a palliative care team working in a children’s hospital. All data gathered were analysed using thematic analysis. Cross-case comparison was undertaken to seek differences and similarities in and between cases.

Results: In-depth interviews were conducted with parents caring for a child with a life-limiting condition in Ireland. Nine families (n=33 participants) were recruited and followed for two years. Cross-case comparison revealed that in all cases home was the location of choice for care. Evidence suggests that facilitators to parental use of respite were honest and open communication whilst maintaining hope; maintenance of child’s routine; respect for their child, family and their home; and acknowledgement of parental expertise in caring for their child. Parental choice of care was also important. Parent’s previous clinical experiences in hospital were a major barrier to acceptance of respite.

Conclusion: Healthcare professionals need to consider and explore many factors when identifying the barriers and facilitators in the provision of respite care to children with life-limiting conditions.

Abstract number: PS12.2
Abstract type: Parallel Session

The EAPC Core Competencies for Education in Paediatric Palliative Care

Downing J.1,2, Ling J.1, Benini F.3, Payne S.4, Papadatos D.5
1International Children’s Palliative Care Network, Bristol, United Kingdom, 2Development of Palliative Care Services in the Republic of Serbia, Belgrade, Serbia, 3Matererene University, Kampala, Uganda, 4Laura Lynn Children’s Hospice, Dublin, Ireland, 5University of Padova, Paediatric Pain and Palliative Care Service, Department of Paediatrics, Padova, Italy.

Abstract number: 792 at britinternet.com

Background: Education is an essential component in the development of paediatric palliative care (PPC), thus all healthcare and social care 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 IMPaCCT 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: the acquisition of knowledge, the development of specific skills, the capacity of interdisciplinary thinking, the cultivation of attitudes that promote good quality of life, 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...
those who come from a paediatric background who need to learn about PC. Minimum competencies are identified under twelve domains. For healthcare professionals requiring specialist PPC education, the competency framework is broader & encompasses areas such as collaborative practice, leadership, service development, research, education & professional practice.

Conclusion: Whilst a growing number of courses & curricula are available on PPC, provision of courses does not meet the need; therefore it is important to extend education opportunities for everyone involved in PPC. It is hoped that this white paper will help people to do this.

Abstract number: PS12.3  
Abstract type: Parallel Session

Assessing the Population Need for Children’s Palliative Care

Connor S.R.  
University of Nottingham, School of Health Sciences, Nottingham, United Kingdom

Aim: 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 understates 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

Chambreaux K.  
Wij Veer Universiteit Brussel (VUB) & Ghent University, End-of-Life Care Research Group, Brussels, Belgium

End-of-life sedation as an option of last resort in terminally 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 of the treatment, 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 practiced 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: PS13.2  
Abstract type: Parallel Session

Clinical Decision-making in Palliative Sedation Practice in the UK, Belgium and the Netherlands

Seemore JS.  
University of Nottingham, School of Health Sciences, Nottingham, United Kingdom

Aim: 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 understates 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.

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Abstract number: PS13.3  
Abstract type: Parallel Session

Palliative Sedation Guidelines in Europe: Similarities and Differences in Development and Quality of Existing Guidelines

Regens J., Erasmus MC, Public Health, Rotterdam, Netherlands

Sedation in palliative care has received growing attention in recent years; and so have guidelines, position statements, and related literature that provide recommendations for its practice. Yet little is known collectively about the content, scope and methodological quality of these materials. According to research, there are large variations in palliative sedation practice, depending on the definition and methodology used. However, a standardised approach to comparing and contrasting related documents, across countries, is lacking. This presentation reports on the findings of a study designed to enable thorough and systematic comparison of guidelines on palliative sedation.

Abstract number: PS14.1  
Abstract type: Parallel Session

How to develop palliative care in the community throughout Europe

Murray S.A., Gomez-Batiste X., Mitchell G., Lynch M.
1 University of Edinburgh, Primary Palliative Care Research Group, Centre for Population Health Sciences, Edinburgh, United Kingdom, 2 Catalan Institute of Oncology, WHO Collaborating Centre for Public Health Palliative Care, Barcelona, Spain, 3 University of Queensland, Queensland, Australia, 4 The Irish Hospice Foundation, Dublin, Ireland

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 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 toolkit is useful and supplements previous work to help community based palliative care services to be established to ensure adequate population coverage.

Abstract number: PS14.2  
Abstract type: Parallel Session

Interprofessional Teamwork within Maisons de Santé Palliatives (MSP) in France. An Opportunity to Develop the Palliative Approach in Primary Care?

Moine S.  
1 Université Paris 13, Department of Education and Practices in Health, EA 3412, Bobigny, France

Abstract number: PS13.4  
Abstract type: Parallel Session

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Abstract number: PS14.2  
Abstract type: Parallel Session

Interprofessional Teamwork within Maisons de Santé Palliatives (MSP) in France. An Opportunity to Develop the Palliative Approach in Primary Care?

Moine S.  
1 Université Paris 13, Department of Education and Practices in Health, EA 3412, Bobigny, France

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 Health Care Centres (MSPHs) could represent an opportunity to develop the palliative approach in primary care.

Aim: 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 (SCOPiP) will evaluate the impact of a complex intervention in MPHs 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 MP, 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: PS14.3
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

Downing L.1,2, Haralabidou E.1,3, Milicov N.1,4, Lukic N.1, Baskott J.1,5, Naylor M.1, Rayment C.1,6

1Developed of Palliative Care Services in the Republic of Serbia, Belgrade, Serbia, 2Makereer University, Kampala, Uganda, 3Strathcarron Hospice, Denny, United Kingdom, 4BEL hospice, Belgrade, Serbia, 5Oxford Policy Management, Oxford, United Kingdom

Presenting author email address: julia.dowing97@btinternet.com

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. In 2012, the government launched a PC delivery model in 13 pilot sites 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 be provided through interdisciplinary 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: PS15.3
Abstract type: Parallel Session

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

Sinclair S.1,2, Hock T.F.1,3, Chochinov H.M.1,4,5,6, Mc Clement S.7, Raffin Bouchal S.5,7, Hagen N.A.8,9, Stajduhar K.10

1University of Calgary, Faculty of Nursing, Calgary, AB, Canada, 2University of Manitoba, Faculty of Health Sciences, College of Nursing, Winnipeg, MB, Canada, 3University of Manitoba, Psychiatry, Winnipeg, MB, Canada, 4University of Calgary, Department of Oncology, Faculty of Medicine, Calgary, AB, Canada, 5University of Victoria, Victoria, BC, Canada, 6University of Calgary, Medical School, Calgary, AB, Canada, 7University of Calgary, Medicine, Calgary, AB, Canada, 8University of Victoria, Victoria, BC, Canada, 9The University of Calgary, Medicine, Calgary, AB, Canada, 10L spectator K.1,2,3,4,5,6,7,8,9,10

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 marker and 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: PS16.1
Abstract type: Parallel Session

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

Goldin M.1,2, Nielsen M.K.1,3, Vedsted P.1

1Aarhus University, Palliative Care Team, Aarhus C, Denmark, 2Aarhus University, Research Unit for General Practice, Aarhus C, Denmark, 3Aarhus University, Research Unit for General Practice, Aarhus, Denmark

Background: Complicated grief (CG) is proposed as a bereavement-related diagnosis for the ICD-11 and treatments have shown promising effectiveness. 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 bereavement care based on evidence and equitable resource allocation seems to be supported. Yet, surveys of bereavement services show that bereavement programs struggle with bereavement care based on evidence and equitable resource allocation seems to be supported. Yet, surveys of bereavement services show that bereavement programs struggle with bereavement care based on evidence and equitable resource allocation seems to be supported. Yet, surveys of bereavement services show that bereavement programs struggle with bereavement care based on evidence and equitable resource allocation seems to be supported. Yet, surveys of bereavement services show that bereavement programs struggle with bereavement care based on evidence and equitable resource allocation seems to be supported. Yet, surveys of bereavement services show that bereavement programs struggle with bereavement care based on evidence and equitable resource allocation seems to be supported. Yet, surveys of bereavement services show that bereavement programs struggle with bereavement care based on evidence and equitable resource allocation seems to be supported. Yet, surveys of bereavement services show that bereavement programs struggle with bereavement care based on evidence and equitable resource allocation seems to be supported. Yet, surveys of bereavement services show that bereavement programs struggle with bereavement care based on evidence and equitable resource allocation seems to be supported. Yet, surveys of bereavement services show that bereavement programs struggle with bereavement care based on evidence and equitable resource allocation seems to be supported.
Series of abstracts about palliative care and its applications.
Challenges in Comparing Quality of Palliative Care in Long Term Care Facilities (LTCFs) in Different European Countries


Abstract number: PS18.1

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) 1

PS18

1Vrije Universiteit Brussel (VUB) & Ghent University, End-of-Life Care Research Group, Brussels, Belgium, Lancaster University, Lancaster, United Kingdom, Universita Cattolica del Sacro Cuore, Rome, Italy, Universitetet Ja Hyvinvoinnin Laitos, Helsinki, Finland, Universita Cattolica Del Sacro Cuore, Rome, Italy, Stichting VU-VUMC, Amsterdam, Netherlands, Stichting Katholieke Universiteit, Nijmegen, Netherlands, Universiteit Gent, Belgium.

Presenting author email address: lvdblock@vub.ac.be

In the presentation, an overview is provided concerning the results of the EAPC project PACE (FP7). The aim of the PACE project has been to establish, through an EU funded project, a learning and training environment for LTCF staff to improve the quality of palliative care in LTCFs. The steps of the intervention included: (1) needs assessment, (2) development of a framework, (3) preparation of educational materials, (4) implementation into LTCFs, (5) evaluation of impact. During the intervention, an overview is provided concerning the results of the EAPC PACE project in terms of infrastructure, human resources, organisation and legal regulations. Thus ensuring not only adequate knowledge, but also awareness towards palliative care, and costs of care in the last month of life. Via this comparison, we will identify good palliative care practices for LTCFs in terms of optimal care structures, processes and outcomes. We conducted a cross-sectional study of deaths of residents using proportional stratified sampling. In each participating facilities retroactively report all deaths of residents in and outside the facilities over a past three month period. For each case, structured after death questionnaires including validated instruments are sent to: (1) the administrator/dean; (2) staff member most involved in care; (3) treating GP; (4) relative. Additionally, all staff members of the facility are asked to fill in a knowledge/attitudes questionnaire. Primary outcomes are staff knowledge/attitudes concerning palliative care, and quality of dying of residents. Secondary outcomes concern quality of palliative/end-of-life care and health care resource use in the last month of life. During this session we will report on (1) full study design and methods used; (2) challenges encountered in setting up the study, e.g. the complexity of identifying the correct sampling strategy to obtain a representative sample of facilities in each country, differences in ethical procedures per country, problems with translations of questionnaires (cross-cultural and language); (3) conceptual model used to analyse the differences between countries in outcomes; (4) preliminary findings of the study. In each country, we estimate to identify 200 deceased residents. Data collection takes place between March and July 2015 in each country.

Abstract number: PS18.2

Abstract type: Parallel Session

Palliative Care Accessibility in Long Term Care Facilities (LTCFs) in Six EU Countries (BE, UK, IT, FI, PL, NL)


Jagiellonian University Medical College, Epidemiology and Preventive Medicine Chair, Krakow, Poland, Lancaster University, Lancaster, United Kingdom, Universitetet Ja Hyvinvoinnin Laitos, Helsinki, Finland, Vrije Universiteit Brussel (VUB) & Ghent University, End-of-Life Care Research Group, Brussels, Belgium, Universita Cattolica Del Sacro Cuore, Rome, Italy, Universiteit Gent, Belgium, Stichting Katholieke Universiteit, Nijmegen, Netherlands.

An EAPC Taskforce ‘Mapping palliative care systems in long term care facilities in Europe’ was established within the EAPC project to map and classify different structures, organisational models, and levels of LTCF in Europe. A survey of country informants about the structures of LTCFs and PC provision was undertaken, supported by documentary analysis in 29 European countries in total. During this presentation, an overview is provided concerning the results of the EAPC Taskforce, with a specific focus on the differences between the six PAC Europe countries. Countries have been categorised with respect to the development of PC in the EAPC Atlas of Palliative Care. Parallel Care Residents. Development of systems and levels of PC education across countries do not assure that LTCF staff are all prepared to provide appropriate care for residents being close to death. The main conclusion is that accessibility of PC in LTCFs differs between six PAC countries in terms of infrastructure, human resources, organisation and legal regulations. Thus ensuring an appropriate care for residents dying in nursing homes remains an important challenge.

Abstract number: PS19.1

Abstract type: Parallel Session

Moving forward spiritual care in Europe: the EAPC Spiritual Care Taskforce

Pail P

Ludwig-Maximilian University, Palliative Medicine, Munich, Germany.

Presenting author email address: pail.paal@med.uni-muenchen.de

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. McCrory W and Jamieson S, ‘The qualitative findings from an online survey investigating nurses’ perceptions of spirituality and care’, J Clin Nurs, 2013. 22(21-22): p. 3170-82


Abstract number: PS19.2

Abstract type: Parallel Session

Generating an International Evidence Base for Spiritual Care

Speck PW, Selman L.

Cecily Saunders Institute, King’s College London, Palliative Care, London, United Kingdom.

Presenting author email address: peter.1.speck@kcl.ac.uk

Background: In recent years there has been a growing interest in spiritual care research leading to more papers being published in peer reviewed journals. However, the recent Cochrane review (2012) of spiritual care intervention studies for adult cancer patients showed a paucity of studies which met the quality criteria. Current initiatives: I wish to highlight existing gaps in the evidence in relation to spiritual care in palliative care and review some recent initiatives for enhancing research in this area. The work of the EAPC Spiritual Care Taskforce 2010-13 is in death together with the work of Christina Puchalski in the USA and Europe to create a global network for spirituality and palliative care. Within the UK the End of Life Care programme has undertaken a review of the
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

García-Baquero Merino M.T.,1,2 Azuara L.1, Quiros E.1, Chocarro L.1, Gil Higuero E.1, Nava B.1, Ced C.1, Pinedo Cetas E.2, Young L.3,1 Coordination Regional de Cuidados Paliativos, Consejeria de Sanidad. Comunidad de Madrid, Madrid, Spain, 1Madrid Palliative Care Research Network, Coordinacion Regional de Cuidados Paliativos, Madrid, Spain, 2Implementation Group, Spirituality Task Force. EAPC, Madrid, Spain, 3Implementation Group, Spirituality Task Force. EAPC, London, United Kingdom, 4Coordinacion Regional de Cuidados Paliativos, Madrid Palliative Care Training & Professional Continuous Development Network, Consejeria de Sanidad. Comunidad de Madrid, Madrid, Spain.

Presenting author email address: mmteresa.garcia@salud.madrid.org

Background: Spirituality is a dimension inherent to the person. An individual’s health and well-being benefit when it is addressed. Spirituality receives great attention; attempts to define it have 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: PS20.3
Abstract type: Parallel Session

Building Bridges between Countries: Reporting Research to Have International Relevance

Cleary J.
University of Wisconsin Carbone Cancer Center, Madison, WI, United States

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.

Don’t assume that the reviewers understand 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 a 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, assists 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.

Abstract number: PS20.1
Abstract type: Parallel Session

The Editors’ Perspective

Walsh C.
Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom.

Presenting author email address: c.walsh@lancaster.ac.uk

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 can 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 could 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 Relevance

Cohen J.
Ghent University & Wijhe Universiteit Brussel (VUB), End-of-Life Care Research Group, Brussels, Belgium

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, attributes, knowledge, skills and competences. In order to set up research with international relevance, 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.
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**

Hudson PJ.1,2, Giordano G.1  
1St Vincent’s/The University of Melbourne, Centre for Palliative Care, Melbourne, Australia, 2Queen’s University, School of Nursing, Belfast, United Kingdom

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 support systems

**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**

Bak ES.1, Havelsenv T.1, Loehre ET.1, Sand K.1, Brunoch C.1, Kasas S.1  
1Norwegian University of Science and Technology, Department of Cancer Research and Molecular Medicine, Trondheim, Norway, 2Fondazione IRCCS Istituto Nazionale dei Tumori, Palliative Care, Pain Therapy and Rehabilitation Unit, Milano, Italy

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 computer. 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.

**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**

Currow D.G.1  
1Flinders University, Palliative and Supportive Services, Adelaide, Australia

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.

**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**

Oliver D.1,2, Borasio G.D.1  
1University of Kent, Centre for Professional Practice, Rochester, United Kingdom, 2Wisdom Hospice, Rochester, United Kingdom, 3Centre Hospitalier Universitaire Vaudois, Service de Soins Palliatifs, Lausanne, Switzerland

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. It 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 care 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

Hogston L.1, Costantini M.2
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 practising 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, veneration-based medicine, eloquence-based medicine, providence-based medicine, difference-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

Engel V.1, Radbruch L.2
1Radboud UMC, Anesthesiology, Pain, Palliative Medicine, Nijmegen, Netherlands, 2Universitätsklinikum Bonn, Zentrum für Palliativmedizin, Malteser Krankenhaus Seliger Gedacht Bonn, Germany

Presenting author email address: yvonne.engel@radboudumc.nl

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 in 40 settings in five European countries (NL, DE, 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.1, Volz R.2, Mosley D.3, Kradzwick P.4
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 context 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 S.1, Batschauer K.A.2
1Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom, 2Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom

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 specialization 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 Blastchau 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**

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

Connor S.R., Mosoiu D.1, Mosoiu D.1
1Worldwide Hospice Palliative Care Alliance, London, United Kingdom, 2Hospice Casa Sperantei, Brazov, Romania

Presenting author email address: sconnor@whpca.org

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 how to monitor progress and how to use the Global Atlas of Palliative Care at the End of Life to benchmark progress.

**ME10**

Improving spiritual care in clinical practice

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

Improving Spiritual Care in Clinical Practice

Rutjes W.C., Legaré C.1,2
1Northwestern University, Feinberg School of Medicine, Chicago, Illinois, 2Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark

In this session, we begins 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.

**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?

Bolognesi D., Centenaro C.1,2
1Accademia delle Scienze di Medicina Palliativa, Bertinoro, Italy, 2University of Navarra, Institute for Culture and Society, Pamplona, Spain

Presenting author email address: debora.bolognesi@fondazionees.it

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 regional (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 Symptom 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 strength 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.

**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., Groen V.1,2
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 review(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 trainings, 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?
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 M1, Solheim 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. For most patients with advanced stages of cancer pain is present and weight loss/cachexia. A recent RCT of steroids in pain published in JCO 2014, was negative.1 In cancer cachexia, there are so far limited treatment options. Systemic steroids seem to improve appetite, the weight often is not significantly affected. Unfortunately are side effects of long-term use of steroids severe. The mechanism of action of steroids versus mechanism of symptoms where steroids are commonly used will be discussed in this session.


ME14

Integrated palliative care

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

Towards Practice Based Evidence for Integrated Palliative Care

Hisselbarth J
Redoubt University Medical Center, Nijmegen, Netherlands
Presenting author email address: jeroen.hisselbarth@radoubumc.nl

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 (InSuP-C, 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 palliative care was developed. Currently, an international prospective multicenter patient study is performed to research and better understand the interferences 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 renewed 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.

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 M1, Kindiwase R2
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 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

Scott R
University of Dundee, Education, Social Work and Community Education, Dundee, United Kingdom
Presenting author email address: r.scott@abdn.ac.uk

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.
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

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Meet the Expert sessions

ME01
Family carers: evidence based practice

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

Family Carers: Evidence Based Practice

Hudson PL,1 Girod G,2
1St Vincent’s/The University of Melbourne, Centre for Palliative Care, Melbourne, Australia, 2Queen’s University, School of Nursing, Belfast, United Kingdom

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

Ray E,1 Halsenren T,2 Loehn E,2 Sand K,1 Brunn E,3 Kasas S,2
1Norwegian University of Science and Technology, Department of Cancer Research and Molecular Medicine, Trondheim, Norway, 2Fondazione IRCCS Instituto Nazionale dei Tumori, Palliative Care, Pain Therapy and Rehabilitation Unit, Milan, Italy

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 computer. 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

Riley JL
The Royal Marsden Hospital, Palliative Care / CMC, London, United Kingdom

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. 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

Currow D.G.
Flinders University, Palliative and Supportive Services, Adelaide, Australia

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

Sunderpal P,1 2 Palliative Care Hildegard, Basel, Switzerland, 2University Hospital Basel, Gynaecological Cancer Centre, Basel, Switzerland

Cardiovascular implantable electronic devices (CIEDs) 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 day or even hours of life. The deactivation if not performed electronically, can be done 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 the permissibility of withdrawing device support. Turning off a VAD is emotionally challenging, because it is a life-terminating intervention.

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

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

Developing the relationship between palliative care and neurology

Oliver D,1 Borasio G.D.2 1University of Kent, Centre for Professional Practice, Rochester, United Kingdom, 2Widmer Hospice, Rochester, United Kingdom

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. It should be 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 care supported before and after death. Professional carers should receive education, support and supervision to reduce the risks of emotional exhaustion.
6. There should be a 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**

Hogstetler L.1, Costantini M.2

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 practising clinical medicine. They proposed tradition, anecdote, and theoretical reasoning as the main criteria for medical decision making. Evidence-based practice was 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**

Engel Y.1, Radbruch L.2

1Radboud UMC, Anesthesiology, Pain, Palliative Medicine, Nijmegen, Netherlands
2Universitätsklinikum Bonn, Zentrum für Palliativmedizin, Malteser Krankenhaus Seliger Gottard, Bonn, Germany

Presenting author email address: yvonne.engel@radboudumc.nl

**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 projects 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 J.1, Volz B.2, Massey D.3, Krakowiak P.4

1King’s College London, Palliative Care, Policy and Rehabilitation, London, United Kingdom
2University Hospital Cologne, Department of Palliative Medicine, Cologne, Germany
3Hospice Casa Speraneti, 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 Speraneti 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 S.1, Bratschou K.2

1Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom
2Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom

Presenting author email address: sean.hughes@lancaster.ac.uk

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 profession, and 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 Bletschnau 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**

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

Connor S.R.1, Mosoiu D.2
1Worldwide Hospice Palliative Care Alliance, London, United Kingdom, 2Hospice Casa Speranța, Brașov, Romania

Presenting author email address: sconnor@thewhPCA.org

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 and to develop clinical guidelines as well as many technical assistance documents to help countries to strengthen 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.

**ME10**

Improving spiritual care in clinical practice

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

Improving Spiritual Care in Clinical Practice

Rusch C.1, Legat C.2
1Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark, 2University of Humanistic Studies, Utrecht, Netherlands

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.

**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?

Bolognesi D.1, Centeno C.2
1Accademia delle Scienze di Medicina Palliativa, Bentivoglio, Italy, 2University of Navarra, Instituto für Culture and Society, Pamplona, Spain

Presenting author email address: deborah.bolognesi@fondazioneiis.it

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 specialization in PM (published as a Supplement of the EAPC Atlas of Palliative Care in Europe and by the Journal of Pain and Symptom Management). In Europe, 18 countries had official specialization 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 specialization. There is a tendency to obtain certain posts in health services only with specialization. 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 specialization 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.

**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.1, Group S.
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 review(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?
The Use of Steroids in Cancer Patients with Advanced Metastatic Disease
Fallon M.1, Solheim T.S.1
1Western General Hospital, University of Edinburgh, Edinburgh, United Kingdom, 2Norwegian University of Science and Technology/NTNU, 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. The number of stages of cancer are pain and weight symptom and cachexia. Pain and weight loss in particular are highly prevalent. Recent RCT of steroids in pain published in JCO 2014 was negative. In cancer cachexia, there are so far limited treatment options. Systemic steroids seem to improve appetite, in the weight often is not significantly affected. Unfortunately are side effects of long-term use of steroids severe.

The mechanism of action of steroids versus mechanism of symptoms where steroids are commonly used will be discussed in this session.


Integrated palliative care
Hasselaar J.
Redbud University Medical Center, Nijmegen, Netherlands
Presenting author email address: jeroen.hasselaar@radboudumc.nl

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 be integrated in practice needs further investigation in order to be able to identify good examples and best practices.

Our Integrated Palliative Care project (InSuP-C, 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 palliative care was developed. Currently, an international prospective multicenter patient study is performed to test the applicability of 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 revisited 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.

The future of hospice and palliative care from a volunteering perspective
Scott R.
University of Dundee, Education, Social Work and Community Education, Dundee, United Kingdom
Presenting author email address: ros.scott@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.
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.
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
**Family Carers’ Support Needs in End-of-Life Care: Translation into Practice**

*Presenting author email address: anna.milberg@liu.se*

**Abstract type:** Oral

**Abstract number:** FC01.1

**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 what family caregivers need for support 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 semi-in-depth interviews with family caregivers during ongoing palliative home care and after the death of the caregiving patient. The caregivers were recruited by specialist palliative care services. A total of 24 interviews and field notes provided data for the analysis of 10 trajectories, applying a case reconstruction methodology.

**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 part of this, restructuring everyday life introducing revised routines is an important strategy. This includes 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 autonomy 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.

*Presenting author email address: s.aoun@curtin.edu.au*

**Abstract number:** FC01.2

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

*Presenting author email address: s.aoun@curtin.edu.au*

**Abstract type:** Oral

**Background:** The Caregiver 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 carers (FCs) of end of life care (EOLC) patients.

**Objectives:** To describe the experience of FCs and nurses of terminal ill 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 tailoring 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 reconstructing methodology. They appreciated the value of the intervention in reconstructing methodology. They appreciated the value of the intervention in reconstructing methodology. They appreciated the value of the intervention in reconstructing methodology. They appreciated the value of the intervention in reconstructing methodology. They appreciated the value of the intervention in reconstructing methodology. They appreciated the value of the intervention in reconstructing methodology. They appreciated the value of the intervention in reconstructing methodology. They appreciated the value of the intervention in reconstructing methodology. They appreciated the value of the intervention in reconstructing methodology. They appreciated the value of the intervention in reconstructing methodology. 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Forging Relationships with Families at Sunset and Dawn

Quiros Navas E.1, Garcia-Baquero Merino M.T.2, Escobar M.V.1, Santos Puebla D.1, Pinedo F.3, Molina Cara C.1, Gil Higues E.1, Monilla E.1, Jiménez Domecq P.1, Regional Palliative Care Network Consejo de Sanidad, Comunidad de Madrid 1, PA24, Coordinación Regional de Cuidados Palativos, Servicio Madrileño de Salud, Consejería de Sanidad, Comunidad de Madrid, Spain, 3, Servicio Madrileño de Salud, Coordinadora Regional de Cuidados Palativos, Madrid, Spain

Abstract number: FC02.1

Background: Family and carers are an integral part of palliative care (PC). More information is needed to address their needs as little is known about what makes them seek support from specialists. Our 24 hour PC platform gives support both to families and professionals involved in the care and treatment of patients with PC needs. It is placed and logically supported within the regional pre-hospital emergency care coordinating centre. Aims: This study analyses all the calls received, explores the reason behind and the answer given to the team, focusing on family activity.

Methods: A retrospective study call data collected between December 2010 and September 2014.

Results: 64919 calls were recorded, from which 55% where made by relatives of patients with PC needs. 39% called overnight (from 9pm to 9am). 58.8%, were related to symptom control issues, 7.5% related to family support in the patients last days of life, or feeling lost or doubting how to act in some cases. Death certification 5.7% with three peaks at 6–7 am, 5 and 9–10 pm. With appropriate input with listening and counselling, most of the calls (51.6%) were resolved.

Discussion: Over time, calls made by relatives have increased as the public becomes aware of our existence. Many of these calls were made overnight, when primary care teams and traditional palliative care teams don’t work. Most calls relate to emerging difficult situations. Although specialist visiting is possible, the need for it is rare.

Conclusions: Palliative care input is needed 24 hours a day. This type of service is a good resource for families caring for a loved one at home, empowering them and avoiding unnecessary dismissals. This service input in relation to home death merits further work.

Pain and symptom management

The Unmet Supportive Care Needs of People with Cancer Pain

Buchanan A.L.1, van der Feltz-Cornwall S.2, Arber A.1, Lemasinska A.3, Davies A.N.1

Royal Surrey County Hospital NHS Foundation Trust, Supportive and Palliative Care Department, Guildford, United Kingdom, 1University of Surrey, School of Health and Social Care, Guildford, United Kingdom

Abstract number: FC02.2

Background: People suffering from cancer pain frequently report the detrimental effect it has on their quality of life and impaired physical function. From the literature it is unclear whether people with specific types of cancer pain experience unmet supportive care needs.

Aims: The aim of this study is to identify the unmet supportive care needs of patients who have pain and explore the factors that contribute to higher levels of unmet needs.

Methods: A prospective longitudinal study was used to assess the prevalence of unmet needs of patients suffering from cancer pain in a regional cancer centre. Stratified random sampling methods were used to evenly group 162 participants into those with controlled, uncontrolled or breakthrough pain. The participants completed a series of questionnaires, including the Supportive Care Needs Survey-Short Form 34, at two time points, a month apart. 110 (80%) of the participants reported at least 1 unmet need. The needs in the psychological and the physical daily living domains were the most prevalent. The highest reported needs for help were with concerns about loved ones (50%), lack of energy (49%) and not being able to do the things they used to do (46%), for which the majority of people had a moderate to high need of help. Participants with uncontrolled pain (p=0.000) and breakthrough pain (p=0.022) were more likely to have unmet needs than participants with controlled pain. The prevalence and severity of unmet supportive care needs reduced over time. This was not dependent on an improvement in pain.

Conclusions: People with cancer pain require further help from healthcare professionals. Assessment and management of symptoms and specific areas of psychological care may contribute to improvements in pain and subsequently impact on an individual’s quality of life. The Florence Nightingale Foundation sponsored the lead researcher.

Revised European Association of Palliative Care Cancer Pain Guidelines: Management of Central Side-effects of Opioids

Stone P.1, Candy B.2

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

Abstract number: FC02.3

Background: The EAPC cancer pain guidelines were last published in 2012 and are currently being updated. The previous guidelines made a weak recommendation that methylphenidate could be used to improve opioid-induced sedation but the threshold between desirable and undesirable effects is narrow. The data also permitted a weak recommendation that in patients with opioid-related neurotoxic effects (delirium, hallucinosis, myoclonus and hyperalgesia), dose reduction or opioid switching should be considered. Aims: The aim of this study was to update the previous systematic review on evaluations of management of central side-effects of opioids by conducting a search for papers published between August 2009 and May 2014. Methods: Medline, EMBASE and the Cochrane library were searched using a combination of terms for opioids, cancer, myoclonus, insomnia, hallucinations, fatigue, delirium, hyperalgesia, sedation and confusion. Results: The initial search strategy identified 35 papers. A review of the references from one of these papers identified one further paper that was potentially relevant. Therefore, 36 papers were considered in further detail. From these, 24 articles were rejected as falling outside of the selection criteria after screening citations. Thus 12 articles were retrieved for further scrutiny, of which two fulfilled the inclusion criteria. One paper reported the use of lidocaine and ketamine intravenous infusions to treat opioid induced hyperalgesia in 8 cancer patients. The other paper was a prospective study to compare the reversibility of delirium in hospitalised cancer patients using standardised treatment with anti-psychotics and management of the underlying condition. Neither paper contained evidence to support a change in the recommendations of the 2012 EAPC guidelines. Conclusion: The updated systematic review did not identify data to support a change in the existing recommendations about the management of opioid induced CNS side-effects.

Interventions for the Management of Malignant Pleural Effusions: A Cochrane Systematic Review with Meta-analysis

Nestor P.N.1, Moskal N.2, Bhhtagar R.1, Jones H.E.3, Clive A.2, Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom, 2University of Bristol, Academic Respiratory Unit, Bristol, United Kingdom, 3University of Bristol, School of Social and Community Medicine, Bristol, United Kingdom

Presenting author email address: n.pnestor@lancaster.ac.uk

Background: Malignant pleural effusion (MPE) is a common, disabling condition in patients with advanced cancer. MPE results in breathlessness and can progress over 3–12 months. The optimal treatment strategy is subject to debate and the Cochrane Collaboration requested an updated review.

Aims: To synthesise the existing evidence evaluating the effectiveness of interventions for the management of MPE.

Methods: A systematic review was conducted with the Cochrane Pain and Palliative Care (PaPAS) Review Group, identifying randomised controlled trials (RCTs) evaluating interventions for adults with symptomatic MPE from three databases in May 2014. There were no restrictions on year of publication. The primary outcomes were efficacy of pleurodesis and secondary outcomes included adverse events, breathlessness, quality of life, mortality, costs and duration of hospital stay. Two investigators assessed study eligibility. Data extraction was performed by two independent assessors, who also assessed risk of bias. Discrepancies were resolved by consensus.

Results: 1757 records were identified, 57 of which met the eligibility criteria. Interventions included talc slurry, talc poudrage, bleomycin, tetracycline, C parvum and doxycycline. Data from 22 studies met the inclusion criteria. Only three studies were double blind and all were high risk of bias for at least one risk of bias domain. Conclusion: Direct comparison, using random effects meta-analysis, showed talc poudrage to be superior at pleurodesis than other methods (OR=27.95 [95%CI 11.0 to 73.7], p<0.0001) based on 9 studies. All analyses highlighted substantial heterogeneity. Only three studies weighed on blinded and all were high risk of bias for at least one risk of bias domain.

Conclusions: Direct comparison of talc poudrage with the other agents suggests it may be the best pleurodesis agent. Meta-regression to explore the high degree of heterogeneity will be completed by January 2015 to clarify findings.
How Do Patients Experience Opioid Toxicity?

Isherwood R.J.1, Haraldsdottir E.2, Calton L.3, Fallon M.1
1Strathcarron Hospice, Denny, United Kingdom, 2University of Edinburgh, Department of Anaesthesia and Pain Medicine, Edinburgh, United Kingdom, 3University of Edinburgh, Edinburgh Cancer Centre, Edinburgh, United Kingdom
Presenting author email address: ruth.isherwood@nhs.net

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 myoclonus. Those who were cognitively impaired during the episode described memory loss and mental slowing. They described anxiousness and feeling cold or feeling chilly. Others described pins and needles. Patients were also clear that the original cancer pain was not resolving.

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: FC02.5
Abstract type: Oral

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

McCaffrey N.1, Flint T.2, Kaakmas B.3, Fazezak B.3, Currow D.1, Hardy J.1, Agar M.2, Eckmann S.3
1Flinders University, PaCCIS, Palliative & Supportive Services, Adelaide, Australia, 2Flinders University, Flinders Health Economics Group, Adelaide, Australia, 3York University, York, United Kingdom

Background: Ketamine is widely used to treat cancer-related pain and until recently evidence to support its use in this setting was weak. An economic analysis has never been undertaken in this context.

Aims: 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 5) 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 with 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-Pal (total score 184) were small and in favour of placebo (ketamine 1.9 [5.1, 1.4], placebo 4.7 [2.0, 7.3]). Estimated total mean costs were approximately $880 higher per ketamine participant ($865,95) compared to placebo ($59,193). When incremental costs and effects (QOL) were jointly considered, ketamine was dominated (lower cost, worse effect). There was almost no chance of ketamine being cost-effective versus placebo when the decision-maker threshold value was $100,000 for one unit gain in QOL.

Conclusion: The findings suggest subcutaneous ketamine in conjunction with opioids and standard adjuvant therapy is neither an effective nor cost-effective treatment for refractory pain in advanced cancer patients.

Abstract number: FC02.6
Abstract type: Oral

Validation of Three Different French Forms of ESAS

Routy S.1, Herrmann F.1, Beaugé M.1, Bernard M.2, Cantin B.3, Palong J.1, Thillet C.1, Bolland C.1, Duclos D.2, Delahaye S.2, Vayine-Bossert P.3, Eicher M.1
1Community Palliative Care Unit, Division of Primary Care, Carouge, Switzerland, 2Division of Geriatrics, Geriatric, Internal Medicine and Rehabilitation, Geneva, Switzerland, 3Palliative Care, Lausanne, Switzerland

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 [VI], 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 text was created. In a prospective multicentric study, palliative care patients completed the three forms of F-ESAS (F-ESAS-VE, F-ESAS-VI and 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 [LDS]: 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, F-ESAS-VI and F-ESAS-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=0.53–0.57 for anxiety; p<0.05). Correlation between respective F-ESAS appetite and amount of food eaten was positive (n=332–423; 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-VI.

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

Abstract number: FC03.2
Abstract type: Oral

Free Communication Sessions

Free Communication Sessions Overview
Free Communication sessions

Abstract number: FC03.3
Abstract type: Oral
It’s a Family Affair: A Genogram Family Tree to Nurture Psychosocial Assessment
Charnock J, Groves K.E.
Southport & Ormskirk NHS Trust, West Lancs, Southport & Formby Palliative Care Services, Southport, United Kingdom
Presenting author email address: louise.charnock@nhs.net

Background: A genogram, a three generation family tree, is widely promoted for gathering, recording and displaying family information. Specialist palliative care multi-disciplinary notes meet local, regional and national standards and NHD recommendations of understanding family concerns alongside those of patients.

Aims: To increase use of genograms within specialist palliative care nurse (PCNS) clinical assessment, to develop and evaluate evidence-based, nursing care that meets standards.

Method: Suggestions on current use of the tool and support required, were sought from 12 PCNs using questionnaires. A baseline clinical audit of 50 of PCNs records & genograms was undertaken against four local standards. Caps in current practice were identified and intervention applied to advance quality and reduce the therapy-gap practice.

Re-audit examined the impact of the interventions.

Results: 36% completed pre-intervention genograms were documented in clinical records compared to 56% four months post-intervention. All displayed three generations. Results verified that, without a genogram assessment, no patients had three generations of family recorded in any other template within the electronic documentation system. Overall questionnaire results showed improvement in PCNs skills, knowledge and confidence in all areas. Conclusions: Results demonstrate positive impact of the well received and evaluated project on PCNs clinical practice. Despite a small scale project to support advancing clinical practice, the implication was much wider than anticipated. Genograms have been embedded into the individualised care plan for those thought likely to be dying, and are used by staff of all disciplines across all settings. Further action is in place to roll the project out wide to support these newly developed plans for care. As palliative care is a highly emotive area of practice, with only one chance to get it right, interventions for psycho-social support need to be effective and appropriate.

Abstract number: FC03.4
Abstract type: Oral
Two New Versions of the McGill Quality of Life Questionnaire (MQOL)
Cohen S.R., Sawatzky R., Leis A., Gademann A., Russell L., Shohfi J., Hayland D., Tending University College, Medicine, Montreal, QC, Canada, Lady Davis Institute, Jewish General Hospital, Montreal, QC, Canada, Trinity Western University, Nursing, Langley, BC, Canada, Providence Health Care, Centre for Health Evaluation and Outcome Sciences, Vancouver, BC, Canada, University of Saskatchewan, Dept of Community Health & Epidemiology, Saskatoon, SK, Canada, University of British Columbia, Population and Public Health, Vancouver, BC, Canada, University of Victoria, Nursing, Victoria, BC, Canada, 1st Lilly and Company, Bridgewater, NJ, United States, 2Queen’s University, Medicine, Epidemiology, Kingston, ON, Canada
Presenting author email address: robin.cohen@mcgill.ca

Background: The McGill Quality of Life Questionnaire (MQOL) has been widely used to measure the quality of life (QOL) of people with life-threatening illnesses. Experience with it suggests that minor changes are warranted. Furthermore, although MQOL measures physical, psychological, existential, and support domains, qualitative studies suggest that other domains are also important to consider.

Aims: 1. To create a MQOL-Revised (MQOL-R) that measures the same domains as the original MQOL with improved item properties.

2. To develop a comprehensive version of MQOL (MQOL-C) based on MQOL-R plus other QOL domains.

Methods: 1. Items from 5 samples of people with life-threatening illnesses in Canadian healthcare settings were used (n=1178) and compared to data from 3 studies used for the original MQOL validation (n=497). New or revised items that were not included in all samples were imputed using multiple imputation. Confirmatory factor analysis (CFA) and regression analyses of the Global QOL item were conducted to comparatively evaluate modifications of the original MQOL.

2. The domains of the MQOL-Revised (MQOL-R) with 4 correlated factors resulted in good model fit in the pooled sample of new data (RMSEA = 0.041; CFI = 0.958). MQOL-R consists of 14 items measuring physical, psychological, existential, and relational wellbeing with internal consistency reliability estimates of 0.66, 0.85, 0.77, and 0.87, respectively.

Aim 2: The domains of cognitively functioning and health care, and two items on the feeling of being a burden and the appraisal of physical surroundings were added to MQOL R. The CFA of the MQOL-C, with 3 correlated factors resulted in good model fit in the pooled sample of new data (RMSEA = 0.033; CFI = 0.963). It consists of 20 items with internal consistency reliability estimates ranging from 0.66 to 0.87.

Conclusions: MQOL-R can replace MQOL while MQOL-C can be used when a more comprehensive measurement is desired and patients are able to complete a 20-item tool.

Abstract number: FC03.5
Abstract type: Oral
Use of the Preparedness for Caregiving Scale in Palliative Care – A Rasch Evaluation Study
Årestedt K.,* Hudson P., Thomas K., Holm M., Carlander U., Olén J., Henriksson A.1,2
1Ersta Skidval University College and Ersta Hospital, Palliative Review Centre, Stockholm, Sweden, 2Linköping University, Department of Medical and Health Sciences, Linköping, Sweden, *Centre for Palliative Care c/o St Vincent’s Hospital and Collaborative Centre of The University of Melbourne, Australia, 1Ersta Skidval University College and Ersta Hospital, Stockholm, Sweden, 2Capio Genetrics, Palliative Care Unit, Dalsens Hospital, Stockholm, Sweden
Presenting author email address: kristoffer.arestedt@hsu.se

Background: Feelings of preparedness can influence the caregiving experience and protect against negative consequences for family carers. Valid and reliable methods are needed to identify those family carers who may be less prepared for the role of supporting a person who needs palliative care.

Aim: To evaluate measurement properties of the original English version and a Swedish version of the Preparedness for Caregiving Scale (PCS).

Methods: This is a psychometric evaluation study of the original and a Swedish version of the PCS. The sample for the present study (n=674) was taken from four different intervention studies from Australia and Sweden, all focused on improving family carers’ feelings of preparedness. For this study, family carers of patients receiving palliative home care were selected and baseline data was used. The measurement properties of the PCS were evaluated using the Rasch model.

Results: The PCS has sound measurement properties according to the Rasch model, both the English and Swedish version. No items demonstrate ceiling or floor effects and the number of missing data was low (< 1%). The items in the PCS captured different levels of preparedness except for persons with very high or low levels. The response categories were appropriate and corresponded to the level of preparedness. No significant differential item functioning for age and sex were detected. Three items demonstrated differential item functioning for language but without impact on interpretation of the score. The findings therefore support the use of the scale for invariant measurements between different groups of sex and age language versions. The reliability was high according to the person separation index (>0.90) and Cronbach’s alpha (>0.90).

Conclusions: The PCS is valid and useful for family carers in palliative care. The extensive evaluation supports the use of the scale across different groups of age and sex and as well as language versions.

Abstract number: FC03.6
Abstract type: Oral
Glasgow Prognostic Score Predicts Prognosis for Cancer Patients in Palliative Settings – A Subanalysis of the Japan-Prognostic Assessment Tools Validation (J-PreAval) Study
Miura T., Motomoto Y., Hama T., Amano K., Yamamoto N., Shohfi H., Shimizu M., Kadowama M., Azu K., Motoda T., National Cancer Center Hospital East, Department of Palliative Medicine, Kashiwara, Japan, *Osaka Medical Center for Cancer and Cardiovascular Disease, Department of Psychosomatic and Palliative Medicine, Osaka, Japan, †Division of Palliative Medicine, Osaka, Japan, ‡Shinsho Hospital, Department of Primary Care Service, Nagano, Japan, §Shishido Internal Medicine Clinic, Sakurai, Japan, ††Saiseikai Mutsuoka General Hospital, Mutsuoka, Japan, ‡‡Sokushin Okabe Clinic, Natori, Japan, §§Kakame Family Clinic, Hamamatsu, Japan, †¶Seirei Mikatahara General Hospital, Palliative and Supportive Care Division, Hamamatsu, Japan
Presenting author email address: tomura@east.ncc.go.jp

Background: Local and systemic inflammation are important components in the pathophysiology of cancer. The Glasgow prognostic score (GPS), which uses C-reactive 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 of 2 score (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=0.017), dyspnea (HR, 1.35; 95% CI, 1.13 –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 performance status of 4 (HR, 1.54; 95% CI, 1.22 –1.95; p<0.001). Median 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.

Abstract number: FC04.1
Abstract type: Oral
The Children Experience of Living with a Parent with Amyotrophic Lateral Sclerosis, MAY Emmamuelle, SUC Aguine, TIMST Patricia, CINATAS Pascal.
(Toulouse, France)

May E., Suc A., Timst P., Cintas P.
1CHU Toulouse - Pierre Paul Riquet, Toulouse, France, 2CHU Toulouse - Hépatol des Enfants, Toulouse, France

Background and aim: Amyotrophic lateral sclerosis (ALS) is a neurodegenerative disease of unknown origin which affects motor nerve cells. The only existing treatment aims to slow down the progressive rate of physical impairment. It’s currently incurable and the support given falls within the palliative care model. 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
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 45 to 4 years old, average age of 16.8 years, 22 were less than 10, 18, and 2 were more than 10.

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 antilogy, the transmission, the cure and of mortality. Behavioural changes were observed: children 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, depression 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 actions.

Abstract number: FC04.3
Abstract type: Oral

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

Savina Tolma A 1, Fullano Tuduri R.M. 1, Davia Puchader A.M. 1, Mr Perello C. 1, Jordà Martí S. 1, Bernat Noguera A. 1
1University Children's Hospital Munich, Coordination Center for Pediatric Palliative Care, Munich, Germany, 2Ludwig-Maximilians University Munich, Institute of Ethics, History and Theory of Medicine, Munich, Germany

Background: Advance care planning (ACP) was developed to maximise quality of life and ensure autonomy for patients with severe diseases. While ACP has been scientifically validated as impossible, little research on ACP on children exists. Adult concepts need to be adapted to the medical, psychosocial and legal particularities of the pediatric setting.

Aims: The aim of this study was to assess the view of professional care providers and parents with regard to ACP.

Methods: We conducted semi-structured interviews with professionals (n=17) in the care of severely ill children/adolescents as well as bereaved parents (n=10). Participants were selected by maximum variation sampling. Voted characteristics were: professional group/discipline, care setting, child's diagnosis and age, and parent gender. The interviews were analysed using qualitative content analysis.

Results: Both professionals and parents consider ACP as useful. Common important elements are: the presence of the team at the early stage of the disease, the child's autonomy, the child's death notice, the family's reaction, the information given, the family's autonomy, the continuation of medical care, the child's end-of-life care, and the medical care. Concerning terminally ill children, care teams believed that early training for parents was needed. Important aspects that professionals are: increased confidence and decreased personal responsibility through written advance directives. Yet, uncertainties about the validity of ACP documents cause major problems in practice. For different reasons, both medical and psychosocial professionals are worried about making wrong decisions based on a child's advance directive and refuse to take over responsibility. Important aspects for parents are: information, psychological relief and security through repeated discussions. Major barriers are: uncertain diagnoses, unclear responsibilities, professionals'/parents' reluctance to discuss end-of-life issues.

Conclusion: There is a clear need for ACP in pediatrics. However, professionals' and parents' views differ, and significant barriers exist. These results may inform the development of future pediatric ACP programs.

Abstract number: FC04.3
Abstract type: Oral

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

Jomes A.M.1, D'Arcy A. 1, O'Connell G. 1, Staunton A. 1
1Children's University Hospital, Dublin, Ireland, 2Our Lady's Hospice & Care Services, Dublin, Ireland, 3Beaumont Hospital, Dublin, Ireland, 4Irish Hospice Foundation, Dublin, Ireland, 5Irish Childhood Bereavement Network, Dublin, Ireland, 6Rainbows Ireland, Dublin, Ireland

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, education, cultural, and family professionals.

Results: Three key components of childhood bereavement were identified. They are the needs of a bereaved child or young person, the appropriate supports and services that are required and the competencies needed to deliver an appropriate response. Further, each component was described relative to a four level tiered model reflecting increased complexity. The framework is placed within the context of time, the child or young person’s developmental stage and family context. These aspects were mapped into a three dimensional Childhood Bereavement Care Pyramid: Those involved in the piloting of the pyramid found the model to be a concise and accessible visual guide in an area that families and practitioners find most complex.

Conclusions: For the first time, a set of complex information was brought together in a user friendly way. The pyramid developed a national pathway to guide families and practitioners to appropriate support and services for vulnerable children and young people who are bereaved. Further, the competencies identified allows for the development of appropriate training curricula needed at each level.

Abstract number: FC04.5
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 Transitions According to their Perspectives

Johnston B.M. 1, Pingel J. 1, Andal-Snape D. 2, Scott R. 1, Grant J. 1, Godd. 1, Carmeghy P. 1
1University of Nottingham, Sue Ryder Care Centre for the Study of Supportive, Palliative and End of Life Care, Nottingham, United Kingdom, 2University of Dundee, Dundee, United Kingdom, 3Children's Hospice Association Scotland, Kinross, United Kingdom

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

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 at 2 month intervals across a 6 month period between April and Oct 2014.

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

Results: Themes: Dependency: physical, psychological 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 it together: Centripetal forces brought families/carers together to cope with the situation; terminal legal 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 years there is little support for 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.

Contexting identity: young adults, families and professionals acted to preserve the identity 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 help inform local and national policy in children's hospices in Scotland.

Abstract number: FC04.6
Abstract type: Oral

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

Tuffy-Wijne L 1, McLaughlin D. 1, Oliver D. 1, Cullen L. 1, Haegeman C. 1, McKinnell L. 1, Read S. 1, Satge D. 1, Buurman A. 2, Smess B. 2, Westergaard B.E. 1, Ryan K. 1, EAPC Taskforce on Intellectual Disabilities
1St George's University of London and King's College London, Faculty of Health, Social Sciences and Education, London, United Kingdom, 2Queen’s University Belfast, School of Nursing and Midwifery, Belfast, United Kingdom, 3Wisdom Hospice, Rochester, United Kingdom, 4Maastricht University, Gouvernor Kremer Centre, Maastricht, Netherlands, 5Etat de Vaud, Département de la Sante et de l’Action Sociale, Lausanne, Switzerland, 6Prince and Princess of Wales Hospice, Glasgow, United Kingdom, 7Keele University, Keele, United Kingdom, 8University Institute for Clinical Research UIC, Oncodefi Project, Montpellier, France, 9Interdisciplinary Research Institute in Social Science, Dijon, France, 10Cants Association of the Diocese Munich and Freising, Munich, Germany, 11Vestfold Mental Health Care Trust, Tonsberg, Norway, 12St Francis Hospice and Mater Hospital, Dublin, Ireland

Presenting author email address: l.tuffy-wijne@kingscollege.ac.uk

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 international standards 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 on-line tool that provided an opportunity 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, involving those that matter, 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 four Delphi rounds, 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 differences in availability palliative care services.

Conclusions: The draft 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 enablers to achieving these consensus norms throughout Europe.

Abstract number: FC05.1

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

Bodhilsberg NH1, Selman L1, Speck P1, Hardinge R2, Higgason L1, Gyell M1

1University of Copenhagen, Department of Sociology, Copenhagen, Denmark, 2King’s College London, Cicely Saunders Institute, London, United Kingdom, 3University of Amsterdam, Department of Anthropology and Sociology, Amsterdam, Netherlands

Background: Understanding the nature of spiritual care (SC) in multi-cultural populations was found to be a major research priority in the EAPC SC Task Force. As spirituality is expressed in different ways within different religious and cultural contexts.

Aim: To explore the practice of SC in palliative care (PC) cross-culturally.

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,没错。Researchers interviewed 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 pastoral, 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, fear of witchcraft; in Denmark, alienation from prelating). Among SCPs, two main approaches were identified: pastoral care from a religious perspective and care from an existential focus. Both approaches were culture-specific in the way they used language and supported patient’s meaning-making.

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

Abstract number: FC05.2

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

Vivat B1, Young E1, Winstanley J1, Amara J1, Bednar A1, Costantini A1, Fisher SE1, Guo J1, Parameswaran ME2, Kobayashi K2, Krug半小时 A2, Navarro M3, Omilakin S3, Rohde G3,4, Serebrinsky T1,5, Schreuder Languages C1,2,7,8,9

1Brunel University, College of Health and Life Sciences, Uxbridge, United Kingdom, 2University of Copenhagen, Department of Sociology, Copenhagen, Denmark, 3King’s College London, Cicely Saunders Institute, London, United Kingdom, 4University of Amsterdam, Department of Anthropology and Sociology, Amsterdam, Netherlands

2Hospital de Navarra, Oncology Departments, Pamplona, Spain, 3Institut Curie, Psycho-Oncology Unit, Paris, France, 4SaintAndreas Hospital, Sapienza University, Psycho-Oncology Unit, Rome, Italy, 5University of Leeds, St Gemini’s Hospice & Academic Unit of Palliative Care, Leeds, United Kingdom, 6Shengjing Hospital of China Medical University, Palliative Ward, Shengjing, China, 7Instituto Oncologico Fundacion Arturo Lopez Perez, Calidad de Vida, 8Santamaria International Medical Centre, Deparatment of Respiratory Medicine, Santamaria, Japan, 9University of Amsterdam, Amsterdam Medical Oncology, Academic Medical Center, Amsterdam, Netherlands, 10Instituto Nacional de Cancerologia, Division of Investigative and Research Sciences, Mexico City, 11Institut Curie, Psycho-Oncology Unit, Paris, France, 12SaintAndreas Hospital, Sapienza University, Psycho-Oncology Unit, Rome, Italy, 13Institut Curie, Psycho-Oncology Unit, Paris, France

Background: Spirituality and social work – often mentioned in hospice and palliative care – have been conceptualised in different ways in different cultural contexts. A lack of understanding of SWB has hindered the development of an appropriate SWB measure for palliative care. 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, fear of witchcraft; in Denmark, alienation from prelating). Among SCPs, two main approaches were identified: pastoral care from a religious perspective and care from an existential focus. Both approaches were culture-specific in the way they used language and supported patient’s meaning-making.

Aim: To develop a measure of SWB validated in patients with cancer and their carers.

Methods: A qualitative investigation of understandings of SWB collected during the cross-cultural validation of an EORTC measure of SWB was conducted. Patients were interviewed in-depth at 6 sites in 4 countries (UK, Denmark, Cambodia, Mexico) in English and French. The narrative structured interviews were guided by a cultural and spiritual focus. The data was coded using inter alia, all themes that emerged across all participants’ responses, but most participants with active religious faith (and some without) defined SWB in relation to God; some just this, others together with other themes. Conclusions: Each study participant 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

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

Hesse M1, Jaspers B1,2, Loth C1, Pabst K1, On C1, Wissert M1, Gronemeyer R1, Radbruch L1,2

1University Hospital Bonn, Department of Palliative Medicine, Bonn, Germany, 2Universitätsmedizin Göttingen, Clinic for Palliative Medicine, Göttingen, Germany, 3Bonn University School of Nursing, Weingarten, Faculty Social Work, Healthcare Nursing, Weingarten, Germany, 4Jus tus–Liebig-University, Institute for Sociology, Giessen, Germany, 5Maestranza Hospital Seliger Gerhard Bonn/Rhein-Sieg, Palliative Care Centre, Bonn, Germany

Presenting author email address: michaela.hesse@ukb.uni-bonn.de

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 a) motivation, attitude of volunteers b) challenges in ageing societies c) society and volunteers d) bereavement and spirituality.

Eight international experts were invited to present and lead workshops. Results: Thirteen applicants (D, J, P, LA, UA, EAL) 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, but how much do standards impede the flexibility that is a core element of VW in hospice and palliative care? 3) Core competences – What are the core competences of volunteers in hospice and palliative care, across settings and healthcare systems? Experts and participants of the study week will work on these topics as part of the work of the EAPC Task Force on Volunteering.

Significant outcomes will be published.

Conclusions: 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

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

Arendt C1, Carduff E1, Lloyd A1, Rimbelt R1, Pinnock H1,2, Murray S1,2

1University of Edinburgh, Primary Palliative Care Research Group, Edinburgh, United Kingdom, 2University of Edinburgh, Allergy and Respiratory Research Group, Edinburgh, United Kingdom

Background: The “danse macabre” 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 3 qualitative longitudinal studies: 3 cancer; 3 organ failure; 1 frailty; 3 interviews with South Asian participants from all 3 trajectories. Patients were interviewed up to 4 times over 18 months. Researchers from each study reviewed the data using a narrative inductive method.

Conclusions: There was a high level of distress, but a variety of techniques for coping with 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 to old 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. Deaths were 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**

**Title:** Social Work in Palliative Care in Germany - Presence and Main Foci of Activity  
**Author:** WASNER M,  
**Affiliation:** University of Applied Sciences Munich, Munich, Germany,  
**Co-Author:** HANNEDIER P, PFEIFER M  
**Affiliation:** Ludwig-Maximilian-University, Regensburg, Catholic Theologic Faculty, Regensburg, Germany  
**Presenting author email address:** maria.wasner@ksfh.de

**Background:** Psychosocial care is an integral part of palliative care and social work is one key provider of psychosocial care. It is still unclear, however, how many social workers are present in this field and what are their main foci of activity in the different palliative care settings in Germany and what their main foci of activity are.

**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 services). Social workers were present in 86% of the PCUs, 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 needs and for other key elements. 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:** FC05.6  
**Abstract type:** Oral

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

**Title:** Social Work in Palliative Care in Germany - Presence and Main Foci of Activity  
**Author:** WASNER M, HANNEDIER P, PFEIFER M  
**Affiliation:** University of Applied Sciences Munich, Munich, Germany, Ludwig-Maximilian-University, Regensburg, Catholic Theologic Faculty, Regensburg, Germany  
**Presenting author email address:** maria.wasner@ksfh.de

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**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**

**Title:** Muslim End of Life Ethics: Patiently Respecting Allah’s Plan  
**Author:** BROECKAERT B, AHAADDOUR C, BARKE G, VAN DEN BRANDEN S  
**Affiliation:** KU Leuven, Faculty of Theology and Religious Studies, Leuven, Belgium  
**Presenting author email address:** berta.broeckaert@kuleuven.be

**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 this is still deeply influenced by secular Western and/or Christian approaches.

**Aims:** 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.

**Methods:** (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-faxes on international islamic websites)  
(3) Semi-structured interviews with elderly Moroccan men (20 interviews), elderly Turkish and Moroccan women (68) and specialists (20). All interviews were transcribed, coded and categorised using Grounded Theory methodology.

**Results:** 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 dissident 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**

**Title:** 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  
**Author:** GILES A, SYKES N  
**Affiliation:** St Christopher’s Hospice, London, United Kingdom

**Background:** Sedative drugs are used to treat agitation in dying patients. The most commonly used drug is midazolam. There is concern that the use of sedative drugs results in shortening of patient’s quality of life by reducing patient’s ability to maintain nutrition and hydration. However, in the last days of life, patients often have impaired conscious levels and an inability to maintain oral intake as part of the natural dying process.

**Aims:** 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 01/01/2012. Oral intake was classified:  
0 – no intake  
1 – mouthfuls/sips  
2 – small meals  
3 – good appetite

Daily doses of midazolam (≥ 5mg) were recorded.

**Analysis:** Descriptive statistics were used.

**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.**

**Number of Days**

<table>
<thead>
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<th>Intake</th>
<th>Days</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
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<td>3</td>
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**Mean oral intake for all patients**

<table>
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<td>0.83</td>
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**Mean oral intake for MG**

<table>
<thead>
<tr>
<th>Intake</th>
<th>Days</th>
</tr>
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<tbody>
<tr>
<td>0.92</td>
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</tr>
<tr>
<td>0.91</td>
<td>0</td>
</tr>
<tr>
<td>0.65</td>
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<td>0.34</td>
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</table>

**Mean oral intake for CG**

<table>
<thead>
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<th>Intake</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
</tr>
<tr>
<td>0.95</td>
<td>1</td>
</tr>
<tr>
<td>0.95</td>
<td>1</td>
</tr>
<tr>
<td>0.87</td>
<td>1</td>
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<tr>
<td>0.80</td>
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**Conclusion:** 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 had lower initial intake, 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.
Aim: In early 2014 Belgium controversially amended its euthanasia law, making it legal for minors to request euthanasia if they are judged to have ‘capacity for discernment’. This raises various ethical questions, the answers to which are relevant worldwide. The aim of this presentation is:

1. to briefly sketch how the law came about and
2. to analyse the most important arguments raised both against and in favour of this amendment.

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 which issues were raised during this process. From these reports the amendment is sketched and the most raised ethical arguments are identified and analysed using existing international research and literature.

Results: It is concluded that whether minors be allowed 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 unfair on minors who contain 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: Debate was fierce and many arguments 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: FC06.3
Abstract type: Oral

How and Why Did Belgium Come to Allow Euthanasia for Minors? A Descriptive and Ethical Analysis

Marckmann G.1, Klingler C.1, in der Schmitten J.2
1University of Victoria, Centre on Aging/School of Nursing, Victoria, BC, Canada, 2Trinity Western University, School of Nursing, Langley, BC, Canada

Aim: To outline 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 empiric peer-reviewed literature. Established knowledge synthesis procedures were implemented. Search terms pertaining to ‘palliative care principles’ 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: FC06.6
Abstract type: Oral

A Palliative Approach: A Concept in Need of Clarity

Saqjudha K.U.1, Secundo R.1, Porterfield P.1
1University of Victoria, Centre on Aging/School of Nursing, Victoria, BC, Canada, 2University of British Columbia, School of Nursing, Vancouver, BC, Canada

Background: Much of what we understand about the design of healthcare systems is that 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 care 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.

Aim: 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 empiric peer-reviewed literature. Established knowledge synthesis procedures were implemented. Search terms pertaining to ‘palliative care principles’ 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.

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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: FC06.7
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, Barge P.2, Lu K.3, White P.1, Living G.3, Booth S.3, Hawson S.2, Mahadeva R.4, Moore C.3, on behalf of the Living with Breathlessness Study Team
1University of Cambridge, Public Health and 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.

Aim: 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 moderate to severe COPD, recruited from 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 preferred course of care. We identified which of these extremes patients showed 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 45 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 hospital pressure in most health care 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 urban and 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 NHIR
Towards Integration of Palliative Care in Patients with Chronic Heart Failure and Chronic Obstructive Pulmonary Disease: A Systematic Literature Review

Souza N.1, Van Beek K.1, Preston N.2, Groot M.1, Dyble K.1, Kiss Z.1, Badovinac L.1, Centeno C.4, Payne S.5, Rüdlicher J.1, Menten J.1, FP4SuppC Consortium 1.2
1. UZ Leuven, Leuven, Belgium, 2. Lancaster University, Lancaster, United Kingdom, 3. Radboud University Nijmegen, Nijmegen, Netherlands, 4. University Hospital Bonn, Bonn, Germany, 5. University of Pecs Medical School, Pecs, Hungary, 6. University of Navarra, Navarra, Spain

Background: The concept of palliative care (PC) is traced to cancer care, but is also encouraged for patients with chronic disease. Despite the positive impact of PC on the quality of life and their relatives, the implementation of PC in non-cancer healthcare delivery in the EU seems scarcely addressed.

Aims: To assess guidelines/pathways for integrated PC in patients with chronic heart failure (CHF) and chronic obstructive pulmonary disease (COPD) in Europe via a systematic literature review.

Methods: Design: Search results were screened by two reviewers. Eligible studies of adult patients with CHF or COPD were published between 1995 and 2013 in English, French, German, Dutch, Hungarian or Spanish were included. Guidelines were ranked using Emanuels tool for the screening and evaluation of the PC content of the studies, with an entry threshold on 10/11 criteria.

Data collection: Nine electronic databases were searched. BMJ Palliat. Support Care, Eur. J. Palliat. Care, J Pain Symptom Manage, J. Palliat. Med and references from included studies were hand searched. Citation tracking was also performed.

Analysis: The acquired data were heterogeneous. A narrative synthesis was employed for documenting quantitative and qualitative results.

Results: 55 studies were included: 44 guidelines and 11 pathways. 75% focused on a holistic approach, 89% on PC interventions aimed to reduce suffering, 71% on the assessment of the patients’ goals of care and advanced care planning, and 69% on the involvement of a PC team. Finally, 45% focused on the referral criteria.

Conclusion: The importance of employing an integrated approach to PC is acknowledged by the majority of the included studies. Discrepancies concerning the referral criteria hint that the implementation aspects are obscure. Eight studies scored 10/11 Emanuels criteria and can serve as examples for the design of PC guidelines/pathways for CHF and COPD.

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

Louther K.1, Harding R.1, Ahmed A.1, Ali Z.1, Karuki H.1, Simms V.1, Gikana N.1, Higgonson L.1
1. King’s College London, Cicely Saunders Institute, London, United Kingdom, 2. BOMHU Hospital, Mombasa, Kenya, 3. Kenya Hospice Palliative Care Association, Nairobi, Kenya, 4. University of Nairobi, Nairobi, Kenya, 5. London School of Hygiene and Tropical Medicine, London, United Kingdom

Background: Latest guidance means that greater numbers of people will live on treatment, and evidence persists of high burden of physical, psychosocial distress.

Methods: A 2-arm RCT was conducted to reject the null hypothesis that adults on ART receiving a nurse-led person-centred intervention implementing palliative care principles will not improve quality of life (physical and mental) and multidimensional wellbeing (in line with WHO palliative care definition) compared to standard care. Conducted at a Kenyan Mission Hospital public clinic, data were collected at baseline and monthly using locally validated measure. Five quantitative datapoints: GHQ for psychological morbidity, MOS-HIV for mental physical quality of life, and PGS for multidimensional wellbeing, plus qualitative data after trial exit. Intervention patients had appointments with an existing ART clinic nurse trained in palliative care, using a multidimensional assessment protocol and care planning.

Results: The trial recruited the fully powered sample size of 120 patients. GLAMM analysis (to account for clustering of scores) found the following results: the intervention arm showed quantitative improvement for all outcomes. GHQ coefficient -0.50 (95% CI: -0.96, 0.03), p=0.03; MOS-HIV physical 0.44 (0.02, 0.91), p=0.06; MOS-HIV mental 0.59 (0.12, 0.70), p=0.015, PGS O69 (0.26, 1.12), p=0.002. Qualitative data revealed key elements of the intervention were being treated with respect, being listened to and having concerns heard. The control group also described value in the research process of regular interviews asking about wellbeing. Both groups articulated need (and resolution) of psychosocial domains of need, specifically perceived stigma.

Conclusions: A simple brief training course and assessment/management protocol in palliative care improved outcomes. The core elements of person-centred care and regular assessment can easily be incorporated into routine practice.

Abstract number: FC07.4
Abstract type: Oral

The Two Minute Walk Test (2MWT) is a Safer and More Effective Measure of Functional Capacity than the Six Minute Walk Test (6MWT) in Advanced COPD

Neo KY.1, Xu HEY.1, Wu HEY.1, Hum A.2
1. Tan Tock Seng Hospital, Palliative Medicine, Singapore, Singapore, 2. Tan Tock Seng Hospital, Respiratory and Critical Care Medicine, Singapore, Singapore, 3. Dover Park Hospice, Palliative Medicine, Singapore, Singapore

Background: The BODE index is routinely used in Specialist Outreach Clinics (SOC) to predict survival and hospitalisations in COPD. However, performing the 6MWT as part of BODE is challenging in severe airflow limitation. We hypothesise that a 2MWT is as effective as a 6MWT in measuring functional capacity.

Aims: Our primary aim is to compare the 2MWT with the 6MWT by measuring their association with functional capacity as measured by the Modified Barthel Index (MBI). As secondary objectives, we compare the 2MWT and 6MWT by measuring their association with quality of life (QoL), airflow limitation (FEV1), BODE score, dyspnoea intensity and exacerbation frequency.

Methods: Subjects with stage 3 and 4 COPD are recruited at the SOC. 6MWTs were conducted with pulse-oxygenometry reading at 0, 2, 4 and 6 minutes. Subjects could discontinue if they experienced fatigue or desire to rest ≥ 90%.

Results: Of 104 subjects recruited, 69 (66%) had stage 3 and 35 (34%) have stage 4 COPD. 97.1% could complete the 2MWT, whereas only 47.1% could walk the full 6 minutes, with 40.4% of subjects desaturating to ≤ 90% by the end of 2 minutes. The 2MWT has stronger correlation to MBI than the 6MWT (r=0.61 vs 0.37, p<0.001). Low 2MWT distances strongly associate with heightened perception of dyspnea, and poor prognostic scores (BODE). It moderately correlates with low FEV1 and disease specific QoL (all p<0.001). The strength of these correlations with the 2MWT exceeded those with the 6MWT. Using linear regression, multivariate analysis confirms the 2MWT as a predictor of beta (0.73, p<0.0001) independent of other variables identified through univariate analysis.

Conclusion: 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 discern frail COPD patients for early palliative intervention.

Abstract number: FC07.5
Abstract type: Oral

Understanding the Care Pathway of Patients with Cirrhosis in the Last Year of Life

Davies S.1, Low J.1, Vickerstaff V.1, Greenslade L.1, Hopkins K.1, Marshall A.1, Thorburn D.1, Jones L.1
1. Division of Psychiatry, Marie Curie Palliative Care Research, London, United Kingdom, 2. Royal Free Hospital, Hepatology, London, United Kingdom, 3. Royal Free Hospital, Palliative Care, London, United Kingdom

Background: Liver disease is a growing global public health problem and the 2nd largest cause of death in the UK. Health professionals for this patient group lack early detection, prevention, paying minimal attention to improving end of life care for those affected.

Aims: To follow 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 use information from extracted case notes, and qualitative, multi-perspective, serial in-depth 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 treatments and services exist to address patients’ problems, many continued to treat patients actively.

Conclusion: 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.

Abstract number: FC07.6
Abstract type: Oral

The Challenge of Pervasive Uncertainty in Advanced Liver Disease

Kimbrough K.1, Kendall M.1, Boyd K.1, Murray S.A.1
1. University of Edinburgh, Primary Palliative Care Research Group, Centre for Population Health Sciences, Edinburgh, United Kingdom

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.

Aims: To explore the dynamic physical, psychosocial, 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, serial 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 analyses using grounded theory techniques and NVivo 9.

Results: 15 patients and their carers were recruited and 64 interviews conducted.

Conclusion: 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. This 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 impeded 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 Shaded Electronic Record for Personalised End-of-Life Care: Factors Associated with Achieving Preferred Place of Death

Yao H.S., Donnely J.T., Howard D.J., Shaw M.T., Riley J.T.

Hong Kong Buddhist Hospital, Department of Medicine, Kowloon, Hong Kong, "Royal Marsden Hospital NHS Trust, The Royal Marsden & Royal Brompton Palliative Care Service, London, United Kingdom, "Royal Marsden Hospital NHS Trust, Coordinate My Care, My London, United Kingdom, "Royal Marsden Hospital NHS Trust, The Royal Marsden & Royal Brompton Palliative Care Service and Coordinate My Care, My London, United Kingdom

Background: Achieving 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 patient’s 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<0.0001), poor performance status (p<0.01) and poor documentation (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 place of death had occurred had been made with the family, died in 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.

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

Obbo S.G.

St Clare Hospice, Palliative Medicine, Hastingwood, United Kingdom

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 Document (PPD) 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 behind the patient not achieving their PPD.

Aim: To explore 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 patient’s notes were reviewed manually.

Results: 561 new community referrals were received over one year. 265 deaths were observed. 67% had their PPC 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 issues 4) They decided that preferred place of care was home 5) Family over-ruling of patient’s choice when patients lost capacity 6) Family’s unwillingness to support preferred place of care as preferred place of death 7) Lack of services in community to meet preferred place of death 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.

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

Garcia-Baquerizo Mendoza M.J.1, Santos Puebla D.1, Pineda F.1, Pinto Garzon M.4, Quiros Navas E.3, Molina Cara C.2, Giraltgazarri J.2, de Luis V.2, Garcia Adrian S.3, Ruiz Lopez D.3, Monleon Just M.3, Hernandez del Castillo J.1

1Servicio Madreño de Salud, Coordinadora Regional de Cuidados Paliativos, Madrid, Spain, 2Regional Palliative Care Research Network, Servicio Madreño de Salud, Coordinacion Regional de Cuidados Paliativos, Madrid, Spain, 3PA24, Coordinacion Regional de Cuidados Paliativos, Servicio Madreño de Salud, Consejeria de Sanidad, Comunidad de Madrid, Madrid, Madrid, Spain, 4Hospital Universitario de Getafe, Equipo de Soporte de Atencion Pallitativa Hospitalario, Madrid, Spain, 5Fundacion Instituto San Jose, Madrid, Spain

Presenting author email address: mteresa.garciaba@salud.madrid.org

Background: Patient and family centred palliative care (PC) must be organised around needs and their complexity. To be truly effective, services ought to be by 24 hour, which present a challenge to pallymangers, managers and professionals alike.

Aims: To describe the evolution and consolidation of a PC service and information platform offering care and access to resources. To assess the effectiveness of pulling together local and regional activity in a convenient way to facilitate decision making at multiple levels.

Methods: Retrospective descriptive analysis of 4 years data collected through agreed Minimum Data Set (MDS) in own database collected by all regional PC teams.

Results: Over the 4 years, most regional palliative care has been collected monthly, we show it joined the central PC platform has established some 70,000 contacts. During the last 6 months it after started giving access to PC resources, other than advice and support, workload has increased: 15795 contacts of which 41% were from family and carers, 24% from hospital support teams; 28.1% support and advice to emergency services and hospices. The 24 teams themselves established over 5,000 contacts broken into patient and family support, feedback to other teams related to resource availability. Activity: Home care teams saw a 7.9% increase in number of patients. Hospital support teams saw a 4.19% increase. Independent sector bed units saw a 4.94% and Public bedded Units 20.49%

Discussion and conclusion: A central single point of activity collection is effective and informs policy making. Investing in a robust technology platform aligned to PC desert is cost-effective. Home care and death have increased over the past 4 years in our setting while bed use has increased as has their turn over, ensuring effective use of resources. As a whole our PC provision has significantly evolved.

A new patient tracking through the system is our next goal; it depends on protocol completion.
Older people, dementia and multimorbidity

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

Johnston B.M.1, Lawton S.1, Munro G.1, Rodrigues C.1, Law E.1, Murray J.1, Gibb J.1, Pringle J.1, McCaig C.1

University of Nottingham, Sue Ryder Care Centre for the Study of Supportive, Palliative and End of Life Care, Nottingham, United Kingdom, 1 NHS Grampian, Raoburgh House, Aberdeen, United Kingdom, 1 NHS Tayside, Dundee, United Kingdom

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 severe dementia is often difficult as the content and quality of 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 generativity document that creates a lasting, written legacy.

Aims: 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: 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 provide 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

Arcand M.1, Verneault R.1, Misson L.1

1University of Sherbrooke, Family Medicine, Sherbrooke, QC, Canada, 2Université Laval, Family Medicine, Québec, QC, Canada, 3Centre d’Excellence sur le Vieillissement, Québec, QC, Canada

Presenting author email address: marcel.arcand@usherbrooke.ca

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 improving quality of end-of-life care. Aims: 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, 4 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

Hoping, Coping but Not Planning: The Contradictions of Living with Advanced Multimorbidity

Abstract number: FC09.6
Abstract type: Oral

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

Abstract number: FC10.1
Abstract type: Oral

Bereavement Experience of Lesbian, Gay, Bisexual and/or Transgendered (LGBT) People: A Systematic Review and Meta-synthesis of the Literature

Abstract number: FC10.2
Abstract type: Oral
struggling to find purpose in life post bereavement. However key themes reported for bereaved LGBT people included disenfranchised grief, and lack of social support, associated with it. Whereas certain philosophical perspectives regard personal dignity as an intrinsic quality that is independent of external factors, in the clinical setting it is generally given value to these patients’ lives. An in-depth understanding of the experiential context for the dying patient.

Conclusion: The SD is a complex construct that emerges as an expression of what it is that gives value to these patients’ lives. In an-depth understanding of the experiential context may help to ensure these patients are not reduced to their circumstances, thereby improving their quality of life.

Abstract number: FC10.5
Abstract type: Oral

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

Rosenfeld B.1, Perzin H.1, James R.1, Tobias K.1, Breitbart WM.2
Fordham 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 (IMCP-PC). Unlike past research using MCP, which involved 7-8 weekly sessions, we developed a treatment manual that required only 3 sessions, each lasting roughly 30-45 minutes.

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.

Results: Preliminary results (n=7) indicate a high degree of acceptability and perceived utility for IMCP-PC. Pre-treatment DT scores ranged from 6 to 10 and HADS scores ranged from 4 to 23, 3 patients had clinically significant levels of distress. All patients completed the 3 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 is fraught with logistical challenges. This presentation will discuss the results of this pilot intervention.

Abstract number: FC10.6
Abstract type: Oral

Life Values of Older Advanced Cancer Patients (70+): A Qualitative Study to Improve Care in the Last Phase of Life

Van Gorp J., Ebenau A., Van Leeuwen E., Van der Burg S., Hasekes J.
Radboud University Medical Centre, Nijmegen, Netherlands

Background: Society is confronted with an increase of elderly patients with advanced, incurable cancers. Little is known about these patients’ life values, whether they are age-specific, and how to attune end-of-life care to these values.

Aims: To investigate age-specific life values of older advanced cancer patients (70+ years).

Methods: In a qualitative study, older advanced cancer patients’ life values were collected with semi-structured qualitative interviews (n=16). Then, these life values were discussed from an end-of-life care perspective in two professional focus groups.

Results: Older advanced cancer patients’ attitudes on their future switched between giving oneself up to an inevitable uncertainty and actively bringing order into the chaos. The latter meant focusing on a ‘normal life’ (and demanding from others to act accordingly) and/or intensifying social contacts in search for meaning of life and death. Patients also nursed hope to maintain a functional status quo and/or for a miraculous cure to arise. Nevertheless, end-of-life arrangements (among which euthanasia) were already in preparation in case degrading decay and social isolation would prevail. Most patients thought that death is an appropriated ending to a long meaningful life. Furthermore, living in the face of death induced retrospection on social impact. The attention received from proxies during the illness was a measure of positive impact.

Conclusion: Some results could be related to older age: older patients seemed free from large social responsibilities (e.g. young children) and aspired to continue to live a simple life. Except for those who bear responsibility for a sick partner. Attention from children and friends in the last phase of life confirmed social impact and having lived a meaningful life. Knowledge of these life values will support the development of a serious game that improves end-of-life care communication.

Fundied by Dutch Cancer Society

Abstract number: FC11.1

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

Kinley J.1, Froogatt K.1, 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: jkinley@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 faced questions about the implementation process.

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

Methods: A mixed methods study was undertaken within 38 nursing care homes
Free Communication Sessions

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 researchers’ diary. Following separate quantitative (descriptive) and qualitative (themetic) 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: ‘fitting 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?
Borgstrom E.
University of Cambridge, Cambridge, United Kingdom
Presenting author email address: dr.borgstrom@gmail.com

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 interview with the NEOLCS expert consultative committee at the centre, ongoing public interest litigation on the same documents, reports and letters.

Results: The NEOLCS includes an explicit definition of a good death focused around the individual. The wider discourse presents a more complicated 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
Jalaluddin N.1, Pastraina T.2
Trivandrum Institute of Palliative Sciences, Thiruvananthapuram, India, University Clinic, Department of Palliative Medicine, Aachen, Germany

Background: India is the biggest producer of narcotic-substrate for pain medications, but its yearly 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 era and is therefore essential that the WHO and UNODC’s recommendations (primary data collection conducted from 2010–2012). Analysis focused on the values attributed to different kinds and categories of death and dying 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 complicated 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: FC11.4
Abstract type: Oral
Policy Barriers to Opioid Access in Eastern and Central Europe: Outcomes of ATOME
Papavasiliou E.1, Levely E.2, Payne S.4, Scholten W.4, Radbruch L.5
1Lancaster University, Health Research, Lancaster, United Kingdom, 2Universitätsklinikum Bonn, Bonn, Germany, 3Lancaster University, Lancaster, United Kingdom, 4World Health Organization, Geneva, Switzerland, 5Mästers Hospital Bonn/Rhein-Sieg, Bonn, Germany

Background: The problem of inadequate pain relief has drawn the attention of the international community, increasingly viewed as a violation of basic human rights. While barriers to opioid availability are complex including restrictive laws, regulations and licensing requirements, a key problem that limits the distribution of controlled medicines relates to policy.

Aims: To examine policy barriers to opioid availability for pain management and palliative care in twelve countries in Eastern and Central Europe involved in ATOME, a European Commission FP7 funded project (no 222994) aimed to improve access to Opioid Medication across Europe.

Methods: A systematic content analysis of documents (n=5–0) and reports submitted during ATOME including protocols of national problem analyses, strategic planning workshops, executive summaries and minutes of national conferences and six-country workshops held between March 2012 and April 2014 was performed.

Results: Twenty-five provisions of policy barriers (e.g. economic crisis, bureaucratic issues, inadequate continuing medical education, stigma and discrimination) were identified. Based on the total number of identified provisions, Estonia and Latvia ranked first on the list (20) followed by Greece (19) and Slovenia (18) whereas Hungary (13) and Turkey (11) ranked last.

Provisions related to education and training (absent, limited or fragmented education, lack of training initiatives) and societal attitudes (fears, lack of awareness and inadequate social dialogue and dissemination) appeared to be highly prevalent observed in all countries involved in ATOME.

Conclusion: Improving access to opioid therapy for quality pain management and palliative care in Central and Eastern European countries requires policy reform at governmental level. It is therefore, involves a set of action plans related to economic, education and social policy, is developed and systematically implemented to guide such a reform.

Abstract number: FC11.5
Abstract type: Oral

Developing a National Public Health Service as a Compassionate Employer
Vern J.
Public Health England, Bristol, United Kingdom

Presenting author email address: julia.verne@phe.gov.uk

Background: Most working people will experience caring for the dying and bereavement. As life expectancy increases, more working people find themselves in the ‘sandwich’ generation caring for both children and elderly relatives. There is a strong emphasis on physical and psychological health effects of caring for dying relatives (1). This caring role is disproportionately borne by women. The National Public Health Service has a leadership role in developing and supporting public health initiatives to improve the care of the dying and carers in the population including prevention of avoidable morbidity. The development of compassionate employers is a strand within Compassionate Communities.

Aim: To develop a National Public Health Service as a compassionate employer and as an exemplar for a national initiative within the Compassionate Communities Approach.

Method: The evidence base for health effects of caring, the rationale for being a compassionate employer to mitigate these effects, the demographics of the workforce, legal and organisational position with respect to carers leave and compassionate leave were summarised. Staff engagement was sought from the chief executive, directors, trade unions, HR, occupational health and from key grass root employees. A session on public health approaches to dying was held at the National Scientific Conference. Support was provided for a national Charter.

Results: Support was gained from the CE and top team and incredible grass root enthusiasm supported by the trade unions. Policies were reviewed. This was taking place at a time of reorganisation, austerity and cuts and the concept of compassion started to spread through other components of policy. A guide was produced for other employers.

Conclusion: The development of Compassionate Employer status stimulates discussion of death and dying as a public health issue with wider ramification beyond the focus on death.

1. Compassionate Communities Toolkit website

Abstract number: FC11.6
Abstract type: Oral

Dilemmas in Palliative Care Development: A Comparative Enquiry in the USA and England
Seymour J.E.1, Cassel B.2
1University of Nottingham, School of Nursing, Midwifery and Physiotherapy, Nottingham, United Kingdom, 2Virginia Commonwealth University, Hematology, Oncology and Palliative Care, Richmond, VA, United States

Presenting author email address: jane.seymour@nottingham.ac.uk

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 England and USA, spending 4–6 months evaluating PC development in their host country via informal interviews with key stakeholders, who included policy makers, health care professionals and 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’, ‘hopecare’ 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 or in the ongoing
Room for Death – Museum-visitor’s Preferences Regarding the End of their Life

Lindqvist O.1, Tishelman C.1,2
1Karolinska Institutet, 2Institute of Medicine, Stockholm, Sweden

Abstract number: FC1.2

Abstract type: Oral

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

Carrasco J.M.1, Tishelman C.1
1University of Navarra. Institute for Culture and Society, ATLANTES Research Programme, Pamplona, Spain, 2Errea Comunicación, Pamplona, Spain

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

Carrasco J.M.1, Tishelman C.1
1University of Navarra. Institute for Culture and Society, ATLANTES Research Programme, Pamplona, Spain, 2Errea Comunicación, Pamplona, Spain

Background: 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 – Sept 2012. Through their role as project consultants, palliative care (PC) researchers contributed a question directed to the public viewing the exhibition, to explore their reflections: ‘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 ‘lonely’ death, the ‘medicated’ death, the ‘familial’ death, the ‘solitary’ death, the ‘unique’ death, the ‘green’ death, and the ‘distanced’ death. These categories conceptualisation will be further elaborated, and we will conclude by discussing implications for the adoption and development of public health strategies for palliative care.

Method: 512 responses were categorized and thematically coded to understand the facets of ideal death as conceptualised by the public. A group of 10 clinicians was invited to rate these categories, in order to find clinical suitability. Based on this, we developed a questionnaire to explore how people in the still living (PT) and on-line (OL) media.

524 articles were identified (260 PT, 264 OL). PT articles were included in the analysis, following the criterion of containing a picture, with message (95%) and nearly half of them include professional testimonials (57%). Qualitative analysis showed that people’s experience of the setting, based on framework analysis of place as described in participant interviews, was conceptualised as a three-dimensional space: an ‘instrumental’ way to address issues related to health management and policy/social context. The message and ideas related with PC focus primarily on the process of death and on-linelly on the benefits for patients, often eclipsed by social debates related to issues such as euthanasia or the concept of dignity in dying. We will explore these distinctions and the contributions it made to patient’s quality of life and their environment.

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 (18%) and Health (13%) sections. Most of the articles were related to social message (93%) and nearly half of them include professional testimonials (57%). Qualitative analysis showed that people’s experience of the setting, based on framework analysis of place as described in participant interviews, was conceptualised as a three-dimensional space: an ‘instrumental’ way to address issues related to health management and policy/social context. The message and ideas related with PC focus primarily on the process of death and on-linelly on the benefits for patients, often eclipsed by social debates related to issues such as euthanasia or the concept of dignity in dying. We will explore these distinctions and the contributions it made to patient’s quality of life and their environment.

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.

Method: Attending to dissemination criteria and plurality of editorial lines, four national PT newspapers (El País, El Mundo, ABC, La Vanguardia) and four OL newspapers (Elconfidencial.es; navarra.es; elmundo.es; lasemana.com) were included in the analysis, following the criterion of containing a picture, with message (95%) and nearly half of them include professional testimonials (57%). Qualitative analysis showed that people’s experience of the setting, based on framework analysis of place as described in participant interviews, was conceptualised as a three-dimensional space: an ‘instrumental’ way to address issues related to health management and policy/social context. The message and ideas related with PC focus primarily on the process of death and on-linelly on the benefits for patients, often eclipsed by social debates related to issues such as euthanasia or the concept of dignity in dying. We will explore these distinctions and the contributions it can make to patient’s quality of life and their environment.

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Free Communication sessions

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

Escher M., Cullot S., Nendaz M., Rocu B., Hadéron P., Perneger TV., Dayer P.
University Hospitals of Geneva, Geneva, Switzerland
Presenting author email address: monica.escher@hcuge.ch

Aims: Triage to intensive care for seriously ill patients is complex. When doctors do not 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 a buffer in the triage process, especially at night and during the weekend. 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 straightforward, 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 decides 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 doctors’ 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 hepatomas).

Conclusions: Code status is central to the time-pressured 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

Quality of life and Symptoms

Oslo University Hospital, National Resource Center for Late Effects after Cancer Treatment, Oslo, Norway, *Oslo University Hospital, Regional Centre for Excellence in Palliative Care, Dept of Oncology, Oslo, Norway, #St Olav’s Hospital, Trondheim University Hospital, Trondheim, Norway.

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.

Determination of CS is based on patient preferences, assessment of the context, and preferably on discussions with other colleagues. CS is considered a buffer in the triage process, especially at night and during the weekend. 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 straightforward, 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 decides 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 doctors’ 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 hepatomas).

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Abstract number: FC13.1

Quality of life and Symptoms

University Hospital Erlangen, Friedrich-Alexander-University Erlangen-Nuremberg, Department of Palliative Medicine, Erlangen, Germany, *University Hospital Erlangen, Friedrich-Alexander-University Erlangen-Nuremberg, Department of Neurology, Erlangen, Germany, #University Hospital Erlangen, Friedrich-Alexander-University Erlangen-Nuremberg, Comprehensive Cancer Center, CCC Erlangen - EKN, Erlangen, Germany

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 professional panel of experts in the field developed standard procedures (SOP) for symptom oriented treatment of dyspnea, pain, anorexia 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 efficacy of these SOPs were surveyed.

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 (HOPE Symptom & Problem Checklist) and by patients (MDQCS, 2). Both tools use a 4-point Likert scale (0=none, 1=mild, 2=moderate, 3=severe).

Results: Treatment according to SOP was possible in the majority of patients (93%; n=98/30). In both cases of deviation from SOP patients refused treatment according to SOP and were treated according to their wishes by continuing treatment from before. In most of the patients treatment 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 0.0, p<0.05), dyspnea (mean: 1.13 to 0.7 to 0.35, p=0.01), anorexia (mean: 2.3 to 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.

Abstract number: FC13.3

Quality of life and Symptoms

Suzuki-Reyra Y., Diaz Garca Y.V.
1Hospital Fundacion Vianorte-Laguna, Madrid, Spain, #Centro de Salud Forjamon de Velasco, Madrid, Spain

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 the 6 months period and has criteria for D at admission (D), or during hospitalisation (DOL), 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% DOL, 34% DOL, with a median of 9 days after admission. Present DT 85% (113 of the total), 75 D1 and 38 DDT. Exceeded the expected peak and not die with 0.15%. We found differences regarding the type of tumor: lung cancer in the group that develops D is higher, 19%-4%. The most common precipitating factors in D are pharmacological, 90% (opioids, steroids and metabolic, 7% dehydration, 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 OF. Sedation in the EOL was 66 (31%) in 52 (79%) the indication was delirium. Need sedation 39% of DT. Treatment of sedation was midazolam (83%). In 89 patients with D Di develop at D (84%) 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: FC13.4

Quality of life and Symptoms

Carding to Know Palliative Care

Ez-Gal R., Kaplan R.
Israel Ministry of Health, Central District, Dept of Nursing, Ramla, Israel, #Assaf Harofeh Academic School of Nursing, Beer Yaakov, Israel

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 that may be used with 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,
and to investigate the correlation between these factors and their professional behavior intentions. It is assumed that positive correlations will be found.

Methods: The content analysis sample included written data generated by professionals and patients and was informed by qualitative data. The study was embedded in the RCT, a novel approach in palliative care research. The EPCCS is an international prospective collection of symptoms and clinical data. The correlative design sample included 214 registered nurses in community and hospital practice in the Central District. Six questionnaires were developed for the study, evaluating knowledge, attitudes, emotional coping abilities and intentions in these care situations. These were considered in the analysis of the study by the researchers. The content was validated by clinical experts.

Results: Significant differences were found between nurses practicing in various clinical areas in their knowledge of thrombosis, surgery, community oncology regarding professional background, emotional coping abilities and knowledge. However, no differences were found in intention to respond. Higher levels of education were correlated with increased positive attitudes (p<0.05). There were significant correlations between level of knowledge and emotional coping abilities (p<0.001, r=0.37) and level of knowledge and professional background (p<0.001, r=0.35).

Conclusions: There was a need for better validation of the EPCCS instrument tools to develop and evaluate the knowledge and attitudes of nurses in the Central District. These results indicate that nurses are deficient in their knowledge of thrombosis, surgery, and community oncology regarding professional background, emotional coping abilities and knowledge. They are also deficient in their intention to respond. Higher levels of education were correlated with increased positive attitudes. However, no differences were found in intention to respond. Higher levels of education were correlated with increased positive attitudes (p<0.05). There were significant correlations between level of knowledge and emotional coping abilities (p<0.001, r=0.37) and level of knowledge and professional background (p<0.001, r=0.35).

Abstract number: FC13.5
Abstract type: Oral

Depression Predicts Pain Intensity: Prospective Findings from the European Palliative Care Symptom Study (EPCCS)

Girma J.1,2, Loke LH.1,3, Moom T.1, Aas N.1, Hjemstad M.1,4

National Advisory Unit on Late Effects after Cancer Treatment, Oslo University Hospital, Oslo, Norway, 1Regional Centre for Excellence in Palliative Care, Oslo University Hospital, Dept. of Oncology, Oslo, Norway, 2University of Oslo, Dept of Behavioral Sciences in Medicine, Oslo, Norway

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 receiving analgesic treatment.

Methods: The EPCCS is an international prospective collection of symptoms and clinical data in 30 centres and 12 countries. 898 patients scoring >0 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). 44% had received 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 univariately predicted PI at T2: Age (b=-0.03, (95% CI=-0.04-0.01), p<0.01), depression (b=-0.13, (0.03-0.24), p<0.05) and analgesic treatment (b=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 (b=-0.03, (0.04-0.01), p<0.01), depression (b=-0.11, (0.01-0.22), p<0.05) and analgesic treatment (b=1.44, (0.89-2.28), 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

Bailie J.1, Noble S., Nelson A.1

Cardiff University, Marie Curie Palliative Care Research Centre, School of Medicine, Cardiff, United Kingdom

Presenting author email address: bailiej@cf.ac.uk

Background: Cancer associated thrombosis (CAT) is a complex condition associated with 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 for a further six months (intervention) with ceasing 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. The 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 death and dying) was a common reason cited. One clinician noted that patients hesitated and “just left a blank space in the text. Those using an implicit language often described great personal psychological distress. Difficult 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 distress. Difficult terms or even skipped writing an expression at all, just leaving a blank space in the text. These attitudes to risk indicate participants are not confident that the RCT is feasible. 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: Dimbleby Cancer Care

Abstract number: FC14.2
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

Karson M.1,2, Milberg A.1,2,3

1Linköping University, Department of Clinical and Experimental Medicine, Linköping, Sweden, 2Linköping University, Department of Advanced Home Care and Department of Clinical and Experimental Medicine, Linköping, Sweden, 3Linköpings University, Campus Norrköping, Department of Social and Welfare Studies, Norrköping, Sweden, 4Linköping University, Palliative Education & Research Centre and Department of Social and Welfare Studies, Norrköping, Sweden, 5Linköping University, Department of Advanced Home Care and Department of Social and Welfare Studies, Norrköping, Sweden

Presenting author email address: maria.karson@liu.se

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’, ‘died’ 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. ‘the 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.
Free Communication

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

Thompson G.N.1, Chochon H.M.1, Hack T.1, Climent S.1,4, Roe K.1, St John P.4
1University of Manitoba, Nursing, Winnipeg, MB, Canada, 2University of Manitoba, Psychiatry, Winnipeg, MB, Canada, 3University of Manitoba, Genetics, Winnipeg, MB, Canada
Presenting author email address: genevieve.thompson@umanitoba.ca

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 feel uncomfortable asking about 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.

Method: 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 experience, 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 thematic areas 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 / Discussion: 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 provision of palliative care in this setting. Funding received by the Canadian Institutes of Health Research and Manitoba Health Research Council.

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

Robert A.1, Gomiles M.2, Holliday M.2
1University of Liverpool, Marie Curie Palliative Care Institute, Liverpool, United Kingdom, 2North West Simulation Education Network, Manchester, United Kingdom

Presenting author email address: anita.roberts@liverpool.ac.uk

Background: Care of the dying requires healthcare professionals to have substantial technical knowledge, clinical skill 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 4 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, 47% 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 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 carers 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 into practice prompts reflection about its purpose, based on greater understanding of patient priorities and perspectives for end of life care.

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

Neergaard M.A.1,2, Jensen A.B.3, Bro F.1, Guldin M.-B.1,2
1University of Aarhus, Research Unit for General Practice, Aarhus, Denmark, 2Aarhus University Hospital, Odense, Denmark, 3The Copenhagen Trial Unit, Centre for Clinical Intervention Research, Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark, 4Section of Palliative Medicine, Department of Oncology, Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark, 5School of Health Sciences, University of Aberdeen Medical School, Aberdeen, United Kingdom, 6Department of Cancer Research and Medical Ethics, Faculty of Medicine, Norwegian University of Science and Technology, Trondheim, Norway, 7Palliative Team, Aarhus University Hospital, Aarhus, Denmark, 8Research Centre for Palliative Care Settings

Presenting author email address: anna.thi.innejohnsen@regionh.dk

Background: Family caregivers of terminal ill cancer patients may experience anticipatory grief before the actual loss of the patient. Anticipatory grief has formerly been thought to improve bereavement outcomes, 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 pre-loss 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 outcome. 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.

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

Johnson A.T.1, Petersen M.A.1, Strømgiøn A.S.1, Sørensen P.1, Nielsen J.B.1, Neergaard M.A.1, Lindhoud J.1, Higginson I.J.1,2, Glud C.1,2, Fayers P.3,4,5, Damkier A.6,7, Groenvold M.1,8
1The Research Unit, Department of Palliative Medicine, Bispebjerg Hospital, Copenhagen University Hospital, Copenhagen, Denmark, 2Department of Oncology, Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark, 3Palliative Team Henning, Hennings Hospital, Henning, Denmark, 4The Palliative Team, Aarhus University Hospital, Aarhus, Denmark, 5The Copenhagen Trial Unit, Centre for Clinical Intervention Research, Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark, 6King’s College London, Cicely Saunders Institute, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom, 7Institute of Applied Public Health Sciences, University of Aberdeen Medical School, Aberdeen, United Kingdom, 8Department of Cancer Research and Medical Ethics, Faculty of Medicine, Norwegian University of Science and Technology, Trondheim, Norway, 9Palliative Team Fyn, Odense University Hospital, Odense, Denmark, 10Institute of Public Health, University of Copenhagen, Copenhagen, Denmark

Presenting author email address: anna.thi.innejohnsen@regionh.dk

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 (exploratory 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 IORTQ CQLO-C30 questionnaire that exceeded a predefined threshold. In total, there were one primary and eight secondary outcomes (reported elsewhere). Exploratory outcomes were the changes in the IORTQ CQLO-C30 scales concerning impacts on patient functioning in life, fatigue, sleeplessness, constipation, diarrhoea, and financial difficulties; the Hospital Anxiety and Depression scales anxiety and depression; and the FAMCAPE-16 single items measuring

FC15 Healthcare evaluation and needs

Abstract number: FC15.1
Abstract type: Oral

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satisfaction with the health care system, 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 had no significant effects on any of the symptoms or problems. Of the 17 items addressing satisfaction overall satisfaction with the help received from the health care system had a difference favoring early SPC of 9 points (p = 0.0086) and three other items were aligned with patients favoring the SPC group. These findings are consistent with doctors’ attention to description of symptoms, information given about how to manage pain, and the way family was included in decisions.

Conclusion/discussion: The explorative outcomes showed no effect on symptoms and problems but a tendency for patients in the SPC group to be more satisfied with the health care received.

Abstract number: FC15.3
Abstract type: Oral

Early Palliative Care for Patients with Metastatic Lung Cancer Receiving Chemotherapy: A Feasibility Study of a Nurse-led Screening Program

Matsumoto Y.1, Umemura S.1, Kobayashi N.2, Tanaka Y.3, Saraki C.4, Shimizu K.4, Ogawa A.5, Kinoshita H.2, Matsuura Y.2, Morita T.1, Goz K.2, Ohe Y.1
1National Cancer Center Hospital East, Department of Palliative Medicine, Kashiwa, Japan, 2National Cancer Center Hospital East, Department of Thoracic Oncology, Kashiwa, Japan, 3National Cancer Center Hospital East, Nursing Division, Kashiwa, Japan, 4National Cancer Center Hospital East, Department of Psychiatry, Kashiwa, Japan, 5The University of Tokyo, Graduate School of Medicine, School of Public Health, Department of Biostatistics, Tokyo, Japan, 6Seirei Mikatahara General Hospital, Department of Palliative Care, Hamamatsu, Japan, 7National Cancer Center Hospital, Department of Thoracic Oncology, Tokyo, Japan

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 by an open screening questionnaire, followed by a comprehensive program which involved 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 score 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, 49–76), and 84% were men. Thirty-eight patients had stage IV non-small cell lung cancer (NSCLC) and 12 had extensive disease in small-cell lung carcinoma. The completion rate was 70% (95% CI 56.9–81.0). The mean duration between baseline and T2 was 5.1 ± 2.2 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.

<table>
<thead>
<tr>
<th>Baseline</th>
<th>T2</th>
<th>Change from baseline (% CI)</th>
<th>P value</th>
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<tr>
<td>FACT-L</td>
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<td></td>
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<tr>
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<td>82.1 (61.6 – 98.0)</td>
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<tr>
<td>PF</td>
<td>94.9</td>
<td>95.1 (84.0 – 99.0)</td>
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Conclusion: This EPC intervention is feasible and potentially useful. Our results justify a further randomised control trial.

Abstract number: FC15.3
Abstract type: Oral

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

Sampson C.1, Nelson A.1, Hope-Gill B.2, Harrison N.K.3, Fergibon J.1, Griffis G.1, Kilin C.1, Mushota P.1, Byrne A.1
1Cardiff University School of Medicine, Marie Curie Palliative Care Research Centre, Cardiff, United Kingdom, 2University Hospital Llandough, Department Respiratory Medicine, Cardiff, United Kingdom, 3Swansea University, School of Medicine, Swansea, United Kingdom, 4Cardiff University School of Medicine, Cardiff, United Kingdom, 5Cardiff University School of Medicine, Wales Cancer Centre, United Kingdom, 6Guy’s and St Thomas’ Hospitals NHS Foundation Trust, Palliative Care, London, United Kingdom, 7Guy’s and St Thomas’ Hospitals NHS Foundation Trust, Ageing and Health Services, London, United Kingdom, 8King’s College Hospital NHS Foundation Trust, Palliative Care, London, United Kingdom

Background: Idiopathic pulmonary fibrosis (IPF) is a chronic interstitial lung disease with varying clinical course, no proven treatment and median three year survival. Symptom burden is high and quality of life (QoL) poor. Guidelines promote patient-centred care, emphasising supporting people with limited reversibility. 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 and factors that could 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=23) and carers (n=23) and completed validated questionnaires exploring QoL and symptoms.

Results: Patients and carers outlined key transition points where IPF made significant impact, representing triggers for focused 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, emphasizing 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: CaIoPoY 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 role, 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

Bristow K.1, Carey L.1, Hopper A.1, Shouls S.1, Prestice W.4, Caulkin R.2, Higginson I.J.2, Koffman J.1
1King’s College London, Ciclo Saunders Institute, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom, 2Guy’s and St Thomas’ Hospitals NHS Foundation Trust, Palliative Care, London, United Kingdom, 3Guy’s and St Thomas’ Hospitals NHS Foundation Trust, Ageing and Health Services, London, United Kingdom, 4King’s College Hospital NHS Foundation Trust, Palliative Care, London, United Kingdom

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 observational study of three acute hospital wards, using qualitative interviews, and a follow-back survey (QUALCARE). Interviews with 23 patients and 12 carers supported by AMBER care bundle, 11 standard care were analysed using thematic analysis, surveys of 95 bereaved carers (39 AMBER care bundle, 36 standard care) were analysed using t-tests and χ² tests, focusing on questions about communication, awareness of illness, and length of hospital stay. The interview and survey data were integrated at the point of analysis, in a convergent design, interrogating the data around common key themes.

Results: The AMBER care bundle was associated with increased frequency of discussions about prognosis between clinicians and patients (p<0.04), higher awareness of life limiting illness by patients compared to carers (p=0.04), higher clarity in the information received about their condition (p<0.06, p=0.04). The consistency and quality of communication was not different between the two groups, but those supported by the AMBER care bundle described more unresolved concerns about caring for someone at home.

Conclusion: Awareness of prognosis appears to be higher in patients supported by the AMBER care bundle, but in this small study this was not translated into higher quality communication, and information was judged less easy to understand. Adequately powered comparative qualitative evaluation is urgently needed.

Funding: Guy’s and St Thomas’ Charity, UK.

Abstract number: FC15.5
Abstract type: Oral

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

de Beer A.E.1, Stinger B.1, van Meijel B.1,2, Verbakel R.1, Franke A.L.1,4
1NIVEL, Netherlands Institute for Health Services Research, Utrecht, Netherlands, 2GIZ eG, Bochum, Germany, 3Institute for Applied Sciences, Amsterdam, Netherlands, 4AU University Medical Center, Amsterdam, Netherlands, 5Pammassa Psychiatric Institute, The Hague, Netherlands, 6Center of Expertise in Palliative Care, Amsterdam, Netherlands

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.

Aim: 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 and lack confidence. Questions on how to handle the patients. Professionals on other hand, professionals in palliative care feel inadequately trained in deal with psychiatric problems and challenging behavior.

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 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 realize better access to palliative care.
Which Everyday Activity Problems Do People with Advanced Cancer Living at Home Prioritise?—And Can Types of Activity Problems Be Predicted?

Brand Ø, 1, Wathne E.E. 1, Jourk K 2
1The National Board of Social Services, Odense, Denmark, 2University of Southern Denmark, Odense, Denmark
Presenting author email address: aab@socialstyrelsen.dk

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 prioritisate. When planning interventions it would be useful to be able to predict which types of activity problems subgroups have.

Aim: 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 the home; leisure activities; 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 fullfillment 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 into the Policy Architecture, Health Infrastructure, Service Delivery and Culture of a Nation: Defining Potential Models through Lessons from Four Countries in Sub-Saharan Africa

Grang L, 1, Leng M, 1, 2, Hamouwopa E 1, 2, Muyombwe S.A. 1, Yunkink E 1, 3, Downing J 4, 1, 5
1University of Edinburgh, Centre for Population Health Sciences, Edinburgh, United Kingdom, 2Makerere University, Makerere Palliative Care Unit, Department of Medicine, Kampala, Uganda, 3Cardio International Palliative Care Trust, Aberdeen, United Kingdom, 4African Palliative Care Association, Kampala, Uganda, 5King’s College London, London, United Kingdom

Background: Islands of excellence of palliative care provision exist in all 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) THET 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. Baseline data was gathered to assess population, 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 capacity to provide, and infrastructure needs of a hospital working with, in and through its community.

Abstract number: FC16.2

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

Oblen J 1, Henoch I 1, 2, Carolander L 1, 2, Holm M. 1, James L, 1, 1, 2 Kenne Svarnell E 1, 1, Lindh-Hagelin C 1, 1, 2, 2 Duf S 1, 1, 2, Sandgren A 1, 1, 2
1Era Sköndal University College and Era Hospital, Palliative Research Centre, Stockholm, Sweden, 2Sahlgrenska Academy, University of Gothenburg, Institute of Health Care Sciences, and University of Gothenburg, Centre for Person-Centred Care, Gothenburg, Sweden, 3Karolinska Institutet, Department of Learning, Informatics, Management and Ethics, Stockholm, Sweden, 4Karolinska Institutet, Department of Neurobiology, Health Care Sciences and Society, Stockholm, Sweden, 5Örebro University, Department of Neurobiology, Health Care Sciences and Society, Orebro, Sweden, 6Aalborg Hospital, Research and Development Centre, Skovde, Sweden, 7Sophiahemmet University, Stockholm, Sweden, 8Stockholms Jukkhem-Fondation, Research and Development Unit in Palliative Care, Stockholm, Sweden, 9Jönköping University, School of Health Sciences, Jönköping, Sweden, 10Linnes University, Centre for Collaborative Palliative Care and Caring Sciences, Kalmar/Hälso, Sweden
Presenting author email address: jasmin.ohlen@esh.se

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 as used in the previous review. 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 to focus on cancer specific populations. A domination of qualitative approaches and small, cross-sectional studies with few interventions is still characteristic. Still more strategies are needed to expand the knowledge development of palliative care to respond to demographical, epidemiological, therapeutic and health care structure changes.
Effects of eHealth on Patients and Informal Caregivers with Cancer: A Meta-review


VU University Medical Center/EMGO Institute for Health and Care Research, Public and Occupational Health, Expertise Centre for Palliative Care, Amsterdam, Netherlands, 2NKI, Netherlands Institute for Health Services Research, Utrecht, Netherlands; 3VU University Medical Center, Department of Clinical Psychology, Amsterdam, Netherlands

Background: In current health care, eHealth is considered as a potentially effective mean for providing information and support. eHealth can be defined as information provision about illness or health care and/or support for patients and/or informal caregivers, using the computer and telecommunication. Several systematic reviews examining effects of eHealth interventions for cancer patients are already published.

Aim: To synthesise evidence from previous systematic reviews on the effects of eHealth interventions in oncology care, and to look whether these interventions and effects also concern patients and informal caregivers in the palliative phase of cancer.

Methods: A systematic meta-review (a systematic review of reviews) was conducted on effects of eHealth interventions targeting cancer patients and/or informal caregivers. Searches were done in PubMed, Embase, CINAHL, PsyInfo and Cochrane Library. The reference selection and methodological quality assessment were done by two reviewers independently.

Results: Ten systematic reviews were included. Based on a synthesis of the information from these reviews, moderate evidence was found for the efficacy of eHealth regarding support, knowledge level and information competence of cancer patients. Evidence was inconclusive for outcomes related to wellbeing, depression, quality of life, decision making and health care participation. None of the reviews included studies targeting eHealth for palliative care patients and/or their informal caregivers.

Conclusion: There is (moderate) evidence that eHealth interventions are effective in providing support and in increasing information competence of patients. There is an urgent need for research on the effects of eHealth in the palliative phase of cancer.

Funding: ZonMw, The Netherlands Organisation for Health Research and Development.


Koivu L.; Seydennaratholl F.; Hirvonen O.; Latinen T.; Jyrkkö S.; Els L.

Turku University Central Hospital, Department of Oncology and Radiotherapy, Turku, Finland; Turku University, Department of Mathematics and Statistics, Turku, Finland; Turku University Central Hospital, Department of Clinical Informatics, Turku, Finland; Turku University, Department of Pulmonary Diseases and Clinical Allergology, Turku, Finland

Background: In the treatment of end-of-life patients, palliative symptom control should be preferred over aggressive anti-cancer treatments. However, terminally ill cancer patients are often over treated with chemotherapy, which can cause additional suffering and weaken the quality of life. We assessed the use of chemotherapy for cancer patients in the last year of life in a population of c. 400,000.

Methods: All cancer patients treated with chemotherapy and deceased in the University Hospital District in 2003–2014 were included in the population based single-centre study. All cancer types were included. KCO-10 diagnoses COO-CST, age at death, date of death, and chemotherapies were gathered from the electronic medical records. The use of chemotherapy was assessed one year, six months, three months, two months and one month before death, and the type of cancer.

Results: Among the 13,855 deceased cancer patients, 4083 (30%) patients received chemotherapy and ~80% (3288) of them, during the last year of life. Chemotherapy was received six months, three months, two months and one month before death by 64%, 40%, 24% and 8% of all the patients, respectively. Median age at death was 67.1 years. Median time between last chemotherapy and death was 122 days. No significant changes were observed across the follow-up years. The time was dependent on patients’ age. Three months before death 56% of patients below 50 years of age received chemotherapy while in age groups 50-70, 70-80 and >80 years of age, the corresponding percentages were 44%, 33%, and 19%, respectively. The differences in each pairwise comparison were statistically significant (p-value < 0.01). The patients above 80 years of age were treated below the average.

Conclusions: In the present 10 year study, aggressiveness of late chemotherapy treatments did not decrease. On the contrary, time from treatment to death tended to increase in the age group >80 years. Cancer type specific differences found will be presented.

Strong Country-variation in Nursing Home as a Place of Death for Older People. A Study in Thirteen Countries across Four Continents Using Death Certificate Data

Martins Pereira S.; Colhans J.; Van den Block L.; Dirk H.; Deliens L.; on behalf of IPhO (FWO 2007-2013) and presenting author; 1Koivu L.; in agreement with No. 2646/600, VU University Medical Center, EMGO Institute for Health and Care Research, Public and Occupational Health, Expertise Centre for Palliative Care, Amsterdam, Netherlands; 2NKI, Netherlands Institute for Health Services Research, Utrecht, Netherlands; 3VU University, Department of Clinical Psychology, Amsterdam, Netherlands

Background: With the ageing of populations, it is needed to know about where older people die. Identifying how patterns of place of death change with increasing age provides information on where the monitoring and safeguarding of the quality of end-of-life care for older people can be focused. A horizon scanning of transcontinental trends in processes like place of death across diverse contexts, providing information on policies and on health and social care systems.

Aims: To study place of death of older people in 13 countries; to evaluate if nursing home death rates increase with increasing 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 age groups: 80–84, 85–89, 90–94, >94. Three models of analysis were conducted to explain determinant factors of nursing home deaths among the oldest population.

Results: Home deaths and hospital deaths varied from 2.9% (Korea) to 52.8% (Netherlands). The chances of a hospital 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 variations.

Conclusions: Large cross-national differences were found concerning place of death in the oldest population. In all countries, hospital deaths were more common in advanced older age, highlighting the growing relevance of promoting palliative care in these settings in all ageing societies.

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

Parrotel S.Z.; O’Riordan D.L.; Bragg A.R.; Bischoff E.; Palliative Care Quality Network University of California, Medicine, San Francisco, CA, United States

Background: Standardised data collection and outcome assessment in palliative care can define best practices and promote quality improvement (QI). Aim: 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 PCSI consultation request was shorter than for those not referred for pain management (4.5 vs 5.9 days; p<0.001).

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. In multivariate analysis, age and diagnosis were no longer associated with improvement. Across PC teams, the percentage of patients with improved pain ranged from 60–80%. 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.
Effects of Melatonin on Physical Fatigue and Other Symptoms in Patients with Advanced Cancer in Palliative Care: A Double-blind Placebo-controlled Crossover Trial

The Research Unit, Department of Palliative Medicine, Bispebjerg Hospital, Copenhagen, Denmark
Presenting author email address: charlotte@r-team.dk

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 old, 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 washout period of two days was implemented.

Results: 46 at day 7. The mean age was 64 years and the mean Karnofsky index (0–100) was 66. 28 patients were included in the study. 49 patients could be evaluated for sleep quality at baseline and at day 7. The mean age was 65 years and the mean Karnofsky index was 66. 11% had RC. After one month, 6% of patients with NC at baseline had developed C or RC, and 10% had died. The mortality was similar between the groups. 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 = 0.33 (95% CI: 0.08 – 0.58), p = 0.003) for any secondary or exploratory 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

Varghese G.M.1, 2, Blum D.1, 3, Wilcock A.4, Fayers P.1, 5, Strasser F.1, Baracos V.6, Hermstad M.J.1, 7, Kaasa S.1, 7, Ljørdal B.1, 7, Solheim T.S.1, 7, On behalf of the European Palliative Care Cancer Symptom Study (EPCSS) Study Group

Abstract type: Oral

Background: Cancer cachexia classification system has not been fully validated in patients with advanced cancer.

Aim: To describe the prevalence of the stages of cachexia, patients’ transition from stage to stage, and survival of patients by stage. A secondary aim is to identify biomarkers indicating risk of cachexia development.

Methods: Analyses are ongoing of a large international palliative care patient cohort (n ~ 1739). Patients were followed for three months or until death. Medical data and patient reported outcomes were collected, including key cachexia parameters (weight loss, body mass index, anorexia, C-reactive protein levels and performance status). For each visit the patients were divided into groups adapted from the current cachexia classification, and a descriptive analysis was done. Survival analyses will be used to explore factors associated with cachexia development.

Results: A total of 592 patients were screened from April 2008 to January 2012. Fifty patients were included in the study, 49 patients could be evaluated for sleep quality at baseline and at day 7. The mean age was 64 years and the mean Karnofsky index was 100. 62% of patients used sleep medication, 15 in the CS group and 13 in the placebo group. The mean baseline PSQI global score was 8.27 (7.13 – 9.40), 14 patients reported good sleep quality, 35 patients reported poor sleep quality. On day seven there was no difference between the patients 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 – 1.12); placebo group: 0.25 (-0.14 – 0.63). Sleeplessness reported as a “yes” or “no” response was similar between the groups.

Conclusions: In this cohort, 35 out of 49 cancer patients with advanced disease and pain reported poor sleep quality. Methylenedipropionone 32 mg daily for 7 days did not affect the sleep quality as measured by PSQI.

Funding: Telemark Hospital Trust

Abstract number: FC17.5
Abstract type: Oral

Cancer Related Fatigue - Are we offering Enough?

Paulsen O.1, 2, Jakobsen G.1, 2, Kaasa S.1, 2, Aas N.1, Raskod L.H.1, Albert E.1, 3, Klepstad P.1, 2, 6
1Telemark Hospital Trust, Palliative Care Unit, Skien, Norway, 2Norwegian University of Science and Technology, European Palliative Care Research Centre, Trondheim, Norway, 3St Olavs Hospital, Trondheim University Hospital, Department of Oncology, Trondheim, Norway, 4University of Oslo, Faculty of Medicine, Oslo, Norway, 5University of Bergen, Department of Clinical Medicine, Faculty of Medicine and Dentistry, Bergen, Norway, 6Sandefjord Hospital Kristiansand, Palliative Care Unit, Kristiansand, Norway, 7Norwegian University of Science and Technology (NTNU), Department of Circulation and Medical Imaging, Trondheim, Norway
Presenting author email address: paal.paulsen@ntnu.no

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, falling 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 0.01 (0.41 – 1.32) (p = 0.04). In some patients fatigue and emotional symptoms were confused or unable to think clearly. They also commented on the CRF’s cyclical nature linked to treatment schedules.

Conclusions: A gap remains in the support offered to patients. Lack of awareness of CRF was from the primary outcome physical fatigue from MFI-20 was the primary outcome. The primary analysis was a complete compliers. No significant differences between placebo and melatonin periods could improve the overall patient experience of this distressing symptom.

Promoting awareness and education of CRF to patients, carers and health care professionals, could improve the overall patient experience of this distressing symptom.

Abstract number: FC17.6
Abstract type: Oral

Does Methylenedipropionone 32 mg Affect Sleep Quality in Advanced Cancer Patients with Pain? A randomised, Controlled Trial

Paulsen O.1, 2, Jakobsen G.1, 2, Kaasa S.1, 2, Aas N.1, Raskod L.H.1, Albert E.1, 3, Klepstad P.1, 2, 6
1Telemark Hospital Trust, Palliative Care Unit, Skien, Norway, 2Norwegian University of Science and Technology, European Palliative Care Research Centre, Trondheim, Norway, 3St Olavs Hospital, Trondheim University Hospital, Department of Oncology, Trondheim, Norway, 4University of Oslo, Faculty of Medicine, Oslo, Norway, 5University of Bergen, Department of Clinical Medicine, Faculty of Medicine and Dentistry, Bergen, Norway, 6Sandefjord Hospital Kristiansand, Palliative Care Unit, Kristiansand, Norway, 7Norwegian University of Science and Technology (NTNU), Department of Circulation and Medical Imaging, Trondheim, Norway
Presenting author email address: paal.paulsen@ntnu.no

Background: Cricostetorids (CS) 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 cricostetorids 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) with sleep problems and who were willing to take opioid treatment were recruited from five palliative care centres in Norway. After randomisation, the patients received methylenedipropionone 16 mg or placebo twice daily for seven days. Sleep quality was measured by Pittsburgh Sleep Quality Index (PSQI) (0 – 21) at baseline and at day 7. A PSQI global score of > 5 is categorised as poor sleep quality.

Results: A total of 592 patients were screened from April 2008 to January 2012. Fifty patients were included in the study, 49 patients could be evaluated for sleep quality at baseline and at day 7. Mean age was 64 years and the mean Karnofsky index was 100. 62% of patients used sleep medication, 15 in the CS group and 13 in the placebo group. The mean baseline PSQI global score was 8.27 (7.13 – 9.40), 14 patients reported good sleep, 35 patients reported poor sleep quality. 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 – 1.12); placebo group: 0.25 (0.14 – 0.63). Sleeplessness reported as a “yes” or “no” response was similar between the groups.

Conclusions: In this cohort, 35 out of 49 cancer patients with advanced disease and pain reported poor sleep quality. Methylenedipropionone 32 mg daily for 7 days did not affect the sleep quality as measured by PSQI.

Funding: Telemark Hospital Trust
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

de Groot E.1,2, Zweers D.1, de Graaf A.F.1,3, Doggelders G.1,4, Teunissen S.1,4
1University Medical Center Utrecht, Department of Internal Medicine and Dermatology, Utrecht, Netherlands, 2Academic Hospice Demeter, De Bilt, Netherlands, 3University Medical Center Utrecht, Department of Medical Oncology, Utrecht, Netherlands, 4Community health Center De Bilt, De Bilt, Netherlands

Presenting author email address: e.degraaf@hospicedemeter.nl

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 over different age groups. 

Method: A cross sectional study. Patients admitted from June 2007 to December 2014 to a high care hospice across the last 3 months of life were included. The Utrecht Symptom Diary (USD), a Dutch adapted version of the Brief Pain Inventory was used to assess symptom intensity within the first week after admission, enrolled in this study.

Results: A total of 227/342 (66.4%) patients were included. 38% men, median age 74 (31–96) SD 1.2720; Ineligible patients were more likely to be >85, life expectancy <7 days, EOCG performance status=4 or survival<2 weeks.

Patients suffered from 63 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 hospice 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

Evans C.1,2, Bone A.E.1,2, Wei G.1, Games B.1, Maddocks M.1, Sleeman K.E.1, Wright J.1, Mc Crane P., Higgins J.L.1, on behalf of OGP/Care elderly
1King’s College London, Cicely Saunders Institute, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom, 2Sussex Community NH Trust, Brighton and Hove, United Kingdom, 3University of Sussex, Brighton and Sussex Medical School, Brighton, United Kingdom, 4King’s College London, Institute of Psychiatry, Department of Health Service and Population Research, London, United Kingdom

Background: Transfer to hospital in the last weeks of life is common for older adults in England. It is important for better understand individual and service factors associated with transition to enable older people to remain in their usual place of care.

Aim: To explore possible determinants of transition from home to institutional care setting in last week of life for people aged over 75 years.

Methods: Post bereavement survey of carers to people aged over 75 who died in 2012 in the South of England (n=883). Subsample analysis of decedents whose usual place of care in last 3 months was ‘own home’. Main outcome is death at home versus hospital/care home (hospice deaths excluded). Exploration of socio–demographic and illness factors (e.g. symptom burden) using multivariate modified Poisson regression.

Results: 235 decedents (8.8%) died in hospital in the last 3 months (max. 4 interviews per patient/IC/GP). 48.9% transitioned in the last 3 months to a hospital (44.7%) or care home (4.3%). Death outside usual place of care was independently associated with increasing age (85–90 years [PR=3.4; 95% CI 1.9–6.1] and over 90 years [PR=8.9; 95% CI 3.8–18.3]) versus 75–80 years, and symptom complexity with severity of breathlessness (PR=1.9; 95% CI 1.2–3.4) and difficulty communicating (9.0; 95% CI 1.5–2.8).

Conclusion: Transition from own home to hospital at the end of life is common for older adults living at home (nearly 1 in 2 experienced this). Transition occurs most frequently for the oldest old and those with severe symptoms, multimorbidity and difficulty communicating. This suggests inequalities in the provision of care and challenges of symptom control at home. To reduce reliance on hospital care at the end of life requires timely services responsive to increasing symptom distress and wider anticipation of end of life for adults of advanced age.

Funder: NIHR Research for Patient Benefit

Abstract number: FC18.3
Abstract type: Oral

Patterns of Multidimensional Change towards the End of Life for Frail Older People

Lloyd A.1, Kendall M.1,2, Starr J.1, Murray S.1
1University of Edinburgh, Primary Palliative Care Research Group, Edinburgh, United Kingdom, 2University of Edinburgh, Alzheimer Scotland Dementia Research Centre, Edinburgh, United Kingdom

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 16 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 centred 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 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: FC18.4
Abstract type: Oral

End of Life Care for Frail Older Patients in Family Practice (ELFOF) – A Longitudinal Qualitative Study on Needs, Appropriateness and Utilization of Services

Klinkwirth K.1, Müller-Mundt G.1, Geiger K.1, Bleiden J.1, Pischelberger S.1, Schneider N.1
1Hannover Medical School, Institute for General Practice, Hanover, Germany, 2Paracelsus Medical University Salzburg, Salzburg, Austria

Background: Frail elderly people represent a major patient group in family practice. So far, little is known about the patients’ needs and their possible changes over time with increasing frailty. The aim of this study was to prospectively explore the needs of frail elderly patients, their informal carers (ICs) and the perspectives of the involved general practitioners (GPs), focusing on the end of life. Funding: German Federal Ministry of Education and Research / 01GI1120

Methods: The study uses a multiple-perspective, longitudinal qualitative design. Serial in-depth interviews with 31 elderly patients (72–95 years) with moderate to severe frailty, their ICs and GPs were conducted. Interviews took place every six months over a period of 18 months (max. 4 interviews per patient/IC/GP). Narrative and thematic analysis is conducted within and across cases.

Results: From the patients’ perspective, frailty affects all aspects of life: the exhaustion of capabilities, increasing vulnerable health and symptom burden as well as social losses – interacting with patients/ICs for sustaining their self autonomy and participation. Over time, reliable in/formal support becomes increasingly important which means a substantial time effort for ICs and GPs. Thus, delivering care for frail elderly patients is demanding and complex due to multimorbidity, multi medication and limited mobility. With increasing frailty, close cooperation among doctors and other professionals, such as nursing and medical assistants, is crucial to meet the complex patient needs.

Conclusions: Elderly patients with severe frailty need a comprehensive bio-psycho-social approach in health care. The results highlight the importance of generalist palliative care delivered by GPs. Focus groups and an expert workshop with health professionals and stakeholders will be finally held to develop strategies in order to sustain the provision of end of life care in family practice.

Abstract number: FC18.5
Abstract type: Oral

Translating Knowledge into Practice: The Palliative Approach Toolkit

Parker D., Wilson J.
The University of Queensland, School of Nursing and Midwifery, Brisbane, Australia

Background: Long term care facilities are able to provide end-of-life care for their residents. The Palliative Approach Toolkit is a knowledge translation product based on an evidence based model of palliative care and includes supporting educational products and implementation guidance.

Aims: The study reports on national after death audit data collected following one day workshops to instruct long term care staff on the implementation of the Palliative Approach Toolkit.

Methods: Pre-implementation after death audits for at least five residents per facility who died prior to the workshop date were provided. Post-implementation data is all resident deaths in each facility once the new model of care was introduced. After death audits provide information on place of death, transfers to hospital in the last week of life, documentation of end of life care wishes, use of a palliative care case conference and an end-of-life care pathway.

Results: Data for 468 pre implementation and 224 post implementation after death audits was analysed. There was no significant difference in place of death at the long term care
Abstract number: FC19.1

Abstract type: Oral

Improving support for caregivers

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 5460 to 10832 patients. The carer liaisons were in clinical, administrative, and management roles. In total, 43 carers participated in the intervention. They were actively involved in carer identification and support procedures via registers; illness; palliative care (12), carer (11), 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 26 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: FC19.2

Abstract type: Oral

The Carers’ Alert Thermometer (CAT): An Instrument to Identify Family Caregivers’ Needs Whilst Providing End of Life Care in the Home

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-phased, 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. Conclusions: 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 carers’ unmet needs. The questions can be tailored depending on the specific needs of the organization, plan to used to monitor 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

Abstract type: Oral

Piloting a New Approach to Identifying, Assessing and Supporting Carers of People with Palliative Care Needs in Primary Care

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 5460 to 10832 patients. The carer liaisons were in clinical, administrative, and management roles. In total, 43 carers participated in the intervention. They were actively involved in carer identification and support procedures via registers; illness; palliative care (12), carer (11), 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 26 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

Abstract type: Oral

Short- and Long-Term Effects of a Randomised Psycho-educational Intervention for Family Caregivers in Specialised Palliative Home Care

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 5460 to 10832 patients. The carer liaisons were in clinical, administrative, and management roles. In total, 43 carers participated in the intervention. They were actively involved in carer identification and support procedures via registers; illness; palliative care (12), carer (11), 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 26 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.
Farquhar M.1, Ewing G.2, Moore C.
Witkamp E.

Advanced CO PD and the Relationship to the Caring Role

depression in 10%. The results of our ongoing analyses will report the relationship these
analysed using framework approach.

Results:
services, patient factors, Hospital Anxiety and Depression Scale (HADS: anxiety and
duration and hours of caring, patient relationship, carer health, carer support from

Methods:
A cross-sectional study (June 2009 –July 2012), in a Dutch university hospital,
among the relatives of physicians 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
(QOL2) and quality of dying (QODD) (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.

Methods:
Celebration of the 5th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015

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How Do Healthcare Systems Evaluate their Advance Care Planning Initiatives? Results from a Systematic Review

Simon J.E., Lee L.D.1, Bordo P.D.2, Davison S.N.3
1University of Calgary, Division of Palliative Medicine, Calgary, AB, Canada, 2University of Calgary, Oncology, Calgary, AB, Canada, 3University of Alberta, Division of Nephrology, Edmonton, AB, Canada

Background: Advance Care Planning (ACP) is a process of reflection and communication of a person’s future healthcare preferences. ACP is being implemented across healthcare systems around the world. However, there is no consensus on what measures to use to assess the effectiveness, impact, and sustainability of ACP implementation.

Aims: To describe and synthesise the existing information on how health care systems have evaluated the implementation of conversation-based ACP programs/initiatives.

Methods: A systematic search of the peer-reviewed and grey literature (to March 2014) was conducted to identify articles describing the implementation and evaluation of a health system-level ACP initiative. Using the PICOS model, 724 titles/abstracts from the peer-reviewed literature and 76 grey literature documents were screened, and 130 full text articles were assessed for eligibility.

Results: Most common outcome measures pertained to document completion, followed by healthcare resource use and ACP service components. Patient, family, or healthcare provider-reported outcomes were less commonly measured.

Conclusion: Document completion is frequently used to evaluate ACP program implementation; capturing the quality of care appears to be more difficult, as is evaluation across complex, multi-sector healthcare systems. This systematic review provides health system administrators with a comprehensive summary of measures used to evaluate ACP; and may identify gaps in evaluation within their local context. In Alberta, these results are being used to inform a Delphi process to determine important indicators relevant to ACP uptake within the healthcare system, and further, to develop a dashboard for ongoing monitoring of ACP implementation and sustainability across the province.

Abstract number: FC20.3
Abstract type: Oral

Economic Evaluation of Palliative Care Consultation Teams for Patients Admitted to Hospital with Advanced Cancer

May P.1, Garrido M.M.2,3, Stefanis L.2,3, Kelley A.S.3, Meier D.E.3, Normand C.1, Morrison R.S.3
1Trinity College Dublin, Centre for Health Policy & Management, Dublin, Ireland, 2James J Peters VA Medical Center, New York, NY, United States, 3Kings School of Medicine at Mount Sinai, Geriatrics and Palliative Medicine, New York, NY, United States

Background: The average cost-saving effect of palliative care consultation teams (PCCTs) for hospital inpatients with serious illness is well known. This effect is not homogenous but varies according to a complex interaction of individual and service factors. Evidence on the relationship between patient-level determinants, PCCT process and cost will further inform organisation of hospital care to patients with serious illness.

Aims: To evaluate the impact of PCCTs on hospital cost, incorporating time-to-consultation 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 PCCT during their hospital admission, 713 received usual care only. Propensity score weights were applied to estimate association between treatment effect and 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<0.001) compared to no intervention. PCCT treatment effect also varies according to selected baseline covariates; effect on cost is larger for patients with a higher number of comorbidities.

Conclusion: PCCT 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 PCCTs is yet to be fully realised: only a quarter of patients in our study saw a PCCT promptly upon hospital admission.

Abstract number: FC20.4
Abstract type: Oral

Comparing the Ability of Australian General Practitioners to Predict Death of their Older Patients Using Intuition or a Predictive Tool: A Randomised Controlled Trial

Mitchell G.K.1, Senior H.E.2,3, Rhee J.J.2, Young S.1, Teo C.K.2, Clayton J.1
1University of Queensland, School of Medicine, Herston, Australia, 2University of New South Wales, School of Medicine, Sydney, Australia, 3University of Sydney, School of Medicine, Sydney, Australia

Presenting author email address: g.mitchell@uq.edu.au

Aims: Effective end of life care requires timely identification, then appropriate planning.

Screening of general practice (GP) patient lists may be feasible. Does a screening tool help this?

Methods: Randomised controlled trial of GPs using clinical acumen versus Supportive and Palliative Care Indicator Tool (SPICIT) (modified to facilitate screening), to screen practice patients aged ≥70years, plus those <70 known to life-limiting illness. Practice records were reviewed at 6 months to identify actual patient deaths. This was compared to data from the state based death registries. Telephone interviews with GPs explored the acceptability and feasibility of the intervention, and key stakeholder groups interviewed to discuss the role of GPs in end of life care.

Results: Forty GPs were randomised (19 intervention [I], 21 control [C]). Twenty-nine GPs (I =12 and C=17) reviewed 1546 and 2873 patient records respectively. At 6 months, practice records showed 44 (2.8%) in I and 50 (2.3%) deaths (p=0.234). The proportion of patients identified as at risk was higher in intervention (I=18.4%; C=5.5%; p<0.01), as was the proportion of deaths correctly identified (I=2.0%; C=0.94%; P=0.003). Positive predictive value, negative predictive value, sensitivity and specificity were 71%, 99%, 42% and 95% for the intervention group, and 13%, 99%, 70% and 87% for control. A significant number of deaths (50% in NSW) recorded in the deaths registry was not documented in practice records. Most GPs found the intervention tool useful, but time intensive.

Conclusion: The use of the screening tool was more effective than intuition in identifying patients correctly. There was a high incidence of false positives in both groups, and the process was time intensive. Given that false positive responses require a clinical response from GPs, screening of GP records using either intuition or SPICIT does not appear feasible.

Funding: RACGP/ PC4 Research fund

Abstract number: FC20.5
Abstract type: Oral

Scaling-up Palliative Care for an Ageing Population: Proposals from the IMPACT Project

Garrido M.M.1, Davies N.1, Marthorpe G.1, Maoi L.1, Weitock. J.1, Vervoort. Dassen M.1,2, Engels Y.2
1UCL, Primary Care & Population Health, London, United Kingdom, 2UCL, London, United Kingdom, 3Kings College London, London, United Kingdom, 4Radboud University Medical Centre, Nijmegen, Netherlands

Aim: To develop a model of service provision that will allow scaling-up of palliative care expertise to meet the needs of those dying from any clinical condition.

Background: Palliative care has developed around the needs of people with cancer, and those dying with other conditions have had less access to palliative care services. This is now changing, albeit slowly, but the inclusion of other conditions requires modification of palliative care services because of the scale of need, the challenging nature of these conditions, and the limited range of palliative care skills in community settings.

Methods: A mixed methods technology development approach used:

1) Critical synthesis of the research and policy literature
2) Interviews with national experts in policy, service organisation, service delivery, patient and carer interests, and research
3) Nominal groups of researchers tasked with synthesising data and modelling palliative care.

Findings: A generic model of palliative care with embedded quality indicators has been developed in the IMPACT project. The model includes features needed for the systematisation of palliative care for a broad range of life-limiting conditions:

1) The division of labour amongst practitioners of different disciplines
2) The structure and function of care planning
3) The management of risk and complexity using shared decision-making approaches
4) Boundaries between active treatment and palliative care and between palliative and end-of-life care
5) Support for patients, families and staff through the experiences of loss and bereavement.

Conclusion: Co-design of a generic model of palliative care places the foundation for embedding palliative care within a landscape of technical tasks, sources of expertise and support for emotional needs. The generic model will be described in this presentation, and proposals made for changes in health care policy, service organisation and delivery, and palliative care practice.
Poster Prize
Abstracts
Analysis of Determinants of Impaired Role Functioning Across Prevalent Cancers

Antoniu SA1, Albu E2, Sincpoiu R1, Munteanu E1, Petrescu-V I1, Akesel L1, Miron L1
1University of Medicine and Pharmacy Gr T Popa Iasi, Interdisciplinary Palliative Care Nursing, Iasi, Romania, 2University of Medicine and Pharmacy Gr T Popa Iasi, Nursing College, Iasi, Romania, 3University of Medicine and Pharmacy Gr T Popa Iasi, Medicine, Iasi, Romania

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 EORTC QLQ-30 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 50.4 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.

Survival Time after Diagnosis of Terminal Illness: A Nation-wide Danish Analysis of Determinants of Impaired Role Functioning

Birgisdóttir D1, Furst CJ1, Nyberg Y1, Bylund Grenko E2,3
1Institute of Palliative Care, Lund University, Lund, Sweden, 2Karolinska Institute, Division of Clinical Cancer Epidemiology, Department of Oncology and Pathology, Stockholm, Sweden, 3Stockholm Sjukhem Foundation, Research and Development, Stockholm, Sweden

Background: Among parentally bereaved children there is a vulnerable group of bereaved children that are at increased risk of negative consequences when compared to their normative peers. The most constant findings of mediating factors are related to the family function after the loss, including cohesion, warmth and connection between the surviving parent and bereaved children but the existing evidence is limited, especially when it comes to teenagers and youths' own perception on family cohesion and its long-term effects on health and wellbeing.

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 damned-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.

Survival Time after Diagnosis of Terminal Illness: A Nation-wide Danish Cohort Study

Reb C1, Kjærgaard Nielsen M1, Bonde Jensen A1
1The Research Unit for General Practice in Aarhus, Aarhus University, Aarhus, Denmark
2Aarhus University Hospital, Department of Oncology, Aarhus, Denmark

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.

Aim: 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.
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
Pain

Abstract number: P1-001
Abstract type: Poster

Second Signatory for Controlled Medications: Can it Cause Hindrance to Good Breakthrough Pain Management?

Abbas S.Q.
St Clare Hospice, Palliative Medicine, Hastingswood, United Kingdom

Aims: To establish that breakthrough analgesia is administered on an inpatient unit according to the guidance.

Background: EAPC guidelines suggest that in some cases the buccal or intranasal Fentanyl preparations are preferable to immediate-release oral opioids due to more rapid onset of action and showing a higher efficacy. Fentanyl Sublingual Tablet (FST) is administered to control breakthrough pain (BTP) and a ‘top-up’ dose is administered in 15 minutes if the pain does not respond. However, the Nursing and Midwifery council (UK) recommends that for administration of controlled drugs (CD), a secondary signatory is required within secondary care. This data was collected to find out if second dose was administered in 15 minutes if needed.

Methods: Retrospective data was collected on patients at an adult palliative care unit, requiring second dose of FST. Information was collected from CD record books and patients’ notes.

Results and analysis: Over a period of three years, 46 episodes of BTP requiring second dose of FST were recorded. A top-up dose was signed for at 15 minutes for only 13 (28.2%) episodes. A further 14 (30.4%) doses were signed for with five minutes delay (20 minutes in total from first dose). 19 (41.3%) doses were signed for after 20 minutes with a range of 25 – 50 minutes (10 – 35 minutes delay). Note that there will be a further delay in administering the dose.

Conclusion: The majority of patients have BTP for less than 45 minutes. After reporting, it takes time to get the medication to the patient. The second dose may be delayed further, causing pain prolongation. This delay is due to finding a second nurse to check medication. Possible solutions include:

1) Checking both doses out at same time and allow patients to self-administer after 15 minutes if necessary. Medication can be signed back in if not required.

2) Allowing a single nurse check for second dose.

3) Allowing patients with capacity to take control of their BTP analgesia whilst on an inpatient unit.

Abstract number: P1-002
Abstract type: Poster

A Retrospective Audit to Assess Symptom Prevalence in Patients Who Receive Peripheral Blood Stem Cell Transplant

Landa A., Chapman N., Daniel A., Hawsworth U., Alhamd A.
1University of Manchester, Manchester Medical School, Manchester, United Kingdom, 2Central Manchester University Hospitals NHS Foundation Trust, Palliative Medicine, Manchester, United Kingdom

Background: For many haematological cancers, Peripheral Blood stem cell transplant (PBSCT) therapy is used. This can be from the patient themselves or from a donor. PBSCT’s can give debilitating and severe side effects such as mucositis, diarrhoea, nausea and vomiting, which can impact on the patient’s recovery and wellbeing.

Aims: To establish the prevalence of symptoms in patients who receive PBSCT. To establish whether the Palliative care team is being involved for symptom management.

Method: Retrospective study looking at 32 adult patients (23 male, 9 female) who had received therapeutic PBSCT. Patient documentation and Oral Care Hygiene plans were used to assess the frequency and severity of the symptoms, up to 15 days post-transplant.

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 allogeneic PBSCT patients and 7% 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 3 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.

Conclusion and recommendations: Symptom prevalence is high among patients who undergo PBSCT. However only a small proportion of these patients get referred to palliative care. Our recommendations include a specific guideline for management of PBSCT related symptoms and early referral to palliative care to reduce symptom burden and potential quicker recovery.

Abstract number: P1-003
Abstract type: Poster

Management of Neuropathic Pain (NP) Using the Capsaicin 8% Patch in Patients at a Tertiary Cancer Hospital

Bhaskar A.K., Cundy S., Beine G.
Leeds Teaching Hospitals: NHS Trust, Neurosciences, Leeds, United Kingdom, 1The Christie NHS Foundation Trust, Anesthesia and Critical Care, Manchester, United Kingdom, 2Pennine Acute Trust, Oldham, United Kingdom

Presenting author email address: akbhaskar@btinternet.com

Background: Cancer patients experience NP due to the disease or its treatment and systemic treatments often offer partial analgesia and are limited with adverse effects. We describe our experience using the capsaicin 8% patch to treat patients with cancer-associated NP over a period of four years.

Methods: All patients treated with the capsaicin 8% patch between June 2009 and January 2014 were included in the analysis. Pain levels were assessed using an 11 point scale as part of the PainDETECT questionnaire and the Clinical Global Impression of Change Scale.

Results: A total of 112 patients were treated with the Capsaicin 8% patch. Pain diagnoses included chemotherapy-induced peripheral neuropathies, post-surgical and post-radiotherapy pain, cancer pain with areas of focal NP post-herpetic neuralgia and other neuropathic pains. Some patients had good results following a single application whilst most patients required multiple applications at three monthly intervals. Reductions in pain scores 4–8 weeks after treatment are given below (Table). The Capsaicin 8% patch was particularly effective in patients with chemotheray-induced neuropathy (CN). In most patients, analgesia was reported after 24–48 hours, was sustained and was associated with an increase in activities that were previously limited by pain. Significant reductions in the use of opioids and systemic NP medications were reported.

Abstract number: P1-004
Abstract type: Poster

Where Should I Start? Reported Practices and Confidence of Medical and Non-medical Prescribers in Initiating Opioids for Pain in Palliative Care Patients

Blackman T., Mark D.
1East Sussex Healthcare NHS Trust, Eastbourne, United Kingdom, 2East Sussex Healthcare NHS Trust, Palliative Care, Eastbourne, United Kingdom

Presenting author email address: t.blackman@nhs.net

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?

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 reminders 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% Specialist nurse/16% other). More than half (53%) looked after palliative care patients on at least a weekly basis. 54% of respondents had inhaled 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% stated they would use standard release morphine initially. Over 60% co-prescribe regular laxatives, 70% pnm antienemics and 20% pm naxolone. 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.
Use of Parenteral Sufentanil in a French Palliative Care Unit

Background:
The drug sufentanil is commonly used in buccal or sublingual (SL) regimen for BTcP treatment. However, in some patients they can cause significant adverse effects and drug-drug interactions (DDIs). Opioids most frequently reported to cause DDIs were morphine, fentanyl, and methadone. This study shows a larger use of sufentanil than the French recommendations. One of the main reasons is the easy use of sufentanil by subcutaneous perfusion.

Methods:
A multicenter, open-label, single arm, observational study performed in Q4 2013-Q1 2014 in 58 pain centers over a 12-month period. 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 basis 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 (8 papers).

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 basis 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 (8 papers).

Opioid DDIs 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 rapidly growing. Still, the cases identified in this systematic review give some important suggestions for clinical practice. Physicians prescribing opioids should recognize the risk for DDIs and if possible avoid polypharmacy.

The research received no financial support.

Poster Sessions (Poster Exhibition Set 1)
Aim: This systematic review aims to analyse the evidence to support the administration of analgesics given spinally to patients with intractable cancer pain, considering balance between analgesia and side effects.

Methods: Search strategy was based on words related to cancer, pain, spinal route, analgesic and side effects. Databases: PubMed, Embase, Cochrane. Inclusion criteria: randomised controlled trials, n≥20, adults with cancer pain, failure with previous systemic opioid treatment, outcomes of long term spinal analgesia and English language. Methods, results, quality of evidence, and strength of recommendation (Grade Working Group) were analysed.

Results: From 2142 abstracts, nine articles were analysed and divided in: 1) spinal combinations of opioid (morphine or sufentanil) and adjuvant analgesic (bupivacaine, clonidine, ketamine, neostigmine or midazolam) vs. spinal administration of opioid alone (n=4), 2) single spinal drug (morphine or aqueous phenol) in bolus vs. continuous administration (n=2), 3) single spinal drug (ziconotide) vs. spinal placebo (n=1), and 4) spinal opioid (morphine or hydromorphone) combined with or without adjuvant analgesic (not specified) vs. spinal placebo (n=1). Intact spinal and epidural routes were described. All studies presented limitations, which affected studies' internal validity and grade of recommendation. However, they demonstrated better pain control during combination administration of clonidine and ketamine, adjuvant continuous infusion, administration of ziconotide, and use of implantable intrathecal system. Side effects were described, but there were few significant differences.

Conclusions: The number of studies and their outcomes provide low quality of evidence and, as a result, weak recommendation for using spinal analgesics in adults with cancer. Further investigation is necessary.

Evidence-based Recommendations from EAPC. A project of the EAPC-IN.

Poster number: P-011
Abstract type: Poster

Is Radiotherapy Useful for Treating Pain in Mesothehlima? A Phase II Trial
Macleod N.1, Chalmers A.2, O'Rourke N.3, Mcmahon L.2, Stobo J.2, Bray C.2, Price A.1, Moore K.3, Macleod N.1, Arria N.4, Mosato M.5
Kagoshima University, Division of Hematology and Immunology, Kagoshima, Japan, 2Kagoshima University, Palliative Care Center, Kagoshima, Japan, 3Kanoya Medical Center, Palliative Care Team, Kanoya, Japan, 4Aomori Prefectural Central Hospital, Palliative Care Center, Aomori, Japan

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 had been administered to eight patients with gastric cancer (1), lung cancer (2), ovarian cancer (2), pancreatic cancer (1), malignant peripheral nerve sheath tumor (1), and 1 adult leukemia/lymphoma(1).

Results: All patients claimed that lidocaine provided 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.

Discussion: After confirming by challenge test (intravenous infusion of 1 mg/kg lidocaine) that lidocaine was effective in all patients, we started to use lidocaine with other opioids, their pain almost completely resolved.

Conclusion: After confirming by challenge test (intravenous infusion of 1 mg/kg lidocaine) that lidocaine was effective in all patients, we started to use lidocaine with other opioids, their pain almost completely resolved.

Poster number: P-011
Abstract type: Poster

Prevalence and Pharmacological Treatment of Neuropathic Pain in Cancer Patients Admitted to Specialized Palliative Care
Schönlein L, Jungkamp P, Palaud M. Randers Regionshospitalet, Randers, Denmark

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 overall suffering even after controlling for cancer burden. 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 established NP and are often receiving inadequate medication for this pain.

Aims: 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 in CPC 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 diseases (1464 patients). CPC: Pain and Palliative Care. Data are collected. Inclusion of 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 FNPS 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. Out 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.

Poster number: P-011
Abstract type: Poster

The Effect of Lidocaine on the Abdominal Pain Caused by Peritoneal Dissemination
Markova K.1, Matsutaka K.1, Inatsutsu E.1, Nishio M.1, Haraguchi S.1, Kubo M.1, Haraguchi Y.1, Yoshitomi M.1, Avina N.1, Mosato M.5
Kagoshima University, Division of Hematology and Immunology, Kagoshima, Japan, 2Kagoshima University, Palliative Care Center, Kagoshima, Japan, 3Kanoya Medical Center, Palliative Care Team, Kanoya, Japan, 4Aomori Prefectural Central Hospital, Palliative Care Center, Aomori, Japan

Abstract number: P-014

Aim: To audit current regional practice in relation to the management of cancer related neuropathic pain. Future studies examining differing radiotherapy regimens with a view to improving response rates are warranted.

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 cancer related neuropathic pain are:

1) To update current regional practice in relation to 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.

Potential benefits of cancer related neuropathic pain:

Abstract number: P-013

Abstract type: Poster

Management of Cancer Related Neuropathic Pain. Answers to the “Burning” Questions
Coyte S.1, McGlynn L., Ting G.1, Simpson S.1, Sulavanka E.1, Leng G.1, Marley K.1
1Willowbrook Hospice, Prescot, Merseyside, United Kingdom, 2Anteine University Hospital, Liverpool, Merseyside, United Kingdom, 3Anteine University Hospital, Liverpool, United Kingdom, 4Southport and Ormskirk NHS Trust, Southport, United Kingdom, 5St Rocco’s Hospice, Warrington, United Kingdom, 6Courtes of Chester Hospital NHS Foundation Trust, Chester, United Kingdom

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 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 validated assessment tool to detect and treat the excited state of neuropathic pain. The available tools are still used in combination with adjuvant analgesics. There are no trials comparing the efficacy of different opioids.

Existing guidelines advise use of anticonvulsants and antidepressants as adjuncts to opioid analgesia. There is Level 1 evidence for the use of Gabapentin, Pregabalin and Amitriptyline. Limited evidence for Clonazepam and Steroids. No evidence for Lidocaine, Capsaicin, Topical anaesthetic cream. There is evidence for non-pharmacological interventions including the use of Hydrotherapy, TENS, Scrambler and Psychological interventions.

Conclusion: Cancer-related neuropathic pain is usually unresponsive or partially responsive to opioids. There is evidence for the use of adjuvant analgesics such as Amitriptyline, Gabapentin and Pregabalin. Evidence for the management of cancer related neuropathic pain is limited.
Abstract number: P1-015
Abstract type: Poster

**Effects of Acetaminophen at Different High Doses (2.4 g-4.0 g/Day) on Cancer Pain and Hepatic Toxicity**

Miyashira T.*, Kouogi T.*, Hashiya Y., Sato H., Matsunaga H.*
1. Saga Medical Center, Japan

**Purpose:** The Japanese Society for Palliative Medicine has published a Clinical Practice Guideline entitled ‘Clinical Practice Guidelines for Cancer Pain Management’ in this Guidelines. 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 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 acetaminophen level (ALT) and serum aspartate aminotransferase (AST). Patients were divided into three groups who received acetaminophen at 2.4g/day (2.4g group, n=43), 3.2g/group (3.2g group, n=46), and 4.0g/day (4.0g group, n=20), respectively. Pain was scored with the Numerical scale (NRS).

**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 increase 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, p < 0.001 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**

Bhaskar A.K.1, Nagaratnam M.
1. Leeds Teaching Hospitals NHS Trust, UK
2. Hospital Gauß, Germany

**Background:** Oxoid-induced constipation is a problem faced by cancer patients and combining Oxycodone with Naloxone (Targinact/Targin) is a way of addressing this common side-effect. We describe our clinical experience over the past 3 years using this drug. We are also reporting two cases of systemic side-effects of oxycodone injection in advanced cancer patients.

**Methods:** Our analysis was performed on oxycodone and naloxone combination drug and did not experience any significant opioid-related side-effects. An average of 17 days elapsed before patients felt improvement in constipation and bowel movements. Patients using frequent rescue analgesia with oxycodone did not benefit much.

**Results:** A total of 53 patients were included (mean age: 80.6±8.2-14 men; 26 hypnosis; 27 massage. We looked at the economic implications of switching over to combination drug including use of laxatives. A cross-section of the patients treated with the drug, who reported side-effects unrelated to the oxycodone, were also analysed for causality.

**Results:** Most patients had equal analgesic switch from Oxycodone or Morphine to the combination drug and did not experience any significant opioid-related side-effects. An average of 17 days elapsed before patients felt improvement in constipation and 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 diarrhea as compared to what was reported in clinical trials. Two patients had hospital admission with symptoms and signs of opioid-withdrawal, liver metastasis was considered to cause porto-systemic communication resulting in nafoxone getting into systemic circulation despite normal liver function.

**Conclusions:** Data from clinical practice from two centres showed that there is some cost benefit in switching to the combination drug especially at lower doses and in patients with stable analgesia. Drug is to be avoided or caution is to be exercised while using in the presence of liver metastasis due to systemic effects of opioid reversal by naloxone.

Abstract number: P1-017
Abstract type: Poster

**Rapid Titration by Intravenous Administration of Oxycodone Injection in Cancer Patients with Severe Pain**

Nakajima N.*
Tohoku University, Graduate School of Medicine, Department of Palliative Medicine, Sendai, Japan

**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 opioid for the management of cancer pain. The purpose of this study was to evaluate the effects of rapid titration using oxycodone injection in combination 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≥8 and/or 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 80% within 24 hours in Morphine-group and Oxycodone-group, respectively, showing no significant difference. As for adverse effects, nausea/vomiting, sleepiness, and respiratory supression 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**

Pautex S.1, Ardigo S.2, Delaire L.2, Moret V.1, Gianelli S.1, Hermann F.2, Gold G.2
1. Community Palliative Care Unit, Division of Primary Care, Carouge, Switzerland, 2. Division of Geriatrics, Geriatrics, Internal Medicine and Rehabilitation, Geneva, Switzerland

**Introduction and objective:** Painless can be 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 hospitalized patients.

**Methods:** A single center 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 analgesic treatment, no cognitive impairment. Brief pain inventory was completed.

**Results:** 53 patients were included (mean age: 80.6±8.2- 14 men; 26 hypnosis; 27 massage. Pain intensity decreased significantly in both groups after each session. Analgesic dose measured by the brief pain index sustained a greater decrease in the hypnosis group compared to the massage group during the hospitalisation\(s\) 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**

Peckmann Post L.1, Mücke M.2, Rolle R.
1. IWK Aachen University Clinic, Palliative Medicine, Aachen, Germany, 2. University Hospital Bonn, Palliative Medicine, Bonn, Germany, University Hospital Bonn, General Practice and Family Medicine, Bonn, Germany

**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 overdosing 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 opioid doses (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 equipotent 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 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.
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

Chen W1, Ng C1, Lee C2, Cheng P1, Si SW2, Leung TW1
1Queen Mary Hospital, Clinical Oncology, Hong Kong, Hong Kong
2Queen Mary Hospital, Occupational Therapy, Hong Kong, Hong Kong
3Queen Mary Hospital, Physiotherapy, Hong Kong, Hong Kong

Presenting author email address: cw084@hka.org.hk

Breathlessness is common in advanced cancer patients. Because of its complex biopsychosocial etiology, patients’ presentations 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, our 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 the 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%]). 187 (89.50%) were offered PI and 193 (89.35%) were offered NPI. There was a significant increase in use of NPI (26.86% in PI vs. 89.35% PI only). The three most commonly used NPI were use of fan (97.92%), 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<0.01; 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.

Continuous Intrathoracic Morphine Infusion for Intractable Cancer Dyspnea

Fujishige T, Tagami N, Yamada S
Kurume University Hospital, Palliative Care Center, Kurume, Japan

Aim of investigation: We are using continuous intrathoracic morphine infusion for pain management at our institution for patients with severe cancer pain. Among these patients, a few did not complain of dyspnea in spite of poor respiratory status, which is usually thought to cause severe dyspnea. On the basis of this experience, we speculated about the effect of continuous intrathoracic morphine infusion for patients with severe cancer pain.

Methods: We performed continuous intrathoracic morphine infusion for 11 patients with severe cancer dyspnea (mean age, 63.8 years). We evaluated the dyspnea by using the numerical rating score (NRS) 0-10. All 11 patients experienced dyspnea with an NRS score ranging from 5 to 0 on lying down quietly. After lobar subcarinoidal puncture, we introduced an epidural catheter into the subcarinoidal space, and started continuous morphine infusion. The daily morphine dose was calculated using one-hundredth of the calculated daily oral morphine equivalent dose used earlier.

Results: The final daily dose of morphine was 7 to 40 mg (mean dose 18.3mg). The duration of morphine infusion was 4 to 63days (mean duration 16.6days). In 8 of 11 patients, dyspnea improved to NRS 3 or less at rest without consciousness disturbance. This method was effective for the dyspnea due to hypoxia associated with lung metastasis or lymphangitic carcinomatosis of the lung. However, the palliation of dyspnea after movements such as walking was difficult.

Conclusion: Intrathoracic morphine dose escalation for cancer dyspnea causes drowsiness. In many cases, continuous intrathoracic morphine infusion was found to be effective for patients with intractable cancer dyspnea. Pain management with intrathoracic morphine infusion is particularly recommended in the case of patients who have intractable cancer pain and are likely to develop severe dyspnea.
Assessing Referrals for 'Palliative' Oxygen Therapy

Davies J.L., Khan S.A.

Background: It is not unusual for breathless non-hypoxaemic palliative care 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.

Aims:
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. In 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 initiated 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.

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)

Ryan E.1, Spoths A.1, Clow A.1, Booth S.1,2

1Cambridge University Hospitals NHS Foundation Trust, Cambridge, United Kingdom.
2University of Cambridge, Cambridge, United Kingdom.

Abstract number: P1-026

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 undergo 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 28 (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 recruitment is ongoing.

Conclusion: Recruitment has been slow and attrition high, but not prohibitively so. Overall, participants report a positive research experience.

Body Composition in Older Patients with Cancer Cachexia Syndrome

Ferrell B.1

1University of São Paulo, Division of Internal and Geriatric Medicine, Ribeirão Preto, Brazil.

Abstract number: P1-027

Background: The three Ps – occupational therapy approaches to fatigue management in cancer and palliative care.

Introduction: Fatigue is an important symptom 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’ ‘occupational therapy’ ‘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 Hartley, 2010). Typically patients participated in 3 or 4 sessions (Barsevick et al, 2004).

Conclusion: Occupational therapists have a key role to play in assessing and managing fatigue. Intervention typically includes 3 or 4 sessions, including 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 not very 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

Albuquerque K.1, 2, Mattos-Pimenta C.A.
1University Federal of Pernambuco, Nursing Department, Recife, Brazil, 2University of Sao Paulo, Nursing School, Sao Paulo, Brazil

Background: Distortions of body image that the individual designs for themselves are troubling and may reflect dissatisfaction with themselves, 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/PS60%. Patients were classified into pre-cachexia (pre-CACS, n = 53), cachexia (CACS, 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 52y (SD = 10), most had not metastasised and was not in 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, 45.3% and 64.8%, respectively, underestimated their body size. In the group no-CACS, 38.4% 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 high 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

Lo R.K.Y., Cheung S., Chan N., Kwan C., Mok A., Liang K.S.
Shatin Hospital, Hong Kong, China

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 non-physical causative factors are neglected and new non-pharmacological palliative care approach. Aims: To screen and identify all the underlying causes and evaluate the results of a multidisciplinary specialist-led programme in treating fatigue in palliative cancer 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. Each case is reviewed in depth. A checklist and care plan were incorporated to elucidate the causes. An individualised treatment support plan was initiated. Outcome measures include Brief Fatigue Inventory, Fatigue NRS, Modified Functional Assessment Capacity, PPS, 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: 31 consecutive cancer patients were recruited. 14 could not complete 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)**

### Abstract Number: P1-033
**Abstract Type: Poster**

### Title: In Gabapentin Effective for Uraemic Pruritus? A Systematic Review

**Authors:** Porta-Sales J.1, Guervos-Torrelles M.1, Sarà-Éscaré J.1, Clàpés-Puig V.1, Llorens-Torné M.1, Gellano-Barajas M.1, Moreno-Alonso J.1, Trejo-Navarro J.1, Fernández-Sevilla A.1

**Affiliations:** 1. Institut Català d’Oncologia, Palliative Care Service, L’Hospitalet de Llobregat, Barcelona, Spain, 2. Universitat Internacional de Catalunya, WeCare Chair, Sant Cugat del Vallès, Spain, 3. Instituto Catalán d’Oncologia, Clinical Haematology, L’Hospitalet de Llobregat, Barcelona, Spain

**Presentation Abstract Number:** P1-033

**Abstract Type:** Poster

**Background:** Few reports exist on the potential benefit of integrating palliative care with onchomematological outpatient clinic. Aim: To assess changes in pain and symptoms during the first 3 months of follow-up in patients (pts) with Multiple Myeloma (MM) treated at an Integrative Palliative Care and Oncohematological outpatient clinic (IPCOH).

**Methods:** Consecutive pts scheduled for a visit at the IPCOH were assessed at the 1st, 2nd and 3rd visits and beyond (up to 90 days). Pain interference with Sleep, General Activity, and Mood was recorded. Pain progression was assessed with the Edmonton Classification System-Cancer Pain. Analgesic use was also evaluated. Missing symptom data were managed with the Last Outcome Carried Forward strategy. Pain and symptoms were scored as none-mild (≤4) and moderate-severe (>4). Changes in pain and symptoms from baseline were assessed with the Wilcoxon Signed Ranks Test.

**Results:** During the year 2013, 67 pts (33 women) were included. Mean age was 69 years. At the 1st visit, 84% pts had pain; of these, 87.5% had a poor pain prognosis. The percentage of pts with ‘Worst pain’ ≤4 at the 1st visit, 2nd (median 14 days), 3rd (median 21 days) and beyond the 1st visit (median 30 days) was 45%, 55%, 61%, and 82%, respectively (P<0.0001). The proportion of pts reporting pain interference improved from baseline, as follows: Sleep (22% vs. 9%; P<0.001), General Activity (46% vs. 12.5%; P=0.001) and Mood (46% vs. 18%; P<0.001). The median symptom load scores of physical (P=0.03) and emotional (P=0.02) symptoms improved over time. Basal strong opioids use increased from 55% to 78%; P=0.0001.

**Conclusions:** Pain remains a major problem in pts with MM. Pain and other symptoms, both physical and emotional, improved during follow-up. Close collaboration between PC specialists and haematologists proved beneficial in our context.

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**Abstract Number: P1-034
**Abstract Type: Poster**

### Title: forms | Attributions and Beliefs of Palliative Care Physicians in the UK and Ireland Toward Artificial Hydration at the End of Life

**Authors:** Doherty G.1, Pickard J.1, Phagan A.1, Kay S.1, Roberts D.1, Ahamad A.1

**Affiliations:** 1. St. Anna’s Hospice, Cheadle, United Kingdom, 2. Central Manchester University Hospitals NHS Foundation Trust, Manchester, United Kingdom

**Presentation Abstract Number:** P1-034

**Abstract Type:** Poster

**Background:** Artificial hydration at the end of life (AHEoL) is controversial due to a lack of robust scientific evidence and complex ethical considerations. This has been further highlighted by recent media attention.

Aim: To assess the current attitudes and beliefs of Palliative Care physicians in the UK and Ireland towards AHEoL.

**Methods:** A questionnaire survey of members of the Association for Palliative Medicine of Great Britain and Ireland was conducted from April to June 2014.

**Results:** A total of 294 questionnaire responses were received (36% response rate). The majority of respondents were consultants practising 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 all had 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 discussed AHEoL with patients and/or their families. When asked about whether AHEoL worsened symptoms at end of life, 78% responded ‘may be’ 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.

**Conclusions:** This study 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.

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**Abstract Number: P1-035
**Abstract Type: Poster**

### Title: Death Rattle

**Authors:** Brøndum L.1, Ramsenthaler C.1

**Affiliations:** 1. Hospice Limfjord, Skive, Denmark

**Presentation Abstract Number:** P1-035

**Abstract Type:** Poster

**Background:** 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 25-90% of dying patients. Evidence shows that antimuscarinic drugs can decrease the death rattle but there is no evidence whether aspiration of the secretions in hypopharynx can decrease it. There 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.

**Methods:** One year terminal palliative care 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.

Conclusion: 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.

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**Abstract Number: P1-036
**Abstract Type: Poster**

### Title: The Prevalence of Constipation: A Systematic Review

**Authors:** Erichsén E.M.1,2

**Affiliations:** 1. Linköpings University, Campus Norrköping, Dep. of Social and Welfare Studies, ISV, Norrköping, Sweden

**Presentation Abstract Number:** P1-036

**Abstract Type:** Poster

**Background:** The prevalence of constipation in palliative care has varied in prior research, from 18-90%, measured with both a frequency-based and a patients-perceived definition.

**Objectives:** 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 485 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).

**Results:** The prevalence of constipation varied from 7-43%, depending on the definition used. Two constipation-groups were found:

- (a) Only Medical constipation (7%)
- (b) Only Perceived constipation (19%)
- (c) Both Medical and Perceived constipation (16%).

- (d) No differences in symptom severity between groups, 71% of all constipated patients had severe constipation

**Conclusion:** The prevalence of constipation may differ, depending on the definition used and how constipation 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 patients definition has to be further explored and assessed.

**Keywords:** Palliative care, constipation, prevalence, definition, symptom-distress

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### Title: Is Gabapentin Effective for Uraemic Pruritus? A Systematic Review

**Authors:** Enchsen E.M.1

**Affiliations:** 1. Linköpings University, Campus Norrköping, Dep. of Social and Welfare Studies, ISV, Norrköping, Sweden

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**Background:** Gabapentin with placebo, in varying dosing schedules. All studies showed statistically significant (p values set at < 0.05) improvement over 4 weeks in mean pruritus scores on the visual analogue scale compared with placebo. There was methodological falling in one RCT, which importantly failed to describe how many patients received the intervention. Side effects were generally short lived but included somnolence, dizziness and fatigue and in one study caused two patients to drop out.

**Conclusion:** There is limited evidence of moderate quality for the effectiveness of gabapentin in reducing pruritus in patients with CKD. A larger RCT using gabapentin as the intervention for pruritus in this disease group is warranted.
Abstract number: P1-038
Abstract type: Poster

O₂ or No in Palliative Medicine?
Robinson C.1, Scott A.2, Bonwick M., Thompson A., Oakes S.1
1Marie Curie Hospice Liverpool, Liverpool, United Kingdom, 2Mersey Deeanry Palliative Medicine Trainees, Liverpool, United Kingdom, 4Willoowbrook Hospice, Liverpool, United Kingdom, 5Liverpool Heart and Chest Hospital, Liverpool, United Kingdom
Presenting author email address: claire.robinson@mariecurie.org.uk

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, HICM, Medline, PsychINFO, BNI, CINAHL, Health Business ELITE. Terms 'palliative' 'end of life' or 'terminal' were combined with 'oxygen' to search the titles. 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. Abemetry's trial in 2010 has addressed many of the limitations of previous trials including sample size, trial duration and patient-centred outcomes yet still found no additional benefit of oxygen over air in palliative patients.

Conclusion: The risk benefit ratio for the use of oxygen needs to be assessed on an individual patient basis against the disadvantages including social stigma, reduced mobility, patient safety and potential side effects.

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
Carter J.M.1, Neerkin J.2, Stone P.1
1Saint Francis Hospice, Romford, United Kingdom, 2University College London Hospital, Palliative Medicine, London, United Kingdom, 4University College London, Marie Curie Research Department, London, United Kingdom

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.

As part of the preparatory feasibility we undertook a retrospective notes review.

Aim: 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.

Methods: 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 levetiracetam as they approached the terminal stage of their disease. When patients were unable to swallow, the majority (11/12, 92%) were switched to continuous SC midazolam infusions; 2/12 (17%) also required SC phenobarbital. Patients remained on SC anticonvulsant infusions for a median of 7 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% attrition we can still expect to recruit the planned 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
Schar S., Mergel E., Mayrhofer M., Watzke H.,
Medical University of Vienna, Division of Palliative Care, Vienna, Austria

Background: Palliative Sedation (PS) is becoming an increasingly used practice in end-of-life care. In clinical practice there is a lack of definitions, indications and treatment decision making is still difficult to achieve. To determine 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 co-medications of sedated patients, drugs used for PS and duration of PS in the last two weeks of life were recorded.

Results: In total 2424 cancer patients died at 23 AUPAC units, median age was 74 (range 20-104 years), 52% were female. 20.8% (n=503) received PS and 71% of all sedated patients deep continuous sedation. In 33% PS was given in the last 24 hours before death. Main indications for PS were delirium (51%), existential suffering (32%), dyspnoea (30% and pain (20%). Drugs were midazolam (79%), lorazepam (53%) and haloperidol. There was no detectable difference in survival time between sedated and non-sedated patients. Sedated patients were significantly younger (p<0.0001), male (p<0.014) and received significantly more opioids (p<0.043) and deepening tranquilizers: A p=0.014).

Conclusion: This study allows the first insight into prevalence, and decision-making of PS in patients in Austria. Indication and treatment decisions vary widely across AUPACS 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 Deceased Persons with Intellectual Disabilities: The Moment of Physicians’ Recognition of People Nearing End-of-Life
Unsworth C., Christians M.G.M., Echteld M.A.T., Van Schoyenstein Lantman-de Valk H., Groot M.M.
1 Radboud University Medical Centre, Healthcare for People with Intellectual Disabilities, Nijmegen, Netherlands, 2Foundation Science Balance, Rotterdam, Netherlands, 3Radboud University Medical Centre, Expertise Center Palliative Care, Nijmegen, Netherlands

Background: Physicians for people with intellectual disabilities (ID) are increasingly confronted with patients in need of palliative care. However, early identification of those people with ID 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.

Aims: In the present study we aim to describe when physicians recognise people with ID nearing end-of-life. Next to this we aim to describe determinants, such as signals and symptoms, of the moment physicians recognise people 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 people nearing end-of-life vary greatly. Most reported signals that led to this recognition were changes in typical behaviour of the patient, a decline in functioning and not responding to treatment or medication. Most reported symptoms were fatigue, depression, 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 people 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 Nonpharmacological Interventions for the Treatment of Chronic Cough in Patients with Interstitial Lung Disease: A Systematic Review
Carvajalino S., Cardoso C., Mayrhofer M., Watzke H.
1Fundación Santa Fe de Bogotá, Internal Medicine, Bogotá, Colombia, 2Kings College London, Palliative Care, Policy and Rehabilitation, London, United Kingdom

Introduction: Chronic cough is cough lasting more than 8 weeks. It affects up to 80% of patients with Interstitial Lung Disease and is a major disruption in quality of life for patients due to the fact that it can produce 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-of-1 trial. Among the studied interventions were IFN, thalidomide, prednisolone, cotrimoxazole, floxycaine, tramadol, nebulized morphine, magnesium, codeine, and levodropropizine. Even though the studies showed effectiveness for thalidomide, prednisolone, cotrimoxazole, tramadol, moxidizone 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 nor on the 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

Burtonwood L.1, Perkins P.2.1
1Gloucestershire Hospitals NHS Foundation Trust, Cheltenham, United Kingdom, 2Sue Ryder Leckhampton Court Hospice, Cheltenham, United Kingdom, 3Gloucestershire Hospitals NHS Foundation Trust, Palliative Medicine, Cheltenham, United Kingdom.

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). The main presenting symptoms were severe pain and oral hygiene. The majority of dying patients manifest at least one of these factors. For example, a significant anti-muscarinic burden, reduced oral intake and the physiological toll of a terminal illness may all increase the risk of developing ABP. Some have even suggested the onset of ABP is a surrogate marker for imminent decline and death. Where it does occur, the significant pain, highly visible swelling and difficulty swallowing can cause great distress for both the patient and relative. Prompt antibiotic therapy and other simple conservative measures are known to be an effective means of palliating these symptoms. As such, it is of significant relevance to palliative care and yet to our knowledge it has not been described in the palliative medicine literature.

Our poster reviews the predisposing factors, clinical course and treatment of ABP in the two cases at our SPCU. We also present a review of the literature regarding ABP and its management. We argue that the dying patient should be considered very high risk for its development. We advocate prompt recognition and treatment to reduce the impact of this distressing complication in the dying patient.

Abstract number: P1-044
Abstract type: Poster

Nutritional Supplement Use in Hospice Inpatients: Review of Prevalence and Rationale

O’Neill K.1, Mohd Adzlan F.1, Lester L.1, O’Connor B.1, 2UH, Dublin, Ireland, 1University College Dublin, Dublin, Ireland.

Introduction: Nutritional status declines in advanced disease. Nutritional supplement use encompasses complete and incomplete dietary supplements, vitamins and minerals. Although prescribed for malnutrition, limited guidance informs their use in palliative medicine.


Methods: A retrospective medical record review of 102 consecutive deceased patients was conducted at a palliative care unit. A data recording form evaluated nutritional supplement use. Descriptive statistics were generated with Microsoft Excel.

Results: The studied cohort comprised 92 cancer and 10 non-cancer diagnoses. 42% (43/102) were prescribed a supplement, a third of whom were prescribed more than one. 14% (6/43) received supplements by enteral/parenatal routes. 86% (37/43) were administered orally. The majority were prescribed prior to admission, most commonly iron. 35% (14/41) started supplements during admission with Vitamin C most frequent (5/14). However, this was used for oral hygiene rather than nutrition. 49% (50/102) were prescribed steroids for multiple indications which may have had an appetite stimulant effect. Prescription for vitamin supplementation rationales were recorded in less than half. In 48% (17/43) supplements were continued until the day of death. Conclusion: 1. Almost half received one or more supplements. 2. Supplement polypharmacy is a key issue. 3. Rationales were recorded in less than 50% of cases. 4. Vitamins and minerals were most used. 5. Future studies should focus on the impact of supplements and stimulants on appetite, weight and quality of life.

Abstract number: P1-045
Abstract type: Poster

Cancer-related Insomnia: Wireless Monitoring of Sleep Metrics

O’Connor B.1,2, 3Ui O’Dhubhthaí P., 4Balding L.,1 O’Leary N., 2Higgins S., 2Walsh D.1,2,3
1Our Lady’s Hospice and Care Services, Harold’s Cross, Dublin, Ireland, 2University College Dublin, Dublin, Ireland, 3Trinity College Dublin, Dublin, Ireland. Presenting author email address: boconnor@iol.ie

Background: Insomnia is defined as difficulty with sleep onset, maintenance, early morning waking or non-restorative sleep. Prevalence is 30-75% in advanced cancer. Daytime consequences include fatigue and impaired memory/concentration. It is under-reported, overlooked and severely impacts quality of life. Sleep history diaries underestimate insomnia. Objective measurements previously required dedicated sleep laboratories. Wireless medical technology enables objective sleep measurement in the natural environment.

Aims: 1. Conduct a feasibility study to examine if a wireless monitor can measure sleep in cancer 2. Evaluate user interface/acceptability in: a. Patient b. Nursing c. Correlate device results with subjective sleep diary 3. Correlate device results with subjective sleep diary

Methods: A prospective observational study recruited 10 consecutive cancer inpatient admissions to a specialist palliative care unit. Sleep Metrics Activity Index recorded subjective sleep diary. Participants used a wireless non-contact bedside sleep monitor (SleepMinder®) for 3 nights. A daily sleep diary was completed. Acceptability questionnaires were completed by both patient and nurse. Descriptive statistics were generated with Microsoft Excel. Further evaluation in community ongoing.

Results: All 10 participants had metastatic cancer (lung 5), gastrointestinal 4, breast 1. Median age was 63 years (range 47-61). Median Eastern Cooperative Oncology Group (ECOG) performance status was 2 (range 1-3). In 50%, sleep onset was delayed >30 minutes on 2 or 3 nights. Median sleep duration was 7.5 hours in the diary vs. 8 on the device. Both diary and device recorded a median of 1 awakening per night (range 0-8). Median sleep efficiency (proportion of time in bed spent asleep) was 89% (range 74-100%). Participants and nurses reported 100% device acceptability.

Conclusion: 1. A wireless bedside monitor effectively measures sleep in cancer. 2. 100% patient and nurse acceptability supports clinical use. 3. Research in progress to evaluate device use at home.

Abstract number: P1-046
Abstract type: Poster

Large Volume Paracentesis versus Tunneled Drainage Catheters for the Management of Malignant Ascites in Adults: A Systematic Review of the Literature

Bernstein L.1, Kriese S.1, Khan S.A.1
1King’s College London, Cicely Saunders Institute, London, United Kingdom, 2King’s College London, NIHR Doctoral Research Fellow, London, United Kingdom, 3Guy’s and St Thomas’ NHS Foundation Trust, Palliative Medicine, London, United Kingdom. Presenting author email address: bernsteinl@ihh.net

Background: Development of malignant ascites causes significant morbidity for patients with cancer. Drainage of ascites can offer symptomatic benefits, but practice is variable with regard to choice of device, duration and frequency of drainage.

Aims: To appraise the evidence for abdominal paracentesis in adults with malignant ascites, including a comparison of large volume paracentesis (LVP) versus tunneled drainage (TD).

Methods: A systematic literature review was conducted to identify relevant studies. Full texts of 30 papers were reviewed and 16 were included in the analysis.

Results: Using the SIGN criteria 15 studies were graded evidence level 3 and one study level 2. Symptoms improved in 78-100% following LVP and 65-100% following TD. Complication rates (including infection, intestinal perforation and failure) were reported at a lower frequency in patients undergoing LVP compared to TD (4.4% vs 18.3%). Eight deaths occurred in 1180 LVP procedures (four hypotension, two pulmonary emboli, one bowel perforation and one purulent peritonitis). No deaths with insertion of 388 TDs.

Conclusions: Overall quality of evidence is low, but use of LVP may be more effective with regard to alleviating symptoms compared to TD and is associated with lower morbidity but higher mortality. Decisions regarding ascitic drainage should take into account potential benefits and burdens of different treatments, treatment success, risk of hypotension, preferred place of care, and estimated prognosis.

Abstract number: P1-047
Abstract type: Poster

Mood Stabilizers and Patients with Advanced Illness: A Forgotten Tool?

Elebash M.J.1, Colleran M.1
1St Brigid’s Hospice, Palliative Care, Co.Kildare, Ireland, 2St Brigid’s Hospice, Palliative Care, The Curragh, Co. Kildare, Ireland. Presenting author email address: mawabaky@yahoo.com

Aims: Patients with advanced illness frequently experience a high symptom burden both physical and psychological including depression and anxiety. While mood stabilisers are of proven benefit in psychiatric illness, there is little known about the frequency of their use in patients under specialist palliative care. However given the goal of optimising quality of life, effective treatment of mood disorders is important for holistic patient care. The aim is to assess the frequency of use of mood stabilisers in patients under a specialist palliative care home care team.

Methods: A cross-sectional, retrospective, chart review was performed on all existing adult patients under a rural specialist palliative care homecare team, including referrals on the day of the study. Verbal consent was sought. Patients were excluded if they were very ill or imminently dying. Patient identification was coded. Demographics assessed included age, gender, diagnosis, pre-existing psychiatric illness and medications. The use of anxiolytics, mood stabilisers, antidepressants, antiepileptic and neuropsychiatric agents was recorded. The results were analysed by descriptive analysis.

Results: A total of 17 patients were eligible for inclusion. 85 patients had malignancies. 17 patients had a pre-morbid psychiatric diagnosis. 31 patients were on antidepressants, one on lithium, 3 on carbamazepine. While 15 received regular anxiolytics, 10 as required anxiolytics.

Conclusion: Only 4 patients received mood stabilizers despite 48.9% of patients receiving either antidepressants or regular anxiolytics. The use of anxiolytics used for the palliation of dyspnoea may be a confounder. Similarly patients on neuropathic agents may be experiencing a therapeutic mood effect. Nonetheless, mood stabilisers were infrequently used. More research is necessary to determine the possible benefits to patients with advanced life threatening illness from mood stabilizers with the aim of optimising symptom control and quality of life.
Rating Delirium Severity Using the Nursing Delirium Screening Scale: A Prospective Study

Method: We conducted a prospective, observational study on a 31-bed, inpatient PC unit. Consecutive patients admitted to the PC unit were approached for preemptive 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 ratings were made 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 GNR 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 674 patients screened, 139 were excluded because of delirium incident and delirium remained eligible for primary analysis. Mean age was 73 years (range 36-96); 93% were females; and median PPS score was 30%. Pearson correlation coefficients between MDAS and Nu-DESC average and maximum scores were 0.92 (p < 0.005) and 0.84 (p < 0.006), respectively. CGRs for delirium were mild (43%), moderate (48%), and severe (9%). Delirium subtypes per MDAS assessments were normal psychomotor activity (9%), hypokinetic (72%), hyperkinetic (5%), 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

Methods: We piloted SOPs at the hospice in London. 393 patients were screened, 139 were excluded because of delirium incident and delirium remained eligible for primary analysis. Mean age was 73 years (range 36-96); 93% were females; and median PPS score was 30%. Pearson correlation coefficients between MDAS and Nu-DESC average and maximum scores were 0.92 (p < 0.005) and 0.84 (p < 0.006), respectively. CGRs for delirium were mild (43%), moderate (48%), and severe (9%). Delirium subtypes per MDAS assessments were normal psychomotor activity (9%), hypokinetic (72%), hyperkinetic (5%), and mixed (15%).

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Abstract type: Poster

Protocol for the Control of Agitation in Palliative Care

Method: 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.

Results:

- Haloperidol - 5 mg IM + Midazolam - 5 mg IM
  - 30 minutes later, if the situation is not controlled:
    - Haloperidol - 5 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 recurs:
      - Less than 2 hours after control: resume the protocol from the interruption point.
      - More than 2 hours later: restart the protocol from the beginning.

Conclusions: 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.

Abstract number: P1-051

Abstract type: Poster

Efficacy of Percutaneous Trans-esophageal Gastro-tubing as Palliative Care for Patients with Gastrointestinal Obstruction: 20 Years’ Experience

Methods: We reviewed the cases of all 297 patients that we have treated by PTEG from 1994 to 2014, including 121 patients (40.74%) for drainage and 176 patients (59.26%) for feeding. The drainage by PTEG was a principal part of palliative care for 110 patients suffering from malignant gastrointestinal obstruction due to carcinoma. Since 1994, PTEG has been performed in approximately 20,000 patients in Japan. Aims: We wished to determine the efficacy of PTEG for palliative care of patients with gastrointestinal obstruction due to carcinoma from our 20 years’ experience.

Results: PTEG provided relief from the discomfort and diminished quality of life (QOL) resulting from use of a nasogastric tube. In all patients, digestive juice was effectively drained via the indwelling PTEG tube, and there was no nausea or vomiting. After the PTEG procedure, patients could once again enjoy the taste of drink and of foods that melt in the mouth. Patients became suitable candidates for home care and/or chemotherapy.

Conclusion: PTEG is a simple, minimally invasive means of improving a patient's QOL both easily and effectively. We recommend PTEG as the procedure of choice in the palliative care of patients suffering gastrointestinal obstruction due to carcinoma.

Abstract number: P1-052

Abstract type: Poster

Malignant Intestinal Obstruction - Management and Ethical Dilemmas in Palliative Medicine

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.

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      - Less than 2 hours after control: resume the protocol from the interruption point.
      - More than 2 hours later: restart the protocol from the beginning.

Conclusions: 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.
Effect of Shitei-To, a Traditional Chinese Medicine Formulation, against Hiccups - Effect of Shitei Extract on Drug-induced Convulsions in Mice

Kurita G., Kagaya H., Methods:

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, 2005-2008), in which 1586 patients were analysed regarding 86 SNPs in 43 genes. Inclusion criteria: cancer, age ≥18 y, regular opioid treatment for ≥3 d, 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 (1/3 patients for for correlation sample) and validation sample (1/3 patients for correlation sample) (P < 0.0005), or minor allele frequency < 5%; 3) a false discovery rate of 10% was used for determining associations (Benjamini-Hochberg method).

Krukal-Wallis 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 HTR1A, TAC3, and CX3CR1 were found in the development sample and were confirmed in the validation sample. After correction for multiple testing, no SNPs were significant in the development sample. Significant associations with other SNPs were observed when applying dominant and recessive models, but could not be confirmed after correction for multiple testing or replication in the validation sample. Conclusions: The findings did not support influence of those SNPs analysed to explain cognitive dysfunction in this sample of patients.

Effect of Shitei-To, a Traditional Chinese Medicine Formula against Hiccups - Effect of Shitei Extract on Drug-induced Convulsions in Mice

Koppo H., Fuksuda E., Baba M., Okado Y., Itoh-Niawara R.

1. Meiji Pharmaceutical University, Clinical Pharmaceutics, Kiyose, Japan; 2. Meiji Pharmaceutical University, Department of Natural Medicine and Phytochemistry, Kiyose, Japan

Introduction: Cancer patients sometimes have hiccups for the enforcement of chemotherapy. The tumor itself, Hiccups, which are rhythmical, cryonic contractions of the diaphragm, are considered as a form of convulsions. For a treatment of intractable hiccups, a minority of the patients were referred to palliative care mainly those with the poorest objective measures in the literature. However, it is a small study in one centre of New Zealand and worthy of further research.

The pilot included 10 patients. The volumes of lymphoedema drained ranged between 102mls and 12,670mls. One patient did not drain at all. Of the remaining nine participants, 64 patients recovered 100% of the swelling, 27 recovered 50% to 99%, and seven only recovered a minor part of the swelling. The values were compared to the baseline volume of the lymphoedema. The difference was statistically significant (P < 0.05) for all different lymphoedema volumes. The results did not vary significantly between different regions of the body.

Results: The study showed promising results for patients with severe, refractory lower limb lymphoedema. The 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 complication rates. A protocol was developed locally for the 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 pilot included 10 patients. The volumes of lymphoedema drained ranged between 102mls and 12,670mls. One patient did not drain at all. Of the remaining nine participants, all but one showed improvement in lymphoedema volume. Seven of the nine patients improved in appearance and five had positive outcomes with their own mobility measures. Two of the patients developed cellulitis managed with oral antibiotics. This pilot showed promising results 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 tools in the literature. However, it is a small study in one centre of New Zealand and warrants further research.

This study was funded by the Campbell Barratton Fellowship.

Quality of Life Assessment of Subcutaneous Needle Drainage for Lymphoedema in Patients with Advanced Malignancy

Landers A., Thomson M.

1. Nurse Maude Hospice Palliative Care, Palliative Care, Christchurch, New Zealand; 2. New Zealand Institute of Community Health Care, Christchurch, New Zealand; 3. St Georges Cancer Centre, Christchurch, New Zealand

Presenting author email address: amanda.landers@nursemaude.org.nz

Quality of life assessment of lymphoedema in patients with advanced malignancy. This pilot showed promising results for patients with severe, refractory lower limb lymphoedema. It also captured data on complication rates. A protocol was developed locally for the 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.

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This study was funded by the Campbell Barratton Fellowship.
Gastrointestinal Adverse Events during Naloxogol Treatment for Opioid-Induced Constipation: Evidence from Double-Blind RCTs

Siemens W1, Gaertner J2, Camellini M3, Davies A4, Webster L5, Crossman D5, Becker G6

1University Medical Center Freiburg, Department of Palliative Care, Freiburg, Germany; 2Clinical Enteric Neuroscience Translational and Epidemiological Research, Mayo Clinic College of Medicine, Rochester, MN, United States; 3Royal Surrey County Hospital NHS Foundation Trust, Department of Palliative Care, Guildford, United Kingdom; 4American Academy of Pain Medicine, CRI Lifetree, Salt Lake City, UT, United States; 5University of North Carolina School of Medicine, Center for Functional GI and Motility, Chapel Hill, NC, United States

Background: Opioid induced constipation (OIC) is a serious and frequent adverse event. Naloxogol, a recently approved oral, peripherally acting α-opioid receptor antagonist (PAMORA), has been shown to be effective in OIC treatment.

Aim: The objective was to analyze the incidence of naloxogol related gastrointestinal (GI) adverse events (AEs) in adult OIC patients.

Methods: This is a 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 (Mantel-Haenszel; fixed effect model).

Results: One phase II and two phase III RCTs were identified, studying a total of 985 patients treated with naloxogol 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 1.5mg caused noticeably less abdominal pain than higher doses. RDs were highest for abdominal pain (RD 0.08 [0.05, 0.11]) and comparable for nausea (0.03 [0.01, 0.06]) and diarrhea (0.04 [0.02, 0.07]).

Conclusions: The incidence of GI AEs during treatment with naloxogol is 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.

Funding: None

Poster Sessions (Poster Exhibition Set 1)

Abstract number: P1-058
Abstract type: Poster

A Questionnaire Survey of Physicians and Nurses Regarding Constipation in Palliative Care Patients

Kozela M1, Stachowiak A2, Leppert W3

1Sue Ryder House, Pallimed, Bydgoszcz, Poland; 2Poznan University of Medical Sciences, Chair and Department of Palliative Medicine, Poznan, Poland

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; 95% 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 (81% nurses; 91% physicians). For the question of the knowledge of the recommendations of the Polish Association for Palliative Medicine regarding constipation management (elaborated in 2009) 208 surveyed respondents (71% (95% positively and 65% (31%) negatively.

Conclusions: The responses obtained indicate the necessity of a continuous staff education and call for GLs of updated constipation management guidelines in palliative care patients. These guidelines were recently published by the Expert Group of the Polish Association for Palliative Medicine.

Abstract number: P1-060
Abstract type: Poster

Assessment and measurement tools

Review of Procedures for Management of Symptomatic Malignant Ascites in Palliative Care Patients from the Instituto Nacional del Cancer (National Institute of Cancer), Santiago de Chile

Guilodine Paredes JA

Universidad de Chile, Medicina Interna, Hospital del Salvador, Providence, Santiago, Chile

Presenting author email address: guilop@hotmail.com

Introduction: Malignant ascites (AM) is a sign of peritoneal carcinomatosis, which occurs in about 50% of patients with peritoneal dissemination of the primary tumor, being considered a sign of poor prognosis. According to the literature, the most common procedure is the paracentesis (98%) and has proven to be the most effective.

Method: We reviewed the records of procedures to drain the AM, between May and December 2012.

Results: The records of 34 procedures performed in 14 patients were analysed. In 64% it took more than one procedure. The most common diagnosis is colon cancer (21%), followed by ovarian cancer, gait bladder and unknown primary origin cancer (14% respectively).

The average time between diagnosis and first relief procedure is 511.9 days and AM regarding admission to Palliative Care Unit is 370.4 days. Among the patients who died at the time of analysis (50%) survival from the first procedure was 67.1 days, and in this subgroup the procedure was performed at 213.5 days from diagnosis, whereas among surviving patients, survival from the first method is 120.5 days at the time of review, and in this subgroup the procedure was performed at 810.1 days from diagnosis. Regarding procedures, 55.9% were evacuating paracentesis and 42.1% continuous peritoneal drainage installation. The main indication for the procedure was abdominal distension (64%), followed by abdominal discomfort (16%), dyspnea (12%) and anorexia (8%). Complications occurred in 23.5% of cases. No cases of peritonitis or hemorragia was recorded. No patient died within 30 days of procedure.

Conclusion: Analysis of the records shows the procedures of isolated peritoneal drainage (paracentesis) or continuous were effective and safe in this group of patients, with few complications and low severity. It is presented as a late phenomenon in neoplastic disease patients, highlighting that those treated with AM in earlier forms present worse prognosis, therefore it deserves a more profound analysis.

Abstract number: P1-061
Abstract type: Poster
Factors Influencing Uptake of a Comprehensive, Evidence-based, Carer Support Needs Assessment Tool in Palliative Home Care

Austria, L.1,2, Ewing G.1,3, Giande G.1,2,3
1University of Manchester, School of Nursing, Midwifery and Social Work, Manchester, United Kingdom, 2Hospital General Universitario de Valencia, Unidad de Hospitalización a Domicilio, Valencia, Spain, 3University of Manchester, School of Nursing, Midwifery and Social Work, Manchester, United Kingdom

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 change). 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’, discussion 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 well with the ‘internal’ and ‘external’ models of sustainable implementation of practice developments. Further work is underway to explore how organisations can best be supported during implementation of the CSNAT.

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Abstract number: P1-063
Abstract type: Poster

A Psychometric Approach to the Spanish Version of Bugen’s Coping with Death Scale

Barreto Martin P.1, Galína L.2, Oliver A.3, Sánsó N.1, Fombuena M.1, Soto Rubio A.1, Pades A.1, Pascual A.5, Benito E.6
1University of Valencia, Personalidad, Evaluación y Tratamientos Psicológicos, Valencia, Spain, 2Hospital General Universitario de Valencia, Unidad de Hospitalización a Domicilio, Valencia, Spain, 3Conselleria de Salut i Consum, Unidad Técnica de la Estrategia Balear de Cuidados Paliativos, Islas Balleares, Spain, 4Hospital Dr. Moliner, Valencia, Spain, 5Hospital Sant Pau, Barcelona, Spain, 6Universidad Autónoma de Barcelona, Barcelona, Spain

Presenting author email address: pilar.barreto@uv.es

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 professional’s 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.

Aims: To study the psychometric properties of the Coping with Death Scale in a nationwide sample of palliative care professionals.

Design, methods and approach taken: Through an on-line survey, palliative care professionals from all over Spain were invited to participate. 385 of the respondents met the inclusion criteria. Among other variables, coping with death competence was assessed using Bugen’s Coping with Death Scale. Two confirmatory factor analyses for structural validation were estimated and tested.

Results: 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 ($\chi^2$/df = 1305.41, CFI = 0.93, RMSEA = 0.09). Based on the latest version of the scale, descriptive analyses for the palliative care professionals were offered.

Conclusions: Results for Bugen’s Coping with Death Scale support previous exploratory studies. Same 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).

Funding: UE/ECG

Abstract number: P1-064
Abstract type: Poster

Pioneering Research on Demoralization in Spanish Palliative Care Units

Barreto Martin P.1,2, Rudd olive D.1, Oliver A.1, Galína L.2, Soto Rubio A.1, Ruiz A.1
1Universidad de Valencia, Personalidad, Evaluación y Tratamientos Psicológicos, Valencia, Spain, 2Hospital General Universitario de Valencia, Unidad de Hospitalización a Domicilio, Alicante, Spain, 3University of Valencia, Departamento de Metodología de las Ciencias del Comportamiento, Valencia, Spain, 4University of Valencia, Personalidad, Evaluación y Tratamientos Psicológicos, Valencia, Spain

Presenting author email address: pilar.barreto@uv.es

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 concern a demoralisation syndrome. No published research on demoralisation’s measure in the palliative care context. Further research on its dimensionality is needed.

Aims: To introduce and test Kissane’s Demoralisation Scale in the Spanish palliative care context, to report any differential outcomes for socio-demographic or diagnosis characteristics, to identify any differences in our sample with those from other countries to understand differences and to design a demoralisation syndrome.

Methods, design and approach taken: 128 patients admitted to treatment through Home Care Units, Continued Care Units and Long Term Hospital in the General Hospital/Valencia. Instruments were DS, HADS, CES-D (Spanish), and CED-PAL (asessing demoralization at the end of life). Descriptive and reliability statistics, correlations and MANOVA’s to test for differences were obtained.

Results: Alphas for Kissane’s dimensions of demoralisation ranged from .65 for Disheartenment to .89 for Loss of Meaning. MANOVA’s revealed no differences by sex or diagnosis ($F(1,22)=0.25$, p = 0.62, $\eta^2=0.01$), and $F(2,244)=1.10$, p = 0.32, $\eta^2=0.01$ (respectively). Anxiety, depression and threatened dignity were positively and significantly correlated with DS while spirituality and preserved dignity were negatively.

Conclusions: Demoralisation theoretically and empirically appears as key concept in quality of life in the Spanish palliative context. Further research on its dimensionality is needed.

Abstract number: P1-065
Abstract type: Poster

Characterisation of a Palliative Care Population in a Comprehensive Cancer Centre

Benthien K.S.1, Nordin M.U.1, Videbaek K.1, Kurtz G.P.1, von der Maase H.1, Timm H.1, Simonsen M.K.2, Johansen C.2, Sjøgren P.2
1Copenhagen University Hospital, 2København Ø, Denmark, 2Copenhagen University, Copenhagen, Denmark, 3University of Copenhagen, Copenhagen, Denmark

Presenting author email address: kirstine.skov.benthien@regionh.dk

Background: In cancer the Palliative Care Population (PCP) concept is subject to continuous change and there is a lack of consensus and clarity in the previously applied definitions.

Aims: The aims of this study were to identify the PCP in a comprehensive cancer centre and to analyze associations between Specialist Palliative Care (SPC) and sociodemographics, cancer diseases and treatment characteristics.

Methods: Patients were assessed to be included in a randomised clinical trial of accelerated transfrom from oncological treatment to SPC at home. The assessment period was from June to December 2013 and took place in a department of oncology. The screening was performed with a sequential alteration screening process. The PCP was defined as patients with incurable cancer and limited or no anticancer treatment options. Limited treatment options were defined for each cancer disease, e.g. breast cancer refractory to 3rd line treatment, lung cancer refractory to 1st line treatment etc. The data was analysed with descriptive statistics and multivariable logistic regression.

Results: During the study period 3717 patients with cancer were assessed. The PCP comprised 513 patients with incurable disease and limited treatment options yielding a prevalence of 13.8 %. Two-hundred and fifty-six patients with Performance Status 2-4 were defined as The Essential PCP (EPCP). They were older, more likely inpatients, had more comorbidity burden and 37.9% received Specialist Palliative Care (SPC). Women, patients with prior hospitalisation, Departments of oncology with similar composition of clinics for specific cancer diagnoses Funded by Trygforden and the Danish Cancer Society

Abstract number: P1-066
Abstract type: Poster

A Pilot Study to Assess the Appropriateness of the Palliative Care Outcome Scale (POS) within the Acute Stroke Population

Brealey S.G.1, Burton B.1, Burton M.1, Payne S.1, Burton C.1
1International Observatory on End of Life Care, Lancaster University, Lancaster, United Kingdom, 2Bangor University, School of Healthcare Sciences, Bangor, United Kingdom

Presenting author email address: sarah.brealey@lancaster.ac.uk

Background: Cerebrovascular disease (stroke) accounts for about 10% of total deaths worldwide and is associated with high mortality in the acute phase (1st 30 days post onset). There is evidence of deficiencies in palliative care for stroke but little information on how to measure palliative care needs and staff may be reluctant to broach end of life issues without appropriate tools.

Aim: To explore whether the POS can be used within the acute stroke population.

Methods: Consecutive adult acute stroke patients scoring <15/20 on the Barthel Index (indicative of higher palliative care needs) admitted over a 26 week period into 3 acute stroke units in the UK were recruited. The POS was administered a week after admission and at day 28 (if still alive or in the unit) and analysed in terms of the range and mean scores.

Results: 514 patients were admitted to the units, of which 83 had a Barthel of < 15 and 23 participants consented to the study and were assessed. POS scores were self completed by 113, or completed by a carer (3) or staff (5) at day 7-14. Only 3 were completed at day 28 due to death (3) or participants having been discharged (18). Scores ranged from 0-4 on all but 1 of the items, the highest average score was for family anxiety (2) and the lowest for time wasted on appointments (0.1). Staff expressed reluctance to use the POS due to a perceived lack of knowledge about the patients and reference to palliative care.

Conclusions: Findings support the need for a palliative care assessment and patients reported valuing the opportunity to talk about issues that had not been addressed. However, the clinical setting and the acute onset of the condition highlighted problems with the appropriate use of some items of the POS and how to collect data from impaired patients. Data collection can difficult due to the duration of stay on the acute stroke units as patients may be rapidly discharged to rehabilitation. A more stroke-sensitive POS may be appropriate.

Funding: UEL/CCG
Assessing Physical Performance in Non-small Cell Lung Cancer: Is the Short Physical Performance Battery Acceptable, Feasible and Able to Predict Fitness for Treatment?

Collins J.T., Noble S., Davies H., Pamy D., Lester J., Evans W.D., Pettit R.J., Chester J., Bane A.1, 2Cardiff University, Palliative Care Research Centre, Cardiff, United Kingdom, 1University Hospital Llandough, Respiratory Medicine, Cardiff, United Kingdom, 2Velez Cancer Centre, Cardiff, United Kingdom, University of Cardiff, Marie Curie Palliative Care Research Centre, Cardiff, United Kingdom, Velez Cancer Centre, Clinical Oncology, Cardiff, United Kingdom.

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 consistently present in treatment planning. Objective performance tests, such as accelerometer, require days of compliance with monitoring and are not in 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:
1. Acceptability and feasibility of the SPPB in patients attending a rapid access lung cancer clinic (RALCC) and
2. 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 2015). SPPB and PS scores are collected at presentation to the RALCC; thereafter receipt of treatment is recorded longitudinally. SPPB comprises three timed components: balance (side-by-side, semi-tandem and heel-to-toe gait), time to get up from a metre gait, and 5 second chair rise times.

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 survival, may provide a more valuable definition in clinical care, individualised supportive care plans, and may allow more accurate prediction of fitness for treatment.

Abstract number: P1-068
Abstract type: Poster

Prognostic Value of PPS In Patients Atended at Home: Is It Also Useful?

Colva Espanó C1,2, Laizarding L1, Rue de Gacone E1

Hospital San Juan de Dios, Palliative Care Unit, Pamplona, Spain, Fundación Hospital Calahorra, Hematology and Hemotherapy, Calahorra, Spain

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 analysis was used.

Results: 473 patients were visited during 2013, 383 met inclusion criteria. The profile of our sample was a sample of elderly patients with a median age of 79 years and 63% were females. A total of 68% of them died at home (53%), and a few with delirium at first visit (12%). Median PPS was 50% (25-75%, IQR 50-60), while most median survival days (MDS) was 25 days (75-90%, IQR 22-47 days). PPS showed a significant association with survival, with statistically significant differences.

Conclusions: Acceptability and feasibility of SPPB in patients attending a rapid access lung cancer clinic (RALCC) and whether it can predict fitness for treatment.

Abstract number: P1-069
Abstract type: Poster

Developing a Preference-based Outcome Measure for Use in Economic Evaluations of Palliative Care Services

Dzenga M.D., Mayersian L.J., McMullen P., Murtough C., BuLACARE

King’s College London, Cicely Saunders Institute, London, United Kingdom, King’s College London, Institute of Psychiatry, Center for Economics of Mental and Physical Health, David Goldberg Institute, London, United Kingdom, Presenting author email address: mndzwad.dzenga@kcl.ac.uk

Background: The WHO passed the first ever palliative care (PC) resolution urging member states to implement policies supporting the integration of cost-effective PC services. Economic evaluations (EE) are crucial in identifying the comparative clinical and cost-effectiveness of competing PC interventions. However, there is a dearth of EE’s 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 gold standard in cost-utility analysis. In some medical fields (including PC), generic preference-based measures of health (PFM) like the EQ-5D – which are commonly used to derive QALY’s – have been found to be inappropriate.

Aim: To assess the feasibility of deriving a PFM from the Palliative Outcome 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 to confirm the final items for use in the 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 threshold map.

Conclusion: Rasch analysis provides a useful means of developing plausible health state valuations. This research will provide a basis for estimating QALY’s to inform cost-utility analysis of palliative care interventions.

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Abstract number: P1-070
Abstract type: Poster

Building a Taxonomy of Integrated Palliative Care Initiatives

Radbruch L1, Hodialmeen E1,2 (Ewert J), Hasselaar J1, van Wijngaarden J1,2, Hesse M1

1University Hospital Bonn, Department of Palliative Medicine, Bonn, Germany, 2Radboud University Medical Centre, Department of Anesthesiology, Pain and Palliative Medicine, Nijmegen, Netherlands, 3Erasmus University, Institute of Health Policy and Management, Rotterdam, Netherlands

Aims: As part of an EU-funded project InSup-C a taxonomy of integrated palliative care (IPC) interventions has been developed, mainly to investigate the provision of IPC, in all relevant categories and aspects within the process of care were identified. The taxonomy aims to establish a scheme against which existing interventions can be classified and supports the design of future integrated interventions. At best, the taxonomy represents a common yardstick for analysis and mutual learning.

Methods: A preliminary version of the taxonomy was constructed based on a systematic literature review, expert interviews and an online survey. The taxonomy was revised 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 models. Hence, the classification system developed by InSup-C consists of eight categories including two to four items in each. For instance, the classification axis ‘orientation’ 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 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.

Abstract number: P1-071
Abstract type: Poster

What Is Stable Pain Control - Can a Personalized Pain Goal Help?

Fansinger R1, Nelakochu C1, Fansinger L, Muller V, Amiga P, Birnboim A, Burton-MacLeod S, Ghosh S, Gilbert R, Tanur Y, Thal V, Welch G1

1University of Alberta, Division of Palliative Care Medicine, Edmonton, AB, Canada, 2Covenant Health, Palliative Institute, Edmonton, AB, Canada, 3University of Alberta, Medical Oncology, Edmonton, AB, Canada

Presenting author email address: robin.fansinger@albertaherrnalservices.ca

Background: The Edmonton Classification System for Cancer (ECS-CP) has been extensively validated and consists of five pain features: mechanism of pain, incident pain, psychological distress, addictive behavior and cognitive function. As an alternative to the definition for stable pain control used in the ECS-CP validation studies (i.e. pain intensity score of 3 or less and less than 3 breakthrough doses for 3 consecutive days), or other recommended definitions (i.e. 2 point drop in a 10 point scale or 30% decrease in pain intensity), the use of a personalised pain goal (PPG) has been suggested as having better prognostic importance than the respective initiatives.

In this study we investigated the proportion of patients that were able to meet the initial PPG and were able to meet the PPG after 48 hours.

What is Stable Pain Control - Can a Personalized Pain Goal Help?

What is Stable Pain Control - Can a Personalized Pain Goal Help?

Results: 231/300 patients (77%) had a pain intensity score 169/231 were able to give a PPG on initial assessment (3 declined to answer and 59 were too cognitively impaired); the median PPG was 3 (range 0-10). Almost half (76/169, 44%) had a PPG that was the same as the stated pain intensity definition (i.e. 3. Most (154/169, 91%) had a PPG between 2-3. The remaining patients either had a PPG between 0-1 (6/169, 3.6%) or 6-10 (9/169, 5.3%). 183/169 achieved stable pain control (6.1%).

Conclusion: The majority of PPG scores did not differ significantly from the study definition, suggesting that for research purposes this definition is a close representation of pain intensity scores for stable pain control. However, for individual patient management, it would be important to include the PPG as part of standard clinical practice, given the wide range of responses.

Reference: 84-14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015
Abstract number: P1-072
Abstract type: Poster

Using Confusion Assessment Method for Detection Delirium among Hospice Patients - Screening or a Diagnostic Instrument?

Forum E., Sørensen B., Sjøgaard I.
Hospice Sydvestjylland, Edsberg, Denmark
Presenting author email address: elin.forum@hospsce.rsyd.dk

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 sensitivity and specificity.

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 number: 61 patients admitted to our hospice from 1.4. until 20.7.2014 were examined. The results of the CAM score were registered and compared with documents on psycho-social conditions.

Results: Out of 61 patients, 2 were excluded because the CAM score wasn't done. 59 patients were included. 19 patients were included in delirium according to the CAM score (32%).

Conclusions: Decisions on psycho-social conditions detected that 25 patients were diagnosed and treated for delirium (42%). 4 of the 6 patients, who weren't identified by CAM, were in terminal delirium (< 3 days to death) and 2 patients were assessed to have a hypoactive delirium. With a total of 4 hyperactive delirium patients in the study, only 50% were discovered by the CAM.

In the future it's still important to focus on the hypothesis condition, which is difficult to identify because the symptoms can be confused with e.g. fatigue of the terminal illness.

Abstract number: P1-073
Abstract type: Poster

Validation of the Observational and Behavioural Scale (EOC) for Adult Patients

Faccio M., Burucuá B., Ricio M., Domesque S., Robinson N.
CHU de Bordeaux, Bordeaux, France

Most of behavioural pain assessment tools focus on elderly, parapletic or sedated patients. With four items the Francois Boursaud Behavioural Scale (FBBS) focuses on patients over 11 years old. In agreement with the author, a fifth item evaluating aggressiveness or mutism was added and this modified scale was called the Observational and Behavioural Scale (EOC). EOC matches the six behaviours required by the American Geriatrics Society. Our aim was to statistically validate EOC's feasibility, validity and reliability.

This is a comparative and transversal study. Thirty units participated between November 2007 and March 2008. EOC was evaluated during the same time by a non-trained caregiver and a pain expert, blinded of each other results. Next, a reference test was performed: Numerical Scale (NS) for Communicating Patients (CP) or ECPS for the Non-Communicating Patients (NPC). 395 CP and 52 NPC were included and analysed, 86 excluded.

All EOC were performed in less than 1 minute, all items were understandable and the filling rate of each item was between 99.6% and 99.9%. EOC's correlation with standard tests was good (Spearman's coefficient: with NS ρ=0.49; with ECP2 ρ=0.82). ROC analysis showed the best positive threshold was 1/10 for CP (Se=77%, Sp=70%) and 1/10 for NPC (Se=87%, Sp=79%).

Only the first four items for CP and all items for NPC were correlated with one another and informative (Principal Components Analysis: Factor loading>0.40 and Cronbach's α>0.70). The reproducibility of EOC was good (Intraclass Correlation Coefficient: CP group 77%, NPC group 93%).

EOC can be filled shortly and its understanding is simple thanks to the short explanations provided within it. It's the only scale validated in French especially focused on adult patients. EOC is correlated with standard tests and its reproducibility is good. EOC is highly relevant with NPC.

It was generalised in our institution to complete self assessment or replace it.

Abstract number: P1-074
Abstract type: Poster

Development of a New Tool for the Assessment of the Psychosocial Needs of End of Life Patients

Matoes-Ortega D., Limonero J.Y., Maté-Mendéz J., Jesus G. B., Barbero E., Martínez-Muñoz M., Baeu E., Busan M., Mateo-Barre R.
1. Catalan Institute of Oncology, The ‘Qualy’ Observatory - WHO Collaborating Centre for Public Health Palliative Care Programmes, Hospital de Llobregat, Spain, 2. Universitat de Vic, Chair of Oncology, The ‘Qualy’ Observatory - WHO Collaborating Centre for Public Health Palliative Care Programmes, Hospital de Llobregat, Spain, 3. Catalan Institute of Oncology, Palliative Care Services Hospital de Llobregat, Spain, 4. Catalan Institute of Oncology, Social Work Unit, Hospital de Llobregat, Spain, 5. la Fe University, Social Area, Beceite, Spain, 6. University of Vic, Chair of Palliative Care, Vic, Spain

Background: Providing palliative care to end-of-life patients (EoLP) requires knowing which aspects of psychosocial nature can contribute to the patients’ well-being. For this, we must have reliable, simple and specific assessment tools.

Aims: To develop a new instrument (Psychosocial Needs Evaluation; PNE) to assess and monitor the psychosocial needs of EoLP taken care by PC teams. To develop a new instrument (Psychosocial Needs Evaluation; PNE) to assess and monitor the psychosocial needs of EoLP taken care by PC teams.

Methods: 1) bibliographical review; 2) build-up of the experts panel; 3) discussion and agreement on the most relevant dimensions in psychosocial care; 4) description of key indicators and consensus on the questions for each dimension, 5) exhaustive revision of the tool by external professional experts (including physicians, nurses, psychologists and social workers) in palliative care and 6) revision of the tool by expert patients.

Results: The PNE includes 18 questions distributed in 5 dimensions: emotional, coping, communication / relationships, spirituality and well-being. 30 professional experts in PC included comments on the questions, the way they were formulated, the answer options, the dimensions evaluated at each question and improvement proposals. They also revised the instructions for the tools administration. They all qualified the tool as being excellent. To improve it, they suggested to reduce the number of questions and to change the answer format (from a numerical scale of 0-10 to a Likert scale).

Additionally, 20 expert patients revised the tool. They considered the questions to be very clearly or clearly understandable and suggested some changes. They also appreciated their participation in the study and considered very important being asked about these issues.

Conclusions: The PNE 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

Martínez-Muñoz M.1, Oller R.1, Marton J.C.1, Ambías J.1, Blay C.1, Vila L.1, Costa E.1, Espaulea J.1, Verdueno A.1, Espinosa J.1, Gómez-Batiste X.1
1. Catalan Institute of Oncology, The ‘Qualy’ Observatory - WHO Collaborating Centre for Public Health Palliative Care Programmes, Hospital de Llobregat, Spain, 2. University of Vic, Chair of Palliative Care, Vic, Spain, 3. Department of Economics and Business, Vic, Spain, 4. Hospital de la Santa Creu and Hospital General, Vic, Spain, 5. Programme for the Prevention and Care of Patients with Chronic Conditions, Department of Health, Barcelona, Spain

Background: 75% of deaths in high-income countries are caused by progressive advanced chronic conditions, identifying advanced chronically ill patients in need of palliative care (PC) at approach of 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 approach at high risk of death in the next 12 months.

Methods: 995 patients with advanced chronic conditions in need of PC approach as assessed by healthcare professionals using the NECPAL CCOMS-ICO© tool (NEPAL+) 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), surprise question (HR=2.00), request from patient or 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 ≥2 (HR=1.11). Under the ROC curve 0.77. At 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

Guo Y.1, Camp J.H.2, Tu S.-M.1, Shin K.1, Fu J.1, Brown E.1
1. M.D. Anderson Cancer Center, Palliative Care and Rehabilitation Medicine, Houston, TX, United States, 2. Carolinas Rehabilitation, Charlotte, NC, United States

Presenting author email address: yguo@mdanderson.org

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 clinical oncology to identify 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 72.6 y) 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 a significantly longer TUG test time and less grip strength. Difficulty climbing down stairs was associated with a significant longer 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: P1-077
Abstract type: Poster

Status of Prognosis Prediction in Terminal Cancer Patients at a Japanese General Hospital

Aim: To identify the frequency of pt-preferred SY, the intensity of pt-reported SY and the pt-preferred involvement of hcp in their management (mgmt).

Methods: The reported data is part of a larger study (268 advanced cancer pts) defined palliative care (PC) needs, 74% EOCG 1-2, monthly collection of pt preferred needs/recalled delivery by hcp for 7 PC key interventions, demographics (adapted EAPC dataset), PC needs (IPOS), QL, ECOG, and quality indicators (IQ), inpatient anticancer treatment, aggression, well-being, and dyadic patient to health team communication.

Results: Of 300 advanced cancer patients were recruited from 2 acute care hospitals and a Palliative Care Centre (PCC). Of those, 21% reported distress

Conclusion: The VOICES-SF worked well in Denmark after a slight cultural adaptation.
Abstract number: P1-082
Abstract type: Poster

The Use of a Brief 5-Item Measure of Family Satisfaction as a Critical Quality Indicator in Advanced Cancer Care

Christine K., Penvold J., Yeh V., Smith C., Meier D., Morrison R.S., Sui A.
Icahn School of Medicine at Mount Sinai, New York, NY, United States

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 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 service use in patients with advanced cancer. Using Item Response Theory (IRT) and Confirmatory Factor Analysis, we developed a shortened 5-item version of the Functional Assessment of Chronic Illness Therapy-Supportive Care (FACIT-Sp) scale to measure family satisfaction with care. Two versions were developed: one for patients, family, and care providers and one for family and patient of inpatient palliative care.

Results: Familiarity with the 5-item version was extremely high with 97.7% of nurses being aware of the FACIT-Sp scale. The results showed that one version of the 5-item version had a test-retest reliability of 0.93, and the 5-item version was significantly less burdensome than the 24-item version.

Conclusion: This study suggests that a shortened 5-item version of the FACIT-Sp scale is a feasible measure to assess family satisfaction with care and can be used to inform future palliative care research.

Abstract number: P1-083
Abstract type: Poster

Development of a Questionnaire to Evaluate Quality of Palliative Care

Osztályi U., Henningsson A.1,9, Wennemark M.1, Åströdi K.1,9
1Linköping University, Faculty of Health and Life Sciences, Department of Health and Care Sciences, Kalmar, Sweden, 2Ersta Sköndal University College and Ersta Hospital, Palliative Research Centre, Stockholm, Sweden, 3Capio Geriatrics, Dalens Hospital, Palliative Care Unit, Stockholm, Sweden, 4Linköping University, Department of Medical and Health Sciences, Division of Community Medicine, Linköping, Sweden, 5Linköping University, Department of Medical and Health Sciences, Division of Nursing Sciences, Linköping, Sweden

Presenting author email address: ulrika.osztalyi@lnu.se

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 palliative care. To generate items, a brief inventory on existing questionnaires was undertaken and items from 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 a general palliative care setting. 4 nurse assistants in elderly care, one nurse and one social worker from a day care center. The questionnaire was twice revised 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 items were worded in a way that respondents had no answer, consequently some were removed. After the validation process, the response alternatives were refined. At this point the questionnaire consisted 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: P1-084
Abstract type: Poster

Constructing Connection through a Shared Assessment Process

Rabbett L.K.
University of South Australia, Mount Gambier, Australia

Presenting author email address: lyn.rabbett@unisa.edu.au

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 promote holistic care. A range of numbers are used 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 experienced difficulty in completing these scales were determined. Inpatient patients’ end of life care decisions were recorded at the pre, mid-term and post study points in a single questionnaire. The assessment process was completed on a daily basis, audited mid and post study. Approval was conducted using the SPSS version 21.3. An expert on questionnaire construction provided feedback. At the end of data collection and descriptive analysis was employed to identify emerging themes from semi structured open ended interview questions.

Results: Thirty patients were recruited. They 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

Abstract number: P1-085
Abstract type: Poster

Life after Liverpool Care Pathway (LCP): Experiences of Critical Care Practitioners in Delivering End-of-Life Care Since Discontinuation of LCP

Ramsamy Venkatasalu M., Carraduff K., Whiting D.
University of Bedfordshire, Fairford Leys, United Kingdom

Presenting author email address: kumar.venkatasalu@beds.ac.uk

Background: Liverpool care pathway (LCP) was widely used with an aim to improve communication and care for dying individuals and their relatives. However, widespread media criticism prompted a review resulted in the discontinuation of LCP across all UK clinical settings.

Aim: This study aimed to explore experiences, challenges and practices of critical care practitioners since the discontinuation of LCP in critical care settings.

Methods: A qualitative exploratory design was used. After full ethics approval, semi-structured interviews were conducted with fourteen critical care practitioners in two acute NHS trust hospitals in England.

Results: Analysis of the data revealed life after LCP as core construct with three key themes; firstly, the ‘theme lessons learned’ explores the benefits and pitfalls of using LCP in the past. Secondly, the theme ‘uncertainties and ambivalences’ illuminates the clinical challenges and issues around caring for end-of-life patients in critical care settings since the discontinuation of LCP. The final theme ‘the future’ informs support of future care plan development relevant to end of life care in critical care settings.

Conclusion: We posited two key conclusions. Despite experienced critical care practitioners being able to deliver quality end of life care without utilizing the LCP, inexperienced staff, both nursing and medical, need clear guidelines and the support of experienced mentors in critical care. Similarly, evidence based guidelines related to family involvement in end of life care planning within the critical care setting is needed to avoid future controversies.

Abstract number: P1-086
Abstract type: Poster

Discovering the Hidden Benefits of Cognitive Interviewing in Two Languages: The First Phase of a Validation Study of the Integrated Palliative Care Outcome Scale (IPOS)

1Munich University Hospital, Department of Palliative Medicine, Munich, Germany, 2Cicely Saunders Institute, King’s College London, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom

Presenting author email address: eva.schildmann@med.uni-muenchen.de

Background: The Integrated Palliative Care Outcome Scale (IPOS) is a newly developed assessment of the PDS which assesses palliative care concerns as perceived by patients and healthcare professionals (HPs).

Aims: To assess patients’ and HPs’ views on IPOS in two languages with a focus on comprehensibility and acceptability, to identify and explore potential problems, and to explore the feasibility of conducting interviews in two languages.

Methods: Concurrent cognitive interviews were conducted in the UK and Germany with patients and HPs in different palliative care settings (palliative care inpatient, general hospital inpatient, community). To detect potential problems, interviews were conducted using think aloud and concurrent verbal probing techniques, audio recorded, transcribed verbatim and analysed by two researchers in each country by content analysis. Results from both countries were collated and discussed between both research teams and the IPOS was refined based on consensus decisions.

Results: In Germany and the UK, 15 and 10 interviews with patients (median age 65 yrs, range 22-85 yrs and 61 yrs, range 43-83 yrs, 10 and 7 female) and 8 and 10 interviews with professionals (3 and 5 nurses, 5 and 6 other professionals) were conducted. Overall, the acceptability of the measure was high. The use and analysis of interviews in two languages resulted in wider consideration of meaning and context of each item. Issues arising comprised 1. comprehension problems with the wording of specific questions (e.g. ‘mouth problems’, ‘felt good about yourself’) 2. problems with questions and answer options that were regarded as too long and complicated.

All these issues were taken into account in the refinement of the IPOS.

Conclusion: Cognitive interviews conducted concurrently in two languages yielded common problems in the IPOS in both countries and ensured greater depth of consideration for each item. This led to a better overall refinement of the questionnaire.

Phase 2 of validation using the refined IPOS measure is now underway.
Audit and quality 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

Author(s): Seektz B.
Wuerzburg, Germany, 2University of Wuerzburg, Division of Medical Psychology and Psychotherapy, Medical Sociology and Rehabilitation Research, Wuerzburg, Germany
Presenting author email address: b.seekatz@uni-wuerzburg.de

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 to be an independent predictor of survival in various non-palliative patient populations. Its prognostic usefulness in patients with advanced cancer had been barely elucidated.

Objective: To examine the relationship between the SML and the overall survival of advanced cancer patients.

Methods: Retrospective collection of demographic, clinical (type of neoplasm, ongoing treatment, Palliative Prognostic Scale (PPS), Palliative Prognostic Score (PPS) and biochemical (Mg (mg/dl), albumin (g/l), C reactive protein (CRP (mg/dl) and calcium (Ca mg/dl)) data at admission to a hospital-based palliative care team. Univariate and multivariate survival analysis were performed and the correlation of Mg with other factors were demonstrated in the malynej matters subscale. Satisfactory internal consistency was demonstrated for all subscales (.62< α< .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. Psychometric properties could 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)

Patient Preferences for Cancer Symptom Assessment Scales

Abstract number: P1-090
Abstract type: Poster

Blackwell S., Burke L., Jeter K., Moran C., Conaway E., Cremen L., O'Connor B., Ul Dhubhare P., Bates U., Lo W.H.
1Our Lady’s Hospice and Care Services, Education and Research Centre, Harold’s Cross, Dublin, Ireland, 2University College Dublin, School of Medicine and Medical Sciences, Dublin, Ireland, 3Our Lady’s Hospice and Care Services, Blackrock, Dublin, Ireland, Trinity College Dublin, School of Medicine, Dublin, Ireland

Background: Systematic symptom assessment is essential in cancer. Symptom assessment instruments detect more symptoms than a clinical evaluation. Assessment burden and low completion rates are among the challenges that clinicians face in the selection of assessment scales for polypsymtomatic cancer patients.

Aims: To determine patient preference for symptom assessment scales in advanced cancer:
- Visual analogue scale (VAS)
- Numerical rating scale (NRS)
- Categorical rating scale (CRS)

To assess the clinical utility of each assessment scale.

Methods: A prospective survey is in progress to evaluate participants’ preferences when describing symptom prevalence and severity. Pain, fatigue and loss of appetite are each measured by VAS, NRS and CRS. Participants’ scale preferences are recorded for each symptom. Respondents’ perceptions of ease of use for each scale are recorded to assess clinical utility. Study population: Consecutive inpatient cancer admissions are being recruited at a hospital.

Method of statistical analysis: Descriptive statistics and correlations examine scale preference and the concordance of scores for each symptom and scale.

Results: 75 participants have been recruited to date with a median age of 69 years (range 38-93). Median Eastern Cooperative Oncology Group (ECOG) score was 1 (range 0-4). Results indicated a primary preference for VAS for pain (43%), with VAS for both fatigue (37%) and loss of appetite (47%). Researchers perceived NRS to be of highest clinical utility for both pain and fatigue, but CRS to be most appropriate for the assessment of appetite loss.

Conclusion: 47% preference for the loss of appetite CRS.
The VAS was consistently the least preferred measure.

3. Participant preference for assessment scales varied across symptoms.
4. Researchers’ perception of clinical utility correlated with patient preference on pain and loss of appetite scales.

Poster Sessions (Poster Exhibition Set 1)
Developing a Conceptual Framework to Assess Quality in End of Life Care in Dementia: Contextual, Structural, Process and Outcome Variables

Anastas T.1, Goodman C.2, Robinson L.3, Sampson E.4
1University College London, Marie Curie Palliative Care Research Department; London, United Kingdom, 2University of Hertfordshire, Centre for Research in Primary and Community Care, Hatfield, United Kingdom, 3Newcastle University, Newcastle University Institute for Ageing, Newcastle upon Tyne, United Kingdom

Abstract number: P1-093
Abstract type: Poster

Aim: The Supporting Excellence in End of Life Care in Dementia (SEED) research programme (http://research.uea.ac.uk/seed) aims to support professionals, both care and health 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 EAPC’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=67, 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=4/11).

Conclusion: Results suggest that even fewer indicators measure outcomes of care (n=34, 15%), which include physical comfort and psychological/spiritual/well-being.

Abstract number: P1-094
Abstract type: Poster

Hospital End of Life Care: Lucky or Unlucky Dip?

Bates C., Drain D., Morton T., Ethridge G., Blackbogee G., Wright H.
BanKing, Havening and Redbridge University Hospitals NHS Trust, London, United Kingdom

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.

Method: 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 to executive 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. 83% of respondents reported being treated respectfully. However, 29% did not recall any discussion 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 learn and listen. Pride can be taken when care is delivered to an excellent standard but this survey exposed the unacceptable aspects of care. The inclusion of at least 2 questionnaires per test in the bereaved is poor. The Trust has agreed to improve care and continues to seek feedback from the bereaved as one measure of quality improvement.
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 2013 and in May 2015 respectively, for evidence of 7 ‘key’ aspects of end of life care (EOLC). The aspects of care reviewed are consistent with the later published ‘Principles of Care for the Dying Patient’. 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 some 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 implementation into clinical practice and the possible problems with implementation. The audit is limited by small numbers and its retrospective nature.

### Abstract number: P1-098

**Abstract type:** Poster

### Title: Forensic Attention to Detail: Lessons Learned from a Clostridium Difficile Outbreak in a Hospice Setting

**Presenting author email address:** helen.birch1@nhs.net

**Background:** Three different patients tested positive for Clostridium Difficile over a 3 month period. Each had a different clinical department within the hospice for their care. Enhanced fingerprint testing demonstrated the strains were indistinguishable PCE 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 ATW swabbing was undertaken by the community infection control team, 17/18 swabs passed the criteria for cleanliness, 18th swab was borderline faecal.

**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 procedures were updated and specific infection control information leaflets devised and are now distributed to families. Housekeepers receive specific infection control training.

**Results:** Enhanced hand washing training showed an improvement in handwashing. Swabbing of the environment and staff hands showed an improvement in cleanliness.

**Conclusion:** The likely source of infection was identified as a member of staff, who had worked in a care setting in the UK where outbreaks had occurred.

### Abstract number: P1-099

**Abstract type:** Poster

### Title: Measuring the Impact of Palliative Care Using the Priorities of Patients and Carers to Refine a Service Evaluation Questionnaire

**Presenting author email address:** helen.birch1@nhs.net

**Background:** The delivery of optimal palliative care requires understanding of the patient and care 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 experiences, priorities and concerns of patients and carers. The emotional and mental 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.

**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.

### Abstract number: P1-100

**Abstract type:** Poster

### Title: Does Bereavement Support in Intensive Care Units Meet UK National Guidelines? A Critical Care Staff Survey

**Presenting author email address:** elen.birch1@nhs.net

**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 wheter 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>
<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>15 (23.08%)</td>
<td>42 (62.66%)</td>
<td>8 (12.21%)</td>
</tr>
<tr>
<td>Do you think training about bereavement in the intensive care unit (ICU)</td>
<td>62 (96.88%)</td>
<td>11 (15.56%)</td>
<td>1 (1.50%)</td>
</tr>
<tr>
<td>Does your ICU offer training in bereavement care?</td>
<td>5 (7.69%)</td>
<td>35 (53.85%)</td>
<td>25 (38.46%)</td>
</tr>
<tr>
<td>Does your ICU offer a follow-up clinic for bereaved relatives?</td>
<td>15 (23.08%)</td>
<td>42 (64.62%)</td>
<td>8 (12.31%)</td>
</tr>
<tr>
<td>Do you think that facilities (e.g. relative rooms, meeting rooms) for bereaved relatives in your ICU ensure privacy and comfort?</td>
<td>15 (23.08%)</td>
<td>42 (64.62%)</td>
<td>8 (12.31%)</td>
</tr>
<tr>
<td>Does your ICU offer follow-up for bereaved relatives?</td>
<td>15 (23.08%)</td>
<td>42 (64.62%)</td>
<td>8 (12.31%)</td>
</tr>
<tr>
<td>Do you think that your ICU has a written bereavement policy?</td>
<td>15 (23.08%)</td>
<td>42 (64.62%)</td>
<td>8 (12.31%)</td>
</tr>
</tbody>
</table>

**Conclusion:** We identified significant inadeguacies in the inadeguacy in 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 guidance.

**Abstract number:** P1-101

**Abstract type:** Poster

### Title: Implementing and Assessing a Caring for the Dying Care Bundle

**Presenting author email address:** kclark@calvarymate.org.au

**Background:** Wide variations in the quality of care provided to people dying in acute hospitals exist. A 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:** Approved 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 burden 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-naive people. 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 programs 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

Cicely Saunders Institute / King's College London, Palliative Care, Policy and Rehabilitation, London, United Kingdom
Presenting author email address: susanne.l.de_wolf@kcl.ac.uk

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 patient and family needs and concerns.

Aim: To implement a PPI model in PC research to produce high-quality research with finding relevant to patients and families that influence clinical care, policy and funding.

Methods: Patient 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 iterative PPI implementation model. The PPI implementation model was developed further and refined and agreed by consensus with a executive board of a leading PC research centre, which comprised clinical leads and international researchers. 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 agree on the final 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 effective leadership 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 explore implementation, sustainability 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

Brey H1, Pickard J2, Kay S3, Doherty D4
1University of Manchester, Medicine, Manchester, United Kingdom, 2St Ann’s Hospice, Manchester, United Kingdom

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 related to an instruction for priority of use when multiple strengths of the same drug were prescribed pro re nata (prn) for the management of one symptom. Within part 2, specific formulation details were also frequently missing from the prescription (67%, n=16). This was particularly problematic with strong opioid liquids where different strengths were often available. Other common problems included missing allergy status information, incorrect abbreviations of units, failure to complete the indications 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 by 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

van Trots LD1, Schweitzer Bt, Dujsters M2, Trobye B3
1Netherlands Comprehensive Cancer Organisation (RNO), Utrecht, Netherlands, 2Foundation PaTz, Amsterdam, Netherlands, 3Erste Lijn Amsterdam, Amsterdam, Netherlands

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 (RNO) 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 chairman
- groups were prepared to participate in a pre- and posttest
All groups received training for the chairman. 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

Gómez-Batiste X1,2, Mateo-Ortega D1, Martínez-Murillo M1, Beas E1, Busón M1
1Catalan Institute of Oncology, The ‘Qualy’ Observatory - WHO Collaborating Centre for Public Health Palliative Care Programmes, Hospital de Lloret de Vist, Spain, 2University of Vic, Chair of Palliative Care, Vic, Spain, 3a Caixa Foundation, Social Area, Barcelona, Spain

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 (PSCTs) 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 PSCTs 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 PSCTs 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 PSCTs provide effective interventions and contributes to improve the emotional symptoms and unease of patients and their families.

Abstract number: P1-106
Abstract type: Poster

Quality of Information from Acute Hospitals to a Hospice

Hallerston K, Limbachs J, Gill A, Gale S
1The順 manifold House, Department of Palliative Care, Medinum Vennon Hospital, Northwood, London, United Kingdom
Presenting author email address: kate.hallerston@nhs.net

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 inpatients 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 the case of strong opioids were recorded 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. Indication for medications was not given in 53% (8) patients.

Conclusion: 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: P1-107
Abstract type: Poster

Quality of Information from Acute Hospitals to a Hospice

Hallerston K, Limbachs J, Gill A, Gale S
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Poster

Abstract number: P1-107
Abstract type: Poster

Are COPD Patients Receiving Adequate End of Life Care?
Henderson S.¹; Swan M.¹; Stone S.²
1Woking and Sam Beare Hospices, Palliative Medicine, Woking, United Kingdom, 2Woking and Sam Beare Hospices, Woking, United Kingdom

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 cited as the reason for referral, most common reasons being symptom control and psycho-social 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 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 formal depressive 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: P1-108
Abstract type: Poster

An Audit of Depression Screening in a Hospice Inpatient Unit
Hope E.; McIvor P.; Farry C.; McMullen D.¹
¹Foyle Hospice, Derry/Londonderry, United Kingdom, ²Altnagelvin Area Hospital, Derry/Londonderry, United Kingdom

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 annually from 2007 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.

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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?
Hopwell-Kelly N.¹; Fitzgibbon J.²; Baillie J.³; Nelson A.¹
¹Marie Curie Palliative Care Research Centre, Medicine, Cardiff, United Kingdom, ²Wales Cancer Trials Unit, Cardiff University, Medicine, Cardiff, United Kingdom, ³School of Health Sciences, Cardiff University, College of Biomedical and Life Sciences, Cardiff, United Kingdom

Presenting author email address: hopwell-kelly@cardiff.ac.uk

Background: From 2005 a clinical trials unit has involved lay representatives (‘Research Partners’) as members of trial management groups (TMGs), reviewing documents and chairs 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 that 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’ involvement in TMGs, emails and written communications. Data were coded and a framework analysis was conducted to identify the impact of RPs’ participation.

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 for granted and not developed. Staff members 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

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
Huang M.²
1Mackay Memorial Hospital, New Taipei City, Taiwan, Republic of China

Background: Hospice care has 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 patients.

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: none; 1: minimal; 2: moderate; 3: substantial; 4: severe); higher scores 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. EOCG 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, advanced 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 Care in the Last Week of Life: Results from the MEDILAST Project
Arevalo J.J.¹, Huijman B.A.¹, Geijteman E.C.T.², Dres M.K.², Zuuroom WW.A.³, Perez R.S.G.M.⁴
¹VU University Medical Center, Anesthesiology, Amsterdam, Netherlands, ²Erasmus MC, Medical Oncology, Rotterdam, Netherlands, ³UMC Radioud, Health Quality, Nijmegen, Netherlands

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 52 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, 69% antithrombotic agents and 65% 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 antithrombotic agents in hospitals revealed the use of antithrombotic 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 added to the medication burden of dying patients, especially in hospitals. Clinicians could reduce this burden by a continuous re-assessment 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 111.00.036).

Poster Sessions (Poster Exhibition Set 1)
Abstract number: P-1-112
Abstract type: Poster

The Quality of Palliative Care in the Netherlands
Frokholte B.1, Jansen-Segers M.1, Owonoetokia-Philipson B.1, Middelburg-Heby M.2, van Trigt L.1
1Netherlands Comprehensive Cancer Organisation (iKNL), Palliative Care, Utrecht, Netherlands, 2EMGO Institute, Amsterdam, Netherlands

Background: In recent decades, palliative care in the Netherlands has developed significantly, in part thanks to supporting government policies. Many services and quality tools have been put in place, like hospices, guidelines, consultation and education.

Aim: What can we say about the quality of palliative care in the Netherlands?

Method: Dutch literature, including grey literature and websites from 2008-2013. If there was no recent literature, it had added value in order to describe the field, we also used literature before 2008.

Results: There are no reference guidelines to assess the quality of palliative care in The Netherlands: benchmarks do not exist or are not being widely adopted. We have therefore focused on the identification of obstacles to the development of high quality of care. Research has shown the following:

- In 30% of cases, more frequently in cases of non-oncological disease compared with oncological disease, the primary care physician does not recognize impending death in the last three months of the patient’s life.
- In 22% of the cases, the dying phase is not recognised. This can lead, to unnecessary interventions. Treatment goals remain aimed at curative care for too long (22% in the last 3 months, 6% in the last week).

Symptom relief is not always enough – 28% of terminal cancer patients experience unbearable suffering.

Palliative sedation does not always work well, according to nurses involved (42%), in particular in the area of medication policy, communication and cooperation agreements.

In the last month of life, two out of three patients have to deal with one or more transfers, often to the hospital.

Conclusion: General statements about the quality of palliative care in the Netherlands are not possible. Research points to problems that require attention. Development of a comprehensive system which maps and records the quality of palliative care in the Netherlands is desirable.

Abstract number: P-113
Abstract type: Poster

Palliative Care Professionals’ Views on Guidelines in Palliative Care
Kolies H.1, Schotermeier R.1, Simon S.T.1, Holtz K.2, Bauwens C.1, German National Palliative Care Group for Patients
1Munich University Hospital, Department for Palliative Medicine, Munich, Germany, 2Cologne University, Centre for Palliative Medicine, Cologne, Germany

Background: There is an increasing number of guidelines in palliative care. To foster implementation of these guidelines, knowledge of barriers and facilitators of potential users is necessary.

Aims: To describe barriers and facilitators for the use of evidence-based guidelines of palliative care professionals in Germany.

Methods: Web-based online survey with professionals from the German Palliative Care Association in summer 2014.

Results: 1031/14768 respondents (20%), 65% female, median age 50 years (range 24-79), professional experience median 22 years (range 0-50), 55% physicians, 30% nurses, 14% other professions, specialisation in palliative medicine/care 73%. Barriers to guideline use were: guidelines not up to date (73%), reluctance to change own routine (58%), too many guidelines (49%). Impact of guidelines on current practice 79% (physicians > nurses). Main barriers for guideline use: lack of knowledge 46% (nurses > physicians), lack of motivation 9%, lack of treatment agreement 20%. Positive attitudes towards palliative care guidelines: improve quality of symptom control (97%), care based on up to date evidence (96%), make a difference in patient care (91%). Recommended measures for implementation (+90%) were information from relevant associations, standard operating procedures, publications, and integration in undergraduate training.

Conclusion: Palliative care professionals’ attitudes towards guidelines are quite positive. Special attention should be given on information transfer and on nurses during the implementation process in order to increase adoption of guideline recommendations.

Abstract number: P-1-114
Abstract type: Poster

Performance Measurement and Quality Improvement in Palliative Care: Toward a Minimum Data Set for a Region in Ontario, Canada
Klinger C.1, Pereira J.1, Campbell B.1, fixed Kuhl D.1, Duval T1, Genter C.1,1
1University of Ottawa, Department of Palliative Care, Ottawa, ON, Canada, 2Bruyère Continuing Care, Ottawa, ON, Canada, 3Bruyère Research Institute, Ottawa, ON, Canada, 4Carefor Health and Community Services, Ottawa, ON, Canada, 5The Ottawa Hospital, Palliative Supportive Care, Ottawa, ON, Canada, 6Queen’s University, School of Urban and Regional Planning, Kingston, ON, Canada, 7Champlain Hospice Palliative Care Program, Ottawa, ON, Canada

Presenting author email address: cklinger@bruyere.org

Background: The Regional Hospice and Palliative Care Program coordinates and integrates the delivery of hospice and palliative care services for the entire region, working closely with provider organisations across all sectors from home to hospitals and hospices (baseline; response rate 66%) in the region. Gaps have been detected in several areas including: health care provider education/volunteer training, transition management/wait times, and advance care planning/communication.

Conclusion: The project has identified a set of palliative care standards and linked (priority) indicators, tested the feasibility of an electronic data collection mechanism and discovered gaps that could lead to a quality improvement system via minimum data set for the region and beyond. The standards and respective (priority) indicators will be presented.

Funding: This project was supported by funding from the Local Health Integration Network.

Abstract number: P-1-115
Abstract type: Poster

Vialon Cannulas for Subcutaneous Infusion of Drugs to Terminally Ill Patients in Hospice Home Care
Kozusko M.1, Grot A., Borowicz V.
Sue Ryder Home, Bydgoszcz, Poland

Background: In Poland metal butterfly needles are commonly used for subcutaneous infusions in palliative care. This way of infusion is particularly helpful for patients with advanced age to give hydration or drugs for pain, agitation or nausea. In many cases it helps to avoid hospitalization, secures patient comfort and is easy to perform.

Aim: Prospective study of home care patients requiring continuous infusion of drugs, to estimate tolerability of Vialon cannula (BD Saf-T-intima) compared to metal butterfly needles. To determine the survival time of cannula or butterfly, skin reaction, influence of the type and quantity of drugs on side effects occurrence, viability and satisfaction of patient and personnel.

Material and methods: The study was performed between May and October 2014. Data were collected on 20 home care patients (age 77 (9) from the time of insertion of the first needle or cannula to the time of the replacement. The replacement of the cannula or butterfly was performed as often as it was necessary, but no more often than 3±1 days. After 2 weeks of the study the butterfly needle was changed to Vialon cannula to check survival time. For each patient we used a form to record demographic data, site of insertion, side effects, reasons for removing and the dose of drugs.

Results: The analysis showed that during the last three months of the subacute site was significantly longer with the Vialon cannula (7 vs 3 days). Both patients and nurses preferred the Vialon cannula because it did not need to be changed as frequently as butterfly needle, had less side effects (Vialon cannula 15% vs butterfly needle 85%) and higher level of patient and personnel comfort (very satisfied 99%).

Conclusions: Vialon cannulas were very well tolerated by patients and nurses. It is a good alternative for administration of medications by sc infusion in terminally ill patients because of its survival time and fewer skin reactions.

Abstract number: P-1-116
Abstract type: Poster

Mulholland H.1, Gambles M.A.1, Lowe D.1, Husk L.1, Stewart K.1, Ellershaw J.E.1, McGloughlin T.1,2
1University of Liverpool, Marie CURie Palliative Care Institute Liverpool, Liverpool, United Kingdom, 2Royal College of Physicians, Clinical Effectiveness and Evaluation Unit, London, United Kingdom

The quality of end of life services is a suggested indicator of the quality of all health care provision. NCDAH provides data re:standard of care delivered to imminently dying patients. Aim: Report upon care provided to dying patients and their relatives to highlight areas for improvement in clinical practice and influence policy/funding/research agendas.

Method: Retrospective clinical audit of organisational aspects of care and Clinical data from 1098 hospital records for May 2013 from 131 Hospitals (63% (272) captured 858/2313 (37%) response beraared relatives’ (BR) views via Care of the Dying Care Evaluation questionnaire.

Results: Median age 82, cancer diagnosis 23% (1546), female 51% (3332).

Organisational
- 7 day access to specialist palliative care service (SPCS) in 28% (21%)
- No education/training provision in 24% (18%)
- No Trust Board (TB) representation in 61% (47%)
- No Audit in 57% (44%)

Processes to capture BR views in 61% (47%)

Clinical
- Decisions and assessments routinely recorded eg recognition of dying in 87% (7722 cases)
- ≥5 patient assessments in last 24 hours recorded in 82% (9409) cases

Exclusions: Clinically Assisted Nutrition 45% (2563)/Hydration 59% (3351)

Communication of decisions more likely undertaken with relatives than patients eg

- Least routinely recorded

Spiritual needs assessment Capable patients 21% (715/3391)*Relatives 25% (1623/6573)*

Care of the body after death 46% (1037)

BR views
- Most reported patients were ‘always’ treated with dignity/respect by medical personnel (70%/5277)
- BR felt adequately supported (76%/610)

Reduplicated sample

Conclusions: Organisational processes to include: 7 day access to SPCS/Education/Tub Board representation/audit. Clinical decision documentation and communication to relatives and patients could be improved. Beraared relatives views generally positive, but a significant minority reported negative perceptions of care.

Poster Sessions (Poster Exhibition Set 1)
Abstract number: P1-117
Abstract type: Poster

Measuring the Quality of End of Life Care for Patients with Advanced Cancer on the Intensive Care Unit

Miller S.J., Desai N.V., Gruber P.C., King A., Pattison N., Faragh-Hashim P., Dorney J.M.

Royal Marsden Hospital NHS Trust, Palliative Medicine, London, United Kingdom, 2Royal Marsden Hospital NHS Trust, Intensive Care Unit, London, United Kingdom, 3Royal Marsden Hospital NHS Trust, Oncology, London, United Kingdom

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 treated and active treatment groups to identify factors predictive for EOLC transition.

Results: 38/85 (44.7%) patients transitioned to EOLC on ICU. Of the EOLC group: 56.2% saw palliative care team, and symptom control was achieved in 79%. When discussing transition regarding to EOLC, and resuscitation were mades, 51.4% and 40.5% patients respectively were too unwell to discuss. 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.

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.

Abstract number: P1-118
Abstract type: Poster

Managing Paracentasis in Hospice Inpatients: Does Having a Standard Protocol Improve Patient Safety and Length of Stay?

Naessens K., Lewis L.

Oxford Deanery, Palliative Medicine, Reading, United Kingdom, 2Florence Nightingale Hospice, Aylesbury, UK

Presenting authors email address: katrien.naessens@synergiecare.org

Background: Paracentesis is a considered a safe and effective procedure for managing malignant ascites. There is wide variation in practice across sites, partly regarding rate and duration of drainage and management of hypotension. A 2010 Cochrane Review demonstrates that paracentesis reduced in this patient population by 16%-number of doses post implementation, weekly point prevalence data continued for 14 weeks.

Conclusion: The frequency of hypotensive 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 implementation of a protocol is considered safe and effective for managing malignant ascites. Further research on larger sample sizes is warranted.

Abstract number: P1-119
Abstract type: Poster

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

Nwosu A.C.1, Khodabukus A.F.2, Robinson C.3, Clark R.3, Jones D.4, Green P.4, Watson M.4, Fountain J.E.5

1 Marie Curie Palliative Care Institute Liverpool, 2MCPCL, University of Liverpool, Dept of Molecular and Clinical Cancer Medicine, Liverpool, United Kingdom, 3Willowbrook Hospice, Prescot, United Kingdom, 4Marie Curie Hospice Liverpool, Liverpool, United Kingdom, 5Warwick Hospital, Warwick, United Kingdom

Presenting author email address: a.nwosu@lcl.ac.uk

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.

Aims: To analyse the use, dosage, choice and route of medications used to manage symptoms in the dying.

Method: A prospective and retrospective, multi-professional care 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 (SD 17.47) with cancer (n=172, 62.2%). Most were hospice based (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 (CSI) syndromes were used in 607 (74.7%). In those receiving CSI 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 CSI medications were midazolam (n=162, 78.3%), glycopyramine (n=62, 30.3%) 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%) had a route other than the subcutaneous 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 settings and highlights some differences compared to the NCDAH which 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.

Abstract number: P1-120
Abstract type: Poster

Mapping and Reducing Polypharmacy in a UK Hospice Inpatient Setting

Phippen A.1, Pickard J., Salmon M., Stonie D., Roberts D.2

1 St Ann’s Hospice, Manchester, United Kingdom, 2University of Manchester, School of Pharmacy, Manchester, United Kingdom

Polypharmacy is the prescribing of multiple medications to one individual. The UK Kings Fund report (2013), ‘Polypharmacy and medicines optimisation’, recommends research to improve medicines management. There are no guidelines specific to the field of specialist palliative care, where medication regimens likely pose a significant burden on patients, prescriber and service (cost and manpower). Yet, the extent of ‘inappropriate polypharmacy in palliative medicine is unknown.

Our project aim was to map the levels of polypharmacy and to implement strategies to reduce this in a UK hospice inpatient unit (27 beds).

Baseline data for the number of regular medications, tablets and volume of liquid medication was collected for a total of 41 consecutive inpatients. Weekly point prevalence data (number of medications, tablets and liquids) was collected for each patient on one ward (14 beds) for 10 weeks prior to implementing a series of ‘tests of change’. These focused on education and guidelines on the use of paracetamol, laxatives and knowledge of dose sizes. Post implementation, weekly point prevalence data continued for 14 weeks.

Counter balance measures were employed which included monitoring levels of ‘as required’ medication, of liquid medication and of point prevalence data from the control ward. Test of change was assessed by Shewhart charts and interrupted time series analysis.

Baseline medication levels observed for the patients at discharge were a mean of 9.5 medications per patient, 15.1 tablets and 60mls liquids. Post intervention data demonstrates that polypharmacy reduced in this patient population by 16%-number of medications, 25%-number of tablets and 30%-volume of liquid medicines.

Education and the use of hospice specific guidelines has succeeded in reducing polypharmacy levels in this population of patients. The generation of accredited guidelines on polypharmacy specific to the field of palliative medicine and its care settings are recommended.

Abstract number: P1-121
Abstract type: Poster

Percutaneous Cervical Cordotomy for Mesothelioma (and other Cancer)-Related Pain: Is it Effective and Safe, and is Continued Commissioning Warranted? (Results of the UK National Registry)

Poolman M.1, Mylond C., Byres J., Campion N., Antrobus H., Sharma M.L., Hugel H., Williams M.I., Makin M.K.1, Ekersha L.E.

1 Bangor University, North Wales Centre for Primary Care Research, Wrexham, United Kingdom, 2Betsi Cadwaladr University Health Board, Wrexham, United Kingdom, 3Marie Curie Palliative Care Institute Liverpool, Liverpool, United Kingdom, 4Queen Alexandra Hospital, Portsmouth, United Kingdom, 5Warwick Hospital, Warwick, United Kingdom, 6The Walton Centre NHS Foundation Trust, Liverpool, United Kingdom, 7Aintree University Hospital, Liverpool, United Kingdom

Presenting author email address: m.poolman@bangor.ac.uk

Studying mesothelioma-related pain is essential: in the UK, mesothelioma incidence is rising and expected to peak around 2020. It is often associated with difficult, even refractory, pain syndromes: this is acknowledged by the UK National Mesothelioma Framework which suggested that patients should have access to cordotomy as a palliative intervention.

Percutaneous cervical cordotomy (PCC) involves creating a radiofrequency lesion in the spinohinal tract in the cervical spinal cord. It has utility in unilateral pain syndromes where an acceptable balance between side effects and analysis has been difficult.

There is great inequity in provision: only 4 sites across the UK perform more than 10 per year. Though a systematic review of the sparse literature indicated PCC might be effective and safe, it did not provide evidence to support continued provision. Clinical consensus was reached on the place of PCC in the clinical pathway in the UK and resulted in the launch of a national registry in January 2013.

Up to August 2014, the registry has accrued 87 cases from 4 practitioners. Interim analysis indicated effectiveness: 62% of patients reported in excess of 90% improvement in pain, with 56% having no background pain and 59% no breakthrough pain at discharge.

Qualitative comments support these findings: ‘Haloform cautery was used as a guidewire was not required. The effect is sustained well throughout follow-up, with 51% having no background pain and 52% no breakthrough pain at follow-up. Adverse effects at follow-up include dysaesthesia(21% mod/severe), mirror pain (3%) and headache(11%).

The first full analysis of outcomes for the first 100 cases will be presented. We will reflect on what this means for practice, and consider the impact on and future approach to continued commissioning of UK PCC services. Networking with interested colleagues will clarify whether an international registry is warranted.
Developing Palliative Care Knowledge and Skills in a Heart Failure Team: Does it Improve Quality of Care Delivery?

Weltritz J.1, Poorman M.2, George J.3
1Betis Cavaldadri University Health Board, Wrocław, United Kingdom, 2Ranger University, North Wales Centre for Primary Care Research, Wrexham, United Kingdom, 3Singleton Hospital, Swansea, United Kingdom

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 management of the palliative care needs of their patients. Teaching sessions followed, with subsequent support to imbed into practice of principles of good palliative care, 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

Duarte A.1, Rasmussen B.H.2, Fürst C.J.3
1Institute of Palliative Care, Region Skåne, Lund University, Lund, Sweden, 2Institute of Palliative Care, Region Skåne, Lund University, Department of Health Sciences, Lund, Sweden, 3Institute of Palliative Care, Region Skåne, Lund University, Department of Oncology, Lund, Sweden

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 is being 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 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 consistent and a structured assistance 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 is a stronger inclusion of a variety of patients’ and families’ perspectives.

Abstract number: P1-124
Abstract type: Poster

Systematic Use of a Quality Registry for Palliative Care Development

Sallén L.1,2, Borgman Remes K.1, Vestberg I.1, Fürst C.J.3
1Region Skåne, Lund, Sweden, 2Lund University and Region Skåne, Lund, Sweden

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 for PC care. Since August 2012 all patients registered after death 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, 73.6% 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 comparison 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 care setting we 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.

Abstract number: P1-125
Abstract type: Poster

Caregivers’ Perception of Palliative Sedation: A French Opinion Survey

Sercelec L.1, Pangouf F.1, Craizer S.1, Salacha F.1, Chenivesse C.1

Background: In end-of-life palliative care, appropriate medications may be ineffective in relieving symptoms. When this condition is intolerable suffering, palliative sedation (PS) must be considered. Although guidelines have been developed in France, ethical controversies and inappropriate requests appear to exist in clinical practice. We hypothesis that this situation is due to caregivers’ inadequate knowledge.

Objective: We aimed at investigated caregivers’ knowledge, experience and feelings related to PS.

Methods: We conducted a survey in a French university hospital. Caregivers from departments including dedicated palliative-care beds were asked to fill in a questionnaire composed of 6 items concerning PS definition, experience and emotional impact.

Results: 160 questionnaires were completed by nurses (39%), physicians (37%) and nursing assistants (18%). Of them, 38% had been involved more than ten times in PS. 23% knew the consensual definition of PS and 50% made a clear difference between PS and euthanasia. 24% of caregivers felt unsettled by PS practice. Crossing data showed that less caregivers were destabilised when they made a clear difference between PS and euthanasia than when they did not (18% vs 36%, p < 0.03). There was no statistical relationship between the experience in practice of PS and its emotional impact. Thinking that ‘the goal of PS is patient’s relief’ rather than “a decrease in consciousness” was associated with a better distinction between PS and euthanasia (73% vs 55%, p < 0.05).

Discussion: The present study showed that PS definition, indication and purpose were unclear in a raised awareness population. These results support the idea that PS remains a complex concept. This may lead to heterogeneous practices of PS and ambiguous perception of PS ethics including a deleterious confusion with euthanasia.

Abstract number: P1-126
Abstract type: Poster

Discharge Letters - Improving the Process in a UK Hospice Setting

Shepherd E, Ahmed A
Saint Ann’s Hospice, Manchester, United Kingdom

Background: There is specific national guidance for hospital discharge letters (Royal College of Physicians 2007, UK). None currently exist for hospices, yet the same principles apply to ensure continuation of quality care in the community. Hospice discharge letters are dictated using a template, typed, signed and sent out. There are no time frame standards for this process, compared to a standard of 24 hours in hospitals.

Objectives:
1) Assess if letters follow the hospice template
2) Compare template to national guidance - are missing areas relevant?
3) Assess time for letters to be sent out

Methods: The last 56 discharge letters were compared against the hospice template. Time between discharge and the letter being typed was assessed. The hospice template was compared to the RCP ‘mandatory’ headings.

Results:
5 letters: informing of transfer/death were excluded. Patient details and diagnosis were present in 100%. 44 patients (98%) had their medications listed, but 9 patients (20%) had no allergy status. Of 18 patients on steroids (42%) had no steroid plan. 41 (91%) of the patients had outcomes/actions recorded but with inconsistency in presentation - 10 patients (22%) had a clear plan at the end of the letter. Patients’ preferred place of care (PPC) and preferred place of death (PPD) were included in 16 (36%) and 9 (20%) of letters respectively. The mean time for letters to be typed was 1.6 days with a range of 0-6 days.

Our template included 15 of the 29 RCP ‘mandatory’ headings. Missings included ‘relevant investigations and results’ and ‘medication changes’.

Discussion: We could improve our use of the current template, especially regarding outcomes/actions, PPC and PFD. Potential delays with dictation, typing and signing means the system needs review to ensure GPs receive information efficiently. The template also needs review to comply with national standards where relevant. A focus group is planned to discuss the results and instigate change.

Abstract number: P1-127
Abstract type: Poster
Audit of Record of Pulse and Recording of Atrial Fibrillation in a Hospice Setting

P1-130
Mark Kovar1, Subramaniam S.1,2
1Southport and Ormskirk NHS Trust, Palliative Medicine, Southport, United Kingdom
2Spathology and Ormskirk NHS Trust, Palliative Medicine, Southport, United Kingdom

Abstract number: P1-130
Abstract type: Poster

Background: Atrial fibrillation is a common cardiac arrhythmia, with a prevalence increasing with age – from 0.5% in 50–59 year olds to almost 5% in 80–90 year olds. Potentially distressing symptoms include palpitations, chest pain, dizziness as well as worsening heart failure, confusion and oedema. Recognising AF is important as optimal treatment is specific to AF.

Aim: To determine if AF is documented in Hospice inpatients. To determine if heart rate is assessed on admission.

Method: Computerised patients records, initial Doctors assessment and front of drug chart (Observations taken by nursing staff are documented on front of the chart) of 60 consecutive patients with a diagnosis of cancer admitted to the inpatient unit from October 2013. Data collection proforma used. Retrospective audit.

Results: Mean age was 70 years. 19 patients were EoLC(31.6%) – none of which had a documented pulse rate. These patients were excluded from the results. Of the remaining 41 patients, 4 (9.7%) were documented to have AF. Twenty three (62%) of patients had pulse documented. 32 (78%) of patients had recent electrocardiograms documented.

Discussion: AF was documented in 9.7% of cancer inpatients which is consistent with the reported prevalence of AF (All patients over 75 years). Although HR was documented in over half of the patients admitted to the unit only 1.7% had documentation of rhythm. Given the lack of pulse rate documentation it is likely that in a proportion of patients the condition goes unrecognised. Unless diagnosis is thought about and symptoms of atrial fibrillation actively sought at assessment, consideration of specific treatment may not occur.

Recommendation: We recommend that all patients admitted (except EoLC), have pulse rate and rhythm documented on admission. The admission, if any symptoms (SOB, palpitation, chest pains), then AF should be considered if appropriate. This should be improved also during the admission (if indicated).

Abstract number: P1-131
Abstract type: Poster

Evaluating End of Life Care at a Regional Cancer Centre: Results of a Study Using the VOICES Questionnaire

Emma Sugrue1, Crackley A.1, McKay M.1
1The Clatterbridge Cancer Centre, Specialist Palliative Care Team, Wirral, United Kingdom,
2The Clatterbridge Cancer Centre, Clinical Effectiveness Team, Wirral, United Kingdom

Abstract number: P1-131
Abstract type: Poster

Background: End of life care provided by the regional cancer centre had not previously been formally evaluated. VOICES (Views of Informal Carers-Evaluation of Services) is a validated questionnaire completed by relatives of patients who died in different care settings.

Aim: Assess cancer carers’ experience of quality of end of life care provided at the regional cancer centre.

Method: The VOICES authors gave consent to condense the questionnaire to 35 focussed questions. The hospital Clinical Audit Sub-committee approved the study. Questionnaires were sent to the next of kin of 33 patients who died between April 2012 and December 2013. No reminders were sent. Information on bereavement services was given.

Results: The response rate was 21%. 57.1% felt doctors ‘always’ treated their relative with respect and dignity during the last admission; 85.7% felt the same for nurses. 42.9% felt the care from doctors and nurses was excellent; 14.3% felt the doctors’ care was ‘poor’; 42.9% thought pain was relieved all of the time; 14.3% of patients had said they wanted to die in hospital. 71.4% felt their relative died in the right place. 85.7% felt they were provided with enough support at the time of death. 100% felt they were dealt with sensitively; 42.9% were satisfied with the overall care in the last three months of life as ‘good’, ‘14.3% as ‘excellent’ and 14.3% as ‘poor’.

Discussion: The low response rate makes the validity of the results questionable. Actions to increase the response rate would be important in the future. There was no opportunity for relatives to give explanations for some answers which would have been useful. There are challenges and ethical issues with end of life care studies, including using relatives to assess care rather than patients.

Conclusion: VOICES is one potential tool for evaluating end of life care in a regional cancer centre. There are limitations, making other validated tools potentially more clinically appropriate.
Using Pain and Breathlessness Symptoms as Quality Indicators: An Evaluation of a Palliative Care Service at a Hospital

Abstract type: Poster

Background: Patient reported outcomes are useful to understand if medical 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 (POS). Patients were assessed before and after intervention. A decision to withdraw active treatment was made and documented in the medical record. If the patient remained alive after 72 hours, the intervention was deemed to have been successful. The study was approved by the institutional review board.

Results: 114 patients were included. The mean age was 76 ± 12 years, 57% were females, 91% had a cancer diagnosis, and 62% had a terminal diagnosis. The median POS scores before and after the intervention were 7 (2-16) and 2 (0-6), respectively. The median number of prescriptions per patient was 2 (1-5) before and 3 (1-7) after the intervention. The most frequently prescribed medications were opioids, sedatives, and anti-emetics.

Discussion: The use of pain and breathlessness symptoms scores as quality indicators was feasible and provided useful information for quality improvement. The intervention was successful in 83% of cases, and the patients reported a significant improvement in their symptoms. However, further research is needed to determine if these findings can be generalized to other settings.

Abstract number: P1-138

Developing and Implementing National Evidence Based Clinical Guidelines in Palliative Care

Abstract type: Poster

Background: Palliative care teams are often faced with the challenge of implementing national evidence-based clinical guidelines (CECGPs). This may be due to difficulties in translating guidelines into practice, lack of resources, or resistance to change.

Aim: Developing and implementing national evidence based clinical guidelines in palliative care.

Methods: The Danish Multidisciplinary Cancer Group of Palliation (DMCG-PAL) has been active in developing national evidence-based clinical guidelines since 2010. Participants are from hospices, palliative departments and teams all over Denmark. The group 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.

Results: 59 nurses, 17 physicians, 2 psychologist, 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, lymphoma, death, obstipation, fatigue, fluid therapy, young carers and palliative sedation). Eight guidelines have been accepted by The Danish Caringframework for Guidelines. Three guidelines are published as systematic literature searched document. Guidelines have been sent to Clearinghouse for judgement in autumn of 2014, and seven guidelines will be ready for judgement during 2015.

Conclusion: Through 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 guideline in their own department.

Abstract number: P1-136

Audit of Intravenous Infusions of Bisphosphonates Carried Out in the Community over a Twelve Month Period

Abstract type: Poster

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 transferred to the care of the MMT for future treatments, or in 2 cases were started by the MMT after discussion with their oncologist.

Discussion and conclusion: Patients expressed their appreciation of the service it as avoided attendance at hospital. The infusions were anticipated on many occasions in the patients’ homes.

Abstract number: P1-137

Hospital Discharge Advance Care Plans in the Netherlands: Evaluation of a Pilot Study

Abstract type: Poster

Background: Patients’ preferences regarding end-of-life care and treatment preferences are increasingly being documented in advance care plans (ACP). However, the implementation of ACPs in hospital settings remains limited.

Methods: A pilot study was conducted in a large Dutch hospital to evaluate the implementation of ACPs. The study included 100 patients admitted to the hospital. The ACPs were prepared using a standardized tool and discussed with the patient and their family. The implementation fidelity of the ACPs was assessed through a standardized checklist.

Results: The implementation fidelity of the ACPs was high (92%). The majority of patients (85%) were satisfied with the ACPs. The most common reasons for dissatisfaction were the lack of information on available medical interventions and the lack of information on patient preferences.

Conclusion: The implementation of ACPs in hospital settings is feasible and patients are satisfied with the ACPs. Further research is needed to determine the impact of ACPs on patient outcomes.

Abstract number: P1-134

Using Pain and Breathlessness Symptoms as Quality Indicators: An Evaluation of a Palliative Care Service at a Hospital

Abstract type: Poster

Background: Patient reported outcomes are useful to understand if medical 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 (POS). Patients were assessed before and after intervention. A decision to withdraw active treatment was made and documented in the medical record. If the patient remained alive after 72 hours, the intervention was deemed to have been successful. The study was approved by the institutional review board.

Results: 114 patients were included. The mean age was 76 ± 12 years, 57% were females, 91% had a cancer diagnosis, and 62% had a terminal diagnosis. The median POS scores before and after the intervention were 7 (2-16) and 2 (0-6), respectively. The median number of prescriptions per patient was 2 (1-5) before and 3 (1-7) after the intervention. The most frequently prescribed medications were opioids, sedatives, and anti-emetics.

Discussion: The use of pain and breathlessness symptoms scores as quality indicators was feasible and provided useful information for quality improvement. The intervention was successful in 83% of cases, and the patients reported a significant improvement in their symptoms. However, further research is needed to determine if these findings can be generalized to other settings.

Abstract number: P1-138

Developing and Implementing National Evidence Based Clinical Guidelines in Palliative Care

Abstract type: Poster

Background: Palliative care teams are often faced with the challenge of implementing national evidence-based clinical guidelines (CECGPs). This may be due to difficulties in translating guidelines into practice, lack of resources, or resistance to change.

Aim: Developing and implementing national evidence based clinical guidelines in palliative care.

Methods: The Danish Multidisciplinary Cancer Group of Palliation (DMCG-PAL) has been active in developing national evidence-based clinical guidelines since 2010. Participants are from hospices, palliative departments and teams all over Denmark. The group 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.

Results: 59 nurses, 17 physicians, 2 psychologist, 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, lymphoma, death, obstipation, fatigue, fluid therapy, young carers and palliative sedation). Eight guidelines have been accepted by The Danish Caringframework for Guidelines. Three guidelines are published as systematic literature searched document. Guidelines have been sent to Clearinghouse for judgement in autumn of 2014, and seven guidelines will be ready for judgement during 2015.

Conclusion: Through 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 guideline in their own department.

Abstract number: P1-136

Audit of Intravenous Infusions of Bisphosphonates Carried Out in the Community over a Twelve Month Period

Abstract type: Poster

Background: Intravenous bisphosphonates are routinely administered in hospital. This community service aims to provide interventions at home.

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Conclusion: The implementation of ACPs in hospital settings is feasible and patients are satisfied with the ACPs. Further research is needed to determine the impact of ACPs on patient outcomes.

Abstract number: P1-134
Initiating Opioids in Patients with Advanced Disease: How Well Are We Doing?

Worm G., Mollik F.
East Sussex Healthcare NHS Trust, Medicine, Eastbourne, United Kingdom
Presenting author email address: g.watts@doctors.org.uk

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 well how 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 proformas for inpatients 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 proformas 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 were patients asked about concerns of treatment. Written information was provided in 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

Weatherstone K.L., Saunders E., Lodge P., Hopkins K.
Royal Free Hampstead NHS Trust, Palliative Care Department, London, United Kingdom

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 increase.

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 Genetics teams. 59 referrals (27.5%) were from medical specialties. Patients were mainly referred for symptom control (62%). Only 19 referrals (7.9%) were considered inappropriate. Patients remained under the palliative care team for an average of 9.5 days (range 1-55). 119 patients died (48.4%) 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 admitting 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

Zalemski R.J., Courage C., Judd AL.
Wayne State University, Detroit, MI, United States
Presenting author email address: rzalensk@med.wayne.edu

Background: An initial study in 4 hospital ICUs in Detroit demonstrated that a seven-item palliative care (PC) screen had good predictive value 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 ICU screening instrument in an independent population found the seven-item PC screen had good predictive value for hospital and ICU LOS, mortality, and hospice referral. To assess the relationship between each of the individual screening factors and the outcomes.

Design: The same screen was applied to ICU patients on admission in three different ICUs in two US-cities over a 16-week period. Outcomes included percent patients screened, consulted by 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 (P=0.0001). In only 35.3% who screened negative. Positive screens were associated with statistically significant increases in hospital and ICU LOS, and inpatient hospital mortality and hospice discharge. Items 'admit from Skilled Nursing Facility' and 'Readmission to ICU' were associated with increased hospital and ICU LOS, metastatic cancer, and post arrest with neurologic compromise. Percetced need for palliative care was associated with death or hospice discharge.

Conclusion: Study of the ICU screening instrument in an independent population found the five factors positively 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.

Abstract number: P1-140
Abstract type: Poster

Multi-hospital Replication of a ICU-screen for Palliative Care

Zalemski R.J., Courage C., Judd AL.
Wayne State University, Detroit, MI, United States
Presenting author email address: rzalensk@med.wayne.edu

Background: An initial published study of four hospital ICUs in Detroit demonstrated that a seven-item palliative care (PC) screen had 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.

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Conclusion: Study of the ICU screening instrument in an independent population found the five factors positively 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.

Abstract number: P1-140
Abstract type: Poster

Basic and translational research

Evaluation of Detachment and Clinical Usability of Transdermal Fentanyl Patches in Healthy Volunteers

Kakuda Y., Kunto K., Matzuki Y., Atsuda K.
Kitsato University Hospital, Department of Pharmacy, Kanagawa, Japan
Kitsato University Hospital, Department of Nursing, Kanagawa, Japan, Kitsato University, School of Pharmacy, Tokyo, Japan

Aims: A dose of transdermal fentanyl patch is proportional to its application site area; therefore, the absorption of fentanyl may lower if the patch detaches, and it would lead to insufficient analgesia.

Methods: Sixteen healthy volunteers were enrolled in a study where we investigated appropriate application sites and clinical usability of the three transdermal fentanyl patches available in Japan. Three placebo were administered using a crossover study design: fentanyl 1-day (Fen), 3-days (Dur), and the generic form of Dur (HMT). These placebos were applied to eleven different sites (both sides of upper arm, abdomen, back, thigh, chest and middle of chest). We determined a patch detachment area and incidence of itching sensation considered to be induced by patch application every 24 hours, and evaluated differences between each application site by using Wilcoxon signed-rank test.

Results: With regards to detachment area, the abdomen and upper arms in Fen, abdomen and chest in Dur, and chest in HMT, respectively, showed significant patch detachment compared to other sites (p<0.05). A statistically significant increase of a level of itching among the regions applied when administering Fen, we found statistically-significant increase in itching on the chest and back with the administration of Dur and on the abdomen in HMT compared to other sites, respectively (p<0.05).

Conclusion: It is considered, in Dur and HMT, thigh and upper arms are suitable as an application site because there was less incidence of patch detachment and itching sensation compared to chest and back. Fen, capsule every 24 hours, has showed less detachment and itching sensation than Dur and HMT, reapplied every 72 hours, which would indicate Fen specifically improves the quality of life in patients with cancer pain rather than Dur and HMT.
Background: Diagnosing when someone is in the last hours or days of their life is an ongoing difficulty for clinicians. There is often significant clinical uncertainty and modern medical science is poor at predicting how, when patients will die. It is important to recognise this change, however, to guide appropriate medical management and patient care.

Aims: To review the literature to assess the knowledge of the biology of dying—excepting sudden death.

Methods: A systematic review of the biology of dying was performed using PRISMA guidelines. 2322 articles on MEDLINE and 3016 articles from EMBASE were identified. From 5538 titles, 117 abstracts were selected. Titles and abstracts were examined independently for relevance by Coyle and McDonald, with 43 papers selected for review.

Results: There are no published studies that specifically investigate biochemical changes during dying. The evidence which does exist has been gained from postmortem studies or from patients who have incidentally died, where biological assessments have been undertaken. Hence, there is some knowledge about biochemical changes causing cachexia and anorexia, and limited knowledge about terminal dehydration, terminal secretions, dyspnoea, and agitation. Evidence from these studies seems to suggest the existence of a common dying process and highlight various potential biomarkers, such as Interleukin-2 or Interleukin-6.

Conclusion: There are no specific studies investigating biochemical changes during the dying process. Research into the biological changes at the end of life could develop a greater understanding of the dying process and have the potential to significantly impact the care future dying patients receive.

Abstract number: P1-144

Abstract type: Poster

Health Professionals’ Experiences of Transferring Critically Ill Patients Home to Die. A Comparison of Adult and Paediatric Intensive Care Staff

Morton K.E.1, Coyle S.1,2, Richardson A.1, Coombs M.1, Darlington A.1, S.1
1University of Southampton, Faculty of Health Sciences, Southampton, United Kingdom
2University Hospital Southampton NHS Foundation Trust, NHF Wellcome Trust Clinical Research Facility, Southampton, United Kingdom
3Victoria University, Graduate School of Nursing, Midwifery and Health, Wellington, New Zealand

Background: A significant proportion of hospital deaths occur in intensive care units. In circumstances of treatment withdrawal, death can be planned, raising issues surrounding preferred place of death. The aim of this research was to determine the experiences of UK health care professionals (HCPs) towards transferring critically ill patients home to die and more specifically to compare experiences in paediatric as opposed to adult units.

Methods: An online survey developed to investigate experience, views and barriers to transfer home to die, was sent to HCPs from 409 UK adult intensive care units (ICU). An adapted version was sent to 100 UK neonatal and paediatric ICU HCPs. Comparative analyses of the two datasets were carried out.

Results: A total of 180 HCPs from adult ICUs and 191 from NICU/PICUs completed the surveys. HCPs from NICU/PICUs were significantly more likely to report having experience of transfer home to die than adult ICU HCPs (70% versus 36% respectively; X²=44.570, p=0.000). NICU/PICU HCPs were more likely to disagree that transferring home is a waste of resources (p=0.001), and sought formal support more frequently than adult-ICU HCPs (p=0.001). Female gender of HCP and younger patient age predicted 24.2% of variance in GI for adult-ICU HCPs, 8.3% for spoual ICU patients. Patients with adult-ICU HCPs were significantly more likely to die in a nursing or residential home (p<0.001). This was associated with lower GI for adult but not spoual ICUs. 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 spoual ICUs. 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: P1-146

Abstract type: Poster

Experience of Mourning Counselling in a Palliative Care Department

Carqueja E.1, Perez C., Corrêa C., Gonçalves E.1
Centro Hospitalar de S. João, Palliative Care, Porto, Portugal

Background: It seems consensual that between normal bereavement and bereavement related psychiatric disorders there is a wide range of complicated mourning reactions. Between 10-17% of those who seek psychiatric support show signs of complicated mourning.

Aims: To characterise the carers attending a mourning counselling in a Palliative Care Department in a University Hospital, selected by the Complicated Mourning Screening Protocol (CMSP) developed by the team.

Methods: To analyse clinical records of carers attending the Mourning Counselling between november 2013 and august 2014 using the Worden Theoretical Model (WTM). Risk factors and protective factors of complicated mourning were evaluated by the Barret, Yi and Soler model (2008).

Results: Twenty one carers were evaluated, 14 (67%) selected by the CMSP and 7 (33%) seeking help spontaneously, of which 6 were discharged by not having emotional distress bereavement. Three carers (2 widows and 1 daughter) presented criteria for complicated mourning. By this abstract baseline, 10 carers (48%) were discharged of the mourning consult being in the IV Worden Task (median follow up 53 days, 2.5 appointments). The 11 cares, still accompanied (median follow up 90 days) were all in the V Worden Task at first appointment and the most frequent risk factors were: emotional bond intensity (100%), affective dependency (100%) and rapid disease progression (55%). As protective factors we identified the sense of utility care (91%), self recovery confidence (73%), selfcare capacity (73%) and religious beliefs (63%). Most frequent complaints were sadness and nostalgia.

Conclusion: Our results concerning the complicated mourning are similar to those reported in literature and in the 10 months follow-up about 48% of the carers were discharged for not having emotional distress lost related. At first appointment the majority of carers (60%) were in the III Worden Task.
Identification of Risk Factors and Coping Style of Complicated Bereavement

1Saint Luke Hospital, Oncology, Bucharest, Romania, 2Romanian Society of Palliatology and Ethicist and Theologian.

Abstract number: P1-147
Abstract type: Poster

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 screened, shortly after arrival, using Bereavement Risk Assessment Tool. The questionnaire was conducted using structured interviews and personal observations. The risk and protective factors were identified and compared with the literature.

Results: Of the 252 patients admitted to our department in a period of 2 weeks, 83 patients presented for the first time to palliative care unit and 70 caregivers agreed to respond to the interview. At 23.85% (61) caregivers were identified at least one risk factor positive in more than four groups of factors: comorbidity, 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 protected.

Conclusion / Discussion: The diagnosis of cancer, by its specific progression and prognosis, may be considered an adaptive factor to bereavement.

Most caregivers find the internalised belief in own ability to cope effectively with the death of their loved one.

Abstract number: P1-149
Abstract type: Poster

‘Rising from the Mist’: Systematic Review of Grief Reactions in Family Caregivers of Advanced Cancer Patients

Fardan M., Santos M., Payne S., Leal L., Julio M.
1, SPM-University Institute of Social Sciences, Psychology and Life, Lisboa, Portugal, 2International Observatory on End of Life Care, Lancaster, United Kingdom, 3Fundação Champalimaud - Centre for the Unknown, Lisboa, Portugal

Abstract number: P1-151
Abstract type: Poster

Symptoms and Suffering Perception at the End of Life of Cancer Children and the Impacts on the Caregivers

Bulhões D.
Hospital Cancer Barretos, Pediatrica, Barretos, Brazil

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 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 (Hospital 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. 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). When the 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 time. 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 the burden of symptoms referred by doctors, and negative correlation with palliative care time.
Background: The process of communicating with patients with an advanced life-threatening disease concerning breaking bad news 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, doctors indicate that patients control the situation. Only 64 (40%) doctors feel they are prepared to do it, but they consider their colleagues less prepared than themselves, as only 38 (24%) say that those are prepared to carry out this duty. 124 (78%) 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, 123 (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.

Abstract number: P1-156
Abstract type: Poster
The Crucial Conversations: Communicating is a Skill that Can Be Learned and Trained
First C
The Institute of Palliative Care Lund University and Region Skåne, Lund, Sweden
Presenting author email address: carl_johan.furst@med.lu.se
Background: The need for education and training in communication skills for doctors are well known. Scientific literature, clinical experience and family stories and testimonies address complaints on medical information and less on the emotional response to the needs of patients and families. Aim: To develop and establish a communication skills training course for doctors treating patients with life-threatening diseases.

Method: The course was developed by a group with medical, pedagogical and psychotherapeutic competence and two actors. Courses were evaluated using a specific questionnaire and by reflection by course leaders.

Results: The course is a practical based 2-day course for 12-14 participants focused on specific situations: getting a good start, talking about serious news, transition to end-life care and talking about dying. Most time was scheduled to training with actors in small groups under supervision of an experienced and trained doctor and/or supervisor. Since 2011 eleven 2-day courses were given for >100 doctors and a number of shorter courses based on the course concept. Evaluations showed clearly that training and supervision got the highest scores (>4 on a 0-5 scale). Participants feedback indicated that theory, and especially, research overviews were not requested. The need for case related training, feedback and reflection with colleagues were given highest priority. The trainer/supervisor observations of the role-play sessions so far, indicated that doctors put most attention on medical information and less on the emotional response to the needs of patients and families.

Discussion: The courses meet both unarticulated and voiced needs among doctors. The courses have been successful according to participant evaluations and demands for future courses are high. Future challenges include training of trainers/supervisors and teaching of doctors. There are also demands and needs to develop similar courses for other professional healthcare workers.
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 reason 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).

Conclusions and Discussion: Although confronting, this methodological approach was instrumental in testing 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 were used for process and post intervention. Primary outcome: Person-centred Climate Questionnaire patient version (PCQ-P), Secondary outcome: Consultation and Relational Empathy (CARE) measure; PDQ feedback questionnaires were used by all participants post intervention, in addition to qualitative interviews.

Results: 30 participants, 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

North-East L, Haugen D.R.F., Schaufel M.A.
Haukeland University Hospital, Section for Pain Treatment and Palliative Care, KSK, Bergen, Norway, University of Bergen, Regional Centre of Excellence for Palliative Care, Western Norway, Bergen, Norway
Presenting author email address: nina.elsabeth.hjorth@helse-bergen.no

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三层 points contributed to this safety. (i) Good team-players: both in the health care system and private life, they could provide the necessary courage and setting for these conversations. (ii) 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 health care workers should ask all patients about their needs for communication and planning ahead. (iii) Seize the turning point: The participants in this study preferred the discussions to be at the time of diagnosis and at the different turning points in the disease trajectory. (iv) Transparency: This was important, but difficult to balance. The participants also stressed the importance of using the medical record as a means of communication.

Conclusion: Establishing routine 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 emphasising individually tailored communication.

Abstract number: P1-159
Abstract type: Poster

Patients’ Understanding of Terminology Used in Palliative Care Services

Nollon N1, Høsing S1, Ponnampalam A1
1Norfolk and Norwich University Hospitals, Palliative Medicine, Norwich, United Kingdom, 2St Johns Hospice, Bedford, United Kingdom

Background: Good communication stipulates that we avoid using jargon. However patients’ understanding of terms such as ‘Specialist Palliative Care Nurse’ or ‘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 hospices has changed to include complex symptom control, the subsequent name change to ‘Specialist Palliative Care Unit’ seems logical. However patients’ understanding of this terminology can be problematic.

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 semi structured interviews with 20 participants attending palliative care outpatient clinics. Participants had a range of life limiting conditions and prognoses.

Results: Patients new to the service and those already known were sampled to identify any differences in their understanding. Interviews were recorded and transcribed 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 support on basic nursing and oversight 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 chemotherapy ward. Only 3 patients expressed their understanding of the 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 studies.

Abstract number: P1-160
Abstract type: Poster

Testing and Evaluating a Complex Intervention in Relation to Dignity and Patient Centred Care in the Acute Hospital Setting

Johnston B.M., Buchan D.D., McGurie M., Pringle J., Nanyasomoy M., Gaffney M.1
1University of Nottingham, Sue Ryder Care Centre for the Study of Supportive, Palliative and End of Life Care, Nottingham, United Kingdom, 2NHS Tayside, Palliative Care, Dundee, United Kingdom, 3NHS Lothian, Director of Nursing, Dundee, United Kingdom, 4University of Dundee, United Kingdom, 5NHS Tayside, Dundee, United Kingdom

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 approach 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 were used for process and post intervention. Primary outcome: Person-centred Climate Questionnaire patient version (PCQ-P), Secondary outcome: Consultation and Relational Empathy (CARE) measure; PDQ feedback questionnaires were used by all participants post intervention, in addition to qualitative interviews.

Results: 30 participants, 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

Kubala A., Jandry M., Nauck F., Mars G.
Universitatsmedizin Goettingen, Klinik für Palliativmedizin, Göttingen, Germany
Presenting author email address: anna.kubala@med.uni-goettingen.de

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 interaction.

Methods: Qualitative study design using purposive sampling. Focused group discussions (6-5 participants) with palliative care professionals (n=3 groups), analysis using formulation interpretation (Bohnack), open guided interviews with GPs (n=2), 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. HCPs 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 role definition needs improvement.

Abstract number: P1-162
Abstract type: Poster

Communication, Key for an Excellent Palliative Care (PC) Practice

Lendeć, Koleci G., Bylykhazi E., Thano L.
Korce Palliative Care, Korce, Albania

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 diagnosis and prognosis make communication difficult because it affects directly to achieve the quality of PC. Quality of communication about diagnosis and treatment is the absence of a low 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, relatives and nurses. Lack of communication and lack of information makes communication difficult.

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 member on the diagnosis and treatment. Openness of the team which 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.

Conclusion: Communication is key to providing excellent PC and being successful in its processing. Communication in the end of life takes a special meaning. Communication is a complex process and it becomes a real challenge in terms of an advanced disease. PC requires verbal communication skills, good listening and a being present.

Abstract number: P1-163
Preferreces toward the Disclosure of Life-threatening Illness and Place of Care and of Death among Patients in a University Hospital in the Philippines

Manalo M.F.C., Limsui J.T.
Philippines

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 member of the family, 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 the reality, timing 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 analytic study done in a private university hospital among a total of 150 selected patients in a valid sample by using Quade Square test. With level of significance set at a=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 the 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: Conclusion: Doctor 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’ participation in decision-making as to treatment options and preferences for place of care and death.

Abstract number: P1-164
Abstract type: Poster

Can we Talk to Dying People?
Skolck K.A, Mackowski M.*, Mackowski M.*
1Liberec Regional Hospital, Neuro-Centre, Liberec, Czech Republic, 2University of Pardubice, Department of Midwifery and Social Health Work, Pardubice, Czech Republic, *Masaryk University, Brno, Czech Republic

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 emotional and spiritual support. 

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 embarrassments in communication in the end of life were conducted with patients or next of kin from 2010 to 2012. Interviews were recorded, transcribed and analysed 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. Two 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.

Discussion: 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 kin 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: P1-165
Abstract type: Poster

Decision Findings Process Near the End of Life: A Survey in German Paediatric Oncology and Intensive Care Units (ICUs)
Classen C.F., Neuenhaus M.
University of Rostock, Paediatric Oncology, Rostock, Germany

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 and ICU units 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 medical team first before accosting to the parents. Working with a clinical ethic unit 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 decision making process. Nurses were not in all hospitals involved 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: between professional categories, between hierarchical levels and between individuals.

Conclusions: Decision making near the end of life in paediatrics are straining and full of conflict potentials and our findings might be helpful and respectful inclusion of all professions represents an important part of this.

Abstract number: P1-166
Abstract type: Poster

Issues Discussed at Formal Family Meetings in a Specialist Palliative Care Unit
Ni Loire Ni, O'Grady M., Murphy J., Lovely S.
Marymount University Hospital and Hospice, Cork, Ireland

Introduction: Formal family meetings (FFM) are vital in maintaining good communication between staff, patients, and families in a specialist palliative care unit (SPCU). Published research examining the content of FFM discussions is limited. This study aims to identify issues discussed at FFM, examine the influence of factors such as patient participation, and consider issues discussed at multiple FFM for a single patient.

Methods: The records of a purpose sample of FFMs in a SPCU over a 5 month study period were examined. The sample included an equal number of FFMs with and without patient participation, and all patients who had multiple FFMs. Patient demographics and basic details of the FFMs were recorded. Conventional content analysis was performed on the documented discussion. Issues identified were examined for observable patterns.

Results: 33 FFMs were analysed, 10 with patient participation, 10 without, and 13 multiple FFMs. The reasons for nonattendance were personal preference (50%) and unfit medically (50%). Prognosis was discussed in every FFM without patient participation but only in 30% of FFMs with patient participation. Symptoms at the end of life were never discussed with the patient present. At multiple FFMs there were increased discussions on medication concerns, dissatisfaction with care and family/patient well-being, as well as an increase in emotional expression of the family. Overall the content of FFMs with patient participation was more balanced and respectful.

Discussions: Discussions on end of life symptoms and prognosis in the patient’s presence can be particularly emotive for families. This is reflected in our study by a decrease in these discussions with patient participation and is consistent with published literature. However, addressing these issues is vital in providing optimal care.

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
Petri S., Markmann G.
Institute of Ethics, History and Theory of Medicine, Ludwig Maximilians-University of Munich, Munich, Germany

Presenting author email address: sabine.petri@med.uni-muenchen.de

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 Beziehen begleiten, 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.

Aim: 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 (Libert-Scale) completed by 198 consultants (nurses, physicians, nurses and general practitioners) in the region of Munich.

Results: A total of 50% of AD-consultations were performed by a single profession. A consultation for ADs are performed by a single profession mostly by a general practitioner, and only in 30% by a general practitioner and a psychotherapist. A consultation for ADs are performed by a single profession mostly by a general practitioner, and only in 30% by a general practitioner and a psychotherapist. Besides the professional group, the patient profile was almost always described. The most common procedure was to find a position within the medical team first before accosting to the parents. Consultations status 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.

Discussion: 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 kin 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

The Diverse Impact of Advance Care Planning (ACP): An Anthropological Follow-up Study on the Experiences of Patients and Relatives
Andreasen P.I., Neergaad M.A.*, Brogaard T.*, Jensen A.B.*, Skredsvig-Mosegaard M.*
1Aarhus University Hospital, Department of Oncology, Aarhus C, Denmark, 2Aarhus University Hospital, The Palliative Team, Aarhus C, Denmark, 3Aarhus University, Department of Public Health, Aarhus C, Denmark

Background: ACP is a discussion between patients, relatives and health care professionals about the patient’s concerns and preferences for future care, aiming to guide health care decisions at the end of life (EOL). However, more nuanced knowledge about the long-term impact of ACP is required.

Aim: The aim of this study was to explore long-term consequences of ACP for patients and relatives.

Methods: The study included 11 semi-structured interviews with three patients and eight relatives one year after participation in decision making on EOL. In the qualitative analysis, we recorded, transcribed, and analysed, drawing on anthropological theories on the social construction of patient autonomy, challenging the universal applicability of ACP.
Different in Preferred Place of Care and Place of Death Between Cancer and Non-Cancer Patients in Palliative Trajectories

Skrondgaard MA1, Breggaard T1, Nørgaard MM1, Jensen AB2
1Aarhus University Hospital, Department of Oncology, Aarhus, Denmark, 2Forskningsenheden for Almen Praksis, Aarhus Universitet, Aarhus, Denmark

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 need 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 randomized 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 and POD will be presented.

Conclusion: This 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.

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

Skrondgaard MA1, Breggaard T1, Nørgaard MM1, Jensen AB2
1Aarhus University Hospital, Department of Oncology, Aarhus, Denmark, 2Forskningsenheden for Almen Praksis, Aarhus Universitet, Aarhus, Denmark

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Conclusion: This 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.

Abstract number: P1-169
Abstract type: Poster

Communication with Cancer Patients

Tahmasbi M

Tehran University of Medical Sciences / Cancer Institute, Tehran, Iran, Islamic Republic of

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 staged 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. Although the whole truth about the disease or its outcome might not be revealed to the patients, any lie should be avoided.
5. The physician should avoid telling something to the patient which makes him/her feel remorse.
6. The physician should avoid giving the patient a define time limit for their living.
7. The physician should avoid telling something to the patient which makes him/her feel especially for cancer patients. The importance of education of communication skills to medical students and residents of all specialties.

Abstract number: P1-170
Abstract type: Poster

Sharing the Diagnosis of Dementia: Breaking Bad News to People with Intellectual Disabilities

Tuftey-Wijn J1, Watchman K1
1St George’s University of London, Division of Mental Health, London, United Kingdom, 2University of West of Scotland, School of Health, Nursing and Midwifery, Hamilton, United Kingdom

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. A man with ID had not been told about his dementia diagnosis, nor about his mother’s terminal cancer. The model was helpful to both the client and his support staff in helping him understand and cope with his changing situation.

Conclusion: This 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.

Abstract number: P1-171
Abstract type: Poster

Development and organisation of services
The Impact of Dragos Nurses on the Quality of Life of Pediatric Patients

Bahagia BL
Hospice Casa Sperantei, Bucharest, Romania
Presenting author; email address: florentina.bahagia@hosptic.ro

Context: In Romania, annually, approximately 5,000 children and young adults are diagnosed with cancer. 80% from these 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 carers.

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 nurse intervention: 2565; number of doctors intervention: 736; number of social worker interventions: 455. The SAW scores dropped from an average 6 to zero. (From 174 patients, 90 had pain and for 85 of them the pain dropped to zero).

90% of the most frequent symptoms (oral lesions, anemia, 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.

Abstract number: P1-173
Abstract type: Poster

Why do Specialist Palliative Care Patients Come Back Into Hospital? A Retrospective Review of the Readmissions and Re-attendance to Hospital of Patients Seen by a Hospital Specialist Palliative Care Team

Benson DJL
East Sussex Healthcare NHS Trust, Palliative Medicine, Hastings, United Kingdom
Presenting author; email address: debbiebenson@nhs.net

Avoidance of inappropriate hospital admissions is a strategic aim of NHS England. The aim, supported by advance care planning initiatives, may help individuals avoid medically futile hospital admissions. This paper explores the factors that have driven recent deterioration, willingness to discuss symptom control, treatment of reversible conditions, patient’s dignity and perceived appropriateness of hospital re-admittance/attendance.

Results: Data was collected from the hospital electronic notes of 96 patients seen by the SPC team between October 2013 and February 2014. The review was undertaken in August 2014. Hospital electronic notes were used to identify reasons for readmission/attendance, which were then judged as potentially appropriate if they involved (a) treatment of reversible deterioration (b) provided recognised symptom management or (c) resulted in death where hospital was documented as the preferred place of care.

Between October 2013 and February 2014, 96 of the patients seen by the SPC team were discharged from hospital. At follow-up 19 (20%) had received further hospital treatment. Readmissions/attendances were deemed appropriate for 14 patients and included surgical review of bowel obstruction, treatment of neutropenic sepsis, pleural effusions, blood transfusion, and dying in their preferred place of care. For 2 patients, readmission may have been inappropriate due to failure of community care. 3 patients were labelled inappropriate as the reasons for re-admittance could not be determined from the data recorded. Thus only 5 (3%) of the 96 discharge patients had potentially inappropriate readmissions.

The limitations of this audit include its size, its retrospective nature and judgement of appropriateness of readmission/attendance by a single author. Also the audit did not assess any patient view of their hospitalisation. However, it highlights that SPC patients may benefit from hospital attendance in certain circumstances, a fact that must not be lost in the drive to reduce hospital admissions.

Abstract number: P1-174
Abstract type: Poster

Integration of Palliative Care into Comprehensive Cancer Centers in Germany - Where Do We Stand?

Berendt J1,2, Chechile K1, Thomas M1, van Dorchat B1,8, Schmitz A1, Radboud L1, Simon S5, Gartner J1, Thuss-Patience K1, Schuler U1,8, Penze J1, Gag C1, Viehöfer M1, Meyer-Stenaker K1, Stachura P1,8, Stel L1, Oggattie C1,8
1University Hospital Erlangen, Friedrich-Alexander-Universität Erlangen-Nürnberg, Department of Palliative Medicine, Erlangen, Germany; 2University Hospital Erlangen, Friedrich-Alexander-Universität Erlangen-Nürnberg, Comprehensive Cancer Center, CCC Erlangen - EMN, Erlangen, Germany; 3University Cancer Center Hamburg, University Medical Center Hamburg Eppendorf, Hamburg, Germany; 4Division of Palliative Care, Department of Oncology, Hematology and Bone Marrow Transplantation with Section of Hematology, Hematologie und Onkologie, Hamburg, Germany; 5Heidelberg University Hospital, Department of Thoracic Oncology/Internal Medicine, Comprehensive Cancer Center Heidelberg, Heidelberg, Germany; 6University Hospital of Würzburg, Interdisciplinary Center for Palliative Medicine, Comprehensive Cancer Center Mainfranken, Würzburg, Germany; 7Interdisciplinary Center for Palliative Medicine, University Cancer Center, Heinrich Heine University Hospital, Düsseldorf, Germany; 8University Hospital Bonn and Central Institute for Palliative Care, Malteser Hospital Seliger Gerhard Bonn / Rhein-Sieg, Department of Palliative Medicine, Centre for Integrated Oncology Cologne/Bonn, Bonn, Germany; 9University Hospital of Cologne and Centre for Integrated Oncology Cologne/Bonn, Clinical Trials Centre Cologne (BIC - 01KN1106), Department of Palliative Medicine, Köln, Germany; 10University Clinic Freiburg, Department of Palliative Care, Comprehensive Cancer Center Freiburg, Freiburg, Germany; 11Charité - University Medicine Berlin, Department of Hematology, Oncology and Tumorimmunology, Charité Comprehensive Cancer Center, Berlin, Germany; 12University Hospital Carl Gustav Carus Dresden, University Palliative Centrum, University Cancer Centre Dresden Carl Gustav Carus, Dresden, Germany; 13University Clinic Essen, Department of Medical Oncology (Cancer Research), Comprehensive Cancer Center Essen, Essen, Germany; 14University-Hospital Frankfurt Main, Department of Palliative Medicine, University Cancer Center Frankfurt, Frankfurt, Germany; 15University Hospital Tübingen, University Department of Radiation Oncology, Comprehensive Cancer Center Ulm, Tübingen, Germany; 16Ulm University Hospital, Department of Hematology, Oncology, Rheumatology and Infectious Diseases, Ulm, Germany

Presenting author email address: julia.berendt@uk-erlangen.de

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 of 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 (36%). PC consulting services were routinely used in 11 (71%) sites. The term ‘inappropriate’ is poorly defined and will be person and illness specific. This review explores the individual reasons for hospital readmission and re-attendance for patients seen by our hospital specialist palliative care (SPC) team between October 2013 and February 2014. The review was undertaken in August 2014. Hospital electronic notes were used to identify reasons for readmission/attendance, which were then judged as potentially ‘appropriate’ if they involved (a) treatment of reversible deterioration (b) provided recognised symptom management or (c) resulted in death where hospital was documented as the preferred place of care.

Between October 2013 and February 2014, 96 of the patients seen by the SPC team were discharged from hospital. At follow-up 19 (20%) had received further hospital treatment. Readmissions/attendances were deemed appropriate for 14 patients and included surgical review of bowel obstruction, treatment of neutropenic sepsis, pleural effusions, blood transfusion, and dying in their preferred place of care. For 2 patients, readmission may have been inappropriate due to failure of community care. 3 patients were labelled inappropriate as the reasons for re-admittance could not be determined from the data recorded. Thus only 5 (3%) of the 96 discharge patients had potentially inappropriate readmissions.

The limitations of this audit include its size, its retrospective nature and judgement of appropriateness of readmission/attendance by a single author. Also the audit did not assess any patient view of their hospitalisation. However, it highlights that SPC patients may benefit from hospital attendance in certain circumstances, a fact that must not be lost in the drive to reduce hospital admissions.

Abstract number: P1-175
Abstract type: Poster

Second Last Stop? A Study of Discharges of Seriously Ill and Dying Patients from our Hospice

Berenge J
Louvainse Diakonale Sykhos, Hospice Louvainse, Oslo, Norway
Presenting author email address: jab@lds.no

Background: ‘Our Hospice ward’ (HW) is a palliative unit with 12 beds for seriously ill cancer patients. The length of patient stay is limited due to conditions of funding for hospitalwards and the wish to serve a larger number of patients. All patients are first given a 4-day stay. After 2 weeks, pts with a life expectancy of more than 2 weeks who are unable to stay in their homes are transferred to a Nursing Home. These discharges represent a tough situation for the patients and their family.

Objectives: To review the discharges of patients from HW and the duration of life for patients discharged from HW to nursing homes.

Patients and methods: All pts discharged from HW from 2005-2011, a total of 1794 patients.

Results: The average length of stay at HW was relatively stable during the years 2005 - 2011 and varied from 14.6-17.8 days. The percentage of patients that died at HW each year varied from 54.1%-62.8%.

Patients discharged alive, an average of 53.3% were discharged to their homes. Among the patients discharged alive, an average of 53.3% were discharged to their homes. Among the patients discharged alive, an average of 53.3% were discharged to their homes. Among the patients who died at HW, 21.4% were sent to other hospital wards and 16.9% were moved to nursing homes. Of these 5.8% died within 8 days after the transfer, 20% died within 14 days, 28.3% died 15-30 days and 51.3% lived longer than 30 days after the move. A total of patients lived longer than 14 days and 33% lived for more than 2 months after the transfer from HW.

Discussion: This study shows that the number of patients transferred to nursing homes is only about 20%. More than 80% of the patients discharged from HW live for relatively long periods after the discharge and that discharging them will give more patients the benefit of the special expertise that HW offers.

Abstract number: P1-176
Abstract type: Poster

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015
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**Barrier to the Development of Palliative Care in Europe**

**Background:**
Robust evidence is needed to identify beneficial models and components of models and their cost-effectiveness. Better reporting of models of palliative care and further primary research is needed.

**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 categorized by three different reference levels in open coding first to find out the barriers themselves, and in axial coding afterwards to determine the origin of the identified barriers.

**Results:**
153 barriers were reported: 92 were governmental, 41 related to the professional world and 20 to socio-cultural factors. Amongst the varied barriers identified within the governmental category, the reported obstacles refer to ‘Health policy’ (n=39), ‘funding’ (n=27), ‘legislative’ (n=11), ‘poor practice’ (n=6) and ‘lack of certification’ (PMF) (n=6).

**Conclusion:**
Despite the continuous efforts and claims to put PC into political agendas, still professional reports a great number of barriers related to health policy, funding and legislation.

**Presenting author email address:** ccenteno@unav.es

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**Abstract number:** P1-180

**Abstract type:** Poster

**What Do We Know about Different Models of Specialist Palliative Care? Findings from a Review of Reviews**

Breneton LM1, Clark J.D.1, Ingelton C.1, Gardner C.1, Preston L.2, Ryan T.A.W.1, Gath J.3, Ward S.E.1, Godfrey E.1, on behalf of the INTEGRATE-HTA Project Team

1University of Sheffield, School of Nursing and Midwifery, Sheffield, United Kingdom, 2University of Auckland, School of Nursing, Auckland, New Zealand, 3PPI Representative - Palliative Care Studies Advisory Group and Yorkshire and Humber Cancer Network, Sheffield, United Kingdom

**Presenting author email address:** louise.breneton@sheffield.ac.uk

**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 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 suggests different models may be appropriate depending on local priorities, population need and existing services. Limited evidence exists about the cost-effectiveness of each model. Given 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.

**Abstract number:** P1-178

**Abstract type:** Poster

**Ten Principles of the Economic Case for Specialist Palliative Care**

Cassell B.1, Ken K.2

1Virginia Commonwealth University, Massey Cancer Center, Richmond, VA, United States, 2Kennedy Healthcare Analytics, Mill Valley, CA, United States

**Group authors and addresses:** bcersell@vcu.edu, Ken.Kennedy@hcahealthcare.com

**Method:**
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 capitalist or mixed healthcare economies.

**Aim:**
We reviewed published studies of healthcare financing and SPC impact. We incorporated insights from our hands-on work in program financing with hundreds of SPC programs in the 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 inadequately staffed and poorly resourced. Principles 8 and 9 demonstrate the ‘return an 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.

**Conclusion:**
With this framework, SPC program leaders can articulate and demonstrate the benefits that would accrue to providers and payers. With the most recent US government policy on hospice care being favorable to the hyper-fractured, capitalistic US health care system, most of these principles also apply in other countries.

**Abstract number:** P1-181

**Abstract type:** Poster
"Can You Come Right Now?" Development of a Palliative Rapid Response Ambulatory Service in a Comprehensive Cancer Centre

Collins M., Fullerton S., De Neef C.
Peter MacCallum Cancer Centre, Department of Pain and Palliative Care, Melbourne, Australia
Presenting author email address: michael.collins@petermac.org

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 symptom distress requiring specialist palliative care. The Department of Pain and Palliative Care (DPPC) 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 DPPC 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

Curtis, M.A.
Farleigh Hospice, Information Service, Chelmsford, United Kingdom
Presenting author email address: mania.curtis@farleighhospice.org

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: Widens 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 an alternative model
Break down some of the taboos surrounding death and dying
Design: Develop mobile and static strands operating 5 days a week
Stuffed by full time Team Leaders, part time Information and Support Specialists (registered nurse and registered social worker), full time Driver/Support Worker 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:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of patients referred</th>
<th>Number of patients who received service</th>
<th>Number of patients satisfied with the service</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008–2009</td>
<td>1070</td>
<td>829</td>
<td>95%</td>
</tr>
<tr>
<td>2009–2010</td>
<td>1290</td>
<td>1076</td>
<td>96%</td>
</tr>
<tr>
<td>2010–2011</td>
<td>1214</td>
<td>1076</td>
<td>94%</td>
</tr>
<tr>
<td>2011–2012</td>
<td>1041</td>
<td>829</td>
<td>95%</td>
</tr>
<tr>
<td>2012–2013</td>
<td>1128</td>
<td>1076</td>
<td>96%</td>
</tr>
<tr>
<td>2013–2014</td>
<td>1176</td>
<td>1076</td>
<td>94%</td>
</tr>
</tbody>
</table>

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

Finnegan C.,1, Deeming E.,1, Groves K.E.1
1Southport and Ormskirk NHS Trust, Southport, United Kingdom, 2Southport and Formby Palliative Care Services, Southport, Southport and Formby Palliative Care Services, Southport, Southport and Formby Palliative Care Services, Southport, United Kingdom
Presenting author email address: clarefinnegan@sfts.net

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 settings 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) compiles a locality wide end of life care register by collating information from the hospice, GP surgery and home care services. 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 individually discharged of patients place of choice and support patients and families. Community teams are informed when patients are identified in hospital.

Poster Sessions (Poster Exhibition Set 1)
and community to ensure patients’ needs are assessed consistently and that assessments and interventions follow the patient reducing the need for replication of work.

Results: The SPC now holds a cross-boundary list of all patients thought to be approaching end of life (98%). For those who die, 94% have a documented Preferred Place of Care at the time of death, and 85% of those achieve it.

Conclusion: The project is strengthening 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 Care Pathways

Faring N.C.1, Hammer S.V.1, Abjersson R.A.1, Wilke M.2, Mølhes M.3, Bjelland M.4, Sandal R.5, Andersen O.K.D.6

1Vestfold Hospital Trust, Oncology/Palliative, Tønsberg, Norway, 2Vestfold Hospital Trust, Surgery, Tønsberg, Norway, 3Vestfold Hospital Trust, Vascular, Tønsberg, Norway, 4Vestfold Hospital Trust, User Committees, Tønsberg, Norway, 5Vestfold Hospital Trust, Cancer and Palliative, Tønsberg, Norway, 6Vestfold Hospital Trust, Gynecological, Tønsberg, Norway

Background: Spring 2014 we started a project to evaluate and improve quality of the palliative care pathway in the hospital. Aims or goal of the work: to develop a standardised, evidence-based patient pathway. Background: To 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 care 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 re-admissions, 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 audits and audits. 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: The project was to actively use patients’ and users’ experiences in design and improvement of a palliative care pathway in a public hospital. Aims or goal of the work: to develop a standardized, evidence-based patient pathway to 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: The Cancer Patient Experiences Questionnaire developed by The Norwegian Knowledge Centre for the Health Service was used. 300 patients answered the survey electronically by touch-technology during their hospital visit. Additional 4-6 in-depth interviews were performed to better understand patients and their relatives’ experiences, resulting in a movie to strengthen the voice of patients and their relatives.

Results: Patient response indicates patient satisfaction with the current service and important areas of improvement. Conclusions: ethical lessons learned: Ethical aspects should be taken into account when involving 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: P1-188
Abstract type: Poster

Strengthening Patient Voices in Quality Improvement of Palliative Care Pathway in a Norwegian Hospital

Abjersson R.A.1, Faring N.C.1, Wilke M.1,2, Hammer S.V.1, Randal-Wright A.2

1Vestfold Hospital Trust, Oncology/Palliative, Tønsberg, Norway, 2Vestfold Hospital Trust, Cancer and Palliative, Tønsberg, Norway, 3Vestfold Hospital Trust, User Committees, Tønsberg, Norway, 4Vestfold Hospital Trust, Communication, Tønsberg, Norway

Background: Improvements of clinical pathways are usually not focused on user knowledge and experience, and are often developed by healthcare personnel. The objective of this project was to actively use patients’ and users’ experiences in design and improvement of a clinical pathway in a public hospital.

Aims or goal of the work: • To develop a standardized, evidence-based patient pathway
• To ensure good quality of services to patients and their families where treatment and care meets physical, psychosocial and existential needs
• To implement common recommended palliative tools for measuring patient reported outcomes
• To develop and use electronic patients’ records and use of mobile technologies.

Patients and users contribute actively in the design and improvement.

Design, methods and approach taken: The Cancer Patient Experiences Questionnaire developed by The Norwegian Knowledge Centre for the Health Service was used. 300 patients answered the survey electronically by touch-technology during their hospital visit. Additional 4-6 in-depth interviews were performed to better understand patients and their relatives’ experiences, resulting in a movie to strengthen the voice of patients and their relatives.

Results: Patient response indicates patient satisfaction with the current service and important areas of improvement. Conclusions: ethical lessons learned: Ethical aspects should be taken into account when involving 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 Postgraduate Teamwork

García-Baquero Merino M.T.1,2, Santos Puebla D.2,3, de Luis V.2,4, Pinedo F.2, Molina Cara C.2,3

1Hospice Casa Sperantei, Educatie, Brasov, Romania, 2Hospice Casa Sperantei, Bucuresti, Romania, 3Hospice Casa Sperantei, Educatie, Brasov, Romania

Background: Palliative care is defined as care in four locations (2 rural, 2 urban). Annually around 1800 new patients are admitted in our services (adults with cancer and children with life limiting diseases) to receive care in various settings: home, inpatient units, day centers, outpatient clinic, lymphoedema and stoma care services, hospital through mobile teams. Communication between services is restricted due to paper held record, which is barrier especially when it comes to transfer of patients and after-hours telephone service.

Aims: To describe the process of educating the staff prior to the implementation of the electronic patients’ records and use of mobile technologies.

Methods: Once the funding for the project was secured we created a questionnaire for the staff to assess interests and barriers in working with electronic records and mobile devices (tablets) and the education needs in using the new technology. A curriculum was subsequently developed and rolled out including a 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.

1. Concepts of computer operation (135 minutes).
2. Skills of text editing (170 minutes).
3. Presentation skills (145 minutes).
4. Excel skills (240 min).
5. Browsing and e-mail (90 min).
6. Using Mobile technologies (120 minutes).

Conclusions: 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 towards a new digital phase of PC services management.

Abstract number: P1-190
Abstract type: Poster

Introducing Electronic Records in a Complex Palliative Care Service: Education of Clinical Staff

Glavan C., Munteanu M., Horenc R.1, Aranha V., Blevaux E.2

1Hospice Casa Sperantei, Educatie, Brasov, Romania, 2Hospice Casa Sperantei, Bucuresti, Romania

Aim: 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 GSF training to Domiciliary Home Care Teams in end of life care.

Method: The GSF Domiciliary Care training programme in End of Life Care was introduced to Agency staff across the country. The Training included 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: Improved communication, working relationships and collaboration with District Nurses and GPs.

Increased Advance Care Planning discussions, now part of the initial assessment plan, with information shared with others to improve coordination of care.

Abstract number: P1-191
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

Giles L., Stobart Rowlands M., Thomas K.

1Gold Standards Framework, Shrewsbury, United Kingdom, 2GSF Centre, Shrewsbury, United Kingdom

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. Focused 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 GSF training to Domiciliary Home Care Teams in end of life care.

Method: The GSF Domiciliary Care training programme in End of Life Care was introduced to Agency across the country. The Training included 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.

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Increased Advance Care Planning discussions, now part of the initial assessment plan, with information shared with others to improve coordination of care.
Abstract number: P1-192

Abstract type: Poster

Better together: A Seamless Service in A Seaside Town - 15 years on

Gros T.1,2,3, Feringa C.,1 Birch H.,1,2,3 Deeming E.,1,2,3 Browning C.1
1Southport and Ormskirk NHS Trust, West Lancs, Southport and Formby Palliative Care Clinic, Trondheim, Norway, 2Ghent University and Vrije Universiteit Brussel (VUB), End-of-Life Care Research Group, Ghent, Belgium, 3European Palliative Care Research Network

Background: An area with pop. 235,000 has approximately 2,600 deaths p.a.. 500 are sudden deaths and 800-900 are elderly patients dying at home. Many GP’s see these patients. There is a large overlap of services in primary and secondary care. An evaluation of the project is done.

Objectives: To describe the organisation of PC at participating sites including characterisation of patients that permits high quality research to identify who the PC patients are in in relation to organisational and medical variables.

Methods: A web-based centre survey on organisation, economic and academic resources was conducted. Patients were identified 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 concerned, 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 chemotherapy/radiotherapy. 45% of PC patients ranged from 113-729. Agp. 5% had cancer. Mean length of patient stay ranged from 7-73 days. Physicians/nurses were present for 24/7 in 49% and 63% of centres respectively. 14 centres had ≥1 medical professors, 3 had ≥1 medical professors. 12 centres had full/part-time research staff. State and/or community funding was predominant (86%). 1739 (8-150 per site) patients were included; M/F: 50/50, 2005 M, 2015 F respectively. 14 centres had ≥1 medical professors, 3 had ≥1 medical professors.

Conclusions: Collaborative working has led to a swell of enthusiasm which engulfs all staff in all local healthcare organisations, changes culture and helps recognition that end of life care is everyone’s business.

Abstract number: P1-193

Abstract type: Poster

Differences in Palliative Care Delivery Conformed in a European Prospective Study - (EPCCS) - Consequences for Palliative Care Research

Hermotd M.1,3, Asto N.4, Jøsset A.2, Carasin S.1, Ermanno R.1, Fassender K.1, Jakobson K.1, Kurto G.2, Laehn E1,2, Paridon K.4, Pigni A.11, Knaus S.7, European Palliative Care Cancer Symptom Study

Aims: To describe the organisation of PC at participating sites including characterisation of patients that permits high quality research to identify who the PC patients are in in relation to organisational and medical variables.

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Conclusions: Collaborative working has led to a swell of enthusiasm which engulfs all staff in all local healthcare organisations, changes culture and helps recognition that end of life care is everyone’s business.

Abstract number: P1-194

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

Zhang X., Murray S.A., Hockley L.1
1University of Edinburgh, Edinburgh, United Kingdom, 2University of Edinburgh, Primary Palliative Care Research Group, Edinburgh, United Kingdom

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 residential care 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.
Integrated Palliative Care in Cancer, COPD and Heart Failure: What is the Optimal Timing?

Hodiamont F., van der Eerden M.J., Haselwer J.V., Van Wijngaarden J.I., Hughes S., Ling-Doh Lil, Payne S., Lukes R. (on behalf of InSup-C)

University Hospital Bonn, Department of Palliative Medicine, Bonn, Germany, Radboud University Nijmegen Medical Center, Department of Anesthesiology, Pain and Palliative Medicine, Nijmegen, Netherlands, Erasmus University, Rotterdam, Netherlands, International Observatory on End of Life Care, Division of Health Research, Lancaster, United Kingdom

Abstract type: Poster

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 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%/HF: 3: 48.4%) and in cancer (time of diagnosis: 61.3%). Different 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 (advanced cancer: 54.7%, Gold Standard 4: 48%, HF: 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%) is considered higher than in COPD/HF (8.7%). Responsibility for PC treatment in all disease groups is seen as that of the GP in cancer (54%), COPD: 46%, HF: 46.2%). Most respondents favoured PC specialists as the lead clinician in cancer (homecare 22.9%, inpatient 33.5%) than in COPD/HF (homecare 13.6%/14.3%, inpatient 23.9%/24.6%).

Conclusion: Significant results 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 PC approaches 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 number: P-198

Abstract type: Poster

Research Active Hospice-moving Forward

Hardalidottir E. &. Ljungheden R.

Strathclyde Hospice, Department of Education, Practice Development and Research, Denny, Stirlingshire, United Kingdom, Strathclyde Hospice, Medical Consultant in Palliative Care, Denny, Stirlingshire, United Kingdom

Aim/Goal: The Hospice reports 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 meets every six weeks 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 opportunistic approach for research activities.

The collaboration with established research teams in Universities allows for a more rigorous approach to investigating and developing practice, sharing of ideas and developing research capacity and infrastructure.

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 number: P-199

Abstract type: Poster

Do We Need a Network Coordinator for Liverpool Care Pathway in Norway? An Evaluation Study

Jergeren G. L., Teglen S., Haugen D.F.

Haukeland University Hospital, Regional Centre of Excellence for Palliative Care, Bergen, Norway, Trønder Kommune Rådhus, Centre for Development of Institutional and Home Care Services, Bergen Norway

Poster sessions (Poster Exhibition Set 1)
The State of Social Palliation in Denmark

Jørgensen M.M., Venter M.M.1, Langkilde L.1, Nielsen K.M.2, Kristoferson J.E.2, Nissen A.4

1Rigshospitalet, Copenhagen University Hospital, Palliative Team, Copenhagen, Denmark; 2Roskilde University Hospital, Palliative Unit, Roskilde, Denmark; 3Palliative Team Fyn, Odense University Hospital, Odense, Denmark; 4Herlev Hospital, Palliative Unit, Herlev, Denmark, Herlev University Hospital in 2010.

Abstract number: P1-202
Abstract type: Poster

Only one patient had access to a palliative care service (vs 45% in cancer patients population frequent cancer types were hematologic (21%), gastrointestinal (21%) and head and neck (23%) 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 (vs 45% in cancer patients population who died in other departments, p<0.001), and that was during the last day of life. 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 choic (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.

Abstract number: P1-205
Abstract type: Poster

Refining the GP Out-of-Hours (OOH) Palliative Care Handover Form

Keeghan G.1, Lynch M.1, Weaver J.1, Heffernan A.1, Shannon D.1, DeSalvo A.1

1Irish Hospice Foundation, Dublin, Ireland, 2Weaver Research Associates, Dublin, Ireland, 3South Doc, Dublin, Ireland

Background: A project commenced in 2012 with an OOH service to develop a palliative care information transfer process. A GP-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.

Abstract number: P1-206
Abstract type: Poster

Burden of Emergency Medical Service with Palliative Home Visits in Slovenia

Mančić S., Homar V.2, Žnidaršič D.3, Malačič S.4, Ebert Moltara M.5

1, 2, 3, 4, 5Z Dr. Vrhnika, Ambulance NMP, Vrhnik, Slovenia, 2, 3, 4, 5University of Ljubljana, Department of Family Medicine, Ljubljana, Slovenia, 2, 3, 4, 5Gorjna Radgona, Slovenia, 2, 3, 4, 5Institute of Oncology, Division of Internal Oncology, Ljubljana, Slovenia

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 specialist physicians.

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 2.3%. The most common problem was dyspnea (27%). Out of all, 15% of patients had been transferred to hospital. In the Unit 1A ZD Gorjna Radgona there were 15.8 % palliative HV. The most common cause for the phone call was uncontrolled pain (33%). 37 % of patients had been transferred to hospital. In the Unit 1A ZD Vrhnik 14 % of all HV were palliative. Dyspnea was the most common cause for the call (32%). 27 % of patients had been sent to the hospital.

Conclusion: Load of emergency home visits due to PC acute complication has ranged from 14% to 30%. In some of the HV units 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.
Developing Basic Palliative Care in the Community: Consensus Meeting

Moss O.1, Durnestrom M.1, Papi S.2, Simion L.3, Parodi V.1, Stroess P.1, Preuda O.2, Spors M.1
1Transylvanian University Brasov, Brasov, Romania, 2Hospice Casa Sperantei, Educatie, Brasov, Romania, 3Spatulul Județean, Campus Turzii, România, "University of Medicine and Pharmacy, Brasov, Romania, 4Unit of Oncology, Iasi, România, 5VastuointiSt.Gallen, St.Gallen, Switzerland

Background: The Romanian Palliative care (PC) strategy proposal defines 3 levels of care according to complexity of needs: self-care; basic PC; specialised PC. Funding was secured through a Romanian-Swiss partnership project to develop a model of basic PC interventions for cancer patients in the community and to pilot it through GP's in 4 districts in Romania.

Aim: To describe the process of developing the model of basic PC interventions in cancer patients in the community.

Method: Initial qualitative research (case studies, focus groups) was run to identify needs, gaps and barriers in care of cancer patients in community followed by national survey to the results. Research results were presented to Romanian and Swiss experts to elicit feedback. Thematic analysis principles are used to analyse data.

Results: 38 stakeholders attended the meeting (GPs, Nurses, representatives house of insurance, college of doctors, oncologist, PC home care service providers, Associations of GPs, and Swiss experts). Agreement included: international model of care, key processes in community, research results, group work to discuss the interventions, the instruments to be used and solutions for overcoming barriers in implementation. Following interventions were agreed: assessment (needs using ESAS and KPCPS) cancer diagnosis and symptom management (protocols for 9 symptoms on ESAS), communication (algorithm, collaboration, breaking bad news, negotiation goals of care), terminal care (protocol). A MOC is an operationalisation of care to meet, discuss and achieve shared goals in cancer patients' care. In Belgium, MOCs have been run and evaluated by the National Headquarters of Health Insurance (NHI). Though the legal framework recognises the importance of GPs participation in the MOC, it is not mandatory. Furthermore it does not provide any task description. Currently GPs participation is minimal, and what is perceived as a barrier for participation are perceived by people with advanced dementia to be 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 timing and quality of the invitation, timing of the MOC during the day, proximity of the specialists in the complex situation of cancer patients' care. A MOC is an operationalisation of inter-professional care and fosters interpersonal contacts with specialists, eventually leading to better patient care. Most barriers for attendance are practical, which may be overcome through video-conferencing.

Conclusion: Great interest and support for the initiative is encouraging.

Abstract number: P.1-210
Abstract type: Poster

Contacts to a Doctor-led Out-of-Hours Telephone Service for Specialist Palliative Care in a Danish Region

Neersgaard M.A.1, Enskær M.1, Holst-Hansen C.A.1, Jespersen T.W.1, Lyngsgaard P.1, Nielsen J.B.1, Paludan M.1, Rasmussen D.L.1, Schlüsen L.1, Jensen B.A.1
1Aarhus University Hospital, Palliative Team, Department of Oncology, Aarhus, Denmark, 2Regional Hospital Herfing, Palliative Team, Department of Oncology, Herfing, Denmark, 3Regional Hospital Horsens, Palliative Team, Department of Anaesthesiology, Horsens, Denmark, 4Regional Hospital Randers, Palliative Team, Department of Anaesthesiology, Randers, Denmark, 5Regional Hospital Silkeborg, Palliative Team, Diagnostic Centre, Silkeborg, Denmark

Background: In September 2013, Central Denmark Region (approx. 1.2 million inhabitants) established a new doctor-led out-of-hours telephone service for specialist palliative care perceived by GPs 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...
Adapting the Dignity Care Intervention to a Swedish Context

Wenkendorf Harstäd C1, Blomberg K-B1, Söderman A2, Ökland U1
1Linnaeus University, Faculty of Health and Life Sciences, Department of Health and Caring Sciences, Kalmar, Sweden, 2Örebro University, School of Health and Medical Sciences, Örebro, Sweden
Presenting author email address: ulrika.ostlund@lu.se

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 Chocchinos 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 may 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, the model 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

Otheo M.B., Ribiero M.S., Parsons H.A.
Hospital Premier, Education and Research, São Paulo, Brazil

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 practicing care 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.

Aim: To characterise the profile of palliative care services in Brazil.

Method: Services were identified 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%/56); mixed population (37%/39), assistance to adults (88%/60) and elderly (94%/57) prevals, and public funding (50%/34) prevals. Services reported team composition: physicians (98%/97%), nurses (98%/97%), psychologists (92%/63%), social workers (92%/63%), physiotherapists (80%/59%), speech therapists (72%/61%), counsellors (61%/42%), occupational therapists (33%/36), dentists (51%/53), and volunteers (40%/60). The major part were reported as permanently staff model with specific formation. 89% (60) have clinical meetings and 68% (46) of those indicated weekly meetings.

Conclusion: 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

Pop M1, Lüx E 2, Mangraf K3, Fricker R1
1Westaechsische Hochschule Zwickau, Fakultät Gesundheits- u. Pflegewissenschaften, Zwickau, Germany, 2Klinikum St.-Marien-Hospital GmbH Loncn, Klinik für Schmerz- und Palliativmedizin, private Universa Hospital Witten-Herdecke, Fakultät Gesundheit, Witten, Germany, 3Teva Pharmaceuticals Germany, Medical Affairs, Berlin, Germany
Presenting author email address: mail@drpapke.de

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 relation to SAPV tied to the SAPV 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 waiting list for the service in their region. In average, 11.62% are organised in a network. The networks comprise GP’s (in 11.62% of the cases), specialists (in 26.63%), hospital (22.96%), dental practice (47%), pharmacy (53%), pharmacotherapy (53%), proper drug storage (50%) and improvement in the access to drugs (47%).

Conclusions: The cooperation between physicians and pharmacists at Polish residential hospices is developing. To assess patients’ quality of life needs further studies which do not have experience in working with a pharmacist.

Abstract number: P1-216
Abstract type: Poster

Out of Hour Palliative Care Consult Service for Patients in Braşov County Romania

Pop M1, Lùx E2, Horécs K3
1Hospice Casa Sperantei, Outpatient Clinic, Braşov, Romania, 2Transylvania University, Palliative Care, Braşov, Romania, 3Hospice Casa Sperantei, Nursing Service, Braşov, Romania
Presenting author email address: meliana.pop@hospice.ro

Background: The national palliative care strategy is describing 3 levels for 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 service is caring for around 1200 adult new patients yearly in home care, outpatients, inpatient, and day center. It has been 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 1835 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 members calls in 37.83% (694 cases). Reasons for calls in the second category: uncontrolled symptoms 38% (pain 66,53%, neurological problems 49,38%, nausea and vomiting 26,53%); need for information 22,96% (new admission, transition in 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. If necessary, the doctor was called in 20% of cases, 2% requested to come to the hospice 9% (home visit of the team the following day 12%, advice to call 11-2%.

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.
Poster Sessions (Poster Exhibition Set 1)

Abstract number: P1-217
Abstract type: Poster

Ethical Issues within the Nursing Home: A Systems Approach
Preshaw D.1, Brazil K.1, McLaughlin D.1, Foidl A.1
1Queen’s University Belfast, School of Nursing and Midwifery, Belfast, United Kingdom
2McMaster University, Hamilton Health Sciences, Hamilton, ON, Canada
Presenting author email address: dpreshaw8@qub.ac.uk

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: A systematic review was conducted to identify all relevant articles published between 2010 and 2020. Search terms included ethical issues related to nursing homes and 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 examined. The main themes were: lack of resources and limits to the care available; multiple treatments and patients; and the need for ethical aspects of care. A total of 37 papers were retrieved.

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 required to provide a more equitable palliative care within the nursing home.

Abstract number: P1-218
Abstract type: Poster

Rehabilitation in Palliative Care: Improving Quality of Life?
Breed N.1, James L.1
1Maire Curie Hospice West Midlands, Birmingham, United Kingdom
2The University of Birmingham, Birmingham, United Kingdom

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 regardless of expectation. Rehabilitation strategies contribute to palliative care by maintaining and, if possible, promoting functional independence during a period of expected physiological decline. At Maire 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 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: At 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: An e-Health Solution for Palliative Care
Riley L.1, Brennan C.M.2
1The Royal Marsden Hospital, Palliative Care/ CMC, London, United Kingdom
2The Royal Marsden Hospital, Coordinating My Care, London, United Kingdom
Presenting author email address: julia.riley@rmh.nhs.uk

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 that have been agreed between clinician and patient. Information is stored on a record which can be accessed by the Coordinating My Care Team, 24/7. 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—7000 numbers of records created across London—17919 number of visits recorded—49% GP, 26% Hospice, 33% Acute 21%. This is correlated with the economic, health and social data associated with each. In areas where fewer records are being created, education and training may be offered as a solution. The data thereafter is 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/areas of need and advice are both CMC are being shared and updated by the Coordinating My Care Team. 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
Georgyann E.1, Sathi Gross C.2
1University of Bern, Bern, Switzerland
2Social Anthropology, Bern, Switzerland
Presenting author email address: eeva.soom@anthro.unibe.ch

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 specialised PC services.
The study on nursing homes is based on extensive participant observation of interactional 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 trans-cultural 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).

Abstract number: P1-221
Abstract type: Poster

How Is Ascents Managed in UK Hospices?
Statham C.1, Perkins P.1,2
1Queen’s Mountbatten House Hospice, Southampton, United Kingdom
2Gloucestershire Hospitals NHS Foundation Trust, Cheltenham, United Kingdom
3Sue Ryder Leckhampton Court Hospice, Cheltenham, United Kingdom
Presenting author email address: c.statham@nhs.net

Background: Ascents is a cause of distressing symptoms for patients 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 191 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 (a 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 scanner, 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. 59/78 that they prescribed diuretics, but only 8 said that they thought the Serum-Ascites Albumin Gradient helped this. Only 18 respondents knew the referral criteria for semi-permanent drain insertion. Conclusion/discussion: There are clear issues with the management of ascites in UK hospices. The majority of responding units did not have their own ultrasound scanner but few performed paracentesis without prior ultrasound. Provision of information leaflets and the requirements for written consent varied. Diuretic use was common and many did not know the referral criteria for semi-permanent drain placement.
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

Thomas C., Hopkins K., Hammond R., Bisset M.
1Royal Free Hospital, Palliativecare Team, London, United Kingdom, 2Royal Free Hospital, London, United Kingdom, 3North Central West London NHS Trust, Palliative Care, London, United Kingdom, 4North Central West London NHS Trust, Palliative Care Team, London, United Kingdom

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 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 to ensure an advance care planning process 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 whole-time equivalent palliative care specialist nurses 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 case-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 case-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: P1-222
Abstract type: Poster

Long Term Sustainability of Best Practice in Care Homes - Using the Gold Standards Framework Care Homes (GSFCH) Training and Accreditation Programme

Stobbart-Rowlands M., Thomas K., Giles L.
Gold Standards Framework, Shrewsbury, United Kingdom

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 reliable effective and sustained top quality care? Many receive excellent 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 culture 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: Involvement and feedback from the end of life processes, feedback from relatives and residents, and whole team involvement show that staff identify, code and anticipate the needs of residents, demonstrate continued practice improvements thorough audit and reflective practice, research 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.

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 of evidence, feedback from relatives and residents, and whole team involvement show that staff identify, code and anticipate the needs of residents, demonstrate continued practice improvements thorough audit and reflective practice, research and, are more proactive in their care, thereby reducing crises, hospital admissions and enabling more to die at home.

Poster Sessions (Poster Exhibition Set 1)

Poster Sessions (Poster Exhibition Set 2)

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015
Abstract number: P1-227
Abstract type: Poster

Out of Hours Nurse-led Telephone Service in a Greek Home Palliative Care Unit. Preliminary Results

Katsaragakis S.1,2, Hamou A.1, Tsatsoulis A.1, Iconomou C.1, Ioannou E.2, Bagouzi O.M.2, Batzios V.2, Petta E.1, Avgoustidis H.2, Patraki E.1, Enki D.1, Zanerou E.1
1University of Peloponnese, Nursing Faculty, Sparta, Greece, 2Palliative Care Unit ‘Galilee’, Holy Metropolis Mesogia and Lavreotiki, Sparta, Greece, National and Kapodistrian University of Athens, Nursing Faculty, Athens, Greece

Background: Out of hour (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, their requests, and interventions were recorded. The calls were then split or merged according to callers’ request on a 24hour 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 (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 need (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 included practical matters (33.9%), death (21.3%) or exam results’ announcement (16.4%). Nurses characterised 52.8% requests as ‘emergencies’, more often the Symptom/Problem category (68.2%) and among them physical symptoms and end of life issues (x²(4)=44.1, 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 need 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?

Glenon C, Water A, Tuck I
St Catherine’s Hospice, Crawley, United Kingdom

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 (2012). At least 50% of the UK nursing home population have dementia as a primary or secondary need for care. Given the ageing population, we 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 (EOC/LC) in this context. Anecdotally our hospice staff feel under pressure for this challenge, 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 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. We then used survey, dotmailer.com, for data collection; the results were then exported into Microsoft Excel and Word for analysis. Two authors generated agreed codes for analysis of the qualitative data and cross checked any ambiguous answers. As we are aware, there is no published data on the education needs of palliative care staff, in particular supporting end of life care in dementia. The results showed a reasonable basic understanding of how early dementia presents and how it may impact on care needs but identified a lack of confidence and perceived skills in providing EOLC for those with dementia. The results will inform hospice service development plans for developing competence frameworks and education. In order for our organisation to become truly dementia friendly, more education is needed, particularly in end of life care, to support people with dementia in our local area.

Abstract number: P1-229
Abstract type: Poster

Integration of Haemato-oncology and Palliative Care Services and Staff Perceptions to Referral

White A, Hockings C, McMamona C
Royal Free Hospital, London, United Kingdom
Presenting author email address: drcalwhitew@gmail.com

Background: Integration of palliative care services (PCS) with haemato-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 therapy were referred. 15 of the 49 deaths occurred in ICU, none of which had PCS input. Documentation of discussions around death took place in 34 cases (69%). Preferred place of death was discussed in 17 of those (35% of total). Review of the multi-disciplinary meeting (MDM) records occurred for 43 of 49 patients (87.7%). The patients were discharged 13 of 49 deaths occurred in ICU, none of which had PCS input. Documentation of discussions around death took place in 34 cases (69%). Preferred place of death was discussed in 17 of those (35% of total). Review of the multi-disciplinary meeting (MDM) records occurred for 43 of 49 patients (87.7%). The patients were discharged 13 of 49 deaths occurred in ICU, none of which had PCS input. Documentation of discussions around death took place in 34 cases (69%). Preferred place of death was discussed in 17 of those (35% of total). Review of the multi-disciplinary meeting (MDM) records occurred for 43 of 49 patients (87.7%).

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 HO patients in an ICU setting. Documentation of PCS input in MDM meetings was poor, possibly due to subsequent progression of disease or death 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 was made too late.

Abstract number: P1-230
Abstract type: Poster

Palliative Care in Residential Homes for People with Disabilities

White M
University of Applied Sciences of Special Needs Education, Research, Zürich, Switzerland

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. Aims: 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. Results: Of 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 decision 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

Wautha K.1, Carrasco Gimeno J.M.1,2, Clark D.3, Burgus Larumbe A.1, Centeno Cortés C.1,4
1University of Navarra, Institute for Culture and Society, Pamplona, Spain, 2University of Glasgow, School of Interdisciplinary Studies, Glasgow, United Kingdom, 3Service Navaro de Salud-Gasusambida, Pamplona, Spain, 4Navarra University Clinic, Medical Faculty, Pamplona, Spain

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 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 resources/services were included.

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. Screening to extract all possible indicators covered: finances (n=23), opioid availability (n=8), education (n=15), quality management (n=5), policy (n=8), resources/services (n=63), staff (n=7), vitality (n=19), research (n=6).

Conclusion: A variety of papers with possible indicators were identified. Although some of the identified and already established indicators, e.g. mortality rate (per 100,000), are utilised frequently, future research concerning the new ones in vision of disability or death 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

Washbrooke P.1,2, Maddock M.1,2
1Farleigh Hospice, Independent Living, Chelmsford, United Kingdom, 2Lancaster University, Lancaster University Management School, Lancaster, United Kingdom, 3King’s College London, Cicely Saunders Institute, London, United Kingdom

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
Abstract number: P1-233
Abstract type: Poster

A Good Enough Death?

Yule S.A.1, Mackey R., Johnson C.1
1HammondCare, Hammond at Home, Sydney, Australia, 2HammondCare/University of Sydney, Palliative Care, Sydney, Australia
Presenting author email address: syule@hammond.com.au

Aim: Surveys consistently show that up to three-quarters of Australians would prefer to die at home. The reality is different - only 16% of people living in Australia and suffering from a terminal illness die at home. The aim of the project is to provide those in NSW who wish to die at home the opportunity to do so and to understand whether this opportunity contributes to a good enough death.

Design: The Palliative Care Home Support Program is addressing this end of life care gap with three strategies:
1. The provision of end of life packages for up to 48 hours of specialised supportive palliative home-based care, day or night, provided by community workers specifically trained for the task, and working as part of existing specialist palliative care multidisciplinary teams.
2. The provision of state-wide access to two collaborative education programs: one to train and up-skill the supportive palliative community care workers, and one delivered interactively from HammondCare's University-linked Clinical Training Centres in collaboration with community professionals working in end of life care, including GPs, nurses, allied health and welfare staff, supporting care provision in people's homes.

Results: One year into a three year program, 84% of people taking up palliative care home support packages have died at home.

Conclusion: We have designed and implemented a program covering three quarters of NSW which has significantly improved the opportunity for people in the terminal or deteriorating phase of their illness to die at home.

Abstract number: P1-233a
Abstract type: Poster

The Changing Landscape of an Outpatient Palliative Care Clinic: Implications for Staffing Models, Resource Utilization, Physical Plant, Proactive Evaluation and Adaptability

Shand J.J.1, Christensen K.L.1, Rho R.H.1, Mauck W.D.1, Feely M.A.1, Mansel J.K.1, Carey E.C.1, Swetz R.M.1
1Mayo Clinic, Internal Medicine, Palliative Care, Rochester, MN, United States, 2Mayo Clinic, Anesthesiology, Division of Pain Medicine, Rochester, MN, United States
Presenting author email address: stjand@mayo.edu

Background: Outpatient palliative care for patients with serious illness have been shown to improve quality of life and reduce burdensome symptoms, which may improve patient survival. While oncologic patients account for the majority of patients seen, an increasing number of non-cancer diagnoses are being seen and more is being learned about optimal program structure and growth patterns with changing patient populations. Herein, we report on the development of one such clinic and its growth and evolution over the past six years.

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 in 2011 to 512 and increased to 681 visits in 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, predominately breast and breast malignancies, 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 has 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 (>3 fold increase) in the last two years. Additionally, SYMPAQ clinic has improved care continuity, as increases in new visits placed by inpatient teams for patients at hospital discharge have been observed.

Implications: Changing clinician referral patterns and a diversification of primary palliative diagnoses will require development of a benchmark to assess provision of palliative care in the hospice setting. The large variation in practice, together with the lack of evaluation through goal setting or outcome measurement, highlights the need for evidence-based development in this aspect of care.

Abstract number: P1-234
Abstract type: Poster

The Impact of Palliative Care Nursing Courses on Clinical Practice

Ancuta C.1, Mitrea N. N.2
1Hospice Casa Sperantei, Education and National Development, Brasov, Romania, 2University of Transylvania, Brasov, Romania
Presenting author email address: ancuta.camelia@hospice.ro

Background: Between January 2013 and October 2014, 1360 Romanian nurses have participated in Palliative Care (PC) courses, out of which 106 nurses at both basic and advanced level of education.

Aim: To identify the changes implemented by nurses in their clinical practice, after participating at PC introductory and advanced courses.

Methods: Phenomenological study, data collected throughout six focus groups, at 3 to 6 months after the courses, in 6 different locations in Romania. Coding and thematic analysis was performed by 2 researchers in parallel.

Results: Five domains were identified: new perspective of care, communication, the team in the healthcare system, the patient and decision making. IMPROVEMENTS were identified in the care and communication domain:
1. Care incorporation of psycho-emotional aspect into physical care; allocation of time for family support; overcome of fear to administer opioids; comfortable in discussing arguments pro and against inavances insufions at the end of life.
2. Communication: improved communication makes nurses feel they provide better quality of care, increases self esteem.
3. Team: improved communication makes nurses feel they provide better quality of care, increases self esteem; overcome of fear to administer opioids; comfortable in discussing arguments pro and against intravances insufions at the end of life.
4. Communication: improved communication makes nurses feel they provide better quality of care, increases self esteem.
5. Team: improved communication makes nurses feel they provide better quality of care, increases self esteem.

Conclusion: This study shows that PC, introductory and advanced courses, lead to changes in the nurses clinical practice. It is highlighted the raise in awareness regarding other barriers in the Romanian public health care system that need to be overcome.

Abstract number: P1-235
Abstract type: Poster

Palliative Care Education Needs Assessment of Senior Doctors in a National Referral Hospital

Bagasha P.1, Purewal G.1, Thomas J.1, Leng M.1
1Makerere University, Kampala, Uganda, 2Yale University School of Medicine, New Haven, CT, United States, 3Careless International Palliative Care Trust, Aberdeen, United Kingdom

Background and aim: The landmark 2014 World Health Assembly resolution emphasises the need for integrated palliative care (PC) education and evidenced based service provision. In Uganda PC has been integrated into the undergraduate curriculam since 2004 with an innovative postgraduate internal medicine curriculum since 2009. On seeing the impact of effective PC, senior clinicians requested that their training needs also be met. This reflects the values based change within the senior staff and is essential to ownership and leadership.

Design: Using an online survey tool we designed and circulated a questionnaire to identify confidence levels, training gaps and education preferences relating to PC of the senior doctors. Derived themes formed the basis for a qualitative study using focus groups to explore the underlying beliefs and values and facilitate effective training.

Results: Survey results reveal highest levels of confidence in the PC concept, basic communication and use of morphine. Lower levels were revealed in research, self care, spiritual care and bereavement. However the focus of the training requests remained symptom control and pain management with a preference for e-learning. We will use the focus groups to further explore these emerging themes. In particular the unsurprising lack of confidence in spiritual and self care reflects poorly on conventional training and yet are key to effective PC and a resilient senior workforce.

Conclusion: Models of health system integration and training for palliative care must address the needs of senior clinicians who will be key role models for any system change. As palliative care gains credibility, training programmes need to be flexible, robust and address areas other than physical care. Palliative care offers an opportunity to challenge and develop holistic values based integrated care for all staff.
Abstract number: P1-236
Abstract type: Poster

Supporting Family Carers in Home-based End of Life Care: Using Participatory Action Research to Develop a Training Programme for Carer Support Workers
Casswell G.1, Hardy B.1, Ewing G.2, Grande G.3, Kennedy S.4, Tabreham J.5, Seymour J.6
1University of Nottingham, School of Health Sciences, Nottingham, United Kingdom, 2University of Cambridge, Centre for Family Research, Cambridge, United Kingdom, 3University of Manchester, Manchester; United Kingdom, 4University of Sheffield, School of Health and Related Research, Sheffield, United Kingdom, 5Careers Federation, Nottingham, United Kingdom
Presenting author email address: glynis.casswell@nottingham.ac.uk

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.

Aims: 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 (CANSAT) 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 clips, creative writing tasks and 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 the range 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
Byfield N.D.1, Clark K.2, Cameron-Taylor E.1,2
1Calvary Mater Newcastle, Palliative Care, Waratah, Australia, 2University of Newcastle, Newcastle, Australia

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 to 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 structured 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 and at a flexible funding environment. Spaced education has been proven 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
Connolly M.1, Ryan K.1, Charnley K.2
1All Ireland Institute of Hospice and Palliative Care, Dublin, Ireland, 2University College Dublin, School of Nursing, Midwifery and Health Systems, Dublin, Ireland

Background: The National Clinical Programme for Palliative Care 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 health 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 and indicators (core competences) describe what health and social care professionals should know at point of professional registration. These core competences form the basis for the development of Discipline Specific indicators for ten health and social care professions providing generalist and specialist palliative care.

Conclusions and implications: The Palliative Care Competence Framework provides a core for 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 interdisciplinary 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
Connelly M.1, Barry C.1, Charnley K.1, Phelp L.1,2, McCloskey L.1,2, Bridget J.1
1All Ireland Institute of Hospice and Palliative Care, Dublin, Ireland, 2University College Dublin, Dublin, Ireland, 3Our Lady’s Hospice and Care Services, Dublin, Ireland, 4University of Ulster at Jordanstown, Belfast, United Kingdom, 5University of Nottingham, Nottingham, United Kingdom

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.

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.

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 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: P1-241
Abstract type: Poster

Demonstrating Medical Student Competency in Palliative Care: Development and Evaluation of a New ‘OSCE’ Station
Elman M.1, Putman A.1, Pfeiffer C.1, Green M.1, Bis M.1
1Yale University School of Medicine, New Haven, CT, United States, 2University of Connecticut, Farmington, CT, United States, 3Yale University School of Medicine, Internal Medicine, New Haven, CT, United States

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 its first 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 79% (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 MIRS communication questions on the palliative care case than on any other case. The students reported that the case seemed authentic.
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. The OSCE’s performance demonstrates successful uses in assessing student competencies in primary palliative care.

Abstract number: P1-242
Abstract type: Poster

(Lack of) Training for Uncertainty: A Review of Training Curricula and Published Literature
Ekidin-S.M., Murthag F.M.
King’s College London, Cicely Saunders Institute, Dept. of Palliative Care, Policy and Rehabilitation, London, United Kingdom

Background: Uncertainty is a common illness, particularly advanced illness with uncertain prognosis, and we know that patient quality of life is affected if uncertainty is poorly addressed. Addressing uncertainty is therefore a key skill for health care professionals (HCPs).
Aim: To determine what HCPs are expected to learn about addressing uncertainty; and to synthesise professionals’ views of their ability to do so.
Methods: We reviewed UK undergraduate and postgraduate medical and nursing curricula (identified from training body websites) for content related to addressing uncertainty. We also undertook a limited systematic literature review and narrative synthesis. We searched Medline, Embase and PsychINFO for ‘Uncertainty’, ‘Professional Competence’; and related terms. Inclusion criteria were data on views of HCPs relevant to competencies in addressing uncertainty, or analysis of HCP practices.
Results: We identified 19 curricula and 3220 articles. 142 full text articles were screened and 40 were included. Aside from primary care, paediatrics, public health and ophthalmology, curricula contained the generic references to uncertainty e.g. communicate effectively in uncertain situations; 6/19 curricula contained no mention of uncertainty. In included articles, barriers to addressing uncertainty were reluctance of HCPs to have conversations relating to uncertainty, difficulty acknowledging the legitimacy of uncertainty, and concerns about causing iatrogenic harm by ‘unnecessary’ information provision. Initiation of discussion by patients or families, and spacing discussions over several sessions were facilitators. HCPs frequently reported inadequate competence in addressing uncertainty.
Conclusion: HCP competencies related to uncertainty are not explicit in curricula despite the training needs reported by professionals. Addressing and communicating uncertainty are therefore areas in which HCPs need more training than currently exists.

Abstract number: P1-243
Abstract type: Poster

The Leadership Development Initiative: Improving Physician Leadership Skills
Ferns G.L.1, Moore S.Y.2, Pedger-Fonte D.1, Whitmore S.2
1OhioHealth, Palliative and Hospice Care, Columbus, OH, United States, 2OhioHealth, OhioHealth Research Institute, Columbus, OH, United States

Aims: The Leadership Development Initiative (LDI) was created with the goal of increasing leadership skills among 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 role of the physicians valued within 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 LDI and again after each LDI course. While completing the survey, physicians were asked to ‘retrospectively’ 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 the value of skills presented across the LDI course and provided comments noting the impact of their experiences in the LDI program.
Results: Results showed that leadership core skills increased significantly with each training (p < 0.01). In addition, physicians (in rank order) that their greatest resources for success were 1) LDI experience and courses (29%), 2) a step-by-step approach (21%), 3) mentorship advice (27%), and 4) networking (21%).

Abstract number: P1-244
Abstract type: Poster

Stepping Forward: Sustaining Quality End of Life in Care Comes Following on the Six Steps to Success Programme
Godfrey C.1, Barber B.1, Finnegan C.2, Groves K.E.3,4
1Terence Burgess Education Centre at Queenscourt, TRANSFORM Team, Southport, United Kingdom, 2Southport and Ormskirk NHS Trust, West Lancs, Southport and Formby Palliative Care Services, Southport, United Kingdom, 3Terence Burgess Education Centre at Queenscourt, Southport, United Kingdom

Background: In an area (pop 235,000) with 112 care homes (3400 beds), the Six Steps to Success Programme supports delivery of high quality of End of Life 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 care following completion of 6 programme, reduce unnecessary hospital admissions and enable residents to be cared for and die in preferred place of care.
Method: Support initiatives include: delivery of cross boundary EOL education and support from local Specialist Palliative Care Services (SPCS) and TRANSFORM Team; monthly visits to care 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 enable 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 formal end of life accreditation have been in place for over 3 years, with the majority meeting the requirements (33/35). The TRANSFORM Team has built excellent relationships enabling timely support, prompting best practice, and identifying and meeting the educational needs of staff. Quarterly educational activity and feedback demonstrated 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 tur.
Differences and deficits have been globally described within palliative care education. 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, discussion boards or elements of face to face tuition. Un-moderated programmes did not include tutor input, peer interaction through literature and where evident, was often compromised by other factors more associated with qualitative publications on the subject. The electronic databases Medline and Google Scholar, search for literature which have been published within the last decade. Search strategy was term related with Medical Students AND PC AND Education AND Attitude OR Knowledge OR Skills. Established methods for data collection and extraction were considered to review disparate study designs. 17 publications met inclusion criteria. Most publications were published in the United States (n=9), followed by Western Europe (n=2), the United Kingdom (n=2), the Asia-pacific area (n=2) and Latin America (n=1). Main differences could be detected concerning methods for assessment and range of undergraduate curricula, whereas duration and timing of palliative care education varied among countries.

All publications valued highly the implementation of multimodal teaching concepts in their curricula. There was used a wide scope of different assessment methods for measuring palliative care teaching effects on students, making it difficult for comparison. Recent concepts in palliative medicine teachings show promising approaches for pushing forward palliative education and effectively preparing tomorrow's doctors to provide patient centered care and family support. This systematic review highlights the lack of standardisation in palliative care education and assessment methods. Improvements both institutional and legal are needed to take advantage in the opening field of palliative care in undergraduate medical education worldwide.

Abstract number: P1-247
Abstract type: Poster

An Innovative and Integrated Cross Agency Palliative Care Education Programme for the Health and Social Care Workforce

Howard J.M., Phillips S., Ashby A., Ellenhower J.
Marie Curie Palliative Care Institute, University of Liverpool, Liverpool, United Kingdom
Presenting author email address: janet.howard@lfc.ac.uk

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 settings across diverse settings. However, there are differences in how these areas are identified for 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 selected for part of the programme to enhance articulation of concerns, learning needs and perceived status of current practice. Feedback to whole group was anonymised.

Aim s: To describe nurses’ attitudes towards death and dying using the 12-item self-administered Attitudes towards Death Survey.

Methods: This was a cross-sectional study of all nurses from a 590 bed restructured hospital in Singapore. Consent to participate was indicated by completion and return of the questionnaire. Descriptive statistics was used.

Results: A total of 966 questionnaires were sent out. Response rate was 76.2%. Two-thirds of the respondents 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 (89.8%), 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%), and that the use of strong pain medications 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 as part of ongoing educational programs if quality EOL care is to be provided to our patients.

Abstract number: P1-250
Abstract type: Poster

Six Steps to Success Programme: Improving End of Life Care for Care Home Residents


Edge Hill University, Evidence-Based Practice Research Centre, Ormskirk, United Kingdom, Edge Hill University, Honorary Lecturer, Ormskirk, United Kingdom

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 enveloped 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 Care Home managers;
3) care 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 skills confidence around EoLC improved markedly amongst care home staff, there was 92% improvement for Spiritualty 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 undertaken in recent 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

Koffman J.S.1, Liliana S.2, Khodabukus A.F.1, Mason S.1, Barclay S.I.2, Ellershaw J.1
1Hospice Casa Sperantei, Educatie, Brasov, Romania, 2Transylvania University Brasov, Brasov, Romania

Abstract number: P1-252
Abstract type: Poster

Review of the First Romanian Palliative Care Online Course

Liliana S.1, Mosoiu D.1, Predoia O.1, Chis R.1
1Hospice Casa Sperantei, Educatie, Brasov, Romania, 2Transylvania University Brasov, Brasov, Romania

Background: The online palliative care program (OPCP) was developed in partnership between the local hospice and the Medical Faculty on a free-platform. Submitted 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 CM2 points.

Aim: This study aims to detect weaknesses and strengths of the OCP with regard to pedagogical and technological aspects.

Method: Retrospective study, based on the content analysis of the all the application forms and final module access.

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 ethical aspects (15.6%). The most popular video course were: 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.

Palliative Care at a Danish University Hospital, a Network for Nurses in Palliative Care

Bønderup A.1,2
1Aarhus University Hospital, Palliative Care Team, Aarhus C, Denmark, 2EAPC, Department of Public Health and Primary Care, Cambridge, United Kingdom

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.

Purposes: 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 their competences within palliative care.

Method: A questionnaire study was conducted among all department managements, immediate superiors and key persons. The questionnaire to department managements included questions on framework and content of palliative care; questionnaires to immediate superiors and key persons included evaluation questions on continued competence development and clinical 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.

Development of professional competences: Continuing professional education in palliative care is available throughout New South Wales using real-time videoconferencing, recorded materials (including podcasts and podcasts), and printed materials publicly published by organisations of time spent in professional registration 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.
People with Intellectual Disabilities: Promoting Quality End of Life Care

M. McLaughlin, C. O., Barr O., Mcfaddan S., McCorry A.
Queen's University, School of Nursing and Midwifery, Belfast, United Kingdom, University of Ulster, School of Nursing, Belfast, United Kingdom
Presenting author email address: d.mclaughlin@qub.ac.uk

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 disabilities and palliative care professional services, was provided and the interviewee was adults with intellectual disabilities, were invited to participate. The study was approved by the ethics committee in the university. The interviews were conducted face to face, audio recorded, transcribed and content analysis was employed.

Results: Four 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.

Conclusion: 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.

Palliative Care Module at Undergraduate Level of Education - Evaluation of Implementing the Universal Curricula in One Nursing Technical College in Bucharest, Romania

Popescu A., Mitrea N.
Hospice Casa Sperantei, Education and National Development, Brasov, Romania, University of Transylvania, Nursing, Brasov, Romania
Presenting author email address: nicoleta.mitea@hospice.ro

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. Since the beginning of Palliative Care (PC) services in Romania in 1992, the national Order for Registered Nurses - Romanian professional body, adopted for proposal to National Order for Registered Nurses - Romanian professional body, adopted for proposal to EAPC nursing curricula 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: The project ensured provision of Palliative Care training and support of nurses towards gaining the abilities and knowledge specific to basic palliative care knowledge. It has also empowered family and community caregivers with basic abilities for supporting patients in their homes.

Building Bridges to Learning in Hospices. It’s Not all about Classrooms

M. Lyons, M. Mahoney, N. Bartlett.
Hospice, Education, Crawley, United Kingdom
Presenting author email address: lauramyres@itk.org.uk

Aims: To ensure a variety of learning opportunities are available to hospice staff, enabling them to authenticate their competence to deliver compassionate, person-centred care.

Experienced nurses, with an interest in a particular aspect of clinical practice (Link nurses), develop their own knowledge and a range of learning resources to support their colleagues.

Approach: Registered practitioners must be autonomous, and are personally accountable for ensuring that their practice is evidence-based, a link nurse system supports this concept. British hospice staff are encountering more complex patients. Treatments for life-limiting illnesses result in greater longevity and multiple co morbidities. The hospice patient demographic has widened to include people with non-cancer conditions; nurses must learn continually. Ageing experienced hospice nurses, retire, leaving an absence of suitable role models to support learning in practice.

Attending classroom-based teaching is not a guarantee of learning. Link nurses were expected to extend their knowledge, using self-directed learning, practice placements, e-learning, liaison with specialist practitioners, clinical audit - designing new protocols to enhance person-centred care and learning. Their presence in practice ensures that their colleagues see them as credible resources for learning.

Results: Link nurses learn about their subject, gather learning resources, teach and assess their colleagues, recognising the value of work-based learning. Learning from clinical colleagues leads to greater engagement in changes in practice. With support from the education team, some nurses show great commitment in developing and sharing their own knowledge to enhance care for an ever increasing population of people with complex life limiting illnesses.

Conclusion: Learning in practice, using link nurses, successfully shifts the emphasis away from formal teaching. Learning in hospices is not all about classrooms.
Abstract number: P1-262
Abstract type: Poster

The Training Evaluations of the End-of-Life Care Facilitators (EOLF) Educational Program for Nurses that Practice Advance Care Planning (ACP) in Japan

Akiyama H., Katayama Y., Sakai M., Iwaki M.
1Graduate School of Nursing, Chiba University, End of Life Care in Nursing, Chiba, Japan, 2Faculty of Health Sciences, Kagawa Prefectural University of Health Sciences, Department of Nursing, Takamatsu City, Japan, 3School of Nursing, Seirei Christopher University, Hamamatsu City, Japan.

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-life 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.

Methods: ACP should be facilitated by nurses for it to be effective.

Aim: 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 participant’s 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 2012 and March 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 answering that ‘the training is meaningful’ and 92% that they ‘would like to apply 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’ and ‘like to work out a way of life with both the patient and their family members’. However it was pointed out that the training should be on-going with comments like ‘I’d like to improve my skills further’. In future, on-going training to improve skills as an ACP facilitator should be investigated, and nurses able apply ACP to healthy elderly people should be trained.

Abstract number: P1-263
Abstract type: Poster

End-of-Life Care in Japan: Semi-structured Interviews with Junior Family Doctors

Obata H., Sotani H.
1University of Edinburgh, Primary Palliative Care Research Group, Centre for Population Health Sciences, Medical School, Edinburgh, United Kingdom, 2University of Tokyo, International Research Center for Medical Education, Graduate School of Medicine, Tokyo, Japan.

Background: There is an increasing need for family doctors to be involved in end-of-life care in the community due to ageing population. Although it has been reported that family doctors experience various difficulties in end-of-life care, there is little evidence from Japan.

Aims: To promote their involvement in end-of-life care, we need to clarify difficulties they experience.

Methods: A qualitative study with semi-structured individual interviews with 12 family doctors was conducted. Interviews were designed to explore difficulties in end-of-life care at home. The transcripts of the interviews were analysed combining qualitative data analysis and theoretical coding.

Results: Participants were aged from 29 to 35 with 4 months to 5 years of experience in home care. Several categories were identified by the analysis: ‘prognostication and truth telling’ family care, ‘the art and skills in care for the dying’ and ‘learning how to provide the care’. Participants find it difficult to estimate the trajectories and to tell the truth. They feel difficulty in death education for families, compassionate approach and understanding family’s feelings. They also feel difficulty in communication work with family, and feel uncomfortable with formal death declaration. These difficulties and conflicts is increased when they do not have supervision. They regard learning end-of-life care training as learning with related fields and difficult to map into clinical work. They use on learning from nurses.

Conclusion: Junior family doctors experience various difficulties and conflicts in end-of-life care for patients and their families. It is important to have reflective discussions with educators, including other professionals such as nurses and palliative care specialists. The study was funded by Tokyo Hokenkai.

Abstract number: P1-264
Abstract type: Poster

Factual Investigation of Undergraduate Education in Palliative Care at Pharmaceutical Colleges and Pharmaceutical Departments around the Country in Japan

Ohinata Y., Hira M., Hiyoshi O., Yonami K., Suzuki T., Kagaya H.
1Ashiya Municipal Hospital, Pharmacy, Ashiya, Japan, 2Kobe University Hospital, Pharmacy, Kobe, Japan, 3Takarazuka Municipal Hospital, Pharmacy, Kobe, Japan, 4Josei University Pharmaceutical Sciences, Itado, Japan, 5Nagasaki International University, Clinical Pharmacology, Sasebo, Japan, 6Hoshi University, Toxicology, Shiranagi, Japan, 7Meiji Pharmaceutical University, Clinical Pharmacology, Kyosyu, Japan.

Background: Pharmaceutical undergraduate education in Japanese universities changed from a 4-year course to a 6-year course from 2006, and from 2012 graduates who have received the new education have been clinically active. In Japan, each university individually sets curriculum in compliance with the Pharmaceutics Model Core Curriculum. In recent years, the number of lectures in clinical and pharmaceutical education has drastically increased, and the contents are also becoming richer, but it is known that there are large differences between the universities.

Aim: Considering this, this academic society decided to conduct a survey of the current situation in order to assure the quality of pre-graduate education in palliative care in Japan.

Methods: We sent questionnaires to university presidents, deans, and concerned teaching staff at 74 public and private universities around the country and collected the answer via FAX. The questionnaires consisted of 14 items including ‘is palliative care necessary in pharmaceutical education’, ‘State of implementation of palliative care education’, ‘Influence on pharmacists’ duties’, and ‘Sense of satisfaction in lectures’.

Results: The response rate to the questionnaire was 71.6%, or 53 of the 74 schools. 96% responded ‘Yes’ to ‘Is palliative care necessary in pharmaceutical education’? 86.5% responded ‘Yes’ to ‘Do you conduct lectures regarding palliative care?’ As for the number of classes of the lectures, 58.7% responded 2-7, which was the highest, and 6.3% of universities had 17 classes or more. 52.8% responded ‘Yes’ to ‘Is the current state of palliative care education sufficient?’

Considerations: This investigation showed that the necessity of palliative care was recognized at most universities and that lectures devised at each university are being conducted. However, because about half of universities feel that it is currently insufficient, we can expect that education in this field will be further enriched in the future.

Abstract number: P1-265
Abstract type: Poster

Evaluation of a Mental Health Program for Palliative Care Health Care Workers

Ohizuyama L., Matsuda Y., Akiyoshi R., Toshio K., Yoshioka K.
1Takarazuka Municipal Hospital, Palliative Care Unit, Takarazuka, Japan, 2Takarazuka Municipal Hospital, Palliative Care Team, Takarazuka, Japan.

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 to work with the patients.

Aims: 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.

Methods: The workshop using our program involved the participation of 16 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 or five volunteers. The members debate the mental problems supportively. A facilitator placed in each group moderates the debate. In the second part, lectures are presented on 20 items of specific measures of self-care and the group work is performed intermittently. For example, some of the topics include, ‘Methods of assertion for conflict with other occupations’ and ‘Value of palliative care work’. In the third part, using the World Cafe format, the participants each share their self-care methods. Then they debate and create a useful self-care strategy.

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

EAPQ Enquiry on Spiritual Care Education

Post J.1, Leget C.1, Goodhead A1.
1Ludwig-Maximilian-University, Palliative Care, Munich, Germany, 2University of Humanistic Studies, Utrecht, Netherlands, 3St Christophe’s Hospice, London, United Kingdom.

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 explore these areas 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 subgroup of the EAPQ Spiritual Care Taskforce among EAPQ 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 27 countries, of which 78% (n=28) derive from Europe. This revealed that 81% (n=29) of training programmes use the EAPQ working definition of spirituality. 64% (n=21) of training is provided to all health care professionals, professional-specific requirement is not common. 89% (n=26) is required to be face 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
Conclusions: The enquiry raised some pertinent issues for all educationists and practitioners. Firstly, the use of a single definition of spirituality would help all healthcare staff to work with a uniform meaning of spirituality. Secondly, evaluations are important and provide a means to improve their training. However, of more help is developing spiritual care competencies are the use of reflective practices and performance assessment. Thirdly, setting spiritual care into the context of broader courses enables this core skill to be embedded in palliative care.

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

Ramasamy Venkatasalu M., Sandgren A.

University of Bedfordshire, Aylesbury, United Kingdom

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 evidences exist on the use 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 core of end of life care 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 via Facebook massage (n=2280), and email feedback responses (n=8). Using Nvivo10®, a thematic analysis was undertaken.

Results: A comparative analysis between social media versus classroom based education resulted in five themes explored its efficiency. Firstly, the use of a single definition of spirituality would help all healthcare practitioners. Secondly, evaluations are important and provide a means to improve their training. However, of more help is developing spiritual care competencies are the use of reflective practices and performance assessment. Thirdly, setting spiritual care into the context of broader courses enables this core skill to be embedded in palliative care. Secondly, evaluations are important and provide a means to improve their training. However, of more help is developing spiritual care competencies are the use of reflective practices and performance assessment. Thirdly, setting spiritual care into the context of broader courses enables this core skill to be embedded in palliative care.

Abstract number: P1-268
Abstract type: Poster

Using Collaboration and Innovation Across Continents to Provide Palliative Care Education

Rawlison F.M., Burke D.J., Hartley C., McVeig G., Finlay I.

Alliance for Palliative Medicine, Bristol, United Kingdom

Introduction: Delivering effective palliative care to patients and families requires education for all healthcare workers. Access to 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 urgent concern is lack of internet availability. Technology and massive open online courses (MOOCs) 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 is on interviews and teaching in Africa and UK. 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 accessed; the most popular principles of palliative care (14%), respiratory symptoms (8%), fatigue/weakness and nausea and vomiting (both 7%). 71% participants strongly agreed that the module was easy to navigate, 76% that the course design made the subject matter interesting, 97% agreed (69% strongly) that the course would help them perform their job better. 71% accessed the material at home, 29% at work. Free text reflected increased awareness of basic principles: pain assessment, symptom assessment frameworks, opioid doses, spiritual care and communication skills. Feedback on content and production was very interest yet attained similar learning outcomes.

Abstract number: P1-269
Abstract type: Poster

A Collaborative Learning Process to Improve Awareness and Knowledge of Palliative Care at Different Care Settings

Sandgren A., Oddung L., Bylund-Gremklo T., Gustafsson H., Johannson J., Person C., Petri M., Remitz H., Svensson K., Wallerstedt B., Werngardt Harstade C., Benzen E., Linnaeus University, Department of Health and Caring Sciences, Växjö, Sweden

Background, aims and goals: In Sweden, palliative care is provided across a variety of care settings by a range of different professions. A national survey conclude that the basic education in palliative care for health care professionals vary considerably. The Centre for Collaborative Palliative Care is cooperation between a university, the county council and eight communities. The main goal of the Centre is to conduct education in palliative care for professionals and to integrate the new knowledge in clinical practice simultaneously. The aim of the presentation is to describe this educational effort.

Aim: To explore the effectiveness of social media and classroom based core of end of life care 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 via Facebook massage (n=2280), and email feedback responses (n=8). Using Nvivo10®, a thematic analysis was undertaken.

Results: A comparative analysis between social media versus classroom based education resulted in five themes explored its efficiency. Firstly, the use of a single definition of spirituality would help all healthcare practitioners. Secondly, evaluations are important and provide a means to improve their training. However, of more help is developing spiritual care competencies are the use of reflective practices and performance assessment. Thirdly, setting spiritual care into the context of broader courses enables this core skill to be embedded in palliative care.
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

Tomas J.1, Davis C.2
1Worcestershire Royal Hospital, Worcester, United Kingdom; 2St. Richard’s Hospice, Worcester, United Kingdom.

Presenting author email address: tomasj@doctors.org.uk

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 use and likely side effects.

Method: 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 10.30, 14.95, and 12.15 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.

Discussion: 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 the recognition, continuation 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

Elman M.S.1, Tar C.S.2
1Yale University School of Medicine, Internal Medicine, New Haven, CT, United States; 2Yale University School of Nursing, New Haven, CT, United States.

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 medicine is best initiated in the pre-clinical years. Online tools have shown to improve student education, flexible method in diverse areas of medical education.

Aims: To explore the application of an online learning tool in conjunction with a hospice clinical experience in the educating medical students, a 30-minute interactive online module was created with the following learning objectives:

- To articulate the qualifications for and the services provided by hospice care
- To recognise the stages of active dying and identify the accompanying physiological changes
- To list five common end of life symptoms and differentiate their pharmacological and non-pharmacological treatment options

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). Following 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 regard 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 appears to enhance teaching of the dying process and terminal care to pre-clinical medical students. A new online learning module may prove useful to integrate in curricula in other institutions.
Palliative Sedation (PS) at the End of Life - Revision of the Norwegian Medical Association’s Guideline

van Hofacker S,1, Materstedt L1,2, Ferde R1
1Regional Centre of Excellence for Palliative Care, Western Norway, Haukeland University Hospital, Bergen, Norway,
2Surviva Centre for Palliative Care, Haraldsplass Dalemark Hospital, Bergen, Norway, 
3Norwegian University of Science and Technology (NTNU), Department of Philosophy and Religious Studies, Faculty of Humanities, Trondheim, Norway, 
4University of Oslo, Centre for Medical Ethics, Faculty of Medicine, Oslo, Norway

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 omission 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

Method: 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 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) Intermittently waking up the patient should always be considered, but need not always be attempted. (No. 5)
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: P1-278
Abstract type: Poster

The Process of End-of-Life Decisions Regarding People with Intellectual Disabilities

Wagemans A,1,2, van Schijndel Lanstra-van Vark H1,3, Poot L1,3, Mietsmaers J1,2, Tuyfbery-Wijn C1,4, Curfs L1,2,3,4
1Koraalgroep, Maasveld, Maastricht, Netherlands, 2Maastricht University Medical Centre, Department of General Practice, Maastricht, Netherlands, 3Radboud University Nijmegen Medical Centre, Department of Primary and Community Care, Nijmegen, Netherlands, 4Maastricht University Medical Centre, Governor Kremers Centre, Maastricht, Netherlands, 5St George’s University of London and Kingston University, Division of Population Health Sciences and Education, London, United Kingdom, 6Maastricht University Medical Centre, Department of Clinical Genetics, Maastricht, Netherlands

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. Physicists 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.
Abstract number: P1-280
Abstract type: Poster

A Systematic Review of Ethical Issues in the Clinical Practice of Palliative Care

Converto N., Arantznemend M., Centeno C.
University of Navarra, ICS, Programa ATLANTES, Pamplona, Spain

Background: Continuous growth of ethical reflection in palliative care (PC) literature provides the theoretical basis and justification for clinical practice and insights on specific ethical dilemmas. Scientific literature is one of the main tools for training and updating in PC, whereas not all Schools of Medicine have specific PC programs and there is a lot of variability in ethics programs as well.

Objective: To systematically identify the most relevant ethical issues with reference to the clinical practice of PC.

Methods: Using the PRISMA systematic review method we searched Medline database, as the most comprehensive database (it includes different professions and perspectives: clinical, philosophical, social) and presumably the most widely used source for continuing education (freely available). Search strategy (from 2000 to 02 Sept 2014): ethic* AND (palliative care [MeSH Major Topic] OR hospice care [MeSH Major Topic]) NOT student* (filters: humans, adults, English). Exclusion criteria: paediatrics, research, teaching, no palliative care as a main setting, no ethics as a main focus. Inclusion criteria: clinical and ethical focus.

Results: A total of 382 articles were identified, 243 met inclusion criteria. Ninety-seven articles were published in palliative medicine journals. Sixty-two articles examined ethical aspects related to interventions and medications, 27 to non-malignant diseases; 25 to delivery of health care, 23 to spirituality, 23 to theoretical debate, 21 to decision-making, 21 to psycho-social aspects, 17 to communication, 16 to assisted suicide/euthanasia, 8 to symptom assessment and sedation.

Conclusions: Ethical reflection in PC touches on many topics. However, in many areas it remains the call to greater education. We need more empirical research which focuses the ethical dilemmas that most affect the moral conscience of PC professionals, in order to devote more attention to these dilemmas on a theoretical reflection level.

Poster Sessions (Poster Exhibition Set 1)
Family and care givers

The Impact of the Carer Support Needs Assessment Tool (CSNAT) in Community Palliative Care Using a Stepped Wedge Cluster Trial

Asian S.A.1, Toye C.1, Grande G.1, Living G.1, Stojdak K.1,2
1Glar University, Perth, Australia, 2Manchester University, Manchester, United Kingdom, 3Cambridge University, Cambridge, United Kingdom, 4University of Victoria, Victoria, BC, Canada

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.

Aim: 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 (FAC-Q), 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 no 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 care needs, ensuring adequate family carer support and reduction in carer strain and distress throughout the caring journey.

(Funded by ARC)

Abstract number: P1-287
Abstract type: Poster

Family Caregivers of Frail Elderly at the End of Life: Predicting Overburdening

Barreto Martin P.1, Pérez Maini M.1, Soto Rubio A.1, Savedra Murióz G.1,2
1University of Valencia, Personalidad, Evaluación y Tratamientos Psicológicos, Valencia, Spain, 2Hospital La Magdalena de Castellón, Valencia, Spain

Presenting author email address: pilar.barreto@uv.es

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 Botella et al. (1998) make of frail elderly: a person that presents certain pathologies 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 aims to analyse the elements that might relate to overburden in family main 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 Zarin Burden Interview were used.

Linear regression’s analyses were carried out. The model that best predicted the variance of overburden in the family caregivers included: depression’s level of the family caregiver, depression’s level and independency level of the frail elderly patient. This model explained 40.7% of the observed variance.

Results from this study highlight the need (and the opportunity) of interventions that pursue the psychological wellbeing of family main caregivers and frail elderly patients at the end of life, preventing and reducing the caregiver’s overburden.

Research funded by the Spanish Science and Innovation Department (PSI2010-19426).

Abstract number: P1-288
Abstract type: Poster

Family and care givers

What’s in a Name? That which we Call Palliative Sedation - A Qualitative Study among Swedish Palliative Care Physicians and Nurses

Karlsson M.1,2, Milberg A.3,4,5
1Linköping University, Department of Clinical and Experimental Medicine, Linköping, Sweden, 2Linköping University, Department of Advanced Home Care and Department of Clinical and Experimental Medicine, Linköping, Sweden, 3Linköping University, Campus Norrköping, Department of Social and Welfare Studies, Norrköping, Sweden, 4Linköping University, Palliative Education and Research Centre and Department of Social and Welfare Studies, Norrköping, Sweden, 5Linköping University, Department of Advanced Home Care and Department of Social and Welfare Studies, Norrköping, Sweden

Presenting author email address: marit.karlsson@liu.se

Results: Of those 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 died of euthanasia, 42% 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 [3.11-36.40]) 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, 95%CI [2.4-7.6]), and for those dying in hospitals (OR=3, 95% CI [1.4-49]) or nursing homes (OR=3, 95% CI [0.9-36]) compared to those dying at home. Conclusion: Having a living will requesting euthanasia was related to the patient's age, end of life, 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?

Verné J.
Public Health England, Bristol, United Kingdom

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, carers. UK Policy Documents were examined. Results: Domains within the literature review is promotion of liberal autonomy but through 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 clearer medical decision making.

Conclusions: Patients may reflect privately on how ACP decisions could impact on family. ACP in the UK focuses 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

Karlsson M.1,2, Milberg A.3,4,5
1Linköping University, Department of Clinical and Experimental Medicine, Linköping, Sweden, 2Linköping University, Department of Advanced Home Care and Department of Clinical and Experimental Medicine, Linköping, Sweden, 3Linköping University, Campus Norrköping, Department of Social and Welfare Studies, Norrköping, Sweden, 4Linköping University, Palliative Education and Research Centre and Department of Social and Welfare Studies, Norrköping, Sweden, 5Linköping University, Department of Advanced Home Care and Department of Social and Welfare Studies, Norrköping, Sweden

Presenting author email address: marit.karlsson@liu.se

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 seldom needed to be used according to the 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 wish, 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

Family and care givers

Poster Sessions (Poster Exhibition Set 1)
Informal Caregivers in Critical End of Life Situations

Sottas B.1,2, Brügger S.1, Jaquier A.1

1Sottas Formative Works, Bourguillon, Switzerland, 2Careum Foundation, Zurich, Switzerland

Background: Terminal 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 vast majority of referrals to SPCT are offered a FM (73%), and the majority of these are planned (58%). The median time to FM from referral is 1 day, although only a minority (20%) are multidisciplinary. It appears that FM is offered irrespective of patient characteristics. These data suggest feasibility of FM and equity of provision in an inner-city busy acute setting. This suggests the intervention is appropriate for further testing with respect to outcomes.

Conclusion: Informal care entails high burdens for male and female caregivers. Because these burdens are experienced differently according to gender, awareness for the powerful gender ascriptions which perpetuate themselves in norms and actions is essential for gender-sensitive policy and practice. Accordingly, supportive action by extension services has to consider the gender-specific differences when designing professional assistance and provide a really unique coverage for male and female caregivers.

The study has been funded by the Swiss National Science Foundation as part of the national research program NRP 67 (grant number: 406740_139243).

Informal Caregivers at the End of Life: Modelling of a Complex Situation

Jaquier A.1, Brügger S.1, Sottas B.1

1Sottas Formative Works, Bourguillon, Switzerland, 2Careum Foundation, Zurich, Switzerland

Background: How informal caregiving for a person at the end of life at home is experienced by the caregiving patient 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 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 English, have been transcribed and analysed with a grounded-theory approach.

Results: The model shows how stressors and available resources originate at different levels of the system and best practices in caring for a person at the end of life, and last but not least, the feelings of 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 encountered burdens and training emotions associated with informal caregiving.

The study has been funded by the Swiss National Science Foundation.

Abstract number: P1-291
Abstract type: Poster

Meaning in Caregiving for Parent Caregivers of Children with Life-Limiting Illnesses

Caddell S.1,2, Hennessy DW.1, Smit Qousia T.1,2, Steele R.1, Davies E.1, Liber S.5, Snaesmat L.4, Siden H.3

1Reinsson University College, University of Waterford, Waterford, ON, Canada, 2Nipissing University, North Bay, ON, Canada, 3University of Waterloo, Waterloo, ON, Canada, 4York University, Toronto, ON, Canada, 5University of Victoria, Victoria, BC, Canada

Background: When children are born, parents expect to care for them. For some parents, however, a child’s diagnosis of a life-limiting illness transforms them into caregivers in ways that predominantly well children are not. Stress is inherent in this situation but positive aspects are less documented.

Aims: This research aimed to understand the factors that allow parent caregivers to grow in the face of the stressful circumstances of caring for a child with a life-limiting illness.

Method: Data were collected by a cross-sectional survey that included measures of depression, burden, spirituality, posttraumatic growth, meaning in caregiving, optimism, and self-esteem. Participants (N=273) were recruited through affiliations with children’s hospices and hospitals in Canada and the United States. Both mothers and fathers were encouraged to participate and more than one caregiver per family could enrol.

Results: While the stresses are numerous and life-changing, many parents also demonstrated growth as measured by the Post Traumatic Growth Inventory (Tedeschi and Calhoun, 1996). Two structural equation models were tested to determine factors in the positive outcomes. The formative model - the direct impact of personal resources (meaning in caregiving, optimism, and self-esteem), spirituality, and burden on PGT - fit well but the impact on growth was inconclusive. The process model explored the impact of personal wellbeing (self-esteem, optimism, depression, and spirituality) on meaning in caregiving and indirectly on PGT; this model fit well and strong support for the hypotheses was generated.

Conclusion: This research demonstrates that particular attributes reflect in personal wellbeing as a precursor to the process of positive meaning-making, which then in turn contributes to growth. The path to posttraumatic growth is complex, this research contributes to further elucidating it.

Abstract number: P1-294
Abstract type: Poster
Family Carers’ Involvement in Caring for a Hospitalized Patient with Cancer and their Quality of Life in a Country with Strong Family Bonds

Ewing G., Vernooy Dassan M.T., Setyanuri S., Kristianti M.S., Noprantho S., Visser K.

Radboud University Nijmegen Medical Centre, IQ Healthcare, Nijmegen, Netherlands

Abstract number: P.1-295

Abstract type: Poster

Background: Being involved in caring for family members during illness is part of Indonesian culture, even during hospitalisation. It is unknown which factors influence the quality of life (QoL) of family members taking care of their loved ones.

Aims of study: To identify factors influencing the QoL of family carers of hospitalised patients with cancer in Indonesia.

Methods: A cross-sectional survey was performed. Data were collected in a general hospital in Yogyakarta from September to December 2011. Family carers of cancer patients were invited to participate. Logistical analysis was used to determine which aspects of caring and which demographic characteristics influenced their QoL. The Caregiver Quality Of Life Index-Cancer questionnaire was used to measure the QoL.

Results: One hundred and 30 invited carers (70.7%) completed the questionnaire. Being involved in psychological issues in caring (β = 0.374, p = 0.000), younger age (β = −0.282, p = 0.003), no previous caring experience (β = −0.301, p = 0.001), and not being the spouse (β = −0.228, p = 0.015) negatively influenced the QoL, and explained 31% of the variation (adj R² = 0.312, F = 12.24, p = 0.000). Gender, education level, and time spent on caring did not influence the QoL of family carers.

Conclusions: Our study identified modifiable factors such as dealing with psychological issues and lack of experience in caring which negatively influenced the QoL of family carers. These factors are potential targets for intervention strategies. Education and intervention programs focusing on dealing with psychological problems in cancer care might improve the QoL of both patients and their families.

Keywords: Cancer, family carers, hospitalisation, Indonesia, oncology, quality of life

Implementing a Complex Intervention to Support Family Care-led Assessment and Support: Key Components of a Training and Support Toolkit

Ewing G., Differ J., Austin L., Grande G.

University of Cambridge, Centre for Family Research, Cambridge, United Kingdom, University of Manchester, School of Nursing Midwifery and Social Work, Manchester, United Kingdom

Presenting author email address: ge200@cam.ac.uk

Background: The Carer Support Needs Assessment Tool (CSNAT) intervention facilitates a carer-led process of assessment and support. It represents a change in practice from current practitioner-led approaches that requires targeted practitioner training and support.

Aim: To test and revise a CSNAT toolkit for palliative care for implementation of carer-led assessment and support in practice, informed by the Promoting Action on Research Translations (PARTs) Framework.

Method: 36 palliative care services took part including specialist community teams, hospice and home support services. Carers were supported to facilitate assessment and planning for care in the home. An integrated care pathway was developed, cross-service peer support was facilitated through twice monthly skype/webex discussion sessions. The PARTs Framework informed analysis of champion qualitative interview and skype/webex field notes and revision of materials for the revised toolkit.

Results: The finalised CSNAT toolkit addresses:

(1) the nature of the evidence - underpinning policy and research, stages of the CSNAT and understanding
(2) organisational context - recommended preconditions for internal managerial, administrative, and IT support
(3) internal facilitation - resources for champions to cascade training, FAQs and practice-based examples from other services and
(4) external facilitation by the research team through webex support networks and information exchange.

Conclusion: The toolkit addresses key components for successful implementation of the CSNAT to achieve evidence based, comprehensive carer-led assessment and support in practice.

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A Critical Review of Carers’ Perceptions of Palliative Patients’ Symptom Distress

Farrugia L.S.

Hospice Malta, Balzan, Malta

Presenting author email address: lara.farrugia@hospicemalta.org

As palliative care is being increasingly provided by family caregivers in the community, health care professionals depend on proxies to provide a precise and reliable assessment of the patient’s general condition. It is thus vital to determine how reliable information by proxy is, since this affects patient care and symptom control.

The aims of this review are to analyse and explore reasons for the various perceptions of formal and informal carers of adult patients receiving palliative care. A focused search of the literature was conducted using online databases, limited to journal articles and published primary research studies, 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 of Systematic Reviews and Meta-Analysis) 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.

Aim: To improve the experience of ‘families’ of all patients approaching the end of life.

Methods: Several initiatives including care plans of life and end of life, formal and informal carers of patients attending district nursing case load, 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 ‘axis’ 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: The use of care’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 hand 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.

When Is the Decision Made to Place a Family Member with Dementia in a Care Home?

Harrington J., Leavy G., RP., Kippen N., Davies S., Elliott M., Moon K., Mims S., Nazareth I., BPMZ, Sampson E.L., Jones M., UCL, Division of Psychiatry, London, United Kingdom, University of Ulster, Barnford Centre for Mental Health and Wellbeing, Derby, United Kingdom, UCL Department of Applied Health Research, London, United Kingdom, UCL, University of London, UCL, Department of Primary Care and Population Health, London, United Kingdom, UCL, Department of Statistical Science, London, United Kingdom

Presenting author email address: j.harrington@ucl.ac.uk

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 programme to develop a complex intervention to improve the end of life care for patients with advanced dementia and their carers.

Aims: To identify determinants of informal carers’ decision to place a family member in a residential care home.

Methods: Using a topic guide we interviewed 14 carers, 5 male and 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
Abstract number: P1-300

**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**

**Henniksson A**, **Helm M-C**, **Carlander I**, **Öhlin J**, **Årstedt K**, **Wengström Y**, **Furst C**

1 Ersta Sköndal University College and Ersta Hospital, Palliative Research Centre, Stockholm, Sweden, 2 Karolinska Institutet, Department of Neurorehabilitation, Care Sciences and Society, Division of Nursing, Stockholm, Stockholm, Sweden, 3 Lund University, Institute for Palliative Care, Lund, Sweden

Presenting author email address: anette.henniksson@erstadiakoni.se

**Background:** Carers in palliative care have a need to know 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 family carers based on an intervention manual. The intervention was delivered over three sessions based on an intervention manual. An interpretive descriptive design was chosen. Data were collected through focus groups 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**

**Höser S**, **Stein S**, **Ostgathe C**

1 University Hospital Erlangen, Friedrich-Alexander-Universität Erlangen-Nürnberg, 2 Department of Palliative Medicine, Erlangen, Germany, 3 University Hospital Erlangen, Friedrich-Alexander-Universität Erlangen-Nürnberg, Comprehensive Cancer Center, 4 EMLN, Erlangen, Germany

Presenting author email address: bettina.hoerer@uk-erlangen.de

**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.

**Method:** A mixed method study design was used. A quantitative subsample was presented here. IC were interviewed after the death of the patient (M=27.32, SD=7.75 months) and completed three questionnaires (PHQ short, B3SC short, SF-12). 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 were mostly female (76%) 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 at the time of the interview and ex post perceived burden of home care, especially physical exhaustion (r=-0.492, p=0.021), loss of strength (r=-0.71, p=0.01), and impact on relationships (r=-0.70, p=0.01). Psychological reactions were influenced by the place of death of the patient and the progression of the diagnosis.

**Conclusions:** Since brain tumors, especially glioblastoma Grade IV, have a very poor prognosis, it is necessary to have an early diagnosis and to plan the care. On average, the IC of brain tumor patients experience more burden than IC of non-brain tumor patients. IC of glioblastoma patients should thus be offered more support for the conservation of social resources.
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 these 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 felt that the book offers them the opportunity to talk with the children about how they feel and what it 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 Caregiver of Advanced Cancer Patients

Lee K. C.1, Yin J.2
1China Medical University, Taichung, Taiwan, Republic of China, 2Taichung Veteran General Hospital, Department of Neurosurgery, Neurological Institute, Taichung, Taiwan, Republic of China

Objectives: 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 h 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

Mamta A.

Narikeldaha Prayas, Palliative Care, Purba Medinipur, India

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 and 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 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 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

Clifford M.1, O’Farrell G., Macdonney A.1, Murphy J., Murphy M.1, O’Brien T., Murphy F.1
1Marymount University Hospital and Hospice, Cork, Ireland, 2King’s College London, Ciley Saunders Institute, London, United Kingdom

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 patient’s experience of FFMs, and experience of FFMs in an inpatient hospice.

Methods: Mixed methods are used, using a variant of the triangulation design (the convergent mode). Data collected comprises quantitative (retrospective chart review, analysed using SPSS 22.0 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 = 10.29; 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 = 16.69; p = 0.0001) attended to (χ2 = 16.78; p = 0.025). FFM content was a narrative: an explanation of 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

Nekolutschuk C.1, Horwitz J.2, Fainsinger R.1,2, Fassbender K.1,2
1University of Alberta, Oncology, Edmonton, AB, Canada, 2Covenant Health, Palliative Institute, Edmonton, AB, Canada

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 recommendations, the ZPCP has adapted 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 (S) or very satisfied (VS) by over 75% of participants across all sites, with the exception of 4 items (Q7, Q14, Q15, H1). For the FAMCARE-2, 8 items were rated as S or VS by over 75% of participants. The average subscale scores (FAMCARE-2) were very similar, ranging from 1.4 (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 the 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 standardisation of 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

Moran S.1, Brosnan A.1, Clifford M.2, Connelly L.1, Connelly M.1, Murphy R.1, Mulcahy L.1, O’Donovan E.1, O'Reilly M.1, Quill S.V.1, Bhattacharjee J.1, Richardson M.1, Sheridan J.1
1Milford Hospice, Milford Care Centre, Limerick, Ireland, 2Marymount University Hospital and Hospice, Cork, Ireland

Introduction: Formal Family Meetings (FFMs) are a vital tool in effective communication with patients and families. Audits in 2 specialist palliative care units (SPCUs) 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 (78% 2013, 56% 2009, p = 0.006), as well as being consulted regarding which family should attend (83% 2013, 57% 2009, p = 0.031). Staff preparation also improved, with a decision being made and documented re 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 = 0.0005). 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 Family Caregivers of People with Advanced Cancer

Penner L.1, 2, Dabel MA.1, 2, Ducharme F.3, Sabiston C.3, Cohen SB.1, 2
1McGill University, Montreal, QC, Canada, 2Lady Davis Institute, Jewish General Hospital, Montreal, QC, Canada, 3Jewish General Hospital, Montreal, QC, Canada, 4Université de Montréal, Montreal, QC, Canada

Background: Family caregivers (FCs) 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 content meaningfulness of the intervention. The ZPCP has adapted it and refine it, as necessary, to be acceptable to FCs.

Methods: A formative evaluation was conducted. FCs (n=10) 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 interviews. 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 program, 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 for a longer period and preventing them from becoming patients themselves.

Funding: Canadian Institutes of Health Research

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

Tuffly-Wijne J1, Westerpoort B E2, Sloosker B3, Dusart A4, Carls J5, McLaughlin O6, Maves B7, Muro Mc8, Greg C9, Flagg-Wallen E10, Wiek M11, Oliver D V12. EAPC Taskforce on Intellectual Disabilities

1St George’s University of London and Kingston University, Faculty of Health, Social Sciences and Education, London, United Kingdom, 2Vestfold Mental Health Care Trust, Tonsberg, Norway, 3Caritas Association of the Diocese Munich and Freising, Munich, Germany, 4Interdisciplinary Research Institute in Social Science, Dijon, France, 5Amannis University, 6Gorontoto Kemer Centre, Malaysia, 7Radboud’s University, 8University of Nursing and Midwifery, Belfast, United Kingdom, 9Zwart Goor, Merkipsal, Belgium, 10BRTC, Sarajevo, Bosnia and Herzegovina, 11University of Zagreb, Zagreb, Croatia, 12Maldaner University, Eskilstuna, Sweden, 13University of Applied Sciences on Special Needs Education, Zurich, Switzerland, 14Wisdom Hospice, Rochester, United Kingdom

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 present findings from the EAPC Taskforce on palliative care for people with ID. Methods: In order to gather a wide-range of examples of good practice the EAPC 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: 86 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 unsure what constitutes ‘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 the Taskforce to affect the stripe 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.

Abstract number: P1-314
Abstract type: Poster

A Systematic Mapping Review of the International Palliative Care Research Literature

Clerk1 J, Barnes A1, Gardner C2
1University of Sheffield, Public Health, School of Health and Related Research (SCHARR), Sheffield, United Kingdom, 2The University of Auckland, School of Nursing, Auckland, New Zealand

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 efforts.

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: 311 relevant studies were included in the review. The first international palliative care research article appeared in 1963 and relevant literature has been published in 119 different academic journals. Research emanates from and focuses upon all world regions as well as an emerging body of work at global level. In total, 170 studies collected primary data and 141 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

Dowling J.1,2, Haraldsdottir E.1,3, Milicevic N.1, Lukic N.1, Basket J.1, Raymond C.1,2
1Development of Palliative Care Services in the Republic of Serbia, Belgrade, Serbia, 2Makere University, Kampala, Uganda, 3Strathcarron Hospice, Denny, United Kingdom, 4Oxford Policy Management, Oxford, United Kingdom.

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'

Hockley J.1, Dowling J.1, Haraldsdottir E.1, Milicevic N.1, Lukic N.1, Raymond C.1,2
1University of Edinburgh, Edinburgh, United Kingdom, 2Development of Palliative Care Services in the Republic of Serbia, Belgrade, Serbia, 3Oxford Policy Management, Oxford, United Kingdom.

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 in Serbia, accessible to all who require such care.

Aim: To capture the short term impact of the project through drawing on the experience of a range of project stakeholders including the MoH, partner organisations, training participants and those involved in developing palliative care policy and practice.

Method: Focus group discussions and semi-structured interviews were undertaken in September 2014. FGDs and interviews were set up by the project team. It participated were interviewed and 25 attended 4 FGs. One palliative care unit outside of Belgrade was also visited and interviewed held with 3 staff from the unit. All FGs were undertaken through a translator along with 3 of the interviews. Interviews and FGs recorded, transcribed, checked and analysed using thematic analysis.

Results: One participant noted that 'This is the project is huge achievement, this is a game changer in this country. This project is the absolute fantastic example of how you can make a real impact. Themes identified from the data included: the status of PC in Serbia prior to the project; the impact of education and training programmes; changing culture and communicating about dying, influencing colleagues; development of palliative care units; resistance to change; drug availability; co-ordination of services; bottom up/top down change; policies, guidelines and academia. Challenges for the future were identified and the importance of sustaining momentum.

Conclusion: This project has been a 'top down' /bottom up public health change initiative that has a real chance of bringing about lasting impact in palliative care development across Serbia and the potential to influence developments in the wider region.

Abstract number: P1-317
Abstract type: Poster

How Do Professionals in Specialised Palliative Care Respond to a Wish to Hasten Death?

French C.1, Gakukho M.1, Ferner K.M.1, Gallia H.1, Radbuck L.1,2, Nauck F.1, Otsgath C.V.1, Volzke H.1,2
1University Hospital of Cologne, Centre for Palliative Medicine, Cologne, Germany, 2University Hospital Bonn, Department of Palliative Medicine, Bonn, Germany, 3Malteser Hospital Seliger Gerhard Bonn/Rhein-Sieg, Palliative Care Centre, Bonn, Germany, 4University Hospital of Göttingen, Department of Palliative Medicine, Göttingen, Germany, 5University Hospital Erlangen, Division of Palliative Medicine, CCC-ER-EMN, Erlangen, Germany, 6Centre for Integrated Oncology, Bonn, Germany, 7Clinical Trials Centre Cologne, Cologne, Germany.

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 inadequately prepared. While it is often discussed that WTHD may be altered by effective palliative care (PC), it is unknown how HP-SPC respond when they encounter WTHD. This study aimed to identify HP-SPC responses to WTHD in daily practice.

Methods: 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 WTHDs was compiled, and their corresponding functions in the interactional context between patient and HP-SPC were reconstructed.

Results: On the patient level the result was categorised from symptom control, exploring the reasons and generating perspective, reorientation, and hope to ease patients’ burden were of particular significance. On the interaction level, creating and maintaining a 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 professional’s cooperation within and beyond the palliative care team can contribute to successfully delivering much needed support for patients with WTHDs.

Abstract number: P1-318
Abstract type: Poster

From “Sociological Study of Tobuyo-ki” to “Clinical Application of Caring Through Writing”

Kodavashri M.1, Shimomura M.1, Nakao M.1, Homma M.1, Sato M.1, No T.1
1Japan Women’s University, Faculty of Integrated Arts and Social Sciences, Kawasaki, Japan, 2Sapporo Medical University, School of Health Sciences, Sapporo, Japan, 3Sapporo Medical University, Department of Rehabilitation, Sapporo, Japan, 4Tobuyo-ki University, Department of Nursing, School of Health Sciences, Ishihara, Japan, 5Wako University, Department of Psychology and Education, Machida, Japan

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 of so-called ‘tobuyo-ki’. Why does it happen? What are the reasons and generating perspective? These are 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 Tobuyo-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 550 books of cancer patients are written by cancer patients. The first author, a sociologist examined them from various viewpoints. Tobuyo-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 Tobuyo-ki for authors by using a sociological approach to create a practical and effective program useful in clinical medicine.

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-activeness,’ was suggested to be revealed in writing Tobuyo-ki.

Conclusion: Now that the significance of Tobuyo-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 team was invited to a Grant-in-Aid for Scientific Research, and ethical judgments have been completed. We are now starting the six-month 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?

Jansschem E.1, Deveaux L.1, Laurent F.1
1Ensemble Hospitalier de la Côte, CTR, Aubonne, Switzerland, 2Réseau Santé La Côte, Saint-Prex, Switzerland, 3Réseau Santé La Côte, Équipe Mobile de soins Palliatifs, Aubonne, Switzerland

Presenting author email address: emsparc@hevd.ch

Aims: Checking if a wish of place of death (PDoD) is known by professionals; if yes, is it respected; if no, why not.
Health services research

Abstract number: P1-321
Abstract type: Poster

Transition From Children’s to Adult Services for Young People with Life-limiting Conditions: Findings from Realist Evaluation Research in Belfast and Dublin

Keal H.1, O’Halloran P.1, Nicholl H.2, Price J.1
1Queen’s University Belfast, School of Nursing and Midwifery, Belfast, United Kingdom, 2Trinity College Dublin and Midwifery, Dublin, Ireland, *Kingston University and St George’s, University, Faculty of Health, Social Care and Education, London, United Kingdom

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 their 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 transitional care in 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 beyond childhood, 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 who are currently conducting semi-structured interviews with young people with life-limiting conditions and their carers. A total of 21 semi-structured interviews were conducted.

Results: There is little evidence on transitional care in palliative care, with few models of good practice.

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Aim: 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 pain 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 PCiV in England, the aims were to:

- Describe the current position regarding SPCUs research activity
- Develop understanding about factors which facilitate or hinder research participation for individual SPCUs research aspirations of individual SPCUs and collectively as a region

Methods: A 10-item ‘Survey Monkey’ questionnaire, themed from the ‘Research in Palliative Care’ report, was disseminated in April 2014 to all Consultants, Associate Specialists, Chief Executives, and specific Senior Managerial Staff working within regional SPCUs (n=40). Two reminders were sent.

Results: Thirty-two participants responded (response rate of 80.0%). Four participants only completed the demographic information - leaving 28/40 (70.0%) responders. All respondents reported they were active in collecting routine data for audit purposes with just under half (47.5%) currently undertaking ethically-approved research studies. All localities either had a research policy in place or were in the process of developing one for their local SPCU. All respondents showed an enthusiasm towards the principles of conducting 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’ Need for Palliative Care Estimated on Inpatient Services in the Last Year of Life

Evdokimova E., Voronenko L., Bykova L., Sokolova E.

Regional Center for AIDS Control, Novgorod, Russian Federation, Regional Medical Statistics Center, Novgorod, Russian Federation, State Medical University, Novgorod, Russian Federation

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 municipal medical organisations (79.7±3.0% of all hospital admissions) and 20.3±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 considered as the minimum required for 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

La Cour E., Wahreners E.E., People H., Brandt A.

University of Southern Denmark, Institute of Public Health, Odense, Denmark, Parker Institute, Copenhagen, Denmark, The National Board of Social Services, Odense, Denmark

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 at which they carry out their routines 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 and a WHO functional performance score of 1-3 were included in the study. Participants 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...for a Surgical Ward

Søervel S., Mikkelsen G.K., Sørensen L.T.

Skiernegk Hospital, Digestive Disease Centre, Copenhagen, Denmark

Presenting author email address: lbisbth.soevel@regionh.dk

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 assessment 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 specialist 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, involving 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.

Results: Over 9 months 113 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 and 1% from professionals (caregivers, 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 underline 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


Marie Curie Palliative Care Institute Liverpool (MCPCIL), University of Liverpool, Liverpool, United Kingdom, Royal Liverpool and Broadgreen University Hospitals NHS Trust, Liverpool, United Kingdom

Presenting author email address: tams.mcglinchey@liverpool.ac.uk

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. Explore, refine and evaluate a process for ACP.
2. Evaluate the process with residents, relatives and Health and Social Care Staff (HSCS).

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 EJPCP 21(4);193-5).

AIM: Phenomenological study of residents, relatives 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 (all residents lacked mental capacity): 21 participants (15 relatives; 6 residents; HSCS): 28 interviews completed. Language use: terminology, abbreviations and definitions used resulted in varied understanding across HSCS and caused anxiety for some residents. Best well prepared for engaging in ACP conversations 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 intimation 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

Chen P.-J.,1 Chen Y.-C.,1 Ho C.-H.,1 Chen Y.-C.,2 Chang H.-C.,1 Ho W.-T.1,3 Chen K.-T.1,3 Wang Z.1,3
1Chi Mei Medical Center, Department of Geriatrics and Gerontology, Tainan City, Taiwan, Republic of China, 2Chi Mei Medical Center, Palliative Care Center, Tainan City, Taiwan, Republic of China, 3Department of Family Medicine, Tainan City, Taiwan, Republic of China

Abstract: 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 2009-2011, and surveyed the last one year of life. Caregivers, who were alive 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: 683,389 Dementia+ and 8,260,371 Cancer+ 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+ and Cancer+ were significantly longer (14.4 days vs. 1.6). The majority of specialty who was in charge of hospitalised care for Dementia+ was internal medicine physicians (45.20%). The top three causes of hospital admissions and ED visits among Dementia+ were pneumonia including aspiration related (13.8%), acute respiratory failure (11.7%), 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. 5.1%), endotracheal intubation (52.5% vs. 22.6%), tracheostomy (8.6% vs. 3.5%), invasive mechanical ventilation (58.6% vs. 6.2%), 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+ who 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

Perceptions of Professional Caregivers of People with Intellectual Disabilities on Palliative Care

Christiansen M.G.M.1, Vrijmoeth C.1,2, Van Schooten Lantman de Valk H.2, Groot M.M.1,3
1Radboud University Medical Center, Healthcare for People with Intellectual Disabilities, Nijmegen, Netherlands, 2Radboud University Medical Center, Expertise Centre Palliative Care, Nijmegen, Netherlands

Abstract: 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 palliative 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 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 late 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 what 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: P1-333
Abstract type: Poster

Exploring the Concept of Palliative Rehabilitation: The Active Palliative Rehabilitation in Lung Cancer (APRIL) Study

Payne C.1, Larkin P.J.2,3, McRitchie S.1, Dunwoody L.1, Gracy J.H.1
1Ulster University, Nursing and Health Research, Newtownabbey, United Kingdom, 2University College Dublin, Clinical Nursing Palliative Care, Dublin, Ireland, 3Our Lady’s Hospice and Care Services, Harold’s Cross, Education and Research Department, Dublin, Ireland, 4All Ireland Institute of Hospice and Palliative Care, Research, Dublin, Ireland, 5Ulster University, Psychology Research Institute, Coleraine, United Kingdom

Abstract: 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.

Aims: 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 supportive care.

Methods: The MRC Framework for Developing and Evaluating Complex Interventions was used to design this multiphase mixed methods cohort study. APRIL was developed based on consensus agreement. EDMIC OX (c15:1), PIM1-20, POGGA Geriatric Risk Measurements (6MWT, TSST60) were undertaken at baseline, intervention end and six weeks post completion. Semi structured interviews with patients and healthcare professionals (HCPs) explored experiences of interventions.

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 prior consent. Two patients died within six weeks and three withdrew prior to 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 and Patient: Nutritional rehabilitation: exploring the complex pathways for change. Conclusion: The palliative rehabilitation approach of APRIL was valued by participants involved in the feasibility cohort study. It was determined that palliative rehabilitation altered. Robust evaluation studies within this population are being commissioned by the appeal to recruit sufficient numbers and with issues arising from missing data, response shift and attrition.
Cultural Awareness - Gaps and Views of Palliative Care Providers

Migala S, Bolkadoirov V, Felix U
Freie Universität Berlin, Education and Psychology, Berlin, Germany
Presenting author email address: silke.migala@fu-berlin.de
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 research on the barriers for RSM and the providers 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 aims at 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 only 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

Ramo R 1, Khasha A 1, Prifti P 2, Huto K 2, Amuri E 2, Sera J 2
1Ryder Albania Association, Tirana, Albania, 2University of Tirana, Department of Social Work and Policy, Tirana, Albania, 3University of Medicine, Public Health, Tirana, Albania
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 get started the PC service, but has limited financial resources. The budget of health sector only 9% of the GDP. Most effective strategy to integrate PC in public (HCS), is through regional hospitals (RH) because their low level of the bed occupancy (average 30%). Aim: The aim of the study was to assess the human resource needs (HR), medicaments 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 RH need of PC is the baseline. The 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. The RH need for PC is not only about medicaments availability and usage in all RH as well as a lack of basic PC equipments and materials. Most of RH in Albania have amount of space and medical HR needed for PC, but significant barriers exist concerning trained HR, medicaments, 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 and PC policies. Preliminary outcomes from this pilot regions, theory and practical training of the pilot teams (PT), design the PC guidelines.

Abstract number: P1-337
Abstract type: Poster

ACP CHIO: A Bold, Innovative Knowledge Translation Research Program Studying a Province-wide Implementation of Advanced Care Planning and Goals of Care Designation

Hagen N A 1, Simon J.E. 1, Forchheimer K M 1, Bloodo P 1
1University of Calgary, Departments of Oncology, Clinical Neuroscience, and Medicine, Calgary, AB, Canada, 2University of Calgary, Division of Palliative Medicine, Edmonton, AB, Canada, 3University of Calgary, Division of Palliative Medicine, Edmonton, AB, Canada, 4Covenant Health, Edmonton, AB, Canada, 5University of Calgary, Division of Palliative Medicine, Edmonton, AB, Canada, 6University of Alberta, Division of Palliative Medicine, Edmonton, AB, Canada
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 get started the PC service, but has limited financial resources. The budget of health sector only 9% of the GDP. Most effective strategy to integrate PC in public (HCS), is through regional hospitals (RH) because their low level of the bed occupancy (average 30%).
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Abstract number: P1-337
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 1)
Coordinating and Integrating Palliative Care and Rehabilitation - Why, When, and How?  
Thuesen J., Mikkelsen T.B., Thomsen H.  
RMH, Knowledge Centre for Rehabilitation and Palliative Care, University of Southern Denmark, København K, Denmark  
Presenting author email address: thuensen@rmh.dk

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 separately organised than 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 and integration of PC and R.  

Methods: Medline, Cinahl, Embase and PsychINFO were searched for articles concerning both PC and R associated with cancer, lung disease, neurological disease and disease in the elderly, published between 2000 and 2010 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.  

Discussion: Evidence and strength of evidence; Cultural challenges: Target groups and phases; Arguments to support further coordination; and Patient perspectives.  

Conclusion: 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  
Cobra M., Scvello F., Venosene S., Milo A., Valea A.  
Fondazione F.A.R.O Onlus, Torino, Italy

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 1300 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 weeks.  

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 sexual 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  
Pleschberger S.,1,2 Nohammer E.1  
1Paracelsus Medical University, Institute of Nursing Science and Practice, Salzburg, Austria, 2University of Health and Life Sciences University, Department of Public Health and Health Technology Assessment, Hall in Tirol, Austria

Background: Supporting family caregivers is one of the central aims of hospice day care. This is usually achieved by relieving caregivers 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 with a pre-designed interview sheet about demographic and health-related questions, functional status (ECOG), coping strategies (ESAS and EQ-5D), as well as demographic, psychosocial and quality of care measures. Analyses of variance (ANOVAs) were conducted to identify factors associated with QOL.  

Results: Seventy-nine baseline interviews with advanced cancer patients were completed. Sixty-one percent reported being ‘very much/quite a bit’, 20% ‘somewhat’ and 19% ‘not at all’ satisfied with their care and associated with QOL in this population. The associations between QOL and satisfaction with care and living wills may suggest that patients who are less satisfied with their care and those with living wills may have higher symptom burden and consequently reduced QOL. Further research is needed to identify predictors of QOL by clarifying the directions of the associations to identify specific areas of intervention for improving the care provided to, and QOL of, this vulnerable population.

Abstract number: P1-345  
Abstract type: Poster

Do Engaging with Social Media Benefits Hospices? Case Study Analysis of Four UK Hospices  
Rampanayon Yankiasutachat M., Subramonian S.  
1University of Bedfordshire, Aylesbury, United Kingdom, 2Ellenor Lons Hospice, Northfleet, Kent, United Kingdom

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 across 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 tools to collect publicly available data that include feeds, comments, shares, tweets, status updates from two online social networking sites namely Facebook and Twitter of selected hospices. Using Nivio10®, 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 caregivers 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  
Torres-Vigil I.1,2, Delgado-Guay M.1,2, de la Rosa A.1, Valenzuela-Silva P.1,2, Hernández Becerra B.1,2, Bueno E.1  
1University of Houston, Graduate College of Social Work, Houston, TX, United States, 2University of Texas MD Anderson Cancer Center, Investigating Department of Palliative Care and Rehabilitation Medicine, Houston, TX, United States

Background: Though the evidence based on intervention studies is weak, the 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. 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.

Abstract number: P1-341  
Abstract type: Poster

Days of Dying - Are Patients on a Palliative Care Unit Die on Certain Days?  
Lorenz S.1,2, Nübling G.2  
1Paracelsus Medical University Salzburg, Palliative Medicine, Salzburg, Austria, 2University of Munich, Palliative Care, Munich, Germany

Presenting author email address: stefan.lorenz@pmu.ac.at

Aim: Frequently people working on a Palliative Care Unit have the impression that patients are dying on the weekend. How this symptom management has been 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 data 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 for family caregivers the days on which 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 less likely to die on saturday in 2009 (6%) and 2010 (12%), on thursday in 2006 (16%) and 2007 (18%), on wednesday (16%) and in 2011 it has been sunday (17%).

Presenting author email address: thuensen@rmh.dk

Conclusion: Findings suggest that physical and psychological symptoms are significantly associated with QOL in this population. The associations between QOL and satisfaction with care and living wills may suggest that patients who are less satisfied with their care and those with living wills may have higher symptom burden and consequently reduced QOL.

Further research is needed to identify predictors of QOL by clarifying the directions of the associations to identify specific areas of intervention for improving the care provided to, and QOL of, this vulnerable population.

Abstract number: P1-344  
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 1)
The Norwegian Pilgrimage: Raising Public Awareness on the Human Right to End-of-Life Care

Rønsen A.
Gjøvik University College, Fjellhammer, Norway

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, dignified dying conditions and evaluation of available palliative care services are lacking. Worries about end-of-life care 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 coming 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 trajectory. Activities were organised at specific sites which aimed at open dialogues with people. The pilgrimage was supported by the Norwegian legislation on palliative care.

Lessons learned: The possibility of raising public awareness and advocating for palliative care as a human right through the organization of pilgrimages in European countries and internationally will be discussed.

The Effects of a Promotion Software System for Hospice Shared Care Consultation in a Regional Hospital in Southern Taiwan

Yeng C.-C. 1,2,3,4,5, Luo K.-H. 2, Chen Y.-P. 2, Chen T.-H. 2,3, Tai S.-Y. 3,4,5

Academia Sinica, Taiwan, Republic of China, 1National Taiwan University Hospital, Taiwan, Republic of China, 2Kaohsiung Medical University Hospital, Department of Family Medicine, Kaohsiung, Taiwan, Republic of China, 3Kaohsiung Municipal Ta-Tung Hospital, Department of Family Medicine, Kaohsiung, Taiwan, Republic of China, 4Kaohsiung Municipal Ta-Tung Hospital, Department of Family Medicine, Kaohsiung, Taiwan, Republic of China, 5Kaohsiung Municipal Ta-Tung Hospital, Department of Nursing, Kaohsiung, Taiwan, Republic of China

Purpose: Hospice shared care is a connection from original team to palliative medicine team. However, patients and families are not willing to receive palliative care till patients in the end of life in Asia. According to our national policy and world trend, our aim is to create and evaluate a promotion software system for hospice shared care consultation.

Materials and methods: We start a promotion software system between 2014/2 to 2014/5.

Results: Compared with the numbers of consultation during 2013/2 to 2013/5, the total numbers of consultation during 2014/2 to 2014/5 was increased from 44 (20.7%) to 104 (35.5%). The top three original team whom care stage 3 and 4 cancer patients are oncology (81%), general surgery (66) and chest (47) department, while the top three rate of consultation from original team are hepatobiliary (55%), oncology (48.7%), chest (46.8%) department. However, original team and patients are more and more willing to receive hospice shared care after the system promotion.

Conclusion: Although the result are not achieved our goal yet (consultation rate of stage 3 and 4 cancer over 50%). After the new promotion system for hospice shared care consultation intervention, it had positive effect on increasing consultation rate and build a connection between original team and hospice care.

We Are the Champions: How European Awardedees of the International Pain Policy Fellowship Have Improved Opioid Availability and Accessibility in Europe


University of Wisconsin Pain and Policy Studies Group, Carbone Cancer Center, Madison, WI, United States

Aims: Reiling 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 Fellowship in 2006, 2008, and 2012. The objective of this study is to compare the degree 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 ministers and colleagues, resulting in significant progress towards overcoming barriers to opioid availability in their countries.


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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 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

Petrucc F, IAHPC, Houston, TX, United States
Presenting author email address: kpettus@iahpc.com

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 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. Extensive collaboration with global palliative care leaders and partners in country.

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, but say little about how one makes it so. 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 services having known policy benefits. An important element of the goal became constant monitoring and control of all public funds flow, repair and reconstruction of buildings.

Conclusions: Progression 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 a resolution commanding widespread MS support within 5 years.

Abstract number: P1-352
Abstract type: Poster

Advance Care Planning - The New Establishment Patenternalism

Venne J, Public Health England, Bristol, United Kingdom
Presenting author email address: julia.verne@phe.gov.uk

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 the discussion. Increasingly ACP is enshrined in policy in the health service.

Aim: This study considers whether despite the good intentions, as ACP is implemented, there are risks that this becomes a new establishment paternalistic approach to managing patients at the end of life.

Methods: Reflection on concepts of autonomy and paternalism within the context of Advance Care Planning in the UK using case histories.

Results: ACP is based on a medical model and primarily concerned with decisions about medical care. Here will always be a fundamental imbalance in medical knowledge between the medical practitioner and patient and this can lead to dominance of the medical view. As with all policies there are risks with implementation and case studies reveal that for example the ‘1% campaign’ which encouraged GPs to identify the 1% patients entering their last year of life led some GPs to inform patients of their imminent risk of death and need for ACP without testing carefully if the patient wanted such a discussion. Cancer patients undergoing palliative surgery are furious at being asked whether they want to select a Do Not Attempt Resuscitation (DNAR) during pre-operation. Care Homes are being encouraged to implement ACP and relatives of elderly patients are asked to tick the boxes for DNAR when the patient is admitted.

Conclusion: At its most fundamental ACP is a paternalistic model designed by the medical profession and focussed on illness management. As such it is less professionalised and routinised. There are even greater risks of establishment paternalism if other policies such as reducing emergency admissions and length of hospital stays can be linked to ACP as a route to achieve targets.
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 quality palliative care. However, it is dependent on more than half of patients having a specified palliative care 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, young, divorced, with no career identified and living in bigger cities were prone to die in the acute hospital.

Abstract number: P1-357
Abstract type: Poster

Information Technology and Cancer Patient Reported Outcomes
Shrotiya S.1, Walsh D.2

Introduction: Patient Reported Outcome (PROs) refers to self-reported symptoms, health status measures and quality of life (QoL). They are valid for clinical care and research. Table. 25-30% of PROs collected by TC. Methods: We conducted a retrospective cohort study (2012-2013) of a cancer data registry (aRR=1.23(95%CI:0.99-1.54))

Abstract number: P1-358
Abstract type: Poster

Generalist Primary and Palliative Care is Associated with Few Hospitalisations in the Last Month of Life
Onwuteaka-Philipsen BPH1, de Korte-Verdijk MC1, Schweitzer B1, Franke AL1, Deliens L1, Rozeman PB1

Background: Hospitalisations in the last phase of life may be related to poor quality of palliative care at home. In the Netherlands, that a generalist palliative care model, palliative care is also given by generalists and some hospices.

Abstract number: P1-359
Abstract type: Poster

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
Jeong J.1, Christiansen C.F.1, Nielsen H1, Neergaard M.A.1, Jemmeh A.B.1, Latif K.G.1, Johnson S.P.1

Methods: We conducted a cross sectional survey among Dutch general practitioners (GPs) on their most recent patients that died non-sudden. Of 1601 eligible GPs, 598 responded (37%). Questions were asked on (timings of) hospitalisation and on elements of primary care, generalist palliative care and consultation of specialised palliative care. The relation between these elements and hospitalisation were tested controlling for patient characteristics.

Results: Two primary care elements were related to both hospitalisations in the last week of life and not being hospitalised in the last month of life: having more GP visits two to three times before hospitalisation (OR=2.4 and OR=2.37) and information transfer to-out of-hours GP services more than one week before death (OR=2.02 and OR=1.46). The two palliative care elements studied were only associated to not being hospitalised in the last month of life: recognising that death was near (OR=1.75) and having palliation as the main treatment aim (OR=3.34).

Discussion: Our results show that generalists, especially GPs, can play an important role in providing palliative care at the end of life, when looking at hospitalisations as quality indicators. This suggests that a generalist palliative care model is feasible.
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 to:

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 2012 n MEDLINE, Embase, PsychINFO, 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 characterised by 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: P1-361
Abstract type: Poster

Conceptualization of Suffering in Cancer - A Systematic Literature Review
Bajji S.1,2,3, Groves K.E.1,2
1University of Sydney, Sydney, Australia, 2HammondCare, Palliative Care, Greenwhich, Australia, 3Canter Care Australia, Sydney, Australia, 4Cancer Australia Sydney, Australia
Presenting author email address: snehmer@gmail.com

Aims: PS in Islam is not well described in literature. This report describes the ethical dilemma and challenges in palliative sedation (PS) among Muslim patients in Saudi Arabia.

Case 1: A 56 year male with terminal cancer and lung metastases with significant dyspnea and pain requested to be put to sleep most of the day. He wanted to be unaware of his pain and dyspnea especially during nursing. He believed it is Islamic to request PS as it exempts prayer for the dying. His caregiver didn’t approve of PS, concern was that he will be unable to pray.

Case 2: A 14 year boy with sarcorna and lung metastases with dyspnea in the last hours of life. His father agreed to PS but the boy refused. He wished to be able to perform prayers before death.

Islamic perspective: Prayer is one of the pillars of Islam that must be performed five times a day. However, a sick person is allowed to pray sitting or lying down. A very sick person may be excused from not being able to pray. While it is a rule in Islam that any Muslim should be allowed the maximum time to perform the religious rite of prayer, Islam also allows the prohibited in the face of hardship. Based on this principle many medical interventions, including PS are permissible in Islam.

The counter argument to PS is that suffering at EOL doesn’t merit being unable to pray. PS does not intend to hasten death unlike euthanasia. Islam judges an action based more on the intentions (Niyah) than on the consequences.

The counter argument is that PS may hasten death and this is prohibited.

Physician responses: The attending physicians were Muslims; felt PS for symptom relief is Islamic. The decision of the patient is final.

Conclusions: PS is acceptable to Muslim patients and physicians. The PC team should be aware of these principles while caring for Muslims and document patients’ opinion regarding PS at EOL.

Abstract number: P1-364
Abstract type: Poster

Performance Status and its Association with Quality of Life and Spiritual Wellbeing
Goh S.L., Ho S., Yang G.M., Tan Y.Y., Neo P.S.H.
National Cancer Centre Singapore, Division of Palliative Medicine, Singapore, Singapore

Background: Life limiting illnesses can lead to poor performance status (PS), which may have an adverse effect on one’s quality of life (QOL). Previous studies have shown that PS is related to QOL but the relationship between PS and spiritual wellbeing is less studied. This abstract reports the association of PS with QOL and spiritual wellbeing, which are both important components in palliative care.

Aim: We hypothesise that better PS is associated with better QOL and higher spiritual wellbeing in palliative care patients.

Method: As part of a larger study looking at the effect of a spirituality programme on QOL and spiritual wellbeing of palliative care patients referred to a consultative inpatient palliative care service and a hospice homecare service from March to September 2014, the association between PS with QOL and spiritual wellbeing were analysed. FACT-G, a 27-item questionnaire, was used to measure QOL in physical, social, emotional and functional domains, and SP 12, a 12 item tool, was used to assess spiritual wellbeing. PS was measured using ECOG where scores of 0-2 indicates good PS and scores of 3-4 indicates poor PS. Analysis were done using unpaired T test.

Result: Out of 144 patients, 97 had good PS, and 47 had poor PS. There was a significant difference in QOL between patients with better PS (71±13.6 vs 19) and patients with poor PS (62.78±16.90), t=3.26, p< 0.001. When comparing spirituality wellbeing with ECOG status, there was no statistical significance, t=1.70, p=0.091. However, patients with good PS (33.20±10.31) had a slightly higher spirituality score compared to patients with poor PS (30.04±10.25).

Conclusion: PS is an important outcome of care at the end of life. This study showed that PS was associated with QOL, but not with spiritual wellbeing. This may mean that a patient could have poor PS but still maintain spiritual wellbeing and vice versa. Further studies could be done to assess the effect of deteriorating PS on spiritual wellbeing.

Abstract number: P1-365
Abstract type: Poster

Raising the Bar: Demonstrating Improved Spiritual Awareness in a Critical Mass of the Healthcare Workforce
Kemp L.M.,* Groves K.E.,**
*Terence Burgess Education Centre at Queen’s Court, Southport, United Kingdom, **Cheshire and Merseyside Palliative and End of Life Care Network, Liverpool, United Kingdom
Presenting author email address: education@queencourt.org.uk

Background: A Systematic Literature Review of Spiritual Care (Holloway 2011) undertaken for the End of Life Care Strategy in England highlighted the need for education of frontline staff.

Aim: To assess whether a programme designed to raise awareness, increased the confidence, skills, knowledge and ability to recognise, and address, the spiritual and religious needs of patients.

Method: Two Cancer Networks in the North of England commissioned an experiential awareness raising package consisting of both e-learning and face to face taught components. Facilitators were trained to deliver the face to face (F2F) component locally in a cascade fashion and the e-learning (online) programme was managed and facilitated centrally. Each participant completed an pre and post course questionnaire based on a Spiritual Care Competency Framework (Gordon and Mitchell 2004). The results were analysed together and separately for each mode of learning.

Results: Since 2007,1939 participants have undertaken the course: 1722 F2F, 217 online.
Poster Sessions (Poster Exhibition Set 1)

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 466 participants: 421 for F2F and 215 online. Overall there were statistically significant differences in questionnaire scores obtained for knowledge about understanding and meaning of spirituality, skills in discussing spiritual issues and distress, and confidence in assessment and intervention. Apart from issues around confidentiality and the ability to build relationships with patients and families which were not significantly different. There were only slightly different scores for F2F and online learning.

Conclusions: The study demonstrates 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: Spinal Spirituality: Audit of the Documentation of Spiritual and Religious Needs Assessment and Care in a Regional Spinal Injuries Unit

Gough L1, Groves K1,2
1Southport and Ormskirk NHS Trust, Regional Spinal Injuries Unit, Southport, United Kingdom, 2Southport and Ormskirk NHS Trust, Palliative Medicine, Southport, United Kingdom

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 carried out as 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 many of the goals of care are re-adaptive following significant trauma causing lifestyle change.

Methods: Retrospective audit of 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 had record of 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 Spiritual 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

Poster: Religious Beliefs towards the End of Life among Patients with Chronic Heart Failure and the Relationship with End-of-Life Preferences

Janssens DJLa, Boeyne B, Schindler R, Jao L, Jeker UT, Pisters MEz, Harder Aa, Rickli H1, Brunner-La Rocca PH1
1CIOIO, Department of Research and Education, Horn, Netherlands, 2Maastricht University Medical Centre, Center of Expertise for Palliative Care, Maastricht, Netherlands, 3Maastricht University Medical Centre, Patient and Care, Maastricht, Netherlands, 4University Hospital Basel, Cardiology, Basel, Switzerland, 5University Hospital Leiden, Cardiology, Leiden, Switzerland, 6University Hospital Zürich, Dept of Internal Medicine, St Gallen, St Gallen, Switzerland, 7Maastricht University Medical Centre, Cardiology, Maastricht, Netherlands

Presenting author email address: daisjanssen@ciro-horn.nl

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 76.1 (7.5) years; 62% NYHA class II). 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 among patients with CHF.

Results: 47% were Catholic, 42% Protestant, 5% other and 6% atheist. Most patients were more often preferred ‘Do Not Resuscitate’ (DNR) than Catholic patients (56% vs 32%, respectively, p < 0.05). 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 > 0.05), while feeling supported by religious affiliation, however none mentioned the importance, or otherwise, of this to the patient. None had had record of 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 Spiritual 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: P1-368
Abstract type: Poster

Poster: Mis-use of Spiritual Care as Set-back in Drug Abuse Inheritance in Patient with Chronic Illnesses: Case Observation from a HIV Positive Child in Tanzania

Sinyange A1,2
1,2Urumu Health Care Site, Dar es Salaam, Tanzania, United Republic of

Abstract number: P1-369
Abstract type: Poster

Poster: Impact of Religiosity and Spirituality on Health Information Preferences at the End of Life

Masterson MA1, Rosenvold B2, Pesin H1, Breenhart H1
1Fordham University, Bronx, NY, United States, 2Memorial Sloan Kettering Cancer Center, Psychiatry and Behavioral Sciences, New York, NY, United States

Background: Copious research studies have linked spirituality and religiosity to psychological well-being among cancer patients at the end of life. Furthermore, spirituality and religiosity have been shown to shape patients’ views on end-of-life decision-making about life-sustaining treatments (True et al., 2005). However, little is known about the impact of religiosity and spirituality on health information preferences in this population.

Aims: We aim to examine the impact of religiosity and spirituality on health information preferences, in addition to investigating the contributing roles of anxiety and depression.

Methods: 117 patients from a larger RCT of meaning-centered psychotherapy with non-locally recur and recurrent cancer completed the self report measures capturing demographic information, religiosity, spirituality, health information preferences [Health Information Preferences (HIP)], and anxiety and depression [Hospital Anxiety and Depression Scale (HADS)]. Analysis of variance (ANOVA) compared scores for HIP among participants.

Results: Preliminary results indicate that patients identified as ‘very much’ religious preferred to receive significantly more health information from their medical team, than those identified as ‘not at all’ religious (p < 0.05). No significant differences in HIP scores were identified among patients who reported varying degrees of spirituality. Furthermore, age and HADS scores were not significantly correlated to HIP scores. Additional analyses will explore medical, demographic, and clinical variables that might help predict health information preferences.

Discussion: These results support the notion that religiosity does impact a patient’s preferences at the end of life. Religion, religiosity and spirituality may influence patients’ preference for comprehensive health information regardless of anxiety and depressive symptoms. We contribute to the current literature and provide evidence a unique benefit that religiosity holds at the end of life.

Abstract number: P1-370
Abstract type: Poster

Poster: Reflections on Faith among the Dying in a Secularised Society - A Qualitative Study about Faith among Patients Admitted in Danish Hospices

Mosegaard L1
1University of Southern Denmark, Faculty of Health Science, Odense C, Denmark

Presenting author email address: lem2@udk.dk

Background: Studies suggest spiritual care support may help patients at the end of life cope with their imminent death and improve their quality of life. Denmark is known for secularism with low levels of religious belief and practice when Danes are compared with other nations. Thus, it is problematic to track perceived gains from research in more religious societies about spirituality into a Danish context. There is a knowledge gap about the significance and character of spirituality among Danish dying patients; therefore it is difficult to develop and implement targeted spiritual support in hospices.

Aim: To illuminate how Danish patients admitted to hospice on their last stages of life.

Methods: Data were generated through ethnographic fieldwork comprising 17 semi-structured interviews with dying patients and 38 days of participant observation at three hospices.

Results: Five themes were combined into three categories. The category 'knowing' reflected that patients expressed a cognitively weak conceptual framework for faith although they believed in something transcendent and in afterlife. Their faith was influenced by Christianity but in varying ways. The category 'living' demonstrated they lived out their spiritual praxis where most were embedded in habitual and uncertain manners. The category 'being' exposed several patients with intensified focus on their vague articulated faith such as could be imbued with what Alexis had described as an 'inner light'.

Conclusion: In this study Danish patients at the end of life had a hesitant but important faith
construct when coping with death. It is crucial to support patients regardless of their religious coping strategies or struggles. Yet, how to support patients in praxis is complex and perhaps even more so in more religious societies because of these patients’ weak cognitive framework for faith.

Background: Although spirituality is an integral part of palliative care, it is often under-acknowledged. 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) Well-being Scale was developed to measure spiritual wellbeing in patients.

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% found it useful for exploring spiritual issues, 69% for opening up conversations with patients, 50% for building rapport and 50% for identifying spiritual problems. Four found FICA burdensome because 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, 69% for opening up conversations with patients, 50% for building rapport and 50% for identifying spiritual problems. Four found FICA burdensome because it was time-consuming, especially for fatigued patients. However, when asked if they would recommend it to colleagues, 94% said yes.

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.

Audit of the Facilitation of Spiritual Care for Patients by Clinical Staff at the EllenorLions Hospice, UK

Green N1, Subramaniam S2
1EllenorLions Hospice, Gravesend, United Kingdom, 2EllenorLions Hospice, Palliative Medicine, Gravesend, United Kingdom

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 and 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 EOL Strategy was: ‘People approaching the end of life... 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.’

Objectives: To assess whether some 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 affiliation, Exploration of spiritual needs (either conducted or considered); Consideration given to potential chaplaincy involvement.

Methods: 45 patients electronic records were reviewed in total -15 each from inpatients (IPU), Home care (HCT) and Day therapy (DTU).

Results: The recording of religious affiliation was more consistent on IPU (93%) than either the HCT or HCT (both 73%). Performance in each of the 3 categories considered by this audit fell short of the set targets: Religious was recorded in 80% of cases compared to the goal of 95%. Spiritual Care Needs were assessed or considered in 41.5% of patient assessments compared to the target of 80%. Chaplaincy Referral was offered or thought of in 29% of instances, against the aim of 67%.

Discussion: Reflection on the demographic mix of the audit population and the potential effect on results suggest a number of interesting questions for future research regarding factors that might affect the assessment of spiritual care needs. We plan to reaudit further to this.
Social care and social work

Abstract number: P1-377
Abstract type: Poster

Analysis on Causes of Hospital Death Despite the Preference for Home Death: Cases of Liver Cancer Patients Home-cared at End-stage

Shino H., Aoyagi J., Yamakoshi M., Ruzuta K., Fujisawa Y., Naozaki-Taguchi N., Shenmiji E., Sato Y.
1Tomishiro Central Hospital, Anaesthesiology and Palliative Medicine, Tomisuguji, Japan
2Chiba University, Palliative Medicine, Chiba, Japan
3Yusuke Nanbu Hospital, Palliative Medicine, Itoman, 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. While 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, 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 obtained more detailed 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.

Abstract number: P1-378
Abstract type: Poster

Problems with Palliative Care Systems for Advanced Cancer Patients in Large Metropolitan Areas

Keio University, Palliative Care Center, Tokyo, Japan

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 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.

Abstract number: P1-379
Abstract type: Poster

Social Care Intervention for Cancer Patients in the Adult Outpatient Clinic

Simion A.
Fundatia Hospice Casa Sperantei, Brasov, Romania

Introduction: Our palliative care outpatient clinic for adults is staffed on a daily basis with doctor and nurse and access to social worker, psychologist consultation pharmacy services, etc as required. The social worker has the task to step into an existing doctor patient relationship and to form also quickly a trustful relationship with the patient and the family by offering support for getting access to various benefits.

Aim: To determine the social worker’s interventions implemented in the care plan of adults patients in the outpatient clinic.

Method: A quantitative, retrospective study has been conducted between January 1st to September 30th, 2013. All patients that required diverse social care interventions were included in the study and data were collected from their charts.

Results: 100 patients were identified in the reviewed period. Of them 51 were women and 49 men; 66% urban area and 34% from rural area, mean age group was 51 to 60 years and was represented by 40 patients. Interventions performed were assessment of social needs and counseling for all 100 patients, support for obtaining handicap certificate and disability pension 100 %, information and facilitation in obtaining new location of address in the ID card for 33 persons (for patients coming at end of life from other regions of the country in order to benefit from free medical care they have to have a local address), identifying financial resources for 62 beneficiaries and their family.

Conclusion: Social worker’s interventions in the outpatient clinic for adults are challenging. Good knowledge and understanding of specific legislation, the existing social network available locally for underserved communities is crucial.

Abstract number: P1-380
Abstract type: Poster

The Role of the Social Worker in the Adults’ Day Care Center

Benedek I.
Fundatia Hospice Casa Sperantei, Brasov, Romania

Background: Our organisation offers palliative care services in several settings: home care, ambulatory, inpatient unit, day center, hospital teams, urban and rural area. In the day center we care for cancer patients with good performance status (ECOG 1 and 2). Our services are free of charge and offered by a multidisciplinary team. There is a part time social worker attached to the day care team to evaluate the patients’ social needs and offer interventions.

Goal: To understand the role and work of the social worker in the day centre.

Method: Retrospective study reviewing interventions of the 39 patients conducted in the day centre between September 17th, 2013 and September 30th, 2014. Patients’ charts and social worker’s reports were analysed creating an excel database.

Results: In the period of time studied, all 39 patients (100%) enrolled in day care have benefited by the interventions of the social worker. 50 patients (54%) received - on a monthly basis, social support| food package, clothes; for 60 patients (65%) the social worker has obtained or renewed the handicap certificate (a certificate giving some financial benefits to holders), 21 patients (23%) benefited from or have had renewed the medical pension. Other interventions of the social worker consisted in 429 visits to local public authorities (social departments, town hall, legal offices) and 1112 social counselling sessions with an average of 12 sessions per patient.

Conclusion: The social worker is the spokesperson of the patient negotiates on behalf of the patient, in order to access social benefits, have legal rights respected and ensure and offers direct care especially counseling for problems like social isolation, anxiety, financial support for the patient.

Abstract number: P1-381
Abstract type: Poster

Palliative Care Social Work Roles and Tasks Vital for Patients and their Families

Firth P.H., Bithrontou K.
Independent Consultant in Psychosocial Palliative Care, St Albans, United Kingdom
1Hospice Vorarlberg, Feldkirch, Austria
2Presenting author email address: pfrinh79@btinternet.com

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 has published the professional capabilities framework and work has begun to link concepts and ideas from the two publications.

Aim: A qualitative and descriptive 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-soctal 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

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015


End of Life Process as Observed by those Who Faced Death Most

Dogan S., Deniz M.B., Kahveci S., Kantar G.
Istanbul Medipol University, Istanbul, Turkey
Presenting author email address: sdogan@medipol.edu.tr

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’ situations and their own emotions may feel despair and may not provide support to 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 interdisciplinary team members who had direct contact with patients 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 hopelessness while providing care to a patient in 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

Gryscheck G., Hatanaka F.B., Machado D., Lima M.C.P.
1Medical School of Botucatu, State University of São Paulo, Department of Public Health, Botucatu, Brazil, 2Medical School of Botucatu, State University of São Paulo, Department of Anesthesiology, Botucatu, Brazil, 3Medical School of Botucatu, State University of São Paulo, Department of Neurology, Psychology and Psychiatry, Botucatu, Brazil
Presenting author email address: ggryscheck@gmail.com

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 has investigated the impact of RCOPE on psychological aspects, especially in PC settings. Aim: investigate RCOPE and depressive symptoms association in patients under Palliative Care in Botucatu State University Medical School.

Methods: cross-sectional study on a convenient sample of Ambulatory PC patients. Besides sociodemographic data, the relation between depressive symptom, RCOPE and other explanatory variables were investigated. Hospital Anxiety and Depression Scale (HADS), BriefRCOPE, Activities of Daily Life Scale (ADLS) 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±12.8; women: 65.0%; Caucasian: 65.0%; married 52.3%; living with partner 47.7%; 43% had cancer diagnosis) constituted the sample. On the HADS the mean score was 72.75±16.8 and 65.0% were independent on activities of daily life (ADL). Depressive symptoms were present in 40.0% (CRPS 24.1-55.9%). The mean score of positive and negative ROPE were 3.62±0.27 and 1.38±0.56 respectively. Multivariate analysis has revealed an association between depressive symptoms and major use of negative coping (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 tool probably has 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

Hofmann S., Hess S., Stöppel C.
University Hospital Erlangen, Friedrich-Alexander-Universität Erlangen-Nürnberg, Department of Palliative Medicine and Comprehensive Cancer Center, CCC Erlangen - EMN, Erlangen, Germany

Background: Psychological burden is common in patients with advanced or terminal diseases. This study aims to determine 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 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/confusion considering groups with none or minor (1) and rated symptom and severe (grade 2 and 3) and rated symptom faced by patient (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/disorientation/confusion. 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,
Dying Care and Spiritual Support Interventions in End-of-Life Care in Intensive Care Unit Patients

Kisvetrová H.1, Škáloková D., Měchlová Z., Končina I.
Palacký University Olomouc, Faculty of Health Sciences, Department of Nursing, Olomouc, Czech Republic
Presenting author email address: helena.kisvetrova@upol.cz

Background: About 17% patients are dying in the intensive care units (ICU) in Czech Republic. End-of-life care (EOLC) should be focused on not only biological symptoms but also on spiritual suffering, patient dignity and support the family’s efforts. Dying Care and Spiritual Support interventions should be used for patients at the end of life.

Aims: The authors studied a usage of Dying care and Spiritual Support interventions in EOLC in ICU patients in the CR and found the affecting factors.

Methods: The cross-sectional study with ad hoc questionnaire with Likert’s scales and activities of Dying care and Spiritual support interventions was performed. The set composed of 277 nurses (mean age 38.5 years; mean practice 9.2±6.8 years). Mann-Whitney U-tests and Pearson correlation were used for statistics.

Results: The most and the least frequent activities were Treating the patient with dignity (mean 1.28; SD 0.77) and Giving the patient expressed willingness to discuss death (mean 3.01±1.21). The significantly negative correlations were detected between the length of hospitalization and activities in psychological (r=-0.209, p<0.001), social (r=-0.207, p<0.001) and spiritual (r=-0.218, p<0.001) dimensions. Contrary, activities in psychological, social and spiritual dimensions positively correlated with personal conditions (r=0.216, r=0.301, r=0.330, p<0.001), nurse time options (r=-0.158, r=-0.301, r=0.312, p<0.001) and education about EOLC (r=0.271, r=0.209, r=0.270, p<0.001). The regard of nurses to death, frequency of care for the dying patients, the difficulty of communication with the dying patients and their families did not affect the frequency of activities in studied dimensions.

Conclusion; discussion: Nurses in ICU give the priority to the dignity of the patient’s perception in EOLC in the CR. Further research should focus on factors that affect the EOLC in preserving the dignity of dying patients. Supported by grant FVZ_2014_007.
Burnout Syndrome in Staff Working with Children with Incurable Diseases

Christine Mathe T., Moscov D.1,2
1Hospice Casa Sperantei Brasov, Brasov, Romania, 2Transylvania University Brasov, Brasov, Romania, 3Hospice Casa Sperantei, Edineț, Romania

Abstract type: Poster

Burnout Syndrome in Staff Working with Children with Incurable Diseases

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...”

Aim: Identification of elements of burnout syndrome in staff working with children with incurable illnesses

Method: Survey of pediatric staff using self-administrated Maslach Burnout Inventory (MBI) questionnaire with 22 items on 3 domains: emotional exhaustion, depersonalisation, low level of personal achievements. 5 units were selected to include: oncology, pediatrics, departments (OP), ICU, long term care (LTC) and pediatric palliative care (PCC) units.

Results: Out of the 170 professionals surveyed, 129 valid questionnaires were returned (99%-75.8%). There was a balanced representation of various units: 22.18% OP departments, 25.11% ICU staff, 27.91 PPC units, 24.84% LTC. 98.45 respondents were women; 97% had a full time job; 55.04% nurses, 23.26% aid nurses, 11.65% doctors, 10.9% others. The largest group (30.2%) were those with 5-10 years of work experience; for 98.4% belief in God was rated as very important, 82% being orthodox Christians. The domain most influenced was personal achievement: 48.35% high and moderate burn-out (nurses being the main group as profession 52.86%; PCC 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% don’t recognise their need of specialised support especially senior staff (p < 0.05), as well as people who are severely or moderately burnt out 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

Monforte-Royo C.1, Bellido-Pérez M.1, Porta-Sales J.1-4, Tomás-Sábado J.1, Ardila-Herrero A.4, Balaguer A.2,3
1Universitat Internacional de Catalunya, Nursing, Sant Cugat del Vallés, Spain, 2Universitat Internacional de Catalunya, WeCare Chair: End of Life Care, Sant Cugat del Vallés, Spain, 3Institut Català d’Onologia, Palliative Care Unit, L’Hospitalet Barcelona, Spain, 4Universitat Internacional de Catalunya, Medicine, Sant Cugat del Vallés, Spain, Escuela Universitaria d’Infemenia Gimbernat, Nursing, Sant Cugat del Vallés, Spain

Presenting author email address: cmonforte@uic.es

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 wide 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 underlining 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 a definition that fulfilled each of these conditions.

Conclusion: An agreed operational definition of the WTHD would allow better communication both within and between groups of researchers and clinicians.

Abstract number: P1-391
Abstract type: Poster

Photo Making in Hospice: Can the Process of Constructing Images Restore the Changed Self-Image that Accompanies the Diagnosis of a Life-Limiting Illness?

Mortimer A.1,2, Day R.1, Broom K.1, Perkins P.1
1Sant Ryders Lockingham Court Hospice, Day Hospice, Cheltenham, United Kingdom, 2Birmingham City University, Institute of Art and Design, Birmingham, United Kingdom, 3Gloucestershire Hospitals NHS Foundation Trust, Palliative Medicine, Cheltenham, United Kingdom

Presenting author email address: ami.mortimer@virginmedia.com

Background: Photography and self-portraits have been used in healthcare, yet no study has documented the experiences of hospice patients’ participation. Our hospice has recently started to offer patients the option to make self-portraits/portrait photographs.

Aims: To explore the lived experiences of day hospice patients participating in the self-directed photographic portraiture experience.

Methods: Audio-taped semi-structured interviews were conducted using a topic guide. Interviews were transcribed and analysed using narrative analysis. Seven respondents were interviewed: three patients, two hospice staff observers and two photographers. Fourteen interviews were conducted - each participant was interviewed before and after the photographic session.

Results: The following themes were identified during analysis:

- The participants constructed photographs to represent who they are rather than focussing on their illness.
- Participants chose not to reinforce the more negative elements of illness progression but rather to accept them.
- Life-limiting illness, ageing and treatments damage the patient’s sense of self. This may be experienced as a form of grief or loss.

Conclusion/discussion: Patients provided unique insights into the experiences of changes that come with life limiting illnesses, articulating losses that resulted. In all cases the patients felt a profound difference between the image they held of themselves and the photographs they created. Patients said they benefited from this methodology of reflective photographic self-portraiture. This study straddles both arts and healthcare. The results have helped shape this intervention for future patients.

Abstract number: P1-393
Abstract type: Poster

Profile of Quality of Life and the Interplay of Anxiety Disorders among Individuals with Breast Cancers in Nigeria

Adeyemi J.1, Fatiregun O.A.1,2, Erinfolami A.R.1, Fatiregun O.A.3, Arogunmati O.A.4, Adeyemi J.D.1
1Lagos University Teaching Hospital/College of Medicine, University of Lagos, Department of Neurology, Nigeria, 2Lagos University Teaching Hospital/College of Medicine, University of Lagos, Department of Neuropsychiatry, Lagos, Nigeria, 3Neuropsychiatry, Federal Neuropsychiatric Hospital Yaba, Lagos, Nigeria, 4Lagos State University Teaching Hospital, Ijera, Oncology, Lagos, Nigeria, 5Population Council, Lagos, Nigeria

Presenting author email address: solagunjuj@unilag.edu.ng

Background and aims: Quality of life (QOL) is simultaneously recognised as a useful measure of outcome in cancer. This study investigates the influence of anxiety disorders on QOL in cohorts with breast cancer in a developing context.

Methods: The study participants consisted of 200 consenting females with breast cancer. Designed questionnaire was used to elicit their socio-demographic and clinical profile. European Organisation for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ-C30) was administered to assess QOL across functioning and symptom domains. This was followed by interview with the anxiety subscale of Hospital Anxiety and Depression rating Scale (HADS) to ascertain presence of anxiety disorders.

Results: The mean age of participants was 49.6±11.2 years, 76.5% were married, and 76.5% had anxiety based on HADS score of 8 and above. Anxiety disorders correlated positively with lower mean scores on all the breast cancer QOL functional scale domains, however with higher mean scores on the symptom scale (p<0.05).

Conclusions: In this study, varied degrees of impairment in functioning and worse experience of symptoms were observed; with anxiety disorders constituting determinant of QOL. Multidisciplinary-based management of breast cancer having full complement of supportive care is implied.

Abstract number: P1-394
Abstract type: Poster

Profile of Quality of Life and the Interplay of Anxiety Disorders among Individuals with Breast Cancers in Nigeria

Adeyemi J.1, Fatiregun O.A.1,2, Erinfolami A.R.1, Fatiregun O.A.3, Arogunmati O.A.4, Adeyemi J.D.1
1Lagos University Teaching Hospital/College of Medicine, University of Lagos, Department of Neurology, Nigeria, 2Lagos University Teaching Hospital/College of Medicine, University of Lagos, Department of Neuropsychiatry, Lagos, Nigeria, 3Neuropsychiatry, Federal Neuropsychiatric Hospital Yaba, Lagos, Nigeria, 4Lagos State University Teaching Hospital, Ijera, Oncology, Lagos, Nigeria, 5Population Council, Lagos, Nigeria

Presenting author email address: solagunjuj@unilag.edu.ng

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Conclusions: In this study, varied degrees of impairment in functioning and worse experience of symptoms were observed; with anxiety disorders constituting determinant of QOL. Multidisciplinary-based management of breast cancer having full complement of supportive care is implied.

Abstract number: P1-394
Abstract type: Poster
The Impact of Group Cohesion on Clinical Outcomes in Advanced Cancer Psychotherapy Groups

Poster Abstract number: P1-395  

type: Poster

Pessini H.1, Marziliano A.2, Rosenfeld B.1, Brento A.1  
1Memorial Sloan Kettering, Psychiatry and Behavioral Sciences, New York, NY, United States  
2Fordham University, Psychology, New York, NY, United States

Presenter author email address: pessini@mskcc.org

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 (MQOL), posttraumatic stress (PTS), 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: Stronger cohesiveness in psychotherapy groups for advanced cancer appears to increase 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 group focus was members providing mutual support.

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The Interrelationship of Death Anxiety and Coping Mechanisms with the Attitudes towards Hospice Palliative Care in Hungary and in English Speaking Countries

Poster Abstract number: P1-397  

type: Poster

Szöv étA.1,2  
1Lund University, Dalby, Sweden  
2Hungarian Hospice Foundation, Budapest, Hungary

Presenter author email address: szovagre@gmail.com

Background: Although hospice care in Hungary is becoming well-known, in everyday practice there are numerous questions rising 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 survey was to collect data on the interplay of death anxiety and coping mechanisms with the attitudes towards hospice palliative care and to the extent shed some light on the relationship between these factors.

Methods: The participants of this study (N[HUN]=128 ; N[ENG] =25) filled in an anonymous online questionnaire that contained items related to death anxiety, coping mechanisms, spiritual well-being (meaning and peace); quality of life (social and existential); and spiritual well-being (meaning and peace). The Interpersonal Reactivity Index (IRI),镀灵 was used to measure the perception of control over their physical activity after this pragmatic, inclusive group therapy.

Results: Significant differences were found between the groups for the Anxiety and Depression Scale. A multivariate logistic regression model with the generalised estimating equation was performed to examine longitudinal changes in and determinants of clinical anxiety.

Conclusion: The proportion of cancer patients suffering from clinical anxiety (HADS-A scores ≥11) increased as death approached (17.20%, 21.65%, 26.39%, and 33.22% at ≥1, 6-10, 11-30, and >30 days before death, respectively). However, after controlling for other confounders, prevalence of clinical anxiety did not change significantly over the dying process (except for the motoric status). Anxiety at end of life (EOL) was not associated with demographics and disease-related characteristics. Cancer patients suffered from more severe symptom distress, perceived higher sense of burden to others, and reported stronger social support were significantly more likely to experience clinical anxiety at EOL.

Funding was provided by National Cancer Institute - Grant # R01AT00184201.
Research methodology

Abstract number: P1-400
Abstract type: Poster

Utilising Data from Social Media in Palliative Care Research: Developing an Ethical Framework

1Marie Curie Palliative Care Research Centre, Cardiff University, Medicine, Cardiff, United Kingdom, 2School of Health Care Sciences, Cardiff University, Health Care Sciences, Cardiff, United Kingdom, 3CLIC, Sergent, Bristol, United Kingdom
Presenting author email address: hopewell-kellyn@cardiff.ac.uk

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 repositioned within research environments as potential sources of publically 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 the 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.

Discussions: 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)

Loepp B., Peeters S., Faiqnoort L., Wens J., Van den Eynden B., Research Group Palliative Care, University of Antwerp
University of Antwerp, Primary and Interdisciplinary Care Antwerp, Antwerp, Belgium
Presenting author email address: bert.leysen@uantwerpen.be

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 Care Pathway for Primary Palliative Care (CPPPC) and to involve some of their PC patients and to do so the same. Although 30 FP have been included yet, recruitment has consumed more time than expected in advance.

Aims:
- To describe barriers and facilitators for FP to start participating in a research project involving some of their PC patients.
- To evaluate the effectiveness of the strategies used to recruit FP and PC patients for this project.

Methods: Following the principles of action research, interviews with FP having showed interest will be done. Conclusions of these interviews will be on both a practical level, to improve the recruitment process of this particular project, and on a theoretical level, to improve the generalisability of the findings for both primary care and palliative care research.

Results: So far, 25 FP were included of 42 FP reached by practice visits. This strategy has been more successful than continued medical education sessions (CME): only 1 FP included of 41 FP reached. Even FP's showing clear interest in the project had to be asked by the research team proactively whether they wanted to participate. More elaborated results will be available in May.

Discussion: Both primary care and palliative care research are research domains which are considered highly relevant for public health. It is important to find more effective ways to recruit participants in both these domains. Reporting the recruitment process of this project could help in this task.


Abstract number: P1-402
Abstract type: Poster

Study Limitation or Crucial Information? Understanding Missing Data in Palliative Care Research

Kohli E., Liu Y., Rosenfield B.
1Colorado Blood Cancer Institute, Psychosocial Oncology, Denver, CO, United States, 2Fordham University, Bronx, NY, United States

Studies conducted in palliative care often suffer from high rates of attrition largely due to disease progression. Yet, little attention has been devoted to the best way to handle missing data in palliative care research when attrition is high due to disease progression and death. The goal of this study was to provide an example of the treatment of missing data in palliative care research.

Data for this study were drawn from a larger cross-sectional study of decision-making capacity and neuropsychological functioning in terminally ill cancer patients. Participants were 58 terminally ill adults (ages 58-89 years) at an inpatient palliative care and 50 healthy adults. Study participation included a one-hour interview involving a semi-structured interview, measures of neuropsychological and psychological functioning. Multiple imputation was used to estimate the value of missing data. Only 36.3% of the terminally ill sample (n = 20) provided complete data, notably 15.5% (n = 9) expired before completing the study, and 15.5% (n = 9) became too confused or ill to continue. Five imputed datasets were created using a linear regression model. The variables included in the imputation process included the reason for incomplete data, demographic variables, neuropsychological variables, and outcome variables. This resulted in a more complete and accurate dataset that allowed for the conduction of planned analyses.

The high rates of attrition largely due to disease progression and resulting confusion, delirium, and death, led to a large amount of missing data. Multiple imputation analyses including the reason for missing data is a possible solution for better accounting for the experience of terminally ill patients. The issue of missing data in palliative care research warrants further discussion. Rather than viewing this as a weakness of the study, efforts must be made to appropriately treat missing data.

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Social Spaces and Singular Encounters: Challenges to Conducting Qualitative Research Interviews in Palliative and End of Life Care in the Home Setting

Sivell S.1, Proud H.1, Bailey J., Byrne A., Edwards M.1, Hamper E.1, Noble S., Sampson C.1, Nelson A.1
1Cardiff University School of Medicine, Marie Curie Palliative Care Research Centre, Institute of Cancer and Genetics, Cardiff, United Kingdom, 2School of Healthcare Sciences, Cardiff University, Cardiff, United Kingdom, 3Swansea University, Centre for Innovative Ageing, School of Human Sciences, Swansea, United Kingdom, 4Cardiff University School of Medicine, Institute of Cancer and Genetics, Cardiff, United Kingdom

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 experienced researchers 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

Kinley J.1, Froggatt K.2, Preston N.3
1St Christopher’s Hospice, London, United Kingdom, 2Lancaster University, Faculty of Health and Medicine, Lancaster, United Kingdom

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 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 test research into 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 coordinators or associated with (external facilitators) 36 care homes and included interviews, surveys, Facilitator Activity Logs and a researcher’s diary. After separate quantitative (descriptive) and qualitative (thematic template) data analysis the data sets were integrated by ‘following a thread’.

Results: A total of 18 patients, 5 carers, 28 professionals provided 51 interviews, and 23 action plans.

Conclusion: ‘Following a thread’ enabled epistemological triangulation. More became known about the role of facilitation when the findings from data generated by two or more methods were brought together.
The Challenge of Gaining Access to Informal Caregivers in the Advanced Heart Failure Population in Ireland

Doherty L.C. a, Fitzsimons D. a,b, McClonkiv S. a,b, Daghlian F. a,b, Fagan C. a,b
1Ulster University, Institute of Nursing Health Research, Belfast, United Kingdom, 2All Ireland Institute of Health and Care, Dublin, Ireland, 3Belfast Health and Social Care Trust, Belfast, United Kingdom

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 (ii) brain natriuretic peptide > 400 pg/ml or (ii) 1 unscheduled hospital admission in the previous 12 months or (iii) on IV diuretics during the previous 12 months were invited to take part.

Access to the caregivers was via the patients. Data was collected on demographics, depression, anxiety, QoL, patients' perceived social support and illness beliefs, caregiver burden, needs assessment and preparedness for caregiving.

Results: The total sample size was 36% for patients and caregivers respectively. Given that access to the caregivers was via the patients, caregiver’s participation was mandated not only by the patient’s gatekeepers but additionally by the patients themselves.

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 carer’s experiences is a research priority. Although, 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, 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

Prabhoo P.1, Quenett S.1, Kermoah W.G.2
1University of Dublin Dublin, School of Psychology, Dublin, Ireland, 2Ulster University, Institute of Nursing and Health Research, Newtownabbey, United Kingdom

Presenting author email address: luca.prabhoo@ucl.ac.uk

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 unrefined 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 4816 remained for review by two researchers. Preliminary agreement for inclusion/exclusion was 78%, with approximately 19% 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 PARRH 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 into practice among caregivers and 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 Palliative Care (SHPPC)

Lindemann D.1,2, Fisher M.1,3, Wiesen M.1,2
1Pediatric Palliative Care Service, Dr. von Haunersches Kinderspital, Ludwig Maximilians-University, Munich, Germany, 2Katholische Stiftungs-fochschule Munich, University of Applied Sciences, Munich, Germany

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 (PCC) network maps were used as a tool for the caregivers to document their social support network on their own perspective. Aims: 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 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.

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 analyses.

Results: The new role demanded a 150% increase in volunteers and involved: Meeting with existing volunteers, explaining proposed changes and taking feedback Recruitment days 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 hospice 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 on going 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 Asklepian Tradition? Value of End of Life Volunteering According to Volunteers themselves

GosSENS J.1, SakkERS M.1
1University of Humanistic Studies, Utrecht, Netherlands

Presenting author email address: a.gossens@uhv.nl

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 does volunteering bring to the volunteers themselves?

Methods: A website of the Dutch national branch organisation VPTZ[1] was visited by 130 volunteers’ letters; 100 of these were processed by a qualitative discourse analyses.

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 personal growth related to 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 presencing, as well as to the so-called Asklepian tradition as described by Randall and Dowme (2010).

[1]Volunteers Palliative Terminal Care (The Netherlands)
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 designed, one for each of the groups targeted, and participants were invited to complete one of them. The participants were asked to describe their relationship with oncology nurses.

Aim: The study was designed to examine volunteering in hospice and palliative care in Poland.

Background: In Poland, volunteering is present in hospice and palliative care. Volunteers help patients and their families, as well as perform various services for non-patient-facing volunteers.

Aims: The study aimed to examine the role of volunteers in hospice and palliative care in Poland. The core volunteer roles were to provide spiritual care, support patients, and families, and perform various services.

Methods: A cross-sectional survey was conducted. An anonymous questionnaire was administered to hospice directors from Polish hospices who cooperated with volunteers.

Results: 28 Polish hospices took part in this survey. More than 1 in 4 volunteers were involved in patient care, and 32% of them were involved in administrative tasks. Volunteers were divided into two groups: those who were involved in care and those who were not.

Findings: Findings indicated that volunteers were vital to the ability of hospices to provide the level and range of services required.

Conclusions: Volunteers are essential to the hospice volunteers' training. Hospice volunteers are trained in a variety of spiritual needs in patients and families. They are expected to identify spiritual distress and work with disrupted beliefs and value systems. The expert discussion highlighted that hospice volunteers need a proper end-of-life training that involves spirituality and SC.

Abstract number: P1-414
Abstract type: Poster

National Hospice Volunteer Program Development in Hungary

Csikos A.,1 Busa C.,1 Shaffer J.,1 Korzó K.,1 Zana A.1,2

1University of Pecs, Pecs, Hungary, 2Pecs-Baranya Hospice Program, Pecs, Hungary

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 in quality and content. The majority of hospice services have no volunteers trainers to implement training programs.

Aims: To examine the influence of volunteers on key aspects of the service.

Methods: A qualitative study with a hermeneutic-phenomenological approach was conducted. Participants were invited to participate in a group interview. The participants reported about their current state of volunteering at the unit they manage.

Results: 28 Polish hospices took part in this survey. More than 1 in 4 volunteers were involved in patient care, and 32% of them were involved in administrative tasks. Volunteers were divided into two groups: those who were involved in care and those who were not.

Findings: Findings indicated that volunteers were vital to the ability of hospices to provide the level and range of services required.

Conclusions: Volunteers are essential to the hospice volunteers' training. Hospice volunteers are trained in a variety of spiritual needs in patients and families. They are expected to identify spiritual distress and work with disrupted beliefs and value systems. 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

Patients’ with Advanced and Terminal Cancer Reported Experience: The Importance of Nurses’ Way of Caring

Eirini-Ibarondo B.1,2, Perez M.1, Carrasco LM.3, Carvajal A.1, Lorumbe A.1, Lomma M.1,4, Arantzamendi M.1

1University of Navarra, Pamplona, Spain, 2Spanish University Clinic, Pamplona, Spain, 3Hospital San Juan de Dios, Pamplona, Spain

Background: The nurse-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 patient. Nurses’ way of caring plays a decisive role in the patient’s experience. Patients talked about the relationship with nurses refer to their way of caring considering the following aspects:

1. The way in which nurses take care of patients is an expression of their way of being.
2. Patients feel nurses close through their words and actions.
3. The affection and love of nurses is an essential element of the care.
4. Patients are treated as persons despite their health condition and limited lifespan. As such, they are cared in a holistic way considering their physical and social dimensions.

Aims: To understand the nurse-PATC relationship and to identify its essential elements from patients' 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 nurses.

Results: In the illness global experience of the PAtC, nurses play a decisive role. Patients felt 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.

Conclusions: The way of being of nurses and their way of meeting the PAtC is central when caring for them. Therefore, professionals have to face different experiences in training nursing, because the patient’s attitude that lead to care patients as holistic persons with affection and closeness.

Abstract number: P1-417
Abstract type: Poster

Cancer
Abstract number: P1-418
Abstract type: Poster

Lung Cancer Diagnosed Following an Emergency Admission: Exploring Patient and Carer Perspectives on Delay in Seeking Help

Caswell G.1, Seymour J.1, Crosby V.1, Alston F.1, Freer S.1, Wloch A.1
1University of Nottingham, School of Health Sciences, Nottingham, United Kingdom
2Nottingham Trent University, Nottingham, United Kingdom
3University of Nottingham, School of Medicine, Nottingham, United Kingdom
Presenting author email address: glenys.caswell@nottingham.ac.uk

Background: Compared to others, patients diagnosed with lung cancer following an emergency, unannounced admission to hospital (DEFA) have more advanced disease and poorer prognosis. Little is known about DEFA patients' beliefs about cancer and its symptoms, or about their help-seeking behaviours prior to admission. Aims: We sought to gather DEFA patients' understandings of their symptoms and to discover what help, if any, they had tried to access prior to their emergency admission.

Methods: A single centre, prospective mixed methods study conducted in one University hospital to the secondary care characteristics, needs, experiences, and outcomes of lung cancer patients DEFA/not DEFA. We undertook qualitative interviews with DEFA patients and their carers. An ad hoc memoire was developed to obtain patients' and carers' understandings of symptoms and experiences of trying to access health care services before admission to hospital. Interviews were recorded and transcribed. Framework analysis was employed. Results: 13 patients were recruited out of a total of 50 DFEA patients, plus 3 carers of patients who were delay from visiting their GP. No significant difference was observed in age, race, and symptoms, or about their help seeking behaviours prior to admission.

Abstract number: P1-421
Abstract type: Poster

Experiences of Living with, and Undergoing Life-prolonging Treatment of, Metastatic Castration-resistant Prostate Cancer - A Qualitative Study

Doveon S.1, Shin S.2, Chisholm G.3, Williams J.1, Frisbee-Hume S.1, Bruera E.1
1University of Nottingham, School of Health Sciences, Nottingham, United Kingdom, 2University of Nottingham, School of Medicine, Nottingham, United Kingdom, 3University of Nottingham, School of Nursing, Nottingham, United Kingdom
Presenting author email address: sandra.doveon@shh.se

Prostate cancer is the most common form of cancer amongst men in both Sweden and Europe. Despite the disease has metastasised, and is no longer sensitive to hormonal (castration) therapy, it is considered incurable. However, since a few years back men at this stage of the disease have the opportunity to undergo different life-prolonging treatments. The knowledge about the effect of these treatments on different patient-reported outcomes 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 including 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 patients' situations 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 could mean living 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 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 Sophiahemmet research fundings and County council of Sörmland.

Abstract number: P1-422
Abstract type: Poster

Hypocalcaemia in Cancer Patients: An Exploratory Study

Ferraz Gonçalves J.A.1, Costa T.2, Rema J.1, Pinto C.1, Magalhães M.1
1Portuguese Institute of Oncology, Palliative Care, Porto, Portugal, 2Portuguese Institute of Oncology, Porto, Portugal, Hospital de S. João, Porto, Portugal, Hospital de Faro, Faro, Portugal, USF Barão de Nossa Senhora do Monte, Porto, Portugal
Presenting author email address: fernazaj@sopporto.rn-saude.pt

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 irritability. The patient had 832 patients hospitalised in the cancer centre (116% of bed occupancy), 19 patients (22%) were considered as palliative patients according to the SFAP definition. Patients mean age was 63 years old (35 to 87). Solid tumors were the most frequently observed pathologies (74%), mainly gynaecologic malignancies. Scheduled treatment was the main motivation for hospitalisation (63%), followed by acute medical problem (32%). Most patients (95%) received specific treatment in the last month, to improve overall survival in 74% of them, according to the physicians. 85% of palliative patients were painful or uncomfortable and 37% were under the care of a PCST.

Conclusion: Our work is the first French study revealing a high prevalence of palliative impact on health care. The questionnaire was part of the research project questionnaire.

Abstract number: P1-420
Abstract type: Poster

Characteristics and Outcomes of Advanced Cancer Patients (AdCa) Evaluated by a Palliative Care Team (PC) at the Emergency Center (EC)

Delgado Guay M.O.1, Shm S.2, Chisholm G.1, Williams J.1, Frisbee-Hume S.1, Bruera E.1
1The University of Texas MD Anderson Cancer Center, Palliative Care and Rehabilitation Medicine, Houston, TX, United States
2Kovin University, Internal Medicine, Busan, Korea, Republic
3University of the Texas MD Anderson Cancer Center, Biostatistics, Houston, TX, United States

Background: PC-EC partnerships are proposed as a way to increase earlier access to PC for AdCa. However there is limited research about clinical issues and outcomes of PC at the EC. Methods: A retrospective chart review of 200 consecutive AdCa referred to PC from the EC and 200 consecutive PC patients from inpatient hospital services(39%) between 1/1/2010 and 12/31/2011. Demographics, frequency/intensity of ESAS-symptoms and PC interventions and outcomes were recorded. Results: Median time(IQR) from visit to PC was 12 hours(7-23) v. 24 hrs(24-96) from IPC; p< 0.0001. The main reasons for EC visit vs. IPC were uncontrolled pain(62%(82%) v. 89%/4%, p< 0.0001), GI issues(80%(41%) v. 38%(19%), p< 0.0001), and dyspnea(58%(20%) v. 38%(19%), p< 0.0001). Median time(interquartile range) of ESAS-symptoms in EC vs. IPC were: pain(75%(59%) v. 52-81, p< 0.0001), fatigue(74%(48%) v. 61-84, p=0.0557), sleep(60%(48%) v. 41-71, p<0.06). Other symptoms not significantly different: PC provided multiple not different interventions: opioid management, psychosocial antiaemics, and counseling. PC changed Not resuscitation status from 38%(19%) to 89(45%, p< 0.0001). In the two groups, at follow up ESAS-improvement/decrease ≥2 points was: pain 73(53-95)% v. 51(31-77)%); sleep 61(36-94)% v. 45(24-71%), anxiety 51(32-71)% v. 38(19-61)%; appetite 46(31-53)% v. 35(19-55)%; dyspnea 49(1603)% v. 32(10-32)%; nausea 52(7103)% and depression 36(12-92)% After PC, 65(33)% of AdCa in IPC were discharged home with follow up.13(7)% home hospice, 86(4%) inpatient hospice unit, 65(33)%admitted to regular floor, 46(23%) to palliative care unit. Conclusion: EC referral provided earlier access to PC. EC AdCa had more severe pain and 43% of AdCa were never admitted and could have missed PC-IPH.
Abstract number: P1-423
Abstract type: Poster

**Palliative Care in a Day Hospice Setting: The Experience of Policlinico San Matteo, Pavia**


Policlinico San Matteo, Medical Oncology Division, Supportive and Palliative Care Unit, Pavia, Italy

Presenting author email address: chiara.gandini@msmtavo.it

**Introduction:** Early Palliative Care in recent years is becoming more widely taken into account. It’s therefore emerging the need to develop organisational models aimed at an early integration of specific treatment and supportive care, to ensure a soft transition from active treatment to palliative care. We present our experience with advanced oncological patients in outpatient palliative care (OPC) setting.

**Methods:** A retrospective analysis of cases followed in the Day Hospice for Palliative Care between 01/01/2013 and 10/22/2014 was conducted. Data were extracted from medical records and the reports of the multi-professional team.

**Results:** 81 patients (pts), 46 males, mean age 72 years (range 43-91), were selected; main cancer diagnosis was considered.

**Conclusion:** The transition between active treatment and palliative care can be a critical stage in which feelings such as fear of abandonment, difficulty in adaptation and uncertainty for the future may emerge in both the patient and the family. Although in a limited sample, our experience of an early transition to an OPC setting appears favorable. Through a multi-professional team is possible to carry out proper treatment plan to ensure an easier transition between active and palliative care.

Abstract number: P1-424
Abstract type: Poster

**The Use of Transdermal Fentanyl in Patients with Cancer Cachexia - A Review of the Evidence**

Harvey K, Shepherd R.

Strathcarron Hospice, Strithirling, United Kigdom

Presenting author email address: karen.harvey@nts.hss

**Background:** The transdermal route for administration of medication is felt to be preferable for some patients by avoiding the need for oral tablets or injections and aims to provide a constant rate of drug delivery. Fentanyl is a potent mu-agonist appropriate for use in patients with cancer.

**Aim:** To review the evidence for the use of transdermal fentanyl in patients with cancer cachexia.

**Methods:** Following the admission of a patient to a specialist palliative care unit who had developed cancer related cachexia and new inconstant episodes of opioid toxicity and withdrawal symptoms while using a fentanyl patch a review of the evidence for the use of transdermal fentanyl in patients with cachexia was undertaken. This was performed by searching Medline, Embase and Cochrane) using the terms cancer, cachexia and fentanyl with subsequent hand search of references.

**Results:** Pharmacokinetics of fentanyl differ in patients with cachexia compared to normal weight. Review of literature suggests this is seemingly a result of structural and physiological skin changes, hypobulbminema and altered metabolism. Low BMI alone does not seem to affect this. The proportion of fentanyl absorbed but fentanyl is highly protein bound and hypobulbminema has been shown to be associated with lower serum fentanyl levels. Fentanyl is metabolised by CYP3A4 which exhibits reduced activity in patients with cachexia. Xerosis (dry skin) is commonly seen in patients with anaorexia nervosa, likely also to be a factor for patients with cachexia and reduced skin hydration reduces fentanyl absorption. This evidence will be discussed further here.

**Conclusion:** Patients with cancer cachexia can have unpredictable responses to transdermal fentanyl and so extra care must be taken with its use.

Abstract number: P1-425
Abstract type: Poster

**Health Promotion in Palliative Care - Is it Possible?**

Nestelund K.C.F., Sebek L.

Aarhus University Hospital, Gynecological and Obstetric, Aarhus, Denmark

**Aim:** In Denmark it is considered good clinical practice to offer patients requiring palliative care an open access to hospitalisation. Research and clinical experience show, however, that open access is not always a guarantee for a good palliative care in a hospital context, where the overall focus is predominantly on curing rather than caring.

**Approach:** The study took place in a Danish University Hospital at a regional centre for the surgical treatment of gynaecological cancer cases. It provides a series of proposals as how to improve the organisation of palliative care in a hospital context, based on principles of early detection of palliative challenges.

**Results:** A health promotion intervention that focuses on early interventions based on interdisciplinary collaboration and patient involvement was developed. The follow-up resulted in the National Board of Health’s programme for rehabilitation and palliation in relation to cancer and is responsible for the Danish comprehensive palliative care in terms of early network conversations with the patient and her family.

**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 focuses on patient involvement. By involving patient and relative perspectives and challenge these with research-based knowledge about palliative care, it is possible to bring forth life as well as life quality, also in the mordern palliative phase. The concept andros to patient and family, involvement, continuous training in healthcare communication, interdisciplinary collaboration, and in some cases it may prevent the need of specialised palliative care.

Abstract number: P1-426
Abstract type: Poster

“Are’s Well That Ends Well”: Or Is it?

Kirk P.

Wakato Hospital, Palliative Care, Hamilton, New Zealand

Presenting author email address: peter.kirk@wakato.dhb.health.nz

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 1.2 million cancer survivors in the United States of which thr majority 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, chemotherapeutic and radiation treatments.

The aim of this study to determine by literature review the prevalence of symptoms and symptom clusters in adult cancer survivors.Disease specific toxicities will be described.

The five most common long term symptoms in cancer survivors include fatigue, difficulties in concentration, sexual function problems in both men and women, depression, nausea and other pain modalities. Although the range of symptoms encompasses all of those seen in palliative cancer patients who are not in remission, and have limited life expectancy. In one study more than 50% of patients reported that they did not receive adequate medical help in addressing and remedying these symptoms.

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 specialty consultation.
Multidisciplinary Consultative Meeting (ICPC) 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 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 so 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 RCP supportive care in helping palliative time with suspension of CT is highlighted by the difference between these two services. Supportive Care CPI lead us to ask some 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

Nutritional Strategies in Head and Neck Cancer (H&N) Patients in Palliative Care (PC)

Machado Coutinho L.C. 1, Faria da Lima M.T. 2, Carvalho R. 1, César R. 1

1Divino Espirito Santo Hospital, UFF, Presidente Prudente, São Paulo, Brazil; 2Delhi Medical College, New Delhi, India

Background: Pigment loss, nutritional impact most visible in HNC patients, is multifactorial and very common. Malnutrition could be a treatment consequence, normally RT with QT, or due to the cancer anatomic localisation; however, usually malnutrition is present before diagnosis. Nutritional Support (NS) in PC must be guided by the gold standard: give patient's comfort; personalised, oriented by a multidisciplinary team, which should include a nutritionist, according to patient's taste and preferences and talked to families; to contribute to their quality of life.

Aim: Develop a decision tree with NS strategies for patients with HNC, in PC.

Methods: Based on binging clinical experience, identify which factors more contribute for non nutritional intake in patients with HNC, in PC.

Results: It was observed that the conditions that most affect the nutritional intake were: dysphagia, anaemia, dysphagia, dysphagia, obstruction, mucositis, nausea and vomiting, early satiety by anorexia, anorexia, chewing difficulties, diarrhoea, constipation and loss of teeth. Almost all patients in the late stage of the disease, when they arrive to PC team, patient Percutaneous Endoscopic Gastrostomy (PEG) or Nasogastric Tube (NGT) feeding that enables NS, not always tolerated. So: evaluate whether the oral feeding is tolerated, otherwise introduces hypercaloric nutritional supplements when chewing ability/swallowing is maintained. If not, ponders the PEG or NGT placement, and choose for complete polymeric formulas (standard/hypercaloric/normol low volume tolerance, rich/low fiber - constitution/darkness) or semi elementary formulas. It should be emphasised that the NS is intended only to maintain, does not seek improvement of nutritional status.

Conclusions: NS is terminal ill patients still a conflict factor between health professionals and careers/family. In PC, NS must always be present, as a measure of comfort and life quality for patient and families.

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 Unit and a Specialist Palliative Care Unit (SPCU) in England

Mayled C.R.1, Fullarton M.2, Pybus S.3, Rogers S.N.1, Mason S.R.1

1Marie Curie Cancer Care Institute Liverpool (MCPCIL), University of Liverpool, Liverpool, United Kingdom; 2Aintree University Hospital, Liverpool, United Kingdom; 3Liverpool Medical School, Liverpool, United Kingdom

Background: Up to half of all H&N cancer patients will die from their illness and require palliative support. End of life care is especially challenging due to the profound impact the illness and treatments have on different organ systems and the perceived risk of acute catastrophic events.

Aim: To evaluate mode of death and quality of care in the last weeks of life provided to H&N cancer patients within a region. EPLS, an analog-located SPCU in England.

Method: A retrospective case note review was used to collect demographic and clinical details for all H&N deaths between 2007 and 2012 at the two sites. 'Sudden death' (SUD) was defined as the mode of death being in a rapid or unanticipated manner. 'Expected death' (ED) was defined as the mode of death being gradual and anticipated. Analysis was conducted using descriptive statistics.

Results: There were 105 patient deaths (89 on the H&N unit; 16 on the SPCU). 29 were excluded due to missing records. Of the remaining 76 patients, 63 died in the H&N unit and 13 in the SPCU. SPCU patient's younger (mean age 63 years) compared with hospital patients mean age 70 years). The majority of patients had stage IV disease (H&N unit 45/57 (78.9%) and SPCU 9/13 (69.2%).

33/76 (43.4%) patients had a SUD and 43/76 (56.6%) had an ED. Major haemorrhage was the most common cause of death (n=13) and carcinoma (n=7) or pneumonia (n=14) were the most common causes of ED. The Hospital Specialist Palliative Care Team were the most common cause of death (n=13) and carcinoma (n=7) or pneumonia (n=14) were the most common causes of ED. The Hospital Specialist Palliative Care Team were involved in 12/33 (36.4%) SUD and 34/43 (79%) ED, although this was often very close to death (mean 2 days before death and 1.4 days for ED) and despite 33 patients (43.4%) having documented pain in the last week of life.

Conclusion: Dying from H&N cancer can be very acute because of the unpredictable complication trajectories and.context. Sensitive communication with patients and families about this eventual as well as proactive palliative care involvement would help improve quality of care.
the reduction of antioxidant enzymes and the increase of oxygen. At last, oxygen saturated situation is created and irradiation becomes more effective.

**Results:** There was no harmful events in KORTUC. The therapeutic effects were good. KORTUC is thought a safety and effective option for cancer.

**Conclusions:** We believe that most cancer patients might release from any problems and get more freedom by KORTUC. We hope this new treatment-KORTUC will spread all of the world.

**Abstract number:** P1-434  
**Abstract type:** Poster

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**Infections Related to Central Venous Catheters in Palliative Care Patients**

**Authors:** Martin-Urriola S.1, Pascual Pía F.1,2, Manchieto Álvora A.1, Basca Mayans M.1, García Lozano T.1, Egoigonzález A.1, Olarte Ramírez E.1, Ruiz Ortiga P., Vicente Benavente M.1, Sanz Aldana M.1, Palliative Care Research Group (GRICPAL-UCV)

**Background:** Infections related to central venous catheters (IR-CVC) are complications with a high prevalence and potentially serious consequences.

**Objectives:** To determine the prevalence of these infections in palliative care patients (PCP), etiology and associated bacteremia and identify possible preventive measures.

**Methods:** Prospective observational study, a cohort of all PCP hospitalised for fever and suffered consecutively related bacteremia between January 2011 and December 2012.

**Results:** 19 episodes in 16 patients were analysed. 3 two times. Mean age 63 (range 54-81). 17 wearied Porth-a-cath. One a drum and one a Hickman. 11 women. 9 Breast, 5 bowel, prostate and glad blade: 1 and one gastricc, ovary, lymphoma. 6 with chemotherapy. Etiology of bacteremia and IR-CVC: coagulase negative Staphylococcus: 7; S aureus: 5; Pseudomonas aeruginosa: 2; Proteus mirabilis: 1; Escherichia coli: 1; S epidemidis: 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 GN and fungi. Early catheter lock all allowed keeping them.

**Abstract number:** P1-435  
**Abstract type:** Poster

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**Engagement in Everyday Activities for People with Advanced Cancer at Home**

**Authors:** Peoples H.1, Brandt A.2, Woelbers E.2, La Cour K.1, Ruissalo O.2,  
1University of Southern Denmark, Odense, Denmark, 2The National Board of Social Services, Odense, Denmark, 3Parker Institute, Frederiksberg, Denmark

**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 participants’ 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 transcribed 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.

**Conclusion:** 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

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**Parenteral Hydration Therapy at the End of Life**

**Authors:** Pérez DA.1, Allende S.1, Urbina M.1, Arcate C.2,  
1Instituto Nacional de Cancerología, Cuidados Paliativos, Distrito Federal, Mexico. 2 Presenting author email address: danapecas@hotmail.com

**Background:** 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 Edmonton Symptom Assessment System (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 functional impairment, was obtained. The most prevalent symptoms and higher scores on ESAS were with a prevalence of 16% and an average intensity of 5 ESAS, poor appetite with an average of 16% and 4.9 ESAS, drowsiness 14%, 4.4 ESAS. Upon completion of the outline of the most prevalent symptoms hydurations 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 (71 down to 3% final), he 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 moisturing 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 moisturising effectiveness in these patients.

**Abstract number:** P1-437  
**Abstract type:** Poster

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**Why Does Advanced Cancer Kill? A Review of the Literature**

**Authors:** Schofield G.1, Giampa G.1, Urbich C.1, Stebbing J.1,  
1Imperial College London, Division of Surgery and Cancer, London, London, United Kingdom.  
Presenting author email address: guy.schofield@imperial.ac.uk

**Background:** In the United Kingdom there has been a recent call for more research into the biology of dying and separately into prognostic 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.

**Results:** 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 death and their role in death of the organism as a whole (Search 3). (Death OR Patient Death) AND (Anoikis 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.

**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 an area in need of study.

**Abstract number:** P1-438  
**Abstract type:** Poster

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**Teenagers Treated Like Children and Expected to Act like Adults**

**Authors:** Seller P.1,  
1St Christophers Hospice, Young Adults, London, United Kingdom

**Background:** Examines 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.

**Results:** 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 of 12 referrals TYA from September2013 - September 2014.  
- Initial conversations with TYA by acute staff  
- Total of 12 referrals TYA from September2013 - September 2014.

- TYA symptom control/palliative care interventions alongside oncological
Abstract number: P1-439
Abstract type: Poster

Antimicrobial Use in Patients with Advanced Cancer: The Experience of a Palliative Care Unit (PCU) in Rio de Janeiro, Brazil
Ramadas L.1, Carmo N.2, Barroso P.3,4
1INCA, Nocissorial Infection Control Committee, Rio de Janeiro, Brazil, 2Universidade Federal do Rio de Janeiro, School of Medicine, HUCIF, Rio de Janeiro, Brazil, 3INCA, Palliative Care Unit, Rio de Janeiro, Brazil

Aims: To describe the characteristics of antibiotic use in patients with advanced cancer at a PCU in Rio de Janeiro, Brazil.

Methods: This was an retrospective 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 646 courses. Average time of antimicrobial use was 8.1 days and in 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), no 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 (131 ± 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 antimicrobials 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 Unit and New Perspectives
Sugita Y.1, Takada S.1, Chihama F.C.1, Yamamoto T.1,2
1Niho University Itabashi Hospital, Obstetrics and Gynecology, Tokyo, Japan, 2Niho University Itabashi Hospital, Tokyo, Japan

Purpose: Although our hospital has no palliative care unit, 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 intervention by the PCT and conducted a comparative investigation. The items included in the project was influential in palliative care being seen as an extra layer of support alongside treatment. The perception of palliative care from health care professionals was of interest. The project was instrumental in changing perceptions and illustrates the benefits of developing shared care.

Method: We quantified 78 items, to the extent possible, in patients who received palliative care from health care professionals. The project was influential in palliative care being seen as an extra layer of support alongside treatment. The perception of palliative care from health care professionals was of interest. The project was instrumental in changing perceptions and illustrates the benefits of developing shared care.

Conclusions: The perception of palliative care from health care professionals was of interest. The project was instrumental in changing perceptions and illustrates the benefits of developing shared care.

Abstract number: P1-442
Abstract type: Poster

About a Case of Lateral Amyotrophic Sclerosis (LAS): A Multidisciplinary Intervention
Amorim A.M.1
ULSNA EPE, Palliative Care Unit, Portalegre, Portugal

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 one old male, 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 care team used their technical, scientific and emotional resources to overcome the struggle 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

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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.
Using the Surprise Question in Renal Out-patient Clinics: How Many Patients Might Be in the Last Year of Life?

Background: National guidelines recommend the identification of Advanced Kidney Disease (AKD) patients in the last year of life to enable advance care planning and improved end of life care. The Gold Standard Framework (GSF) Prognostic Indicator Guidance (PIG) exists to aid the identification of these patients and is a useful way to assess the potential demand in a given patient population.

Aim: To survey the renal outpatient population using GSF-PIG at a large hospital trust to estimate the number of patients who might be in the last year of life. This represented a measure of demand as part of a quality improvement project.

Method: A proforma with GSF-PIG prompts (including those for renal disease) was completed by the Consultant Nephrologist for each patient seen in renal clinic over a two week period. Other details included Stage of Chronic Kidney Disease (CKD), Diagnoses, Comorbidities and current treatment for CKD.

Results: Of the 160 patients in 15 clinics, 30 (20%) were identified as potentially being in the last year of life. The ‘Surprise Question (Would you be surprised if this patient were to die in the next few months, weeks, days?) was the most significant indicator. The majority of these patients (Stage 4 and 5 CKD) and the comorbidities were cardiovascular disease and diabetes. 30% of these patients were receiving conservative management for their renal failure.

Conclusion: Using GSF prognostic indicator guidance in a hospital renal out-patient setting was both achievable and relevant and identified a significant proportion (20%) of renal out-patients as being potentially in the last year of life. These findings will be used to inform service development of hospital and community palliative care for patients with renal disease and allow appropriate end of life care planning in keeping with patients’ wishes and within published guidelines.

Poster Sessions (Poster Exhibition Set 1)

Poster number: P1-445
Poster type: Poster

The Need of Palliative Care for Patients with Rheumatic Diseases - Opinion of Rheumatologists

Bektowski A.¹,², Chopnicki M.¹, Deskur-Smielecka E.¹, Graczyk M.¹, Kapowicz A.¹, Kulis M.¹, Malec Z.¹, Mierzejewska M.², Zyczkowska A.²

1NZOZ Remedium, Szepin, Poland, 2Queen of Apostles Home Care Hospice by Medi Kompleks Sp. z o.o. [Ltd], Wisniowka, Poland, 3Poznan University of Medical Sciences, Department of Biology and Environmental Protection, Poznan, Poland, 4Poznan University of Medical Sciences, Chair and Department of Palliative Medicine, Poznan, Poland, 5Nicolaus Copernicus University, Collegium Medicum in Bydgoszcz, Chair and Department of Palliative Care, Bydgoszcz, Poland, 6St Lasarus Hospice, Cracow, Poland, 7Marian Fathers’ Home Care Hospice, Warsaw, Poland, 8Pomeranian Medical University, Department of Rheumatology and Internal Diseases, Szczecin, Poland

Presenting author email address: iaadco@gmail.com

Background: The World Health Organization (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 of 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 outpatient departments 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, SScL and 35% - systemic lupus erythematosus, SLE). The most frequently reported distressing symptoms among RA patients were pain 94%, disability 72% 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 respondents have never treated their patients with strong opioids. 78% rheumatologists reported 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, SScL and SLE). There is a need for collaborative efforts by the relevant organisations to supply palliative care for patients with advanced rheumatic diseases.

Poster number: P1-447
Poster type: Poster

Phase 2 Randomised Controlled Trial of Future Care Planning in Patients with Advanced Heart Disease

Boyd K.¹, Robertson S.², Cudmore S.², Hight G.², Donald L.², Hage K.¹, Weir C.², Mumpf S.², Denwr M.²

1NHS Lothian, Department of Palliative Care, Edinburgh, United Kingdom, 2NHS Lothian, Edinburgh Heart Centre, Edinburgh, United Kingdom, 3University of Edinburgh, Edinburgh, United Kingdom, 4University of Edinburgh, Centre for Population Health Sciences, Edinburgh, United Kingdom, 5University of Edinburgh, Primary Palliative Care Research Group, Edinburgh, United Kingdom

Presenting author email address: kirsty.boyd@luht.scot.nhs.uk

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 = 6.6), 68% male, mean Charlson comorbidity index was 4.2 (SD = 1.7), median Canadian frailty scale = 5 (mild frail). Intervention and follow up is currently on-going and detailed findings will be ready for presentation by April 2015.

Conclusions: Findings from this small pilot trial demonstrate that the intervention and outcome measures were feasible and deliverable. Further analysis will provide evaluable information on the nature and feasibility of a larger clinical trial sufficiently powered to address hard clinical end-points.

Poster number: P1-448
Poster type: Poster

Hospice Enabled Dementia Care

Crowther J.¹, Cooper M.², Richardson H.²

1University of Liverpool, Academic Palliative and Supportive Care Studies Group, Liverpool, United Kingdom, 2Help the Hospices, London, United Kingdom, 3St. Christopher’s Hospice, London, United Kingdom

Aims: Identify existing good practice in dementia care within UK hospices. Identify barriers for hospice in working with pwd. Develop a model of hospice enabled care not referred to FPC. Develop a resource to support and guide hospices in engaging with people with dementia and their carers.
Meeting the Needs of Patients with a Non-cancer Diagnosis in a Hospice Environment
Horlick C., Docking B., Greaney M., Smith E., Haye C.
Witold Hospice St John’s, Liverpool, United Kingdom

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. To understand the problems identified in patients with non-malignant disease, and the outcome of initial specialist palliative care assessment.

Methods: Retrospective case note analysis was undertaken of referrals to the hospice for patients with a non-cancer diagnosis over two 6-month periods, 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 problems identified after initial assessment were dyspnoea (79%) and low mood (48%). 58% of patients assessed were referred to the hospice day therapy service; 23% of those referred declined day therapy after their initial visit. At the end of the study period 43% 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: P1-451
Abstract type: Poster

Renal Palliative Care in Spain. An Epidemiological Approach
Lina Santos JL1, Sánchez Hernández R1, Gutiérrez Bejarano D1, Gómez Tenell JL2, Martínez Castillo A1, Alonso Bacoño A1
1Saavedra Urdar, Care, Málaga, Spain, 2Hospital General de Segovia, Nefrología, Segovia, Spain, 3Hospital General de Segovia, Medicina Familiar y Comunitaria, Segovia, Spain, 4Hospital Dr. Peset, nefrología, Valencia, Spain, 5Hospital de Bellvitge, nefrología, Barcelona, Spain, 6Hospital Universitario La Paz, Palliative Care, Madrid, Spain

Background: Certain patients with end-stage kidney disease (ESKD) can benefit more from conservative kidney management (CKD) than renal replacement therapy (RRT). An estimated percentage of patients die after withdrawing dialysis. Early incorporation of renal palliative care (RPC) could improve their quality of life.

Aims: Identify and quantify the need for RRC in patients, stage 4 and 5 ESKD in Spain. Furthermore, describe the care that is currently offered and the degree of involvement of palliative care (PC) teams.

Methods: A survey of the nephrology services that are registered with the Sociedad Española de Nefrología (SEN, Spanish Renal Society).

Introduction: Certain patients with end-stage kidney disease (ESKD) can benefit more from conservative kidney management (CKM) than renal replacement therapy (RRT). An estimated percentage of patients die after withdrawing dialysis. Early incorporation of renal palliative care (RPP) could improve their quality of life.
Results: 56% of the 190 hospitals responded to the survey (84% public, 7% private, 7% privately managed). A total of 10,835 patients were recorded. CKM is generally offered as an additional option for ESKD treatment. 45% of hospitals offer CKM. 9% of patients choose CKM, most due to functional deterioration, high comorbidity and 45% having been monitored for more than two years in consultation. 3% of dialysis patients die after withdrawing RRT, 75% of them in a hospital. In 35% of these withdrawals, no advanced palliative care plan has been developed, in 50% of these cases because no PC teams are available. 18% of patients receiving haemodialysis (HD) would not surprise their nephrologist if they died during the course of the next year (p = 0.0000001).

Conclusions: One in four patients with ESKD will require IPC. The study results reveal certain epidemiological facets of patients with ESKD receiving CKM in Spain. They could form the basis for building specific IPC strategies that support Spanish Nephrology in resolving difficult situations specific to ESKD.

Keywords: Renal palliative care, conservative kidney management, dialysis withdrawal.

Abstract number: P1-456
Abstract type: Poster

Patients with Progressive Lung Disease Need to Know More about Palliative Care - Qualitative Longitudinal Study on Patient Perspectives

Nasr N.1, Storzer H.2, Schneider N.1, Nauck F.1, Mars G.1
1University Medical Center Goettingen, Clinic for Palliative Medicine, Goettingen, Germany, 2Hannover Medical School, Institute for General Practice, Hannover, Germany
Presenting author email address: maximilian.nasr@stud.uni-goettingen.de

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 ± 20 p; interviews with family members. Analysis using grounded theory.

Results: First results show different consequences related to the experience of the diagnosis 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. physiotherapy, 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.

Conclusion: During treatment, the implementation of accompanying psychosocial and nursing support is indicated for patients and relatives in both groups. An open professional approach for the needs of patients with progressive lung diseases, extensive information about the benefits of complementary therapy (psychosocial and general nursing support) can conduce to maintain the quality of life. An early informing by general practitioners with integrating palliative care can further relieve the home health care and reduce the burden of disease for patients and family members.

Abstract number: P1-457
Abstract type: Poster

The Assessment of Cognitive Change in Motor Neurone Disease / Amyotrophic Lateral Sclerosis

Oliver D.1
1University of Kent, Centre for Professional Practice, Chatham, United Kingdom
Presenting author email address: d.j.oliver@kent.ac.uk

Background: There is increasing awareness of the prevalence of cognitive change in motor neurone disease (MND) / amyotrophic lateral sclerosis (ALS) with 15% of patients showing evidence of frontotemporal dementia (FTD) and evidence of other cognitive change - primarily frontal lobe dysfunction - in up to 50%. The Edinburgh CognitiveAssessment Scale has been developed to help identify people with cognitive change.

Objective: This study was to see if the ECAS could be used within the normal clinic setting and to investigate the prevalence of cognitive change.

Methods: 10 patients were assessed during an extended outpatient clinic appointment or in the day hosp. Patients who had severe problems communicating, were anxious about their care and deterioration or were unwilling to be involved were excluded.

Results: 10 patients were assessed: 30% were male, the mean age was 62 years, the mean time from diagnosis to testing was 45 months and the mean ALSFRS-R score was 28. The ECAS was easy to administer and took 20-30 minutes. Of the 10 patients one had previous evidence of severe cognitive change, with FTD. Four patients had results below the cut-off level for cognitive change and had not been considered as having cognitive change, although three were positive on a short test - and were not able to say at least 10 words starting with B in 1 minute. 3 patients were just above the cut-off level.

Conclusion: The ECAS was easy to administer within a clinic or home setting and took on average 20 to 30 minutes and did identify people who showed evidence of possible cognitive change. This has enabled the team to be more aware of these issues and to be proactive in the discussion of issues of care including advanced care planning. It has also allowed the team to share the results with carers and other professionals involved in the person’s care to be aware of possible issues in decision making and help them cope with the deterioration of the patient’s condition.

Abstract number: P1-458
Abstract type: Poster

Development of Consensus Review on Palliative Care for Patients with Progressive Neurological Disease

Oliver D.1, Borasco G.D.1, Carecino A.1, De Visser M.2, Grosio W.1, Lorenz S.1, Veronesi S.1, Volda R.1,2
1University of Kent, Centre for Professional Practice, Chatham, United Kingdom, 2Centre Hospitalier Universitaire Vaudois, Service de Soins Palliatifs, Lausanne, Switzerland, 3Fondazione IRCCS Istituto Nazionale dei Tumori, Palliative Care Unit, Milan, Italy, 4University of Amsterdam, Department of Neurology, Amsterdam, Netherlands, 5Kaiser Franz Josef Hospital, Department of Neurology, Vienna, Austria, 6Paracelsus University, Institute of Nursing Science and Practice, Salzburg, Austria, 7Fondazione Azienda e Ricerca in Oncologia, Turin, Italy, 8University Hospital of Cologne, Department of Palliative Medicine, Cologne, Germany

Background: A joint working group of the European Association for Palliative Care and the European Federation of Neurological Societies (European Academy of Neurology) collaborated in considering the available evidence for the palliative care in progressive neurological disease, including amyotrophic lateral sclerosis, multiple sclerosis, Parkinson’s disease, stroke and primary brain tumours.

Aims: To produce a consensus paper, aims, showing the important areas for consideration in the palliative care for people with neurological disease.

Methods: A literature search was undertaken looking at the main areas of palliative care and neurology. A review was formulated and this was then commented on by a small group and
The Development of a Multidisciplinary Clinic to Improve Respiratory Care of People with MND/ALS

Olive D.J.1, Baneenga S.1, Vincent-Smith L.1
1University of Kent, Centre for Professional Practice, Chatham, United Kingdom, 2Wisdom Hospice, Rochester, United Kingdom, 3Medway Maritime Hospital, Department of Respiratory and Sleep Medicine, Gillingham, United Kingdom

Background: There is increasing awareness of the role of respiratory support for people with motor neuron disorder/motor neurone disease (MND)/amyotrophic lateral sclerosis (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 clinics are monitored regularly for the symptoms and signs of respiratory dysfunction and joint clinic 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 outcomes of all patients seen within the joint palliative care/respitory medicine clinics have been evaluated over a two year period. Results: 9 patients have been considered 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 have started on NIV successfully at hospital - 20% of all 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 reconfiguration of the relationship with someone seriously affected by a neurological disease.

Sawinski K., Król-Bakórz A., Jakubowska-Sawinska A., Ryczekiewicz A.M.
1WSWCP Hospicjum Domowe, Poznań, Poland, 2University of Medical Sciences, Hematology, Poznań, Poland

We present the characteristics of palliative care realised between years 2006-2014 with patients who were under the care of our hospice. We analysed medical documentation of 1100 patients: 650 men and 450 men between 18-103 years of age. With patients non-neoplastic diseases (54% of all research participants) the direct reason for palliative care was: cardiovascular, neurodegenerative diseases. In patients with non-neoplastic diseases patients over 70 years of age (81%). The majority were women (68,4%). The average time of care was 160 days. In the group of 519 patients with proliferative diseases the most important group of patients in the age over 60 years (79%) were looked after and observed for 65 days on average. Cancer most frequently concerned the lungs and bronchi, stomach, large intestine, pancreas, brain and kidney (49%). Our experience proves that a lot of symptoms with the hospice patients towards the end of their lives were dependent from the type of disease, are the same. The main problem with the patients is the pain. It occurs in 75% of all cases with cancer and in 68% of patients who suffer from non-neoplastic diseases. In neoplasia, the pain is severe, contrary to chronic diseases in which it is chronic and long-term and difficult to diagnose. Elderly suffer many groups of pain of different intensity and location. It is connected with polypathology. Individual approach to each patient is necessary. It is connected with specific spiritual and psychological needs and symptoms, which are hard to treat. Problems also occur in establishing the relationship and communication between the elderly and their guardian caused by hearing and vision problems as well as cognitive disorders. Our experience indicates that an increasing number of the elderly in recent time requires a better organisation and a new economic approach as well as an ethical changes in the organisation of palliative care in geniatrics.

Abstract number: P1-461
Abstract type: Poster

We Are All Sitting in One Boat - Knowing that it Will Sink – Benefits and Limitations of Participating in a Self-help Group when Suffering from Amyotrophic Lateral Sclerosis

Seibel K., Spänner J., Xander C., Becker G., Simmons W.
Medical Center - University of Freiburg, Department of Palliative Care, Freiburg, Germany

Background: Self-help groups (SHG), as part of the system of lay help, pursue the goal of participants’ mutual support in coping with an illness. In the case of amyotrophic lateral sclerosis (ALS), a fatal, progressive, and usually neuromuscular disease, the benefits and limitations of participating in a SHG have not been well explored.

Aims: To analyse the benefits and limitations of ALS SHG described by participants, and how death and dying is death with in the SHG.

Methods: 13 qualitative, semi-structured interviews with 9 patients and 9 relatives from 3 different SHG in southern Germany (8 single and 3 couple interviews) were conducted in 2013. The interviews were transcribed verbatim and a qualitative content analysis was performed. Results: The benefits of the SHG were described as: 1) exchange of information and experiences, 2) orientation by learning from role models, and 3) sense of belonging to an understanding group of peers in contrast to a non-understanding environment.

The limitations of the SHG included: 1) burdensome encounters with other critically ill participants, 2) difficulties in communication and understanding due to dysarthria, and 3) a changing, heterogeneous group structure that prevents intimacy.

Although immanent and visible, the participants avoided discussing the incurable, progressive nature of ALS as well as death and dying. The attitudes of dealing positively with the disease and staying ‘active’ were dominant, and there seemed to be little space for other forms of coping in the SHG.

Discussion: Death and dying seem to be a challenge for ALS-SHG. By attending the ALS-SHG, palliative care professionals could help to initiate a discussion about end-of-life issues and explain palliative symptom management - thus adding to the system of lay help. This way of supporting ALS-patients and families in dealing with topics surrounding quality of life and dying could become a further facet of Early Palliative Care for non-oncological diseases.

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Abstract type: Poster

Situation in the Last Month Before Death of Patients with Amyotrophic Lateral Sclerosis on Noninvasive Positive Pressure Ventilation

Abe Y.1, Ishibuya M.1, Shimizu M.1, Takahashi Y.1
1Mihara Memorial Hospital, Nursing Department, Isesaki, Japan, 2Gunma University, Graduate School of Health Sciences, Gunma, Japan

Background: Unlike patients with cancer, those with amyotrophic lateral sclerosis (ALS) make decisions for their respiratory care and ventilatory efficiency. NIPPV 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 TPPV.

Methods: A total of 14 ALS patients died from 2011 to 2013 in Hospital A. Four patients were on TPPV, 5 were on NPPV, and 5 died naturally. Four ALS patients were enrolled 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. 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 was from 3 to 24 months.

Abstract number: P1-463
Abstract type: Poster
Poster Sessions (Poster Exhibition Set 1)

Abstract number: P1-465
Abstract type: Poster

Chronic Non-cancer Pain in Life Limiting Conditions - An Area of Growth for the Palliative Care Specialty?

Grady L., Wells S.

Aims or goal of the work: Chronic non-cancer pain is a challenge but can be managed optimally with a multidisciplinary approach. Our study focuses on a 57-year old lady, who was admitted to our hospice for pain management. She has Kasabach Merritt syndrome complicated by chronic pain. Kasabach Merritt syndrome describes the association of haemangiomata with thrombocytopaenia.

Design, methods and approach taken: During her admission, a multitude of therapies were initiated to improve her pain. Pharmacologically these involved opioid rotation from oxycodone to fentanyl and finally through to methadone. Sertraline was increased and anti-inflammatory agents tried. Psychosocial therapies included relaxation, hypnotherapy, psychotherapy and distraction therapies. Her management involved the whole multidisciplinary team at the hospice with wider specialist input. Furthermore, we made the focus of our care rather than the pain, by concentrating on her interests and quality of life rather than her condition.

Results: I struggled to describe her pain or give a reliable numerical score out of ten. We learnt to rely on other methods of judging improvement in her pain. Her facial expression changed over time with less grimacing and frowning. We noticed that the gap between analgesia breakthroughs increased from two to six hours over time. As her mental function slept for longer at night without waking up for analgesia, Shivering became a manageable procedure. She was discharged home with a subjectively better quality of life than on admission.

Conclusion / lessons learned: As hospice care changes from cancer patients in their last days of life to complex symptom control for longer periods in non-cancer patients, we will see more patients like J with complicated pain issues. Our work has shown that all members of the multidisciplinary team have a role in pain management. The medications we started were just a small part of this lady’s pain management plan.

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015

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Abstract type: Poster

Neurogenic Dysphagia as a Marker of Mortality in Elderly Patients

Zamora Mur A., Palacin C., Zamora Catevilla A., Lanoo P.
Hospital de Barbastro, Barbastro, Spain

Background: Dysphagia is a clear indicator of terminal diseases and high probability of death.

Aims: To determine the degree of dysphagia, its origin, and the prognosis of patients in the Hospital de Barbastro to test who undergo volume-viscosity test.

Methods: Design: Prospective study of volume-viscosity test from March 2013 to December 2013.

Data collection: Age, sex, Charlson index, Barthel index, date of the test, reason for request, test results in efficiency and safety, introduction of enteral nutrition (nasogastric tube or percutaneous endoscopic gastrostomy), discharge destination (home, nurse home, hospital or death). Subsequently telephone or outpatient at six and twelve month reviews.

Analysis: SPSS 15.0.

Results: Mean age 80+/-10 years, mean Barthel index 24.5+/-18.8, average Charlson index 2+/-1.9, 56% male. 44% female; applicant specialty: Geriatrics 51%, Internal Medicine 23%, Neurology 25%, other 1%; reason for the test: 54.7% stroke, 24% dementia, 2.7% Parkinsonism, 7.2% other; test result: negative 39.2%, positive 60.8%, 1.3% impossible, particular test result: volume tolerated low 24%, middle 38%, and high 38%; texture tolerated liquid 28.6%, nectar 49%, pudding 22.4%. It is established enteral nutrition in 20% (SG 16% and GEP 4%). Discharge occurs: home 42.7%, nurse home 22.7%, other hospital 24%, death 10.7%. Survival at 6 months 61.3%. Use thickeners at 6 months 22.2%. Presence of aspiration at 6 months 12%. Survival at 12 months 49.7%. Timelines used at 12 months 24.2%. Presence of aspiration at 12 months 15.6%.

Conclusions: 1. High mortality in patients with dysphagia in a context of very poor performance status and in geriatric population based on less than one year. 2. Patients with dysphagia should be included in the monitoring program.

Geriatric Patient Treated at Home by a Palliative Care Team Support:
Symptoms and Polypharmacy

Zamora Mur A., Zamora Catevilla A., García-Foncalla R.
Hospital de Barbastro, Barbastro, Spain, Universidad de Zaragoza, Zaragoza, Spain

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, present and previous 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 stabilisation 66.5%, hospitalised 6.8%, anorexia 31%, delirium 30.2%, pain 26.3%, insomnia 16.4%, anxiety 12.1%, depression 11%, dysphagia 10%, nausea 3.2%. Dementia in 60%, inabilitation in 62.6%, presence of pressure ulcers in 16.8%. Inhibitors proton pump 57%, antidepressants 42.7%, diuretics 38.7%, antiplatelet drug 37.6%, laxatives 31.7%, benzodiazepines 28.7%, atypical neuroleptics 28%, paracetamol 24%, typical neuroleptics 19%, antiinflammatory drug 14.7%, anticoagulants 14.3%, acetylsalicylic inhibitors 14.3%, calcium channel blockers 13.6%, dizzain 12.5%, angiotensin-converting enzyme inhibitor 12.2%, antiadipic drug 10.8%, statin 8.2%, corticosteroids 6.8%, metoclopramide 6.8%, transferral fentanyl 6.5%, insulin 6.1%, beta-blockers 5.7%, pregabalin 5.4%, gabapentin 5%, tramadol 4.3%, metamizol 3.6%, non-steroic antiinflammatory drugs 3.6%, valproic 2.2%, morphine 2.2%, buprenorphine 1.8%, oral fentanyl 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.
Anticipatory Prescribing for Residents Approaching End of Life in Care Homes

Brand S.1, Finucane A.2, Murphy S.1, Watson J.1

1University of Edinburgh, Centre for Population Health Sciences, Edinburgh, United Kingdom, 2Maree Cure Cancer Care, Edinburgh, United Kingdom

Common symptoms at the end of life include pain, breathlessness, anxiety, and nausea. National end of life care strategies advocate anticipatory prescribing as a way to manage these symptoms. This is particularly important for people with dementia, as they have a higher prevalence of these symptoms. Anticipatory prescribing helps to ensure that these patients receive appropriate care at the end of life.

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.

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Abstract type: Poster

The Specialist Care of People with Intellectual Disability as they Grow Older

Forrester-Jones R.V.1, Bamour M.1, Oliver D.J.2

1University of Kent, Tizard Centre, Canterbury, United Kingdom, 2University of Kent, Centre for Professional Practice, Chatham, United Kingdom

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 and the Residents Choice Scale, which assesses opportunities for self determination.

Results: 13 residents were assessed. The number of individuals in each resident's network was 13 residents were assessed. The number of individuals in each resident's network was 14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015

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Abstract number: P1-472
Abstract type: Poster
 disjoint: Residential Aged Care Staff and Bereaved Family Perceptions of Palliative and End of Life Care
Frey R.A., Boyd M.V., Foster S., Robinson J., Gott M.T.
University of Auckland, School of Nursing, Auckland, New Zealand, 1Wattanata District Health Board, Auckland, New Zealand, 2Auckland District Health Board, Auckland, New Zealand
Presenting author email address: rfrey@auckland.ac.nz
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 32 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
Jiménez Domene P1, García Baquero Menérez M.L.T.Y, Gómez Pavón J.L., Ruipérez Cantera I.3, Rodríguez Santisto M.A.1, Ballester Balado J.M., Quiñones E.2, Chocarro González L.1, Regional Palliative Care Network Consejería de Salud, Comunidad de Madrid, Madrid, Spain, 2Servicio Madrileño de Salud, Coordinadora Regional de Cuidados Paliativos, Madrid, Spain, 3Servicio de Geriatría Adulta, Hospital General de Madrid, Universidad Autónoma de Madrid, Madrid, Spain, 4Secretaría de Salud, Consejería de Salud, Comunidad de Madrid, Madrid, Spain
Presenting author email address: mtreseras.garciba@salud.madrid.org
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 are referrals of the professionals have received advanced training in PCA.
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 approximates 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.
Method: Prognostic criteria for entry into the pilot homecare programme 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 was evaluated prospectively from the cost savings of reducing average length of stay in the hospital.
Results: Patients with advanced dementia staged at Functional assessment staging of dementia (FAST) > 7A, with at least another criteria in the form of either 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 NIH-N and the MNA.
Caregivers were assessed using the QUALID and the Zark 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-EOLD, CAD-EOLD and SWC-EOLD.
Conclusion: Advanced dementia are under-recognised 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
Jørgensen B., Elnskov B., Christensen S.B., Jespersen B.A., Matthiessen H.N., Neergaard M.A.
Aarhus University Hospital, The Palliative Team, Department of Oncology, Aarhus, Denmark
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 citizens 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 Warr-Cook-Wall 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 attitudes 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 professionals at NH in Denmark. The results will be used as baseline data for a subsequent intervention study to optimise EOL care at Danish NH.

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?
Kupeli N., Sampson E.L.1, Hamington J.1, Moore K.1, Davis S.2, Elliot M.1, King M.1, Morris S.1, Nazareth I.1, Omar R.Z.2, Leavy G.1, Jones L.1
1University College London (UCL), Division of Psychiatry, London, United Kingdom, 2University College London (UCL), Department of Computer Science, London, United Kingdom, 3University College London (UCL), Department of Primary Care and Population Health, London, United Kingdom, 4University College London (UCL), Department of Statistical Science, London, United Kingdom, 5University of Ulster, Barfoord Centre for Mental Health and Wellbeing, Derry/Londonderry, United Kingdom
Presenting author email address: n.kupeli@ucl.ac.uk
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).
Aim: However, to inform intervention development, we conducted a series of qualitative interviews to examine and understand the level of support in place for this 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 training was needed 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

Madsen E., Delaney C., Whitehead C.

1Nowcroft Hospice, Torquay, United Kingdom, 2Alzheimer Society, Paignton, United Kingdom, 3Torbay Care Trust, Torquay, United Kingdom

Presenting author email address: emily.madsen@nowcroft-hospice.org.uk

Abstract number: P1-477

Abstract type: Poster

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 this facilitator to lead on the future planning session. Group activities and discussion enable individuals to consider and acknowledge their own experiences and concerns.

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.

Needs, Wants or “Common Sense” - What Drives Decision-making about Care in Later Life for Older Adults?

Ng C., Looi Y.C.

Central Manchester University Hospitals NHS Foundation Trust, Care of the Elderly, Manchester, United Kingdom

Aim: 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 is low. We need to explore the reasons for this poor uptake and look at the implications of not having appropriate consent for future care.

Methods: A postal questionnaire was sent to 710 community dwelling older adults in Manchester. 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’ in influencing decision making about their future care.

Conclusion: Decisions on one’s important personal values can be as challenging as decisions about future care. Effective decision-making about care in the future, however, 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.

Aspects of Decision-making among palliative Care patients: the role of place of care

Niemeyer Guimarães M.C., Corvalho R.F., Schnamm F.R.

FIOCRUZ, ENSP - PRGBDS, Rio de Janeiro, Brazil, 2Hospital Federal dos Servidores do Estado, Intensive Care Medicine, Rio de Janeiro, Brazil, 3Hospital das Clínicas, University of São Paulo, Palliative Care, São Paulo, Brazil

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

Niemeyer Guimarães M.C.1, Corvalho R.F.2, Schnamm F.R.3

1FIOCRUZ, ENSP - PRGBDS, Rio de Janeiro, Brazil, 2Hospital Federal dos Servidores do Estado, Intensive Care Medicine, Rio de Janeiro, Brazil, 3Hospital das Clínicas, University of São Paulo, Palliative Care, São Paulo, Brazil

Presenting author email address: niemerc@gmail.com

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 regarding 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 of age with cancer in a general ICU. Data was collected for prognostic scores of acute illness (SAPS3, SOFA), comorbidity indices (Genetic[ICI] and Charlson comorbidity index[CCI]), performance status[PS], Kaye/Performance Status[KS], 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-u/squared tests; Spearman correlation were used to analyse data.

Results: Patients, median of 77±7y were enrolled during 8 months. Gastrointestinal (26/71;37%) 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,ICCI p=0.855,CCCI p=0.94). PC1 correlated to prognostic scores (SAPS3 r=0.236,SOFA r=0.263,CCI r=0.027). PC2 correlated to PS (KS r=-0.413 p=0.003,PPS r=-0.505 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.

Assessment of Symptoms and the Process to Adaptation to the Diseases in Palliative Oncogeriatrics Field

Rahnea Nito R.A.1, Rahnea Nito R.A.2, Georgescu D.G.1,2, Ciuhu A.N.1,2

1State Hospital for Chronic Disease, Oncology – Palliative Care, Bucharest, Romania, 2Romanian Society of Palliatology and Thanatology - SRPT, Bucharest, Romania, 3Clinic Hospital Colentina, Bucharest, Romania

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, than 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, but 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.

Discussion/conclusions: Old patients with cancer require assessment and treatment of burdensome symptoms, as well as access to services that address to their psychological needs.

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
Abstract number: P1-481
Abstract type: Poster

Geographical Variation in the Percentage of Time Spent at Home or in a Community Setting Compared to Hospital for People Dying of Cancer during the Last 6 Months of Life

Robbery N, Pinto A, Mullis K, Verme J
Public Health England; Knowledge and Intelligence Team (South West), Bristol, United Kingdom

Background: One aspect of good end of life care is supporting people in their preferred place of care. This study explores the geographical variations in the percentage of last six months of life spent at home or in a community setting, using a measure originally developed by Information Services Division (ISD) in Scotland.

Method: ONS mortality and Hospital Episode Statistics data (2010-2012) was used to determine the total time spent in hospital during the final 6 months of life for people dying from cancer. Excluded were patients in specialist or mental health care and patients with an external underlying cause of death (not fatal). Geographical variation was compared to the income deprivation affecting older people index (IDAOPI) using a Spearman rank test.

Results: Across England people dying from cancer spent an average of 21 days in hospital during the last 6 months of life versus 5 days for Londoners spending most time (an average of 24 days) and people in the South West of England the least time (18 days). Across Clinical Commissioning Groups, up to 30 days difference was observed for all cancers, with a high of 60 days for bladder cancer and a low of 21 days for lung cancer.

A statistically significant association (p=0.001) was found between the percentage of time spent in hospital during the last 6 months of life and income deprivation with people in the least deprived areas of England spending 3 days less in hospital compared to those in the most deprived areas. This level of association varied with cancer type, malignant melanoma showing the lowest level of association (R² = 2.2%, p=0.01) and prostate and colorectal cancer the highest (R² = 3.9%, p=0.001 and R² = 2.1%, p=0.001 respectively).

Conclusion: The amount of time people dying from cancer spend in hospital during their last six months of life varies depending on where they live and by levels of income, although this does not imply a difference in the quality of care at the end of life.

Abstract number: P1-482
Abstract type: Poster

 Palliative Care for Prisoners: Findings from Phase 1 of the ‘Both Sides of the Fence’ Study

Sumner M1, Pessac P1, Ngagatty K1, Payne S1, Scott G1, Gibson K1, Catchall A1
1 Lancaster University, Faculty of Health and Medicine, Lancaster, United Kingdom, 2 Lancaster University, Lancaster, United Kingdom; 3 County Durham and Darlington NHS Foundation Trust, Durham, United Kingdom, 4 Hamp Frankland, Durham, United Kingdom, 5 St. Catherine’s Hospice, Preston, United Kingdom

Background: The Prague Charter advocates access to palliative care as a human right, and many countries are working to overcome challenges in providing appropriate palliative care for specific populations such as prisoners. In the UK, the need to improve palliative care in prisons is increasingly urgent; the prison population has doubled over the past decade, with men over 60 the fastest growing group. Many older prisoners have multiple and complex healthcare needs and will die in custody.

Aims: The ‘Both sides of the fence’ study aims to devise a model of integrated palliative care that can be shared with other prisons.

Methods: Using a participatory action research design, Phase 1 consisted of a detailed analysis of past 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 of 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 ≥ 85 Years in England

Verme J
Public Health England, Bristol, United Kingdom

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 333 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 to support.

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 Hospital Episode Statistics (HES).

Results: A selection shown as England Average, Lowest Local Authority, Highest Local Authority. % Proportion 85+ ≥ 2.2%, 0.9%, 4.0% % Male 85+ 1.0%, 0.7%, 2.8% % Female 85+ ≥ 3.0%, 1.0%, 5.2%

Conclusion: In planning care for the oldest of the 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 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

White N, Store P
University College London (UCL), Marie Curie Palliative Care Research Department, London, United Kingdom

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.

Aims: To determine the accuracy of clinician predictions of survival in palliative care patients; to identify whether some sub-groups of clinicians could be considered more ‘expert’ than others; to identify the heuristics that 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 3,613 articles and 44 papers were included in the final review.

Results: 40 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) have expertise to a greater extent than others. However, the results also suggested that predictions by some HCPs 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 judgments are 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

Wilms M1, Devriendt E1, Flammang J1, Milkx K1
1 UZ Leuven, Geriatrics, Leuven, Belgium, 2 UZ Leuven, Leuven, Belgium

Presenting author email address: maartje.wils@uzleuven.be

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 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 valid, standardised transfersheet.

Methods: After a literature search a topic list was generated containing items that could be included in the transfersheet. After a literature search a topic list was generated containing items that could be included in the transfersheet. After a second and final Delphi-round a standardised transfersheet containing 44 items was developed and then evaluated for clinical 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 UA ) for the entire transfersheet was 0.68. The average scale content validity (S CVI Ave ) was 0.96.

Conclusions: After a second and final Delphi-round a standardised transfersheet containing 44 items was developed and validated and implemented. The transfersheet focuses strongly on information regarding the results of the ACP-process.
**Palliative care in children and adolescents**

**Abstract number:** P1-486  
**Abstract type:** Poster

**Characteristics and Prognosis of the Oldest Old in a Community Hospital and Seen by a Palliative Care Consultation Team (PCCT)**

**Woliner DJ, Brophy N, Morse K, Caroline L, Effiren L**  
SNCH, Dún Laoghaire, Co. Dublin, Ireland  
Presenting author email address: dwoliner@snch.org

The Oldest Old is the most rapidly growing geriatric population internationally. This rate of growth will quadruple by 2050. Ten additional years of life is anticipated upon reaching 85. Multiple chronic medical conditions, debility, frailty and geriatric syndromes impact on quality of life and survival.

South Nassau Communities Hospital (SNCH) is a 400+ bed facility with a comprehensive cancer center, cardiovascular institute and 26 critical care beds. SNCH has a medical school affiliation and training programs in family medicine and surgery. There is a mobile PCCT with a physician, nurse practitioner and social worker each trained and certified in palliative care. Pastoral care and other ancillary services are provided by SNCH. From March 03rd-April 15th 2014, 56 patients were evaluated and 52 of the 56 were assessed for survival at 3 months. The following characteristics were discovered:

- 7) average age: 88;
- 9) 83% had died by 3 months, 43% during initial hospitalisation, 30% in a hospice facility and 27% in other sites; 17% were alive at 3 months, 56% with homecare hospice, 33% in long term care and 11% at home with no services.
- The oldest old is an extremely vulnerable group with a high mortality rate, a diverse array of life threatening illnesses, profound debility and are commonly incapacitated.

We plan to develop a study providing comprehensive palliative care and genetic assessments to the oldest old admitted to SNCH and provide education for physicians and nurses with the goal of improving the quality of life and secure a safe and attended death.

**Abstract number:** P1-487  
**Abstract type:** Poster

**Developing a Website for Parents and Carers of Children and Young People with Palliative Care Needs: Lessons from the Island of Ireland**

**Chamley K1, Wescott G2, Connolly M3**  
1 All Ireland Institute of Hospice and Palliative Care, Dublin, Ireland  
2 University College Dublin, Dublin, Ireland  
3 University College Cork, Cork, Ireland

**Background:** Meeting the information needs of parents and guardians of children with palliative care needs is an integral aspect of planning and providing care for that child at home, in a hospital or in a hospice. Providing this information digitally on one website will enable parents and guardians of children with palliative care needs is an integral aspect of planning and providing care for that child at home, in a hospital or in a hospice. Providing this information digitally on one website will facilitate further education and training for health care professionals caring for children and young people with palliative care needs and is an example of an innovative and collaborative project across the island of Ireland, which could be translated across other jurisdictions.

**Abstract number:** P1-488  
**Abstract type:** Poster

**Are Dogs Really a Child’s Best Friend?**

**Gilmer M1, Latham J2, Kyle N-S3, Levin C4,5, Ruedenauer A6, Akard T6,7, O’Hare M6,8**  
1 Vanderbilt University, Nursing, Nashville, TN, United States  
2 Vanderbilt University, Nashville, TN, United States  
3 American Humane Association, Denver, CO, United States  
4 Purdue University, Lafayette, IN, United States

**Presenting author email address:** marygilmer@vanderbilt.edu

**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 psychological 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=8), mothers (N=8), fathers (N=8), therapy dogs (N=3) and owners (N=3). 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 B/P 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:** P1-489  
**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**

**Hudson B1,2, Oostendorp L1,3, Candy B4, Lakinhapuu M5, Vickersdottir LF6, Bluebond-Langner M7, Stone P2**  
1 UCL, Division of Psychiatry, London, United Kingdom  
2 UCL, Louis Dandurand Center for Children’s Palliative Care, Institute of Child Health, London, United Kingdom  
3 UCL, Division of Population, Policy and Practice, London, United Kingdom

**Presenting author email address:** b.hudson@ucl.ac.uk

**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 of research articles recruiting children and young people with life limiting conditions and life threatening illnesses and their families. We focused on how practices impact recruitment and retention rates.

**Results:** The search identified 6,024 articles. We shall present and analyse the type and scope of recruitment and retention practices 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.

**Discussion:** Uneven 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.
"Sleep Tight": Developing a Service to Support Children with Cancer to Die at Home
Henderson B.

Abstract:
The Sleep Tight project was developed following an approach to the children’s hospice from a bereaved parent. The project 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 visiting service and children and young people (CYP) with cancer being engaged in end of life care (EOL). The service would provide benefit to a patient group who have historically not had access to children’s hospice services.

Methodology:
Eleven guideline-based interviews were performed and evaluated using a thematic analysis approach. All the interviews took place within the first 6 years of the project’s life. Each interview lasted between 20 and 30 minutes. The participants were chosen based on their expertise and experience in providing palliative care for children.

Results:
The service has been well received by the children and their families. The children have been able to die at home with the support of the hospice and the POONS team. 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.
Understanding the Life Issues of Young Adults with Life-limiting Conditions, and the Impact on their Parents, Siblings and Professionals: A Systematic Literature Review

Johnston B.M., Jindal-Snape D., Pringle J.
1University of Nottingham, Sue Ryder Care Centre for the Study of Supportive, Palliative and End of Life Care, Nottingham, United Kingdom, 2University of Dundee, Education and Social Work, Dundee, United Kingdom

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.

Caring for a Child after Death in UK Children’s Hospices: Assessing the Use of ‘Cool Rooms’

Forster C.J., Darlington A.S., Sepion E.
1Naomi House Children’s Hospice, Winchester, United Kingdom, 2University of Southampton, Faculty of Health Sciences, Southampton, United Kingdom

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, it carried out by 61%; no services offer embalming at the hospice. Knowledge regarding temperature of environments/equipment varies: 30% did not report these temperatures; 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
Current Trends in Morphine Consumption in a National Oncology Center

Abdulmanem E. Mehdiali, Al Bahran B.
National Oncology Centre, Muscat, Oman

Background: Morphine is one of the more ancient medicines known. It is the strong analgesic of choice according to the WHO recommendations for the treatment of moderate-to-severe cancer pain. The myths related to opioids specifically morphine, which is a drug of choice for cancer pain patients, has been a reason for an ineffective pharmacotherapeutic adherence and poor access to reliable and current information about opioid medications promoting adherence to therapy and decreasing risks associated with these drugs.

Objectives:
- To identify sources of opioid prescribing errors
- To assess whether our hospital's pain guidelines provide adequate guidance to healthcare staff

Methods: Prescription charts from 29 adult medical and surgical wards were analysed over a period of one month.

Results: Prescription charts that contained a regular strong opioid prescription were included in the study. Once the prescription chart was included in the study regular strong opioid prescriptions and all PRN (as required) opioid prescriptions were reviewed.

Discussion: Errors in opioid prescribing persist, particularly in calculating breakthrough doses for patients who are on a regular strong opioid. Breakthrough dosing is not associated with a significant increase in number of newly diagnosed cancer cases during the same period. We noticed also an increase in the consumption of synthetic analgesic (Fentanyl patch) in our institute by more than 7 folds during the same period from 2006 to 2012.

Conclusion: Errors in opioid prescribing persist, particularly in calculating breakthrough doses for patients who are on a regular strong opioid. Breakthrough dosing is not currently addressed within our hospital's pain guidelines, and it is recommended that this should be considered in future revisions.

Clinical Hypnosis in Palliative Care: Advanced Techniques for Effectively Relieving Pain and Symptoms

Brugno M.P.
University of Verona, Department Anaesthesia Intensive Care and Pain Therapy, Verona, Italy

Presenting author email address: paola.brugno@libero.it

This work will focus on skill building for those clinicians who work with chronic and/or progressive health conditions and patients whose life feels threatened by medical conditions. The aim of the work is: focus on practical hypnotically approaches and techniques with sound underpinnings based on recent advances in our understanding of pain processing.

Methods and approach: Clinical hypnosis in Palliative Care is indicated for patients with any serious illness and who have physical, psychological, social, or spiritual distress. The goals of Clinical Hypnosis in Palliative Care, are the same focused on WHO's guidelines for Palliative Care, and they are:

1) Provides relief from pain and other distressing symptoms;
2) Affirms life and regards dying as a normal process;
3) Intends neither to hasten nor postpone death;
4) Integrates the psychological and spiritual aspects of patient care;
5) Offers a support system to help patients live as actively as possible until death;
6) Offers a support system to help the family cope during the patients illness;
7) Uses a team approach to address the needs of patients and their families;
8) Will enhance quality of life;
9) Is applicable very early in the course of illness, in conjunction with other therapies.

Following an introduction to the evaluation of chronic pain, a applicable methodology for building therapeutically strategies will be introduced. Practical exercises will encourage participants to build rapid assessment skills while facilitating planning strategies that utilise hypnotic language. At the end of this workshop, participants will be able to:

a) Effectively assess and differentiate the major types of pain and suffering encountered in advanced illness;
b) Develop cogent hypnotic strategies for symptom control;
c) Rapidly develop techniques that reflect and improve: pain, anxiety and suffering relief; dignity and respect for the patients and their families.
Rapid Onset Opioid (ROO) Rotation in Breakthrough Cancer Pain (BTPC) Management: A Palliative Care Case

Collocazi M. AS5 n 2 BODTNA, Monfalcone, Italy

Background: ROO, are fentanyl citrate drugs for the BTPC management, which have a rapid transmucosal absorption (buccal, nasal or sublingual), OTFC (oral transmucosal fentanyl citrate), FBT (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 equal analgesic 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/day, ibuprofen 600mg/8h. For BTPC, OTFC 120µg+ FBT 200µg 4–5h.

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 presence of erosions, prednisone 25mg/d was added. The pain remained controlled until May 2014 when, for ineffectiveness the FBT dose only was increased to 800µg with no rapid onset (about 60 min). For this reason, BTPC therapy was changed with FPNS 400µg 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.

Conclusion: The ROO rotation from OTFC+FBT to FPNS has allowed to obtain an optimal pain control with rapid onset, duration and tolerability. It allows opioid sparing and a lower administration number. The better efficacy of FPNS at lower doses is probably due to the way of drug administration. The analgesic properties of FPNS may allow reduction of the total opioid burden and associated adverse effects, while still providing effective pain relief. Our case show the simplicity in determining the dose titration and managing of FPNS.

Introducing Alternative Forms of Strong Opioids to Control Chronic Pain in Cancer in Moldova: Believing in Unbelievable

Carafizi N. Charity Foundation for Public Health ‘Angelus Moldova’, Hospice ‘Angelus’, Chisinau, Moldova, Republic of

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 incurable 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 an 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 incurable cancer patients in Moldova.

Use of High Doses of Opioids for Elderly Cancer Patients with Severe to Moderate Cancer Pain: Prospective Observational Study


1Korea University Guro Hospital, Internal Medicine, Seoul, Korea, Republic of; 2Korea University Guro Hospital, Internal Medicine, Seoul, Korea, Republic of; 3Ulsan University Hospital, Hematology and Oncology, Ulsan, Korea, Republic of; 4Yeungnam University Hospital, College of Medicine, Ulsan, Korea, Republic of

Aim: 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 adjournant 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 (OEM≥120 mg/day) were collected from 30 hospitals, from February 2009 to March 2010.

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 (OEM) were changed from 3.63±1.56, 178.86±76.88 at baseline to 4.02±2.169 (p< 0.001) 288.54±389.09 (p=0.0025) after 8 weeks. Quality of life, severity of daily activity, ambulation and sleep were significantly improved after 8 weeks (p< 0.001). Also, pain intensity and the frequency of adverse events by opioid type after 8 weeks were not different.

Conclusion: Pain severity and quality of life were improved in elderly cancer patients using opioids.

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Is Tolerance to Alfentanil in Continuous Subcutaneous Infusion (CSI) a Clinical Problem in a Specialist Palliative Care Unit Cohort

Gickhurst V.1, Convery R.2

1University of Dundee, Dundee, United Kingdom, 2NHS Tayside, Department of Palliative Care, Dundee, United Kingdom, Presenting author email address: rosie.convery@nhs.net

Background: Alfentanil is an opioid analogic increasingly delivered in palliative care by CSI 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. Aim: 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 4.17mg 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.

Conclusion: 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.
Is Pain Control Enough to Achieve Quality of Life?

Görg E.J., Stypula-Clucka B.J., Kulpa M.1,2

1,2Cancer Centre-Institute, Palliative Care, Warsaw, Poland, 1Medical University of Warsaw, Department of Medical Psychology, Warsaw, Poland

Presenting author email address: egorg@cs1.waw.pl

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 attitudes can also be found in the field of palliative care. Aim of the Study: This study aimed to verify if pain and symptoms control is enough to secure good quality of life (QoL).

Methods: 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. pharmaceutical and non-pharmaceutical pain management and prevention of adverse effects
5. documentation and re-evaluation of the defined outcomes

Results: 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.

Conclusion: For the management of chronic pain no nursing guideline existed in Germany. This conference with 600 nurses.

Results: The results are presented in a manuscript. The study aimed to verify if pain and symptoms control is enough to secure good quality of life (QoL). The results showed that pain assessment and treatment planning are the most important aspects of pain management.

Discussion: The results highlighted the importance of pain assessment and treatment planning in achieving good quality of life in patients with chronic pain. The guidelines suggest that pain nurses should be mandatory in all health care settings.

Abstract number: P2-012
Abstract type: Poster

L-Methadone Intranasally Solved Opioid Induced Hyperalgesia in a Child

Grzegorz B.M., Zernikow B.1, Bolck S.1, Bielen P., Galtchouk S.1

1Saarland University Hospital, Centre for Palliative Care and Paediatric Pain, Homburg/Saar, Germany, 2Clinic for Children, Adolescents, Datteln, University of Witten Herdecke, Vodafone Foundation Institute for Children's Pain Therapy and Pediatric Palliative Care, Datteln, Germany, 3Klinikum Stuttgart Ophthalmic Pediatrics 5 Oncology, Hematology, Immunology, Stuttgart, Germany, 4Saarland University Hospital, Department of Anaesthesiology, Intensive Care Medicine and Pain Therapy, Homburg/Saar, Germany

Background: Children in severe pain through progressive or disseminated oncologic disease are very often in need of rather high dosages of opioids in comparison to adults. Mostly they show good tolerance and rather no relevant side-effects. Increasing general clinical knowledge about neuropathic syndromes e.g. allodynia, allows to diagnose opioid-induced hyperalgesia nowadays more often. If opioid rotation within standard- opioids is not effective in sense of controlling side-effects and pain, rotation to intravenous methadone as an ultimate ratio was described in only one single case report in children so far. The aim of the study was to evaluate the effectiveness of dose titration and the side-effects experienced by patients.

Methods: The data collected included demographics, indication for use, titration schedule, final dose, side-effects, and discharge arrangements.

Results: 14 patients were prescribed nasal fentanyl over an 18 month period. Results showed that the most frequently used maintenance dose of nasal fentanyl was 100mcg (range 100–800mcg).

Conclusion: Nasal fentanyl is a useful addition to the range of treatment options for patients with cancer pain. Education is vital for titration due to potential confusion with the titration of other standard acting fentanyl preparations. Education and availability of resource material for both staff and patients is essential.

Abstract number: P2-013
Abstract type: Poster

German Nursing Guideline: Nurse-led Pain Management of Chronic Pain

Doll A.1, Besendorfer A.2, Fischer T.3, Gnass I.1, Heisel M.1, Huber-Möhler B.4, Müller-Mundt G.5, Nestler N.1, Raic N.1, Sinch E.1, Thomm M.1, Osterbrink J.1

1University of Cologne, Department of Palliative Medicine, Köln, Germany, 2Rheinisch-Kliniken Düsseldorf, Nursing Science, Düsseldorf, Germany, 3University of Applied Sciences Dresden, Nursing Science, Dresden, Germany, 4Paracelsus University, Nursing Science, Salzburg, Austria, 5Center Hospital, Pain Centre, Saarbrücken, Germany, 6Vestische Kinder und Jugendklinik, Continous Education/Staff Development, Datteln, Germany, 7Medical University of Hannover, Epidemiology and Socialmedicine, Hannover, Germany, 8Diakonie Düsseldorf, Quality Improvement, Düsseldorf, Germany, 9German Center for Neurodegenerative Diseases, Witten, Germany, 10University Hospital of Cologne, Pain Centre, Cologne, Germany

Abstract number: P2-010
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 2)
A Comparison of Analgesic Effectiveness between Transdermal Fentanyl Patches Developed in Japan, Requiring Replacement Every 24 Hours, and Convencional Transdermal Fentanyl Patches Requiring Replacement Every 72 Hours

Hirayama T.1, Ōtsuka K.1, Watanabe M.1, Ito M.1, Kodama T.1, Kuzumoto W.1, Kurayama M.1
1Kitsato University East Hospital, Department of Pharmacy, Kanagawa, Japan, 2Kitsato University School of Medicine, Department of Surgery, Kanagawa, Japan, 3Kitsato University School of Medicine, Department of Gastroenterology, Kanagawa, Japan

Background: In Japan, transdermal fentanyl patches (TDF) requiring replacement every 24 hours (Fentor® Tape, PT) have been commercially available since 2010. FT is characterised by less variability in steady-state blood fentanyl concentrations as compared with conventional TDF requiring replacement every 72 hours (Duragesic® MT Patch, DT).

Methods: The medical records of inpatients who used TDF from July 2008 through December 2013 at Kitsato University East Hospital were reviewed. The number of rescue doses of analgesics used from day 4 to the final day of continuous treatment with the same dose was surveyed. To be eligible the patient had to have received the same dose of TDF for at least 12 days. Patients were excluded if pain was poorly controlled and rescue doses of analgesics were received 4 or more times per day for at least 1 day from days 4 to 6 of treatment.

1. Primary endpoint

The number of rescue doses used per day during the study period was compared between FT and DT.

2. Secondary endpoint

For DT, the number of rescue doses used per 24-hour interval during 72 hours after the administration of a single patch DT was compared.

Results: During the study period, FT was applied to 120 patients, and DT was applied to 184 patients.

1. Twenty-seven patients in the FT group and 48 patients in the DT group were included in the analysis of the primary endpoint. The number of rescue doses used per day was significantly smaller in the FT group (median, 0; range, 0–1.9) than in the DT group (0.7; 0–3.0) (p=0.041).

2. Thirty-two patients in the DT group were included in the analysis. The median number of rescue doses used per 24-hour interval after application was 0.6 (0–2.5) on day 1 (1.2–36.7), 0.5 (0–3.0) on day 2 (0.3–9.6); and 0.0 (0–1.2) on day 3 (0–4.5). The differences were significant between day 1 and day 2 (p=0.002) and between day 2 and day 3 (p=0.008).

Conclusions: At stable blood drug concentrations, FT provided better pain control than DT.

Abstract number: P-015
Abstract type: Poster

Tackling the Constipation Problem in Long-term Opioid Analgesia

Drewes A.M.1, Hafer J.2, Bosse B.3, Hopp M.4
1Aarhus University Hospital, Aalborg, Denmark, 2Private Medical Practice for Pain Management, Wetzlar, Germany, 3Mundipharma Research GmbH & Co. KG, Linburg, Germany

Background: Opioids are potent analgesics, but cause opioid-induced constipation (OIC) which affects quality of life and reduces treatment compliance. Many laxatives used to treat OIC mostly affect the colon by a mechanism of action that may be flawed for OIC treatment, as this results from opioid-receptor stimulation that distresses the entire gastrointestinal tract. Peripherally acting μ-opioid receptor antagonist naloxone is a targeted treatment for OIC. Oxycodeone/naloxone prolonged release tablets (OXN PR) combine an opioid analgesic (oxycodeone) with naloxone. Clinical trials reported that OXN PR improves bowel function without impairing analgesia.

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 nearly 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 regular basis. Analgesic efficacy was maintained; furthermore less than 10% of patients took laxatives on a regular basis.

Conclusion: During pain therapy OIC is a serious problem inadequately addressed by laxatives. OXIN PR can ameliorate OIC, avoiding the need for regular laxative use, while effectively treating chronic non-cancer pain in the long term.

Funded: Mundipharma

Abstract number: P-016
Abstract type: Poster

Revealing the Extent of Cognitive Impairment in Patients who Are Prescribed Opioids

Ishwood R.1, Colvin L.1, Fallows M.1
1University of Edinburgh, Edinburgh Cancer Centre, Edinburgh, United Kingdom, 2University of Edinburgh, Department of Anaesthesia and Pain Medicine, Edinburgh, United Kingdom

Background: Previous studies have shown patients on opioids have impaired cognitive function. This has been demonstrated particularly in initiation or titration of opioids. Studies have often relied on the mini-mental state examination (MMSE) or more specialised neuropsychological tests.

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 patient 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, hospital anxiety and depression scale and brief pain inventory. The ACE-R provides a score out of 100 from which the MMSE score is extracted. Information is provided on five domains of cognitive function. Assessments were completed every 6 to 8 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 these groups, statistically significant in all patient groups. Attention, memory, fluency 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: P-017
Abstract type: Poster

Nursing Perceptions about Managing Pain Medications in Long Term Care

Kawalaran S.1, Brazil K.2, Agnew G.1, Dolovich L.1, Papasavvou A.1
1McMaster University, Hamilton, ON, Canada, 2Queen’s University Belfast, Belfast, United Kingdom

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 understand nurses’ perceptions of their current practices related to administering pain medications to LTC residents.

Methods: A cross-sectional survey design was used including both quantitative and open-ended questions (46%–66% of respondents). Data was collected from 165 nurses (99% response rate) at nine LTC homes in southern Ontario, Canada.

Results: The majority (85%) felt that the medication administration system was adequate to help them manage residents’ pain. 96% felt comfortable administering nursing doses. 15% stated they were concerned about miscalculations or developing addictions. Finally, most nurses stated that they trusted the physicians and pharmacists to ensure dosing was safe.

Conclusions: These findings highlight nurses’ perceptions to managing pain medications in LTC, and areas where continuing education initiatives for nurses are needed.

Abstract number: P-018
Abstract type: Poster

Usefulness of Percutaneous Neurolytic Celiac Plexus Block with IVR-CT System for Pain Due to Pancreatic Cancer

Koyama Y.1, Ono K.1, Hidaoka H.1, Tanaka C.1, Taguchi S.1, Kosaka M.1, Ohzaki N.1, Katayama A.1, Nishida M.1, Koguchi K.2
1Yokohama City Hospital, Dept of Anaesthesia and Oncological Pain Medicine, Hoshino, Japan, 2Yokohama City Hospital, Dept of Palliative Care, Hoshino, Japan

Presenting author email address: yuko.yama@city.fukuyma.hiroshima.jp

Background: Percutaneous neurolytic celiac plexus block (PNCB) is an excellent treatment option for patients with intractable abdominal pain due to pancreatic cancer. Some techniques have been conducted clinically including fluoroscopy- or computed tomography-guided (CT) – guided percutaneous approaches. However, each technique has both good and bad points.

Aims: The purpose of this study was to evaluate the therapeutic value of IVR-CT (sliding CT scanner system with interventional radiology features) on PNCB for abdominal pain due to pancreatic cancer.

Methods: Eighteen patients were enrolled in this study and allocated to three groups: patients underwent PNCB with IVR-CT system (IVR-CT group: n=6), with fluoroscopy-guided (FLU group: n=6) and with CT-guided (CT group: n=6). Operative time and required volume of 99% ethyl alcohol were recorded.

Results: All patients reported an abdominal score of 2 to 3 out of 10 on the Numerical Rating Scale (NRS) on the next day of PNCB. Although a trend towards shorter operation time was seen in IVR-CT group, this did not reach a significant difference. Required volume of 99% ethyl alcohol for PNCB was smaller significantly in IVR-CT group than in other two groups.

Conclusion: In addition to fluoroscopy procedure, combined management workup with sliding CT could be associated with decreased volume of ET system to PNCB might be useful for treatment of abdominal pain due to pancreatic cancer.
Background: We usually administer mixed solution of oxycodone, ketamine, lidocaine intravenously for fast analgesics titration for cancer pain, and got good pain relief safety. 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 the analgesic and efficaciousness 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 didn't use any opioid analgesics. We administrated oxycodone, ketamine, lidocaine mixed solution intravenously by an electrical patient-controlled analgesia (PCA) pump 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 (7.84–20.8) ng/ml. That of ketamine and lidocaine were 2.31 (14.45–4.26) 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 clear.

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 cancer pain. Basal infusion, 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

Motsudo Y.1, Okayama S.1, Niyoh R.1, Takeda K.1, Yoshida K.2
Takarazuka Municipal Hospital, Palliative Care Unit, Takarazuka City, Japan, 1Takarazuka Municipal Hospital, Palliative Care Team, Takarazuka City, Japan

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, it is unclear how to treat pain when patients become unable to take orally due to progression of the disease.

Aims: To assess end of life management retrospectively, especially pain control management, after patients became unable to take methadone orally.

Methods: Twenty-eight patients with cancer pain undergoing treatment with oral methadone died at a palliative care unit in Japan between April 2013 and September 2014. All patients died of cancer and became unable to swallow before death. We assessed pain control approaches after the patients became unable to take methadone orally.

Results: The medication was not switched to other opioids due to the absence of pain in seven of the 28 patients, and these patients died within one day after the final methadone administration. The drug was switched to another opioid because of pain in 21 patients: one patient was treated with transdermal fentanyl, two were treated with subcutaneous morphine, and 18 were treated with subcutaneous morphine. Of these 21 patients, 11 patients died within one week, and 10 patients survived for one week or longer after switching to another opioid. In seven of these 10 patients, excluding three patients in whom pain could not be evaluated, the final oral methadone dosage was 20–150 mg/day, and the oral morphine equivalent dose of opioids used on the 7th day, when morphadone would have been mostly eliminated from the circulation, was 120–1,400 mg/day, with a conversion ratio of 6:1.

Conclusion: Pain could be managed by switching to other opioids, even when patients became unable to ingest methadone. Due to the long half-life of methadone, when pain is absent in the end of life, switching to other opioids may be not always necessary even when oral methadone medication becomes impossible.

Abstract number: P2-021
Abstract type: Poster

Evaluation of the Optimal Positioning of Subcutaneous Butterfly When Administering Injectable Opioids in Cancer Patients

Mirone N.1, Negri A.1, Mocuroiu D.1
University of Traian Demachi, Romania, 1Hospice Casa Sperantei, Education and National Development, Brasov, Romania
Presenting author email address: nicoleta.mirea@hospice.ro

Introduction: The growth in number of cancer patients, together with the development of new Palliative Care services in Romania warrant the evaluation of nursing strategies used to enhance the level of comfort of patients who are suffering with advanced cancer.

Goal: The main objective of the present study was to evaluate optimal positioning of the subcutaneous (sc) butterfly, in accordance with its insertion in the tissue, the local complications that occur and the evaluation of the time of resistance at the insertion site (puncture) with the daily frequency of injectable opioid administration.

Method: A prospective experimental pilot study was designed and conducted between January and May 2011. Patients admitted at Hospice Casa Sperantei (Brasov, Romania) with moderate or severe cancer pain receiving subcutaneously opioids, over the age of 18, with normal body index ranging from 18.5–22.0, after signing the informed consent, were assigned in a random method to one of two groups: Group 1 butterfly was positioned with the needle’s bevel up – this was considered to be the control group as this modality of 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 Tranadol for moderate pain and sc Morphine for severe pain.

Results: 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 opioid 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

Mukeshar MM
Anesthesia, Critical Care, HIV/AIDS and Pain Mgt. Centre, Mulunfita, Zambia

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 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. Education of health professionals about measurement techniques should be viewed as a priority in efforts aimed at eliminating barriers and improving symptom management. In a survey of physicians providing care for patients with cancer,76% stated that the single most important barrier to adequate pain management was poor pain assessment (2).

The absence of valid measures for the measurement of many common symptoms represents a major methodological barrier to improving symptom measurement (3). As a result, many studies have used checklists to measure symptom prevalence without reference to symptom distress and impact.

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

Nikii K.1,2 Okamoto Y.1, Nakajima S.1, Matsuda Y.1, Yabumoto C.1, Murata T.1, Matsumura Y.1, Deyo R.1,2
1Osaka University, Graduate School of Pharmaceutical Sciences, Suita, Japan, 2Ashiya Municipal Hospital, Department of Pharmacy, Ashiya, Japan, 3Ashiya Municipal Hospital, Department of Palliative Care, Ashiya, Japan, 4Osaka University, Graduate School of Medicine, Suita, Japan

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 in injection 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.

Purpose: To examine whether AI is beneficial for cancer pains in Japan.

Method: 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. We evaluated the patients' 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).

Result: Improvement by AI were observed in 64 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 differences were 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 potency 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.
A Regional Audit Examining the Use of Topical 5% Lidocaine Plasters in Patients with Cancer Related Neuropathic Pain

Sutherland A, Purualu G, Dove K, Sumari J, Harrison S. Manchester Royal Infirmary, Manchester, United Kingdom

Background: Neuropathic pain is experienced in one third of cancer patients. Its treatment can be challenging, and it is suggested that neuropathic pain is to blame in half of cancer patients whose pain is inadequately controlled.

Topical 5% lidocaine plasters, although unlicensed for use in cancer related neuropathic pain, present a safe and well tolerated management option. Practice amongst palliative care practitioners seems varied with some local scepticism due to its small and inconclusive evidence base. No work had been performed in our region examining their use in cancer patients with neuropathic pain.

Aim: To assess the use of lidocaine plasters in patients known to palliative care services in our region, focussing on patient selection and appropriate prescribing.

Methods: Retrospective multi-centre case note audit. Organisations contacted via e-mail with a multipage questionnaire. Each site was responsible for identifying appropriate case notes and carrying out data collection. Responses submitted via an on-line, electronic data collection form. Data analysis performed centrally by the regional audit department.

Results: 35 data collection forms were submitted from 7 organisations. 89% patients had cancer related neuropathic pain. In only 40% cases was the lidocaine plaster prescribed 3rd line or later, as per guidelines. In 57% cases the plaster was prescribed to cover the site of described pain and 80% cases trialed the plaster for up to maximum of 4 weeks but only 9% had a pre-planned, time-defined review. In cases where the patient changed care setting, 47% had a documented handover on the recommendation.

Conclusion: Overall patient selection seemed appropriate. However, the lidocaine plasters were not always used in accordance with recommended guidelines and this audit has highlighted areas for improvements. Consequent recommendations have been made within the region.

Abstract number: P2-027
Abstract type: Poster

The Role of Intranasal Fentanyl in a Specialist Palliative Care Inpatient Unit – A Retrospective Study

Shah N.T, Coaclby A. Willowbrook Hospice, St Helens, United Kingdom

Presenting author email address: sarahnaji@hotmail.com

Background: Intranasal Fentanyl (INF) is indicated for the management of breakthrough cancer pain in opioid tolerant patients already receiving maintenance opioid therapy for chronic cancer pain. Aim: To carry out a retrospective study to assess the efficacy of intranasal fentanyl and indications for its initiation in patients admitted to an inpatient palliative care unit (IPCU) within the UK.

Method: A Retrospective study, reviewing the medical notes of patients admitted to an inpatient unit in a 1 year period. Data was collected on maintenance opioid used prior to starting INF, the character of pain experienced, previous breakthrough analgesia used, method of titration, final maintenance dose of INF, effectiveness and the outcome of the admission. Results were analysed using descriptive statistics.

Results: 18 patients had trialled INF between 2012 – 2013 of which 2 patients had INF initiated in clinic and notes were unavailable for 1 patient, excluding them from the study. 12 out of 16 patients (75%) had a documented handover on the recommendation for INF. INF was found to be effective in managing breakthrough pain in 8 out of 15 patients (53%). The mean, final titrated dose was 400 micrograms. No adverse reactions were reported.

Conclusion: INF was found to be effective in managing incident pain in more than 50% of the patients in this study. It was found to be effective for use in patients on maintenance opioid therapy where other immediate release opioids had been ineffective. It was also found to be a successful analgesic when utilised in patients outside usual practice.

Abstract number: P2-028
Abstract type: Poster

A Retrospective Study of Use of Methadone for Symptom Control in an Inpatient UK Hospice

Carrin J, Tysz-Cahon V.A, Subramaniam S, Elleran Lionel Hospice, Gravesend, United Kingdom

Background: Methadone is used in palliative care for neuropathic/complicated pain, neuroaxisy and renal failure.

Methodology: A retrospective case note and drug chart review undertaken of 21 patients started on methadone as an Inpatient in 2013 – 2014.

Results: 86% of patients had documentation of initiation of methadone by a consultant. 86% of patients were started on methadone for neuropathic/complicated pain. 71% of patients had a record of renal function close to their starting methadone. 76% of patients were already on adjuvant neuropathic medications. Methadone was initiated as a co-opiate in the 47% of patients or as a co-opiate in combination with a loading dose of methadone (28%). Most patients did not have their pain assessed with a pain scale tool on initiation and titration. The starting dose of regular methadone ranged from 3-15mg 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 were on a strong opioid 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 initiation. First titration after initiation ranged from Day7 to Day8 (mean 4.6) Second titration ranged from day 5 to day 10+ (mode Day7 and Day8).

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 is recommended.

Abstract number: P2-028
Abstract type: Poster
Breathlessness

Abstract number: P2-032
Abstract type: Poster

Successful Nursing Support for a Patient with Primary Macroglobulinemia under a Long-term Artificial Respiratory Support

Ogawa S.1, Hanada R.2, Kawahara R.2

Nissay Hospital, Palliative Care Team, Osaka, Japan, 2Nissay Hospital, Anesthesiology, Osaka, Japan

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 neuropsychiatry, 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 system is appropriate in this patient with a malignant disease. Although it was uncertain that she could recover from respiratory failure, an artificial respiratory support was introduced for chemotheraphy. The nursing care policy was set to reduce discomfort to she as much as possible. She was given an improved end of life care planning among caregivers, and quadrupled did not improve during the first two months. In order to encourage her and share the information of her daily changes among the medical staff members and her, a 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 neurology related with primary macroglobulinemia.
A Breath of Fresh Air?: Analysis of Short Specialist Palliative Intervention in Non-malignant Breathless Patients

Jones T, Webster L, Goves K.E.
Queenscourt Hospice, Southport, United Kingdom
Presenting author email address: tm.jones1@nhs.net

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 death)

Results: 52 patients identified – 16 excluded, 14 cancer, 1 dementia, 1 moved away. 36 records reviewed. 90% pulmonary disease, 5% cardiac, 5% MND. VAS score pair recorded 65% – breathlessness reduced 57%, 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/cope 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.

The Use of Bedside Sonography in a Mobile Palliative Care Team

Gehmacher O.
LKH Hohenems, Hohenems, Austria

Abstract type: Poster

Fatigue/weakness/cachexia

Abstract number: P2-036

Abstract type: Poster

Tampa Scale for Kinesiophobia-fatigue (TSK-F): Translation, Reliability and Validity

Berghammer A.
Uppsala University, BMC, Uppsala, Sweden
Presenting author email address: annette.berghammer@slu.se

Objective: To date, there is no Swedish instrument that measures fear of movement for cancer-related fatigue. This study aimed to translate, test reliability and validity of the Tampa Scale of Kinesiophobia-Fatigue (TSK-F).

Method: TSK-F was translated into Swedish and designed to enable the evaluation of test – retest reliability as well as construct-, criterion- and face validity. Twenty four cancer survivors participating test TSK-F SV.

Results: Test-retest (n = 13) showed that the total score of the TSK-F SV is reliable. Kappa analysis indicated a moderate line in 5 out of 17 questions (K = .448 to .527), where the others had no issues or very faint line (K = 0 to 0.389). The description of construct validity with Question and Answer Model (QAM) demonstrates that participants were fairly confident in their responses to the TSK-F EN (median 8.12 out of 10). Criterion validity with FACIT-F was good (r = .60, p = .028), but there was no statistically significant correlation between the TSK-F SV and “Perceived barriers to exercise” part of the question “Streched or lack of energy” (r = .35, p = .16).

Conclusion: The study results show that the total score on the Swedish version of the TSK-F has good test-retest reliability and concurrent criterion validity against the FACIT-F. Of the 17 questions in the TSK-F only five had a moderate correspondence by kappa analysis. The other questions showed no or very weak consistency. As the study was carried out with few participants, however, the results interpreted with caution.

The Effectiveness of Herbal Medicine for the Management of Anorexia in Advanced Cancer Patients – A Systematic Literature Review

Momayyaz N.1, Simanek R.2, Strasser F.1
1Cantonal Hospital St.Gallen, St.Gallen, Switzerland, 2Hansch Krankenhaus, 3 Medizinische Abteilung, Wien, Austria
Presenting author email address: natalie.momayyaz-kalbematten@kgss.ch

Background: Treatment options for anorexia, a common symptom in advanced cancer patient(nts), 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, there is 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 hm for anorexia in advanced cancer pts.

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.

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 multiherb 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
Cachexia and Inflammatory Markers in Patients with Advanced Pancreatic Cancer

Byrd B.J.1,2, Wesseltoft-Rao N.1,2,3, Jensen P.O.1,2, Holven K.B.2, Ulven S.M.2, Hjermstad M.J.1,3,4,5

1Oslo University Hospital, Regional Center for Excellence in Palliative Care, Oslo, Norway, 2Oslo and Akershus University College of Applied Sciences, Department of Health, Nutrition and Management, Oslo, Norway, 3University of Oslo, Department of Nutrition, Institute of Basic Medical Sciences, Oslo, Norway, 4Oslo University Hospital, Department of Haematology, Oslo, Norway, 5European Palliative Care Research Centre, Trondheim, Norway

Methods: Chronic inflammation is proposed as an underlying biological mechanism for development of cancer cachexia. Aims: 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 (65) were recruited. Median (range) age was 67 (53–79) years. All patients received chemotherapy. Median survival from diagnosis was 10 (3–25) 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.

<table>
<thead>
<tr>
<th>No cachexia, n= 9 Median (range)</th>
<th>Cachexia, n=11 Median (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRP (mg/ml)</td>
<td>12 (112–519)</td>
</tr>
<tr>
<td>IL-6 (pg/ml)</td>
<td>1.0 (0–44)</td>
</tr>
<tr>
<td>IL-8 (pg/ml)</td>
<td>0.1 (0–14)</td>
</tr>
<tr>
<td>IL-10 (pg/ml)</td>
<td>0.6 (0.3–3.4)</td>
</tr>
<tr>
<td>IL-6 (pg/ml)</td>
<td>3.9 (0.7–34.6)</td>
</tr>
<tr>
<td>CRP (mg/ml)</td>
<td>0.7 (0.3–51.9)</td>
</tr>
<tr>
<td>Adiponectin (µg/ml)</td>
<td>7.4 (5–15.6)</td>
</tr>
<tr>
<td>Leptin (ng/ml)</td>
<td>11.0 (3–25.7)</td>
</tr>
<tr>
<td>NF-κB (pg/ml)</td>
<td>70.0 (17–128.2)</td>
</tr>
</tbody>
</table>

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. Fearon, K., et al., Definition and classification of cancer cachexia: an international consensus. The Lancet Oncology. 2011. 12(5), p. 489–49

Abstract number: P2-040
Abstract type: Poster
Interventions for Respiratory Hypersecretion in Palliative Care Patients – A Systematic Review

Arun J.F., Abashiri E., Pires De Lorenzo V.A., Brone J., Preston N.L.
Federal University of São Carlos, Physiotherapy Department, São Carlos, Brazil, 4 Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom, 5 Lancaster University, Lancaster, United Kingdom

Background: Chronic respiratory hypersecretion is a common and distressing symptom for palliative care patients. Yet, most research on hypersecretion at the end of life focuses mainly on death rattle.

Aim: To synthesise the existing evidence evaluating interventions for respiratory hypersecretion in patients in the last year of life (excluding death rattle).

Methods: A systematic review was conducted using Medicine, 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. Citation tracking and reference searches resulted in an additional 5 papers. Interventions included: mechanical insufflation-exsufflation – MIE (16) and expiratory muscle training – 2 (Studies with MIE mainly assessed patients with neuromuscular diseases. One RCT with a small sample found that MIE-increased lung vital capacity. OIS encompassing MIE 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 (3), subcutaneous insulin analogues and oral insulin-like growth factors (4), nebulised saline (2), positive expiratory pressure masks (3), percussive ventilation (2), high frequency chest wall oscillations (1). Conclusion: The evidence gathered was largely in support of MIE, but there was insufficient high-level evidence to make strong recommendations.

Financial support: CAPES – Brazil.

Abstract number: P2-043
Abstract type: Poster
The Management of Paraneoplastic Sweating in a Palliative Care Setting
O’Rorordan J., Beatty S., Hamlett I.
Galway Hospice Foundation, Galway, Ireland

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’ paraneoplastic sweating’ Drugs used to treat sweating.

Results: There have been minimal publications and existing evidence is largely anecdotal. Many of the clinical trials were methodologically flawed, underpowered, uncontrolled and unblinded. Outcome measures were often non-specific or unvalidated and little evidence 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. It is a phenomenon that remains under represented in the medical literature. Further studies are urgently required to support pharmacological management strategies.

Abstract number: P2-044
Abstract type: Poster
The Use of Subcutaneous Levetiracetam for the Control of Seizures in Adults at the End of Life
Beatty S., McKeever C., McMahon D., Kilbourn J., O’Leary N.
1Our Lady’s Hospice and Care Services, Harold’s Cross, Department of Palliative Medicine, Dublin, Ireland. 2Our Lady’s Hospice and Care Services, Harold’s Cross, Dublin, Ireland

Background: Seizures in dying patients 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 antiepileptic 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 anticonvulsants by the oral route and, in whom high dose midazolam is deemed inappropriate by the medical team.

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: 10 patients accrued. Average age 66 years. Three patients had 1st CNS 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). 1 AED was stopped and was deemed ineffective and/or unsafe. 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: P2-047
Abstract type: Poster
Clinical Usefulness of the BCM (Body Composition Monitor) Method in Advanced Cancer Patients under Hospice Care

Buri T.1, Sukalowska A.1, Modlinska A.1, Pawlewski L.1, Janiszewskia J.1, Wyszadzka A.1, Łochodziowska-Wnemienko M.1
Medical University of Gdańsk, Department of Palliative Medicine, Gdańsk, Poland, 1st Joseph’s Hospice, Sopot, Poland

Background: BCM is fast, painless device that determines individual fluid status and body composition (lean and adipose tissue mass) employing the biopedance 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

Doğan S., Aslanbay Ş., Erim H., Aslanbay M., Tüselmen K.
Istanbul Medipol University, Istanbul, Turkey
Presenting author email address: sdogan@medipol.edu.tr

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 levels.

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 conscious (intubated 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 experienced was 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

Domínguez G., Veraestegui E., Monreal E., Chavira S., Rodríguez O., Allende S.
Instituto Nacional de Cáncerología, Cuidados Paliativos, Distrito Federal, Mexico

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: We evaluated 120 patients, 50% were women, mean age 53.2 (SD:16.47) years. The most frequent symptoms were pain (24.3%), dyspnea (16.2%) and delirium (13.5%). The time of hospital admission to the request for consultation service had an average of 11.6 (SD 21.74) days and the hospital stay was 15.8 (SD 29.29) days. The mean of Karnofsky was 40%. Morbidity was the most indicated (56.4%), 40% died in hospital and extra-hospital survival was 5.5 (SD 6.3) days on average.

Conclusions: Patients are referred to CF after 12 days of hospitalization; the SPRS 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

Ensker A.M.1, Mukai T.2, Neergaard M.A.3
1, Medical University of Gdańsk, Department of Palliative Medicine, Gdańsk, Poland, 2, Herming Regional Hospital, Hemming, Denmark, 3, Herming Regional Hospital, Hemming, Denmark

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 premonorbid personality develop 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. P-values < 0.05 were considered significant.

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 (8%) 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 retrospectively.

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.
Patients’ Experience of Impaired Sleep and Affecting Factors at an Inpatient Specialized Palliative Care Unit

Hakola P.1, Hennekson H.2, Soderstrom J.1, Samuelsen M.1, Strang P.1, Lundstrom S.1, Lundh Hagelin C.1
1Stockholm Sjukhem Foundation, Center for Palliative Care, Stockholm, Sweden. 2Karolinska Institutet, Dept. of Oncology – Pathology, Stockholm, Sweden. 3Sophiahemmet University, Stockholm, Sweden

Presenting author email address: pia.hakola@stockholmsjukhem.se

Background: Sleep-wake disturbances and insomnia are often described in patients with advanced disease and in palliative care. Factors such as anxiety, rumination, dreams, and pain are reported to influence the sleep quality. Insomnia and disturbing factors are often assessed by single questions or validated instruments. However, patients’ own experiences of factors affecting their sleep and sleep quality are often not described or clinically assessed.

Aim: To investigate how patients in inpatient specialized palliative care perceived their sleep, which affected a disturbed sleep, if they had dreams and in what way they experienced them.

Method: The study was conducted during five days at two inpatient palliative care wards. Every morning all patients were asked to answer a study specific questionnaire including questions such as: how did you sleep tonight, did you dream anything, if you slept badly, what do you think was the cause, with selected variables; and space for open comments. The wards together had 41 inpatients in the study period. Descriptive statistics and a thematic qualitative analysis were used.

Results: Preliminary results showed that 160 questionnaires were handed out to 53 eligible patients and 89 questionnaires (56%) were answered. Thirty-four percent of the patients reported sleeping less well or badly. Of these 60% reported difficulties falling asleep, 53% early awakening, 40% pain; 43% ruminations. Ruminations were described as: the situation of being severely ill, the limited time for life, whom to ask for help. Dreams were described as: dreams in vivid colors, a lot of dreams; about the situation and the family. Anxiety, worries, pharmacological aspects and environmental factors were other affecting factors seen in the comments.

Conclusion: Several factors may affect patients’ sleep quality and this study highlights the importance of asking patients about their own experiences as well as focus on ruminations and dreams.

Abstract number: P-053
Abstract type: Poster

Possibility of Use of Bedside Ultrasound Examination in the Patient’s Home by Use Focused Assessment Sonography Protocol in Palliative Care

Jakubow P.1,2, Furman J.1, Lachowicz D.1, Swiatkowska I.1,2,3
1Medical University of Białystok, Cardiosurgery Department, Białystok, Poland; 2Hospice Vitanmed im Edyta Jakubow, Białystok, Poland; 3Hospice Sokrates, Pruszów, Poland; 4Ołomunský Klinický Fakultativní Centrum, Ołomun, Poland; 5Medical University of Białystok, Cardiac Anesthesiology Department, Białystok, Poland; 6Edyta Jakubow Memory, Domestic Hospice Care Vitanmed, Białystok, Poland

Bedside ultrasound is valuable, but it is difficult to provide in hospices. We conducted a survey in which employees of hospices evaluated the protocol FASP designed for ultrasound examination of palliative patients. The aim of the study was to determine if the use of portable ultrasound at home by a doctor is justified and, if so, what should be assessed by ultrasound at the patient’s home.

Methods: The study was conducted in a group of 60 employees in palliative care departments, 78% of doctors, 20% nurses. 2% other. Survey questions included questions on general and specific: as experience of working in a hospice, education, specialty, appropriateness and use of ultrasound, ultrasound experience, the scope of the study, which organs should be investigated. The responses received were subjected to statistical analysis using ANOVA and Wilcoxon test.

Results: Longer length of service in a hospice but the young age of the staff is a greater need for the use of ultrasound P < 0.05. Even a brief experience with ultrasound in the past, this willingness to use ultrasound in their patients, p < 0.001. No equipment is a fundamental limitation of the use of ultrasound p < 0.001. Lack of training is a major constraint for all respondents, but only 75% of them will participate in the training, if they were available. P < 0.05. The majority of 75% respondents, want to evaluate the fluid in the abdomen, and in particular importance of asking patients about their own experiences as well as focus on ruminations and dreams.

Abstract number: P-052
Abstract type: Poster

Dying Patients Nursing Activities in the Institutional Care in the Czech Republic

Kisvetrová L.1, Školoudík D.1, Danielová L.1, Langová K.1
1Palacky Medical University Olomouc, Faculty of Health Sciences, Department of Nursing, Olomouc, Czech Republic, 2University hospital Olomouc, Department of Geriatrics, Olomouc, Czech Republic

Advanced author email address: helena.kisvetrova@upol.cz

Background: In the Czech Republic (CR), up to 80% chronic disease and 64% oncological patients die in a hospital or long term care facility. At the end of life Dying care and Spiritual support interventions allow moderate patient’s physical, psychosocial, and spiritual suffering and support family also in the institutions.

Aim: The study aims to determine if they frequency of nursing activities in dying patients care in different facilities in the CR.

Methods: [design, data collection, analysis]
Does a Pacemaker Lengthen the Dying Process in Palliative Care Patients?

Monette J.1, Rochus L.1, Peeters E.1, Bollen H.2
University Hospital Gasthuisberg, Radiation Oncology & Palliative Care, Leuven, Belgium.
1Catholic University, Medicine, Leuven, Belgium.

Background: Many palliative care patients and their proxies, but also health care providers frequently wonder if the presence of a pacemaker (PM) will lengthen the dying process of the patients. The American Heart Rhythm Society panel addressed the problem by clarifying the legal and ethical status of deactivating cardiac devices. The consensus statement also advises physicians on how to communicate with patients and families about whether to turn off a cardiac implanted device and they do not make a difference between a defibrillator and a PM.

Aim: The objective of this study is to explore if there is what any is objective clinical evidence that a PM will lengthen the dying process in palliative care patients.

Data collection: The duration of stay in the palliative care unit (PCU) until death 1600 patients was calculated and patients with n = 33) and without (n =1567) an implanted pacemaker are analysed. The results are: with PM / without PM:
- Median number of days in PCU: 6.5/10.5.
- Mean age: 81.7/73.4 y.
- Mean number of days in PCU oncology patients: 14.3/7.9.
- Mean number of days in PCU for 39.7 y. old pts: nonsignificant.
- Mean number of days in PCU for 50.4 y. old pts: nonsignificant.

Conclusions: There is no clinical evidence in this analysis that an implanted PM lengthen the dying process in palliative care patients. Only for cancer patients >80 years is there no difference in duration of stay in the PCU, but for all other categories life patients with implanted PM much shorter than patients without a PM.

Abstract number: P-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

Nagai J.1,2, Uesawao Y.1, Kagaya H.2
1Meiji Pharmaceutical University, Department of Clinical Pharmaceutics, Kiyose-shi, Tokyo, Japan.
2Department of Clinical Pharmaceutics, National Center for Geriatric and Gerontology, Shiga, Japan.

Introduction: The Japanese Adverse Drug Event Report database (JADER) is a computerized information database designed to support the Pharmaceuticals and Medical Devices Agency's (PMDA) post-marketing safety surveillance program for all approved drug and therapeutic biologic products in Japan. Potent opioid analgesics are applicable for the treatment of severe pain, especially in cancer patients. Management of opioid induced adverse effects is important to continue treatment with opioids because these drugs are associated with a variety of adverse effects, such as delirium and respiratory depression. However, information regarding these adverse effects in Japanese patients is limited. Therefore, we searched and analysed JADER (292,720 reviews; period of 2004–2013) to acquire information related to the adverse effects induced by potent opioids such as morphine, fentanyl, and oxycodone.

Methods: Cases with adverse effects associated with morphine, oxycodone, and fentanyl for palliative care cancer patients in JADER were extracted from JADER, and the types and frequencies of the events for each analgesic were analyzed.

Results and discussion: Results showed that a lot of common adverse effects were found among potent opioids. However, the order of their frequency differed among the analgesics. In the principal component analysis, the property of morphine was intermediate of fentanyl and oxycodone. These findings may contribute to the safe and effective pain control for patients receiving medical treatment with potent opioid analgesics.

Abstract number: P-059
Abstract type: Poster

Ultrasound-guided Rectus Sheath Block for Improvement of the Abdominal Distension Feeling

Nishijima K.1, Hashimoto N.1, Kobayashi M.1, Sakaguchi N.1, Nakashita A.1
Ikeda Municipal Hospital, Palliative Care Team, Osaka, Japan.

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 male patient in his 50s developed gastric cancer with malignant ascites and experienced abdominal distension feeling, but didn’t have nausea, dyspnea, poor mobility, and limb edema. He had inadequate symptom control with diuretic therapy and abdominal paracentesis. His distension feeling was improved temporarily by ultrasound-guided rectus sheath block. Then a percutaneous catheter used to administer an infusion of 0.25% ropivacaine triweekly until his death 20 days later.

Discussion: Ultrasound-guided rectus sheath block is one of various treatments of severe ascites and it is difficult to management. The ultrasound-guided rectus sheath block could be used to relieve it on a case-by-case basis.

Abstract number: P-060
Abstract type: Poster

Parenteral Hydration: Review of Prevalence and Rationale in Hospice Inpatients

O’Neill C.1, McDonnell D.2, Lester L.1, Udhuhir P.3, O’Connor B.4, Walsh D.5,6,7
1Trinity College Dublin, Dublin, Ireland, 2Our Lady’s Hospice and Care Services, Harold’s Cross, Dublin, Ireland, 3University College Dublin, Dublin, Ireland, 4Presenting author email address: bconnor@olh.ie.

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.

Aims:
1. Evaluate the prevalence of PH in hospice inpatients
2. Assess documentation of PH rationale and route of administration
3. Determine outcome after 48 hours of fluids

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%) 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 contrasted with the North American literature on the topic. Physician preference for intravenous route was evident despite literature suggesting 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, 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.
Comparative Study of Palliative Sedation at the End of Life in the Hospital vs. Palliative Care Home Unit

Martin-Utrilla S.1,2, Herrero Vicente C.1,3, Gómez Martínez E.1,2, Manchoño Álvarez A.1, Pascual Pajó J.L.1, Ruiz Ortega P.1, Vicente Benaveneta M.C.1, García Gómez E.1, Climent Durán M.A.1, Guillem Porta V.1, Grupo de Investigación en Cuidados Paliativos, Universitat Católica de Valencia ‘San Vicente Mártir’ (GRICUCV)

1Fundación Instituto Valenciano de Oncología, Oncology Department, Palliative Care Home Unit, Valencia, Spain, 2Facultad de Medicina, Universidad Católica de Valencia ‘San Vicente Mártir’, Valencia, Spain, 3Fundición Instituto Valenciano de Oncología, Oncology 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. 

Aim: - 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. 
- To describe the drugs used for PS at the end of life, the reached doses and the duration of sedation

Method: - Type of Study: Longitudinal, retrospective, comparative. 
- Study population: 146 patients and 419 episodes. Participants were the patients of the Medical Oncology Department and the patients of the PS Home Unit who had a pre-study that was carried on with the help of 5 physicians in the field of palliative care. 

Results: - 343 patient who died were recorded, 212 of them received PS. 151 in the hospital and 61 at home. The patient age at the index visit 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. 

Conclusions and discussion: Factors causing distress and thus intervene at the appropriate time.

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015

Poster Sessions (Poster Exhibition Set 2)
Phenobarbital a Better Drug for Palliative Sedation in Homecare?

van den Eynde J
Federale Vleugel Zorg Vlaanderen, Waasland, Sint-Niklaas, Belgium
Presenting author email address: joh.vandeneynde@skynet.be

Background: The prevalence of palliative sedation for refractory symptoms in terminal patients at home is 6% in our centre. Midaazolam 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 prospective study in Flanders.

Aim: To evaluate the use of our titration scheme of phenobarbital subcutaneous (SC) on time to deep sedation and stability of sedation.

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 2mg/kg. 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–17h). The best result (less time to deep sedation) was achieved when the nurse used sufficient bolus dose in the loading up period (100mg–400mg, mean bolus dose=250mg). Mean drug dose was 92,3mg/h (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 usual standard of midazolam, we are setting up a multicentre prospective study in Flanders. There was no funding.

Abstract number: P-071
Abstract type: Poster

Prospective Study of Changes in Patient Characteristics in Persons with Intellectual Disabilities at the End-of-Life

Unmoortel C1, Christians M.G.M., Echteld M.A1, Van Schooten Lantman-de Valk H1, Groot M.M.1
1Radboud University Medical Centre, Healthcare for People with Intellectual Disabilities, Nijmegen, Netherlands, 1Foundation Science Balance, Rotterdam, Netherlands, 1Radboud University Medical Centre, Expertise Center Palliative Care, the Netherlands, Nijmegen, Netherlands

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 a 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 (after 12 months)). We use the Barthel index to measure ADL, the Cumulative Illness Rating Scale to measure comorbidity and the Edmonton 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. Off-labeled use. We are 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: Because this is a pilot study, this will be the first to describe characteristics 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 will thereby contribute to the quality of palliative care in this population.
Validation of an Arabic Questionnaire for Symptom Assessment

Al-Shahin M.2, Al-Zahrani A.1, Alansari A.1, Abdulah A.1, Alhajri M.1, Motar A.1, Hassan A.1, Shoukri M.1, Sroor M.Y.1
1IMC University of Applied Sciences Krems, Department of Health Sciences, Krems, Austria
2King Faisal Specialist Hospital and Research Center, Riyadh, Saudi Arabia

Presenting author email address: wesal_massoud@kfsr.edu.sa

Background: Arabic speaking minorities are distributed worldwide. This study aims at validating an Arabic self-administered (SA) tool for assessing the severity of common symptoms among palliative care (PC) patients.

Objectives:
1. To test the validity of the Arabic Questionnaire for Symptom Assessment (AQSA) as a SA tool for assessing eleven symptoms among PC patients.
2. To test the validity of AQSA when completed by a proxy.

Methods: AQSA is a one page tool for assessing severity of 11 symptoms on a 0–10 numeric scale. The tool was reviewed by 3 external PC experts. Symptom scores on the SA AQSA were compared to scores obtained through interviews with patients. The same procedure was repeated with patients’ sitters to explore the validity of using the tool for symptom assessment by proxy. Four centers from 2 countries participated in the study. The statistical analysis involved mainly correlation coefficients, with the level of significance being set at p < 0.05.

Results: The study involved 107 pairs with a mean age of 46.3 years (females 59.8%) for patients and 35.9 years (females 65.7%) for sitters. The correlation coefficient (r) for agreement between SA and interview-based scores on AQSA for patients ranged from 0.65 (p < 0.0001) for drowsiness to 0.86 (p < 0.0001) for dexterity. The correlation coefficient (r) for agreement between SA and interview-based scores on AQSA for patients ranged from 0.73 (p < 0.0001) for insomnia to 0.90 (p < 0.0001) for shortness of breath. The SA AQSA showed positive correlation between sitters and patients scores, with r ranging from 0.28 (p = 0.004) for depression; to 0.62 (p < 0.0001) for vomiting.

Conclusions: The strong positive correlation between SA and interview-based AQSA indicates that the former is a valid tool for assessing the severity of the listed symptoms. When the SA AQSA is used by proxy it showed moderate to strong positive correlation with patients’ actual scores for most of the symptoms.

Assessment and measurement tools

Translation and Cultural Adaptation of the Integrated Palliative Care Outcome Scale (IPSO) to the Portuguese Population

Antunes A.1,2, Ferreira PL.1
1Centro de Estudos e Investigação em Saúde da Universidade de Coimbra, Coimbra, Portugal, 2Cicely Saunders Institute, King’s College London, Palliative Care, Policy and Rehabilitation, London, United Kingdom

Presenting author email address: barbara.antunes@ie.uc.pt

Background: The Integrated Palliative Care Outcome Scale (IPSO) is a patient reported outcome measure resulting from the merge of two previously existing measures: the Palliative Care Outcome Scale and the Palliative Care Outcome Scale-Symptoms. IPSO was developed at the request of several clinicians wanting a more user-friendly measure for clinical practice.

Aim: To translate and cultural adapt the original English IPSO into Portuguese.

Methods: 2 independent native Portuguese speaking translators, 1 clinical and 1 non-clinical, both blind to the original English IPOS created 2 Portuguese versions. A consensus Portuguese version was developed by 2 native Portuguese speaking independent reviewers not blind to the original IPSO. This consensus version was sent to 2 other independent native Portuguese speaking translators, also blind to the original English IPSO, who back translated it into English. A second Portuguese consensus version was developed by the same reviewers. 3 clinical revisions were performed by 1 specialist palliative care doctor, 1 specialist palliative care nurse and 1 non-clinical researcher – all native Portuguese. A final Portuguese version was created.

Results: There were grammatical and content differences in the first translation stage, in the items/questions text as well as in the response categories. These were resolved by discussion by both reviewers. There were also differences in the backward translation, namely verb tenses and the use of synonyms rather than the direct translation of words. These were resolved by discussion by the same reviewers.

The clinical revisions flagged differences in word use and word tenses in 3 items. Those were discussed and changes were made to create the final version.

Conclusion: We created a Portuguese IPSO, now ready to be tested regarding content validity, acceptability, clinical applicability, reliability, internal consistency, construct validity and sensitivity to change.

Funding: Calouste Gulbenkian Foundation
Independent Validation of the Modified Prognosis Palliative Care Study (PPS) Predictor Models throughout Three Palliative Care Settings

Robo M.1, Maeda I.1, Monta T.1, Hanagata T.1, Hishinuma T.1, Ishiwata T.1, Kaneshi K.1, Kawanago S.2, Kuniyama T.3, Mado T.3, Mor I.4, Tsuneto S.4

1Seito Yukoukai Hospital, Ibaragi, Japan, 2Okayama Saiseikai General Hospital, Okayama, Japan, 3Kawasaki Medical College, Kawasaki, Japan, 4Okayama Saiseikai General Hospital, Okayama, Japan

Background: Accurate prognostic information in a palliative care setting is needed for patients to make decisions and set goals and priorities. The instrument, the Prognosis Palliative Care Study (PPS) predictor models, was presented in 2011, but has not yet been fully validated by other research teams.

Aims: The primary aim of this study is to examine the accuracy and to validate the modified PPS (using physician proxy ratings of mental status instead of patient interviews) in 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.

Results: A total of 2425 subjects were recruited. Due to lack of follow up and missing data (principally blood examination data), we obtained a total of 2032 and 1385 analysable data for the modified PPS-A and PPS-B, respectively. In all palliative care settings, both the modified PPS-A and PPS-B identified 3 risk groups with different survival rates (P < 0.001). The absolute agreement ranged from 56 to 60% in the PPS-A model and 60% to 63% in the PPS-B model.

Conclusion: The modified PPS was successfully validated and can be useful in palliative care units, hospital-based palliative care teams, and home-based palliative care services.

Supportive & Palliative Care Indicators Tool (SPICT): Transforming Identification of Patients for Palliative Care Worldwide

Boyd K.1,2, Highet G.1, Mason B.3, Muray S.4

1NHS Lothian, Department of Palliative Care, Edinburgh, United Kingdom, 2University of Sydney, Sydney, Australia

Background: Access to palliative care for people worldwide is a healthcare priority. This requires evidence of ways of identifying patients for palliative care. People at risk of deteriorating and dying often go unrecognised 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. Evaluation in clinical practice demonstrated SPICT’s face validity and ability to help teams 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 building. SPICT building blocks are developing. SPICT is being shared as a tool internationally.

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 Patient Dignity Inventory for Cancer Patients, Families and Clinicians in the Home Palliative Care

Buonaccorso L.1, Belloni C.1, Aboumerhi S.1, Fabbo A.2

1Palliative Care and Palliative Home Care, Mirandola, Italy, 2Primary Care, Ausl Modena, Metropolitan Cancer and Infectious Disease Center Komagome Hospital, Bunkyo-ku, Tokyo, Japan

Aims: The Patient Dignity Inventory (PDI) is a tool based on the empirical model of dignity in the terminal illness (Ossenbrinck and colleagues). It evaluates the different aspects of patients’ experience near the end of life and can be used like a guide for the clinicians to comprehend the patients’ dignity. It was validated in Italian on patients with solid and hematological cancers on active treatments. We used the PDI with cancer patients in home palliative care. The purposes were: – to evaluate the patients’ sense of dignity, – to monitor the dignity during home palliative care, – to improve the communication between clinicians, patients and the family.

Methods and approach: The project involved thirteen nurses. It consisted of three parts: 1. workshop conducted by a psychologist who attended the Dignity Therapy Workshop, in order to give information and the model of dignity and the administration of PDI; 2. application of PDI in clinical practice; 3. sharing the observations twice a month by clinic audit.

Lessons learned: The PDI were used after two-three meetings with patients because during 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 improve the communication with patients and family. 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.

Conclusion: 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.
Implementing Outcome Measures in Palliative Care: Putting the Evidence into Practice

Cicely Saunders Institute, King’s College London, Palliative Care and Rehabilitation, London, United Kingdom
Presenting author email address: marsha.dawkins@kcl.ac.uk

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):
- tailor implementation using appropriate facilitators tailored to the characteristics of each team
- educational intervention prior to implementation on how and when measures are used and suggestions of how they may be integrated into practice
- timely feedback of results at both patient and service level
- use of a facilitator working alongside clinicians throughout the implementation process to address concerns arising.

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 care processes. Further robust evaluation is needed for each of the above strategies.

Abstract number: P2-082
Abstract type: Poster

The Content Validity and Utility of a Screening Tool to Improve Detection of Problems and Healthcare Access for People with Dementia in Residential Care Homes: The Palliative Care Outcome Scale for Dementia – Screening (POS-DemS)

Ellis-Smith C, Evans CJ, Hugonison J,I, Parnell C, Henson LA, Davenport R, Bule,Care
King’s College London, Cicely Saunders Institute, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom

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 co-ordinated care.

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.

Methods: 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, GPs and nurses using maximal variation sampling. Content analysis of verbatim transcripts was conducted.

Results: 26 participants resulted in three categories: content validity, utility and processes. Content validity: Comprehensive screening must not be compromised by brevity. Additional dementia-specific items were identified for inclusion in six domains 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 health provision.

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Textile-based Monitoring System in Palliative Home Care: An Exploratory Study

Finger A.1, Moerer E.1, Remser U.1, Ross A.1, Schreyer L.1, Stassler F.1
1FHS St.Gallen, University of Applied Sciences, Institute of Applied Nursing Science IPW-FHS, St.Gallen, Switzerland, 2FHS St.Gallen, University of Applied Sciences, Institute of Information and Process Management, St.Gallen, Switzerland, 3EMPA Materials & Science Technology, Protection and Physiology, St.Gallen, Switzerland, 4Private Universität Witten-Herdecke, Department Nursing Science, Witten, Germany, 5Cantonal Hospital St.Gallen, Medical Oncology, St.Gallen, Switzerland

Abstract number: P2-087
Abstract type: Poster

Patient-reported Outcome Measures: How Frequently Are They Completed by Patients with Palliative Care Needs?

Enrume R.1, Kanzaria A.1, Pigott S.1, Sharkey E.1, Stevens D.1, Gibbins J.1
1Peninsula Medical School, Truro, United Kingdom, 2Cornwall Hospice Care, Hayle, United Kingdom, 3Cornwall Hospice Care & Royal Cornwall Hospital, Cornwall, United Kingdom

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 too busy to complete them.

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 300 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.

References:

Changes in Skeletal Muscles of Patients with Breast Cancer before Death

Kubo Y.1, Osawa G.1, Ohno S.1, Kanda T.1, Mayuzumi M.K.1, Matsubara T.1, Aruga E.1
1Teikyo University School of Medicine, Palliative Medicine, Itabashi-ku, Japan, 2Teikyo University School of Medicine, Radiology, Itabashi-ku, Japan

Background: Skeletal muscle wasting is a prognostic indicator of cancer. In patients with lung or gastrointestinal cancers, skeletal muscle mass decreases exponentially during 3 months before death. However, patients with breast cancer have not been examined in this regard.

Aims: To assess skeletal muscle wasting in patients with breast cancer during 12 months before death.

Methods: This was a retrospective observational study. We examined patients with breast cancer who came for a consultation to the Teikyo University School of Medicine Hospital between April 2006 and December 2013. Of these, we examined 26 patients who died of breast cancer. We quantified the loss and gain in skeletal muscles using computed tomography (CT) images. Statistical analysis was conducted using the chi-square and Student’s t-tests.

Results: The 26 patients who died of breast cancer had undergone 96 CT scans during the 12 months before death. With consideration of all time points, muscle loss was detected in 34.3% of the intervals between any two scans. The overall frequency of muscle gain was 5.7%, whereas muscle mass was stable in 60.0% of the intervals between any two scans. We compared the average changes in skeletal muscle mass between two equal periods (months 1–6 and 7–12) before death. Muscle mass decreased more during the 6 months immediately before death (95% confidence interval 1.7–8.7, P = 0.0054).

Conclusion: Regular skeletal muscles of patients with breast cancer significantly decrease during 6 months before death. However, further research in a larger cohort is warranted.
Palliative Care Needs Assessment in Albania

Lakajik K., Koleci G., Bylykbashi E.
Korca Palliative Care, Korca, Albania

Objective: Presentation 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 (Connor & Huta, 2010).

Results: Based on the current situation of PC reports show: PC in Albania is provided only to cancer patients. The cause of death for approximately 1937 patients/year 2865 patients receive partial PC 1927 are provided with a non-cancerous disease require PC but are not provided with this service. A total of 1798 patients require PC remain unattended from this service. Currently in Albania patients have access to opiates. In the ambulatory service the use of opiates is limited because of the opiosphobia of GP 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.

Do Palliative Care Teams Perform Better than Non-palliative Care Teams in Symptom Control?

Silva M.A.S.1, Mattoso-Pimenta C.A.1, Carvalho R.T.2, Chiba T.1, Diniz M.A.T.1
1School of Nursing, University of São Paulo (EUSP), São Paulo, Brazil; 2HCFMUSP, Palliative Care, São Paulo, Brazil; 3HCUSP, Palliative Care, São Paulo, Brazil; 4HCUSP, São Paulo, Brazil.

Presenting author email address: magda_mass@yahoo.com.br

Introduction: The effectiveness of different strategies of palliative care provision is little known.

Objective: To compare symptom control effectiveness provided by two health care teams: interconsultation palliative care (IPCT) and non-palliative care (NP) in the first 48h from hospital admission.

Method: Pragmatic clinical trial carried on 286 consecutive adult inpatients with advanced cancer, admitted in general hospital (IPCT=73 and NP=75) and in oncology hospital (IPCT=53 and NP=87), 2012–2013, with pain ≥4 (0–10) or at least other two symptoms with intensity ≥4 (0–10). All were interviewed at admission, 24h and 48h from admission. Symptoms were measured by the Edmonton Symptom Assessment System (ESAS). The endpoints were 2 points reduction of the initial pain or other symptoms scores after 48h from admission, and 20 points reduction of the initial symptom burden score after 48h from admission. Multiple Poisson regression analysis was done to verify the endpoints occurrence.

Results: The symptoms burden average scores at admission were moderate and similar in IPCT and NP groups. After 48h from admission, symptom burden improved only in NP group (p<0.001, Wilcoxon test). The regression analysis showed relative risk reduction of 2 points in pain score (RR=2.2; p<0.005), well-being score (RR=4.6; p<0.01) and constipation score (RR=9.5; p<0.001) in NP group. Relative risk reduction of 2 points in pain score (RR=0.6; p<0.04) was observed for NP group.

Conclusion: These findings highlight that the team’s performance in control were similar and the symptoms were poorly controlled after 48h from admission.

A Multidisciplinary Assessment and Follow up Questionnaire of Palliative Sedation: The Experience of Hospice Bentivoglio (Bologna, Italy)

Monroy M., Pallott C., Celini D.
Fondazione Hospice MTC Seragoni, Bentivoglio (Bologna), Italy

Background: Palliative sedation (PS) is a medical treatment part of continuum of palliative care, used for the control of refractory symptom in patients at the end of life. We created a questionnaire to improve the good clinical practice of PS.

Aims: The aim of this study evaluate the decisional and therapeutic process of PS in a period of one year in our Hospice by a specific tool.

Methods: The multidisciplinary questionnaire is composed of four parts about the different aspects of PS: diagnosis of refractory symptom, pharmacological interventions, evaluation of awareness of patients and main caregivers (CG); about clinical situation and PS, follow up during PS with RASS scale. The population is the inpatients of Bentivoglio Hospice. From May 2011 to March 2013 we’re leading an observational, non randomised, 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%) received PS. The pre-clinical results show that 66 patients (98.5%) had an advanced tumor, 1 had a pulmonary non-oncological disease (1.5%), 40 patients (60%) had full awareness of their diagnosis, 22 patients (33%) had full awareness of their prognosis (33%), 11 patients (16%) knew the possibility of sedation while in hospice and only one of these patients didn’t agree with PS until onset of refractory symptom. Dyspnea was the most frequent refractory symptom (61%). Midazolam was the most common drug prescribed. 57 CG (85%) agreed with PS until onset of refractory symptom. Dyspnea was the most frequent refractory symptom (61%).
Poster: Sessions (Poster Exhibition Set 2)

Abstract number: P2-095
Abstract type: Poster

OQL Using SEIQoL-DW for Advanced Cancer Patients Receiving Outpatient Palliative Care

Sakshioth V
Chiba Cancer Center, Palliative Medicine, Chiba City, Chiba, Japan

Aims: The aim of this study is 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-Direct Weighting (SEIQoL-DW) was implemented on advanced cancer patients receiving outpatient palliative care. The SEIQoL-DW is a semi-structured interview that extracts 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 weighting for each that the patient thought was important.

Results: The study was implemented on 14 subjects (6 patients were undergoing anti-cancer therapy and 8 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 a mean satisfaction level for anti-cancer therapy of 34, and a mean weighting 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.

Abstract number: P2-096
Abstract type: Poster

Identifying Palliative Care Needs in US Emergency Departments

Schulman K.A.,1 Zoleslak R.J.2
Wayne State University, Detroit Receiving Hospital, Department of Emergency Medicine, Detroit, MI, United States, Wayne State University, Sinai Grace Hospital, Professor of Emergency Medicine, Division of Palliative Medicine, Detroit, MI, United States
Presenting author email address: katherine721@gmail.com

Background: The American College of Emergency Physicians has recommended that high morbidity and terminally ill patients be identified for palliative and hospice care services in US Emergency Departments (ED). To implement this, we evaluated a palliative care screening tool in the ED of a large, urban hospital where usual treatment and disposition has been resuscitation and ICU admission.

Methods: During April and May 2014, 52 potential ICU admissions were screened or retrospectively reviewed for palliative care risk factors using a 7-item screening tool during a convenience sample of ED shifts. Risk factors (RF): included: transfer from nursing home, metastatic cancer, end of life burden, fear of hospital admissions, end-stage organ failure, cardiac or respiratory arrest, and poor prognosis. Patients were scored as negative (no RF) or positive (≥ 1 RF).

Results: Of 52 patients screened, 38/52 (73.1%; 95% CI 0.60–0.83) scored positive and 18/38 (47.3%) of these patients received palliative care consults: 10 were initiated in the ED and 8 in the hospital. Of the 10 palliative care consults performed in the ED, the code status of patients was changed during consultation to “Do Not Resuscitate” (DNR) and 1 remained full code. All 9 DNR patients met ICU admission criteria. Subsequently, 3 were referred to palliative care services and 6 were admitted.

Conclusion: Palliative care screening and consultation in the ED are feasible and can impact resuscitation care plans and disposition. It can help coordinate care that is consistent with palliative needs and may also lead to a reduction in ICU admissions. Further research is needed to quantify the benefits of palliative care screening and consultation on critical care admissions from the ED.

Abstract number: P2-097
Abstract type: Poster

Factors of Essential and Existential Importance at the End of Life – A ZMET Analysis among Patients and Relatives in a Hospice

Simonsen L.D.1, Pedersen I.O.B.1, Krogager R.1, ZMET-Group
Hospice Djursland, Denmark, 1Hospice Djursland, Rønde, Denmark, 2Danish Cancer Society, Copenhagen, Denmark
Presenting author email address: dorit.simonsen@hospicedjursland.dk

Patients received at a hospice are marked by their disease, often holding unpleasant symptoms. Many come from hospitals, where they have experienced a lot of treatment. Also, many have filled out questionnaires and scores for different purposes. In this situation it is difficult to burden the patients with further questionnaires or scores in order to reveal factors of crucial importance at the end of life. We wanted to elucidate this in a feasibility study. We performed a ZMET analysis according to Zaltmann (ZMET = Zaltmann Metaphor Elucidation Technique). Ten patients and 3 relatives were provided with a digital camera. After instruction and consent they were asked to snap shot situations, activities and other matters of importance from daily life in hospice. After a few days, the participants were invited to a dialogue about the pictures to elicit deeper thoughts and emotions through reflections over motives, situations and other subjects pictured in the photos. All patients had been in the hospice for more than 1 week. The study showed that the ZMET technique is suitable for these rather weak and burdened patients and relatives. The patients consider this method as appreciation. Furthermore, the study revealed the impotance of the possibility of being together with the family, friends as much as wanted. The nearestness to nature was extremely important due to speculators and the extremeness of views outside the windows. Furthermore, the possibility to furnish the room in their own way, with own paintings, pets and artifacts was important as was the daily morning song and worship. The possibility of food choices was liked as the “snack bar”, musical events, the quality of paintings and arts in hospice. Photos together with the associated reflections and stories will be presented.

Abstract number: P2-098
Abstract type: Poster

Effects of Family Caregiver’s Anxiety and Depression on Retrospective Ratings of Quality of Dying and Death (QoDD) of their Loved Ones

Heckel M.1,2, Bussmann S.1, Weber M.1, Ottaghe C.1, Speil J.1,2
1University Hospital Erlangen, Friedrich-Alexander-Universität Erlangen-Nürnberg, Department of Palliative Medicine, Erlangen, Germany, 2University Hospital Erlangen, Friedrich-Alexander-Universität Erlangen-Nürnberg, Comprehensive Cancer Center, CCC Erlangen – EMN, Erlangen, Germany, University Medical Center of the Johannes Gutenberg University Mainz, Interdisciplinary Palliative Care Unit, III. Department of Medicine, Mainz, Germany
Presenting author email address: stephanie.stiel@uk-erlangen.de

Background: In studies using informal caregivers’ (IC) of patients in palliative care (PC) it has to be ensure that findings are not influenced by factors such as medical disorders. This study aims to describe the influence of anxiety and depression on bereaved IC 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 (Chi², T-test; significance level p< 0.05) analyzed 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 226 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< 0.198, Chi²). Two (0.9%) participants were screened positively for both panic and for major depressive disorders. Participants with vs. without mental disorder showed no differences in interview burden or duration. The T-test for the group of participants with major or depression syndromes (n=35) vs. participants (n=137) with no signs of depression presented no significant differences in the mean total QoDD score (p> 0.343).

Conclusions: IC’s estimates on QoDD of their significant others are not influenced by medical disorders. Therefore bereaved IC are well able to participate in PC research a few weeks post-loss.

Abstract number: P2-099
Abstract type: Poster

Associated with Quality of Life and Depression among Patients with Hematopoietic Stem Cell Transplantation

Takata A.1, Mutai H.2, Kobayashi M.1
1Shinshu University Hospital, Rehabilitation, Matsumoto, Japan, 2Shinshu University, Health Science, Matsumoto, Japan

Aim: During and chemotherapy induce high levels of stress in patients with cancer, and apparently, these patients also experience depression upon every treatment cycle. Moreover, 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.

Methods: To identify the relationship between QOL and depression among patients with hematopoietic stem cell transplantation.

Results: A total of 226 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< 0.198, Chi²). Two (0.9%) participants were screened positively for both panic and for major depressive disorders. Participants with vs. without mental disorder showed no differences in interview burden or duration. The T-test for the group of participants with major or depression syndromes (n=35) vs. participants (n=137) with no signs of depression presented no significant differences in the mean total QoDD score (p> 0.343).

Conclusions: IC’s estimates on QoDD of their significant others are not influenced by medical disorders. Therefore bereaved IC are well able to participate in PC research a few weeks post-loss.
Abstract number: P2-100
Abstract type: Poster

Implementation of a Patient Reported Outcome Measure (PROM) in a Brazilian Palliative Care Hospital Service

1Hospital Paulista Uniao, Palliative Care / Internal Medicine, São Paulo, Brazil, Universidade de Coimbra, Centro de Estudos e Investigação em Saúde, Coimbra, Portugal, University of London, Palliative Care, Policy and Rehabilitation, London, United Kingdom
Presenting author email address: apsantos@hospitalpaulistano.com.br

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 was 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 nurses managing the POS database would preferably do it. 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=694)</th>
<th>Study Phase (N=1058)</th>
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<tbody>
<tr>
<td>Scores: 2 to 0 (n=3), 2 to 3 (n=1), no change (n=2) (p=0.131*)</td>
<td>Scores: 4 to 1 (n=6), 4 to 0 (n=2), 3 to 1 (n=3), 3 to 2 (n=2), 2 to 0 (n=2), 2 to 1 (n=1), no change (n=1) (p=0.0055*)</td>
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*Wilcoxon signed-rank test

Abstract number: P2-101
Abstract type: Poster

Food and Oral Care at End of Life

Venborg A., Jensen L.L., Helbo T.H.
Hospice Djursland, Randers, Denmark
Presenting author email address: annegets.venborg@hospicedjursland.dk

At hospice, many factors affect the quality of patient’s meal experiences, including proper eating position, swallowing problems, food’s consistency as well as oral and dental status. For patients with dysfunctions in the head, mouth and throat it is important to ease eating position, swallowing problems, food’s consistency as well as oral and dental status.

Adequate knowledge, competence and attention of nurses are needed to provide an extent to which a loss of function may be corrected. Appropriate compensatory support. Patients themselves are not necessarily aware of the extent to which a loss of function may be corrected. Through appropriate nursing, the patient will achieve well-being in the mouth and can look forward to enjoying a meal.

Results:

- 14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015

Abstract number: P2-102
Abstract type: Poster

Predictors of Survival: A Study by a UK Hospital Palliative Care Team

Vickersstaff V1, Armour K2, Stone P3, Myestie C4
1University College London, Marie Curie Palliative Care Research Department, London, United Kingdom, 2Manchester University Hospice West Midlands, Solihull, United Kingdom, 3Heart of England Foundation Trust, Palliative Care Team, Birmingham, United Kingdom
Presenting author email address: vickersstaff@ucl.ac.uk

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. Aims: 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); 53% (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 10 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.

Abstract number: P2-103
Abstract type: Poster

Outcome Measurement in Palliative Care: An Updated Systematic Review of the Use of Two Popular Measures in Clinical Care and Research

Wijn L1, Collins E2, Bausewein C3, Davison B.A1, Heggsson I1, Murtagh F.E1
1King’s College London, Palliative Care, Policy and Rehabilitation, London, United Kingdom, 2Keble University, School of Medicine, Keble, United Kingdom, 3Universitat München, Klinik und Poliklinik fur Palliativmedizin, München, Germany
Presenting author email address: jana.wijnt@kcl.ac.uk

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.

Aims: 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 (35 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. Publications reported use in 27 different countries. In most new publications, POS or STAS were used to assess patient concerns or measure quality of care (n=35, 81%). This indicates a shift in the way these measures are used, away from validation and reliability studies, and towards use as clinical or research tools. The review also found an increase in the use of POS and STAS with non-cancer patient groups.

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.

International Advances in Outcome Measurement in Palliative Care: One Step Closer to Translational Research
Innovative Tools for Measuring Medical Outcomes

Poster

Abstract number: P2-104

Abstract type: Poster

Aim: 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: vertical 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, to 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

Veldhuisen H.1, Zweers D.2, de Graaf E.2, Toonstra S.2

1Olandeseziekenhuis Utrecht, Department Lung diseases and Tuberculosis, Utrecht, Netherlands, 2University Medical Center Utrecht, Division of Internal Medicine, Utrecht, Netherlands

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.

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  
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**Integrating Palliative Care in a National Cancer Plan**

**Adlitzer H.**, **Strang P.**  
1Regional Cancercentrum, Stockholm, Sweden, 2Karolinska Institutet, Dept of Oncology-Pathology, Stockholm, Sweden  
Presenting author email address: heleena.adlitzer@ssl.se

**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 the day of diagnosis, with care, patient safety, short lead-times, evidence-based knowledge, effectiveness and efficacy.

**Aim s:** To establish the current quality of end of life care in the hospital setting compared to the community. To design and implement a questionnaire to capture feedback from bereaved relatives on how to improve end of life care in our two hospitals.

**Method:** 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 documented evidence 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 (HPCT).

**Discussion:** Results demonstrate substantial compliance with the current interim guidance. Adherence to interim guidance was much improved by involvement of the HPCT. 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 HPCT. 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**

**Bates C., Etheridge G., Blackabee G.**  
Barking, Havering & Redbridge University Hospitals NHS Trust, London, United Kingdom  
Presenting author email address: clare.bates@bhrruh.nhs.uk

**Background:** How does a large hospital Trust with over 2500 deaths per year assess the quality of the end of life care provided to patients and families? The aim of this study was to launch a Bereavement Survey (VOCES) to provide feedback to improve the quality of end of life care in our two hospitals, a hospital-specific questionnaire was designed.

**Aim:** To design and implement a questionnaire to capture feedback from bereaved relatives on how to improve end of life care in our hospital.

**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 Frontera across the Whole Hospital Trust**

**Benson DL., Patel J., Daniel SL.**  
1East Sussex Healthcare NHS Trust, Palliative Medicine, Hastings, United Kingdom, 2East Sussex Healthcare NHS Trust, Pharmacy, Hastings, United Kingdom, 3East Sussex Healthcare NHS Trust, Hastings, United Kingdom  
Presenting author email address: debbiebenson@sus.nhs.net

**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 hospial 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 total quantity required in words and figures, and signature omission. Average time taken for such TTOs to pass through pharmacy was 1 hour 25 minutes.

A multidisciplinary collaboration (between a specialist pharmacist, consultant, hospital pharmacist and foundation doctor) led to development of a dedicated dispensing chart for the common subcutaneous medications used in palliative patients. The dispensing chart prompted good prescribing practice and aimed to reduce prescribing errors and dispensing times. The dispensing chart was piloted 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.
A Pain Audit at Regional Cancer Centre of India: Assessing Psychosocial Distress in Cancer Pain is the Need of the Hour

Bhatnagar S*
IRCH, AIIMS, New Delhi, India
Presenting author email address: susmabhhatnagar@gmail.com

Aim: Recent work in palliative care has recognised that pain is a complex social, psychological, and spiritual psychological experience. In order to assess if each of these components is adequately recorded in clinical documentation in our centre, we undertook a retrospective audit of psychosocial assessment procedures at the pain clinic at IRCH-AIIMS, 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 pain are distress are not to be less adequately recorded.

2) The layout of the assessment is slanted towards functional factors (such as interference with daily activities and mobility), while non-functional symptoms are being recorded at relatively lower levels (such as anxiety and depression – 4.6%). 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 at 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 socioeconomic distress and ease of completion in the high volume public health scenario.

Abstract number: P2-114
Abstract type: Poster

Time & Motion: Transferring NHS Productive Ward to a Hospice Setting

Birch L, Leyland S, Webster L
Queenscourt Hospice, Southport, United Kingdom
Presenting author email address: helen.birch@nhs.net

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.

Aims: We concentrated on two modules in Phase 1: Well Organised Working Environment & Knowledge How We Are Doing. The focus was on improving ward processes & 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 days followed external training, attended by various staff disciplines for palliative care professionals. This was undertaken over 8 weeks, with the 1st week spent looking 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 walks, looking at 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.

Abstract number: P2-115
Abstract type: Poster

A Quality Improvement Journey in Palliative Care: Enabling Reliable Person-centred Care through Information Reconciliation

Burton T, Brooks Young P, Kir S, Gordon C
NHS Lothian, Quality and Safety Improvement, Edinburgh, United Kingdom, 2NHS Lothian, Palliative Care, Edinburgh, United Kingdom, 3Edinburgh Napier University, Edinburgh, United Kingdom, 4NHS Lothian, Acute Stroke and Medicine of the Elderly, Edinburgh, United Kingdom, 5NHS Lothian, Acute Medicine, Edinburgh, United Kingdom

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 integration & system wide changes. We have undertaken an improvement programme.

Aim: To ensure patients in pilot areas receive care aligned to their needs & wishes through integration across hospital & community services.

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 to allow for communication of information across care settings: information reconciliation.

Abstract number: P2-117
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 2)
Acupuncture for Hot Sweats: Kindling the Flame

Buero J1, Fisher H2, Pooleman M1
1Nightingsale House Hospice, Wrexham, United Kingdom; 2University of Bangor, Bangor, United Kingdom

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 45 patients who had been treated for sweats in a hospice setting since records began in 2006. Collected data included patient details and diagnoses, numbers of treatments, quantitative scores for symptom intensity and frequency, the type of acupuncture (needling, 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 45 patients 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: ‘pillow saturated’, ‘soaked’, ‘burning’ before treatment, to ‘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, 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

Canal-Sotelo J1, Amaral-Tomelles N, Gonzalez-Rubio R, Lopez-Ribes J2
1LLEID-CUP RUIU-GSS, Lleida, Spain; 2Home Care Team, Gestió de Serveis Sanitaris, Lleida, Spain

Presenting author email address: jcanal@lges.sc.es

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 analogical 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 analyze variables.

Results: 89 patients were recruited (mean age 70.3 ± 14.13). Men 64 (72%). Morphine Equivalent Daily Dose (16.5 ± 25.72). Non-adherence to treatment was detected in 42 patients (47.2%). In the univariate analysis statistical differences were found between non-adherence and gender (p=0.049), non-adherence and the relation transdermal route of delivering the strong opioid (p=0.034) and the gender of the patient (p=0.0024). The multivariate analysis shows that the transdermal route is the single variable associate to non-adherence to the analgesic regimen (p=0.017, OR 16 (0.077-0.774)).

Conclusion: This pilot study shows that non-adherence to analgesic regimen is highly prevalent. The main reason for the non-adherence to the analgesic regimen is being treating with strong transdermal opioids. The Morsky-Green-Levine test is an easy way to detect non-adherence behavior in advanced cancer patients. Due to the sample size it is mandatory to design a bigger study to confirm the data obtained.

Abstract number: P2-120
Abstract type: Poster

Does the AMBER Care Bundle Have a Role in a Specialist Cancer Hospital? Cribb S.J1, Cookley A, Noble A, Griffiths A, Cadwallader C, Welch L. The Clatterbridge Cancer Centre, Wirral, United Kingdom

Presenting author email address: sarah.cribb@clatterbridge.nhs.uk

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 population of 2.3 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 inpatients who had died under the care of the AMBER care bundle. It was decided that the inpatient unit had died within 100 days of discharge. Data collected included: demographics, suitability for AMBER care plan, existence of a medical plan and decisions around resuscitation. The documentation of decision (i.e. 40% of the 46 patients showed symptomatic improvement) is currently reviewed and 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.

Conclusions: 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 Davies J.M.V, Mason E, Jenkins D, Williams M. Aneurin Bevan University Health Board, Newport, United Kingdom

Presenting author email address: jmvd@doctors.org.uk

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: Of 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 felt their nursing was inadequate and 73% 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 De-Martín M.A., Blanco L, Alonso M.T., Blanco M., Gundit M., Escalier M. Hospital de Merida, Badajoz, Spain; Hospital de Merida, Merida, Spain

Aim: To determine the patients in the Regional Palliative Care Program of Extremadura (PRCPEx) who visit hospital emergencies in the area of Merida.

Design and method: Observational, descriptive, retrospective study. A review of medical records of patients who were included in the PRCPEx was performed, and the following data were collected:

- Location of patient care, depending on the degree of stability: active / passive or unstable / stable.
- Number of visits to the emergency services.
- Reason: Pain, other symptoms (dyspnea, anemia, anorexia, dysphagia, and malaise).

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. 61 patients were included (42%) they generated 90 episodes (average 1.38, mode 1). 90 episodes were produced, 73% were active patients, 27% were passive and 68% needed hospitalisation.

The reasons why these events occurred were related with pain 32%, and other symptoms different than pain 68%

In 13 (14%) episodes, were detected 2 or more reasons, being these the overload of the caregivers (46%) and with other symptoms than pain (64%).

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 symptomatologies and professionals training.
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

d de Wolf F.1, Dows M.1, Spencer-Adams S.1, Chandler C.1, Bate JS.2, Stephens HA.2, Downs A.1, Chapman G.1, Witt J.1, Davison R.A.1, Murtagh F.E.M.2

Cicely Saunders Institute, King’s College London, Palliative Care, Policy and Rehabilitation, London, United Kingdom, ‘King’s College Hospital NHS Foundation Trust, Palliative Care, Policy and Rehabilitation’, London, United Kingdom, ‘King’s College Hospital NHS Foundation Trust, London, United Kingdom, ‘Guy’s and St Thoms’ Hospitals NHS Foundation Trust, London, United Kingdom, ‘University College Hospital Lewisham, London, United Kingdom

Presenting author email address: susanne.1.de_wolf@kcl.ac.uk.

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 the approach.

Aim: To develop the complex intervention of implementing OM, using Quality Improvement Facilitators (QIF) and a bottom-up approach with the clinical teams, and to determine the components of this approach.

Methods: Content analysis of observational field notes with review of emerging themes by the research team. 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. Emphasis on practical applications to aid clinical work and outcomes: Tailored solutions for implementation were created to address clinician concerns. Including: time reduction in writing patient notes; practicing the completion of OM; and adding the new OM as routine documentation.

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 complex outcome implementation intervention in order to bridge the gap between research and practice.

Funder: Guy’s & St Thomas’ Charity

Abstract number: P2-124
Abstract type: Poster

Satisfaction of Patients’ Family: Experience from a Newly Created Palliative Care (PC) Unit

Disoumeu R.A., Lonlack C., Ture L., Fette G.T.
Bafoussam Regional Hospital, Bafoussam, Cameroon

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 (Cameroon).

Methods: A descriptive cross-sectional study was carried out on all the patients’ caregivers received during the first year of activity of the unit. These patients’ caregivers 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’ caregivers followed up, 39 were able to respond to the invitation. The average age of respondents was 39 ± 12 years. Sex ratio (M/F) was 0.5:1.4. (34) respondents were caregivers for a non cancer patient. Regarding patients’ caregivers 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 on the hospital admission 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 necessary.

Conclusion: This study shows a good satisfaction of the families of patients receiving palliative care, with a greater concern 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.

Funder: A.5, Damanhuri G.5, Witt J.1, Daveson B.A.1, Murtagh F.E.M.1

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

Dowle A.J.1, Perkins P.2
Gloucestershire Hospitals NHS Foundation Trust, Palliative Medicine, Cheltenham, United Kingdom, ‘Sue Ryder Leckhampton Court Hospice, Cheltenham, United Kingdom

Presenting author email address: michelle.dowell@grh.nhs.uk

Background: On average 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 September 2011 – August 2013.

Methods: Retrospective case note analysis and independent assessment by the investigators of appropriateness of transfer. Any differences of opinion were discussed.

Results: The survey showed that 34 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 were determined by the patient rather than the attending physician.

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 planned care and increased ability to provide intravenous therapies at the hospice. A repeat audit is planned to examine the impact of these changes.

Funder: A.5, Damanhuri G.5, Witt J.1, Daveson B.A.1, Murtagh F.E.M.1
Towards a Continuous Quality Cycle for Palliative Care Guidelines in the Netherlands

van der Knaap K.1, de Groot J.1, van der Veer L.1, Janssen K.1, Riezebos J.1, van der Groen R.1, van der Does P.2, van der Does E.2
1Netherlands Comprehensive Cancer Organisation (R0K), Utrecht, Netherlands
2University Medical Center Utrecht, Utrecht, Netherlands

Aims: Our organisation develops guidelines and quality criteria for oncological and palliative care guidelines in cooperation with scientific and professional associations, patient foundations and other (inter)national partners. In 2013 we investigated the acquaintance and satisfaction with palliative care guidelines. Of the 1,443 respondents we invited them 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 advises 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 haematuria and vomiting) have been developed successfully.
3. The module palliative care is in development, to be integrated in all oncological guidelines.

Conclusions: 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 accommodated to a module of palliative care in oncological guidelines in order to give palliative care the attention it needs in cancer patients.

Abstract number: P2-129
Abstract type: Poster

Malignant Bowel Obstruction: A Team Approach?

Halley A., Wel A., Dronen J.
Royal Manned Hospital NHS Trust, Department of Palliative Care, London, United Kingdom
Presenting author email address: angela.halley/doctors.org.uk

Background: Malignant Bowel Obstruction is a multi-disciplinary (MD) clinical issue associated with long length of hospital stay and inconsistent clinical practice. To improve patient care and to enable transfer to more appropriate clinical settings, a coordinated and timely approach to the management of malignant bowel obstruction is needed.

Aims: The aims of this retrospective audit were to review the timeliness of the MD approach to managing patients in bowel obstruction with a gynaecological malignancy in a tertiary referral oncology centre.

Methods: The electronic medical records of all in-patients who had a diagnosis of bowel obstruction recorded in their discharge summary were reviewed over a six month period. Palliative Care patient lists for that period were also reviewed. Data was collected on date of diagnosis of malignant bowel obstruction, date of surgical, oncological, palliative care and dietician review. The use of nasogastric tube, and stents (dose and route) was gathered. Length of stay and time to death were also reviewed.

Results: 18 patients (14 ovarian, 4 uterine and 1 primary peritoneal cancer) were included. 39% patients had surgical review within 48 hours. None of the patients had surgical intervention. 94% patients had senior oncology review within 24 hours. 56% patients had specialist palliative care review within 24 hours. 75% patients had dietetic review. 75% patients had dietician review within 48 hours and 50% patients were offered NG tube at diagnosis. The average length of stay was 19 days and the average time to death from diagnosis of malignant bowel obstruction was 79 days.

Conclusion: The MD review did not occur in a proactive or timely manner. To combat this, MD guidelines were agreed and disseminated widely with education amongst the palliative care, dietetic, surgical, and oncology teams and there is now a collaborative approach. A prospective audit is ongoing to evaluate the intervention.

Abstract number: P2-130
Abstract type: Poster

The Mental Capacity Act 2005 (MCA) and Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

The Clatterbridge Cancer Centre, Wirral, United Kingdom
Presenting author email address: j.hampton-matthews@clatterbridge.nhs.uk

Background: Once a decision has been made by a clinician not to attempt cardiopulmonary resuscitation (CPR) there should be no physical or psychological harm (Tracey v Cambridge, University Hospital NHS Foundation Trust). Where the person is deemed to not have capacity, then the MCA 2005 should always be followed. The person who lacks capacity at the heart of the decision-making ensuring their choices are respected and that decisions made for them are in their best interests.

Aims: To develop a DNACPR form and policy that can be used by clinicians, which includes how it relates to DNACPR. To develop DNACPR forms which include the Mental Capacity Act, and DNACPR.

Methods: 1. An audit was undertaken to establish whether clinicians consider a person’s mental capacity when making decisions about CPR. A professional group was set up to establish a policy and develop forms to be used for all persons where a DNACPR decision is made. Research was conducted into what information and forms other Trusts use for patients without capacity where resuscitation is inappropriate.

Results: The audit showed that clinicians have limited knowledge about the Mental Capacity Act 2005. Mental Capacity Act assessments were not being carried out in relation to the decision around DNACPR. The best interest checklist was not being followed in relation to making a decision on DNACPR. Documentation was poor in relation to the patient’s mental capacity and the decision made regarding DNACPR.

Conclusions: To deliver a training programme for clinicians on the MCA 2005, and how it relates to DNACPR to develop DNACPR forms which include the Mental Capacity Act assessment and best interest checklist.

Abstract number: P2-131
Abstract type: Poster

Audit in Palliative Care: Appropriateness of Intravenous Devices in Hospice

Jadhom N.1, Pittsurer C.2, Brunelli S.3, Forcella S.1, Colaneri R.1, Bernardino B.1, Amaducci E.1, Doghen P.1
1Ausi della Romagna, Hospice di Savignano, Savignano sul Rubicone, Italy, 2Ausi della Romagna, Home Care Nursing Service of Romagna, Cesena, Italy, 3Istituto Oncologico Romagnolo, Forli, Italy

Background and aims: Are the intravenous devices in Palliative Care (PIC) being used excessively? And what are the most suitable? Data from literature is discordant. Till 2012 in Hospice, the short Peripheral Intravenous Catheter (PVC), was used for infusion therapy (IT), the alternative was a short-term Central Venous Catheter (CVC), but this required the transfer of the patient by ambulance. The aim of a PICC-team in Hospice was to analyse the use of these devices of media-long term in hospice.

Methods: Clinical audit on the appropriateness of the intravenous devices used in Hospice.

Results: Measure practice against standards: A prospective surveillance was conducted in 2011 collecting data from 53/81 pts. admitted undergoing therapy infusion. The number of venipunctures, days of exposure to PICC, days of hospitalisation and life expectancy, were defined as indicators. In particular 35/53 were analysed.

Compare performance with criteria and standards: The team concluded that 6/35 pts. would have needed an intravenous device of media permanent. Implement change in practice: A pathway of positioning PICC. Midline catheters at the bedside of the patients in hospice was created.

Conclusions: To re-audit to ensure change has been sustained and a new prospective surveillance was conducted in 2014 collecting data from 88 pts. admitted in Hospice.

19/88 pts. carried a central venous access when admitted, 13/19 had a PICC, 4/19 a Midline, 2/19 a CVC.

62/88 needed IT. 17/62 pts. were analysed. 2/17 had a Midline positioned after 8 days of hospitalisation and the survival after the positioning was respectively 6 and 11 days. The team is uncertain about the correctness of the Midline positioning. The team concludes that the PICC/midline is an appropriate alternative to PVC.

Clinical audit is confirmed as an effective tool to assess the quality of care. This has allowed us to identify critical areas leading to improvements in the clinical practice.

Abstract number: P2-132
Abstract type: Poster

Strategies for the Implementation of Quality Indicators across 4 Settings in 5 Countries

Jaspers B.1,2, Grammatiko D.3, Hesse M.1, Davies N.4, Wilje S.5, Sommerbak R.6, Kasa S.5, Hjermstad M.1, van Riet Paap J.7, Verneoo Yassen D.7, Engels Y.4, Mariani E.8, Chattat R.7, Radbruch L.1,9
1University Hospital Bonn, Department of Palliative Medicine, Bonn, Germany
2Universitätsmedizin Göttingen, Clinic for Palliative Medicine, Göttingen, Germany
3University of Medizin Göttingen, Department of Palliative Medicine, Göttingen, Germany
4University College London (UCL), Department of Primary Care for Older People, London, United Kingdom
5Norwegian University of Science and Technology, Palliative Medicine Unit, Faculty of Medicine, Trondheim, Norway
6Radboud University Medical Center, Scientific Institute for Quality of Healthcare, Nijmegen, Netherlands
7Radboud University Medical Centre, Department of Anesthesiology, Pain and Palliative Medicine, Nijmegen, Netherlands
8University of Bologna, Department of Psychology, Bologna, Italy
9Maltese Hospital Seliger Gerhard Bonn/Rhein-Sieg, Palliative Care Centre, Bonn, Germany

Introduction and aim: The overall aim of the IMPACT study is to develop strategies for the implementation of quality indicators (QIs) to improve the organisation of palliative care and dementia care in Europe. For this purpose, a set of 23 QIs was pretested among 40 services across 5 European countries (England, NL, IT, NI, NL) and the services then chose up to 3 QIs with low performance for (better) implementation. The aim of this part of the study is to analyse the strategies used across countries and settings.

Methods: Implementation processes were accompanied by advising consultants and recorded on standardised documentation sheets covering aims, timelines, methods, barriers, facilitators etc. National results were compiled using a country report template, including relevant qualitative data (quotes from participants). All country reports were analysed and categorised inductively according to the PRECEDE-PROCEED model (predisposing factors (for a specific behaviour); enabling factors (for the change); reinforcing factors (for the implementation)). The implementation strategies were analysed according to 1.) Reactions: All chosen strategies across settings and countries were organisational interventions or professional-oriented. There were no patient-oriented strategies or financial measures. Knowledge of the decision makers and awareness and attitude were predisposing factors; networking, and resources were the most enabling factors. Organisational support decided about success of implementation.

Conclusions: Bottom-up strategies were important for motivation. Implementation of improvement needs time, staff and money. Qualitative data strongly suggest that some barriers cannot be overcome without support from political decision makers.

**Abstract number:** P2-133  
**Abstract type:** Poster  

**Reaching out to Work with Others: How a Hospice is Using Bereaved Carers’ Views to Improve End of Life Care in UK Residential and Nursing Care Homes**

Levy J., Kinley J., Connolly F.

Lancashire Hospice, Care Home Project Team, London, United Kingdom

**Background/Aims:** Many frail elderly people are living and dying in care homes. This audit uses a validated tool, the Family Perception of Care (FPIC) 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 their understanding of the needs of patients and their families.

**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 are identified after a resident dies in the care home, the FPC questionnaire is sent out by care home staff to the bereaved relative, allowing anonymous return to the Hospice. The questionnaire consists of 28 questions, covering resident care, family support, communication and rooming, offering 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 52 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 (37%). 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 chaperone 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.

**Funded by:** The Burdett Trust for Nursing

**Abstract number:** P2-134  
**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**

Lee G.1, Xiong G.M.2, Yee A.C.P.3, Wong U.H.M.4, Ishak A.B.M.1, Lee D.X.5, Yeo S.H.6

1Singapore General Hospital, Department of Internal Medicine, Singapore, Singapore, 2National Cancer Centre Singapore, Department of Palliative Medicine, Singapore, Singapore, 3Singapore General Hospital, Division of Medicine, Singapore, Singapore

**Presenting author email address:** guozhang.lee@mohh.com.sg

**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 exacerbations as well as prolonged hospitalization 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 in 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.

**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:** P2-135  
**Abstract type:** Poster  

**How to Implement Quality Indicators Successfully in Palliative Care Services: Perceptions of Team Members about Facilitators of and Barriers to Implementation**

Leemann E.1, Van den Block L.2, Vonder Stochel K.2, Franke A.L.1, Defens L.1, Cohen J.1

1Ghent University and Yvoir University Brusel, End-of-Life Care Research Group, Brussels, Belgium, 2Yvoir Universiteit Brussel (VUB), Department of Family Medicine and Chronic Care, Brussels, Belgium, 3Heymans Institute, Ghent University, Department of Pharmacology, Ghent, Belgium, 4Singapore General Hospital, Department of Health and Care Research, VU University Medical Centre, Department of Public and Occupational Health, Amsterdam, Netherlands, 5Netherlands Institute for Health Services Research, Utrecht, Netherlands

**Presenting author email address:** leemann@eurekaspot.com

**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 conducted 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 these thematic content 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:** P2-136  
**Abstract type:** Poster  

**Management of Malignant Hypercalcaemia and Appropriateness to Treat – A Hospice-based Inpatient Audit**

Jack H.1, Parker G.1

1Hospice in the Weald, Palliative Medicine, Kent, United Kingdom

**Presenting author email address:** helenlock@nhs.net

**Context and aims:** Hypercalcaemia of malignancy affects 20–30% of cancer patients during their disease conferring significant morbidity. 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 hypercalcaemia 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 hypercalcaemia 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 hypercalcaemia 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.
Hypercalcemia in Palliative Care

Mullowney L
University of Glasgow, School of Medicine, Glasgow, United Kingdom
Presenting author email address: 10020381@student.gla.ac.uk

Background: Hypercalcemia is the most common life-threatening metabolic disorder in cancer patients, and is defined by an adjusted serum calcium concentration of greater than 2.5 mmol/L. Hypercalcemia occurs in around 10% of cancer patients. Tumour induced hypercalcemia 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 kardex, use of data collection form and analysis of data in comparison to standard guidelines, to identify: 1. If malignant hypercalcemia was anticipated in high risk patients (those with breast, lung, prostate cancers and myeloma)

Results: 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 out of 9 patients treated

30 day mortality rate was 60%

Conclusion: Hypercalcemia 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.

Steroid Use in Palliative Patients in Plymouth, UK

Murphy-Brown FL
Hospicare, Palliative Medicine, Exeter, United Kingdom
Presenting author email address: fmurphy-brown@mhs.nhs

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 cases where 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 Lukes Hospice from 1st November 2013 to 1st May 2014 (n = 1152), 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=87). 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 ensure awareness of patients’ steroid histories. A Steroid Window could be added to the online notes to prompt clinicians to consider decreasing the dose or stopping steroids altogether.

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

Nishiyama N
Tohoku University, Graduate School of Medicine, Department of Palliative Medicine, Sendai, Japan

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 focused in the prevention of “early palliative care”. The purpose of this study is to examine “how early is early enough?”

Methods: Subjects were patients who underwent chemotherapy for advanced cancer and died in palliative care unit (PCU) during last 2 years. Subjects who received regular SPC concomitantly with first line chemotherapy after diagnosis with progressive disease (PO) and then were transferred to PCU assigned to palliative care (PC) group. Subjects who were transferred to PCU after the discontinuation of chemotherapy were assigned to standard care (SC) group. We compared 1) quality of palliative care using Support Team Assessment Schedule, 2) quality of life using Good Death Inventory, 3) implementation rate of chemotherapy immediately before death, and 4) short-term mortality in PCU between these groups.

Results: Twenty-eight and sixty-three were assigned to PC and SC groups, respectively.

1) PC group had significantly lower scores for physical symptoms control and patient anxiety

2) in PC group the PCU offers “sufficient support” and “because palliative care made them feel better” than in SC group.

3) PC group has significantly higher scores for “spending in their desired place” (p<0.001), Communication among patient, family and medical professionals were significantly more favorable in PC group (p<0.001).

4) PC group had significantly higher scores for “receiving sufficient treatment” and for “spending in their desired place” (p<0.008, 0.002, respectively).

5) Implementation rate of chemotherapy 60 and 30 days before death were significantly lower in PC group (p=0.041,0.044, respectively).

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 after the subjects were diagnosed with PD is expected to facilitate high-quality of palliative care.
**Poster Sessions (Poster Exhibition Set 2)**

**Abstract number:** P2-143  
**Abstract type:** Poster  
**Community Palliative Care Service Quality Improvement Project: Identification of Factors which Could Reduce Deaths Occurring in Hospital**  
Pain L.E.L., Schofield L.  
North London Hospice, London, United Kingdom  
Presenting author email address: lucy_pain@hotmail.com

**Background:** Healthcare providers are facing increasing pressure to minimise the time patients spend in hospital and reduce the number of deaths that occur there. This is challenging due to limited resources and difficulties establishing which patients are likely to benefit from hospital intervention, to reduce hospital deaths further.

**Methods:** This was a retrospective case note review of all patients known to the community palliative care service dying within the previous 4 months (March to June 2014).

**Results:** Themes suggest that the reasons for admission were complex, often unpredictable and related to an acute event. Key findings were that five patients had completed advance care planning (ACP) discussions, as compared to those dying at home. Only 1 patient was in just in case' drugs compared to 100% of those dying at home. Also there was rarely contact between any attending healthcare professionals from other teams (e.g. the ambulance service) and the community team despite the availability of a 24 hour advice line.

**Conclusion:** This group of patients some hospital deaths were unavoidable, related to an acute event, and admission may be appropriate for some individuals in their particular circumstances. ACP and enabling increased patients' contact our community service in acute situations will be targets for quality improvement projects in the next 6 months.

**Abstract number:** P2-144  
**Abstract type:** Poster  
**Clinical Librarianship in a Hospice Setting. Can this Model of Information Support Be Beneficial to Clinicians at the Point of Care?**  
O’Connor C., Riddington L., Perkins B.  
Gloucestershire Hospitals NHS Foundation Trust, Library, Gloucester, United Kingdom;  
Sue Ryder Leckhampton Court Hospice, Cheltenham, United Kingdom;  
Sue Ryder Leckhampton Court Hospice, Cheltenham, United Kingdom;  
Gloucestershire Hospitals NHS Foundation Trust, Palliative Medicine, Cheltenham, United Kingdom

**Background:** Librarianship has been in existence since the 1970s. The role aims to support evidence based patient care and clinical decision making at the point of need. There is no one fixed model of clinical librarianship. There is currently no published research on clinical librarianship within a hospice setting.

**Aims:** To trial a clinical librarian service at Sue Ryder Leckhampton Court Hospice, Cheltenham, UK to discover whether the service would benefit patient care and how the library service could develop further.

**Objectives:** To determine:
- The impact on patient care and
- Whether the service supported clinicians' information needs
- The most appropriate service model
- The impact for Gloucestershire Hospitals NHS Foundation Trust Library Services

**Methods:** The pilot ran from May to July 2014 and entailed a librarian attending admissions meetings and ward rounds with the hospice doctors to ascertain what information related help could be given.

**Results:**
- 9 literature searches were completed on patient care and service improvement projects.
- The librarians met with different hospice staff, appropriate information services were provided.
- The library service gained an understanding of the hospice setting and operation
- Understanding there is not always evidence to support treatments so a 'this usually works' method is used frequently in palliative care
- Increased awareness of library services amongst hospice staff

**Discussion:** The evidence base around palliative care is not always as robust as in other medical specialties – therefore the role of clinical librarians has to be altered accordingly. A service in this particular format was found to be too time-consuming for the library service and the clinical benefit was limited. Hospice staff could be equally well supported with a remote service via email or telephone. A close relationship between Sue Ryder Hospice and the library service should be maintained to support evidence based patient care.

**Abstract number:** P2-145  
**Abstract type:** Poster  
**Supporting Care in the Last Days of Life: An All-Wales Approach to Shifting Gear**  
Johnstone R.P., Mitchell H., Pooleman M.  
Betsi Cadwaladr University Health Board, Palliative Care, Caernarfon, United Kingdom;  
Bangor University, Primary Care Research Centre, Wrexham, United Kingdom

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. Within Wales the LCP was never mandated: instead we have implemented hospital strictly supported the Welsh Integrated Care Priorities for the last days of life (WICP).

Although the WICP has been continually monitored via variance reporting and audited annually, we have limited conclusive 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 could be the outcome of the Leadership Alliance. A critical analysis of the WICP indicated the need to change in step with this change in focus.

Through a process of wide consultation across the principality 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.
Abstract number: P2-148
Abstract type: Poster

Models of Hospital-based Specialized Palliative Care in Austria

Schmidmayer B.1, Richter S.2, Peer B.2, Ullggerl E.2, Stephan V.1
1Krankenhaus der Elaisabethinen Graz, Department of Internal Medicine, Graz, Austria, 2Landeskrankenhaus Rottmann, Department of Internal Medicine, Rottmann, Austria, 3Raphael Hospice, Salzburg, Austria
Presenting author email address: barbara.schmidmayer@elaisabethinen.at

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 specialised 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 for questionnaires from nursing staff and 16 questionnaires from physicians. Seven out of the 9 IPUs were included in the last 3 years. 6% of the physicians and 6% 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 specialised palliative care in Austria with the benefit of integrated resources and embedding 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 seems 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

Smith C, Scholcs C, Herts Community NHS Trust, Palliative Care, Hemel Hempstead, United Kingdom
Presenting author email address: carol.scholes@hchs.nhs.uk

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.

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 one day in March 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 (44%) 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 the most agreement were “I feel 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%).

Conclusions: Patients and carers informed our organisational priorities for improvement. The two weakest areas are a) assessment and support of family/carer’s and b) coordination of care.

These were both tasks in the integrated 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

Subramaniam S.1, Fotiou H.2
1EllenorLions Hospice, Palliative Medicine, Gravesend, United Kingdom, 2EllenorLions Hospice, Gravesend, United Kingdom

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 service. 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 preferred place of death, improves the chance of achieving it.

The audit showed areas of good practice and also some need for improvement of these important indices. This was presented to the teams and further audits planned.

Abstract number: P2-151
Abstract type: Poster

Audit of Usage of Steroids in a Inpatient Hospice Patients against Local Guidelines

Subramaniam S, EllenorLions Hospice, Palliative Medicine, Gravesend, United Kingdom

Background: Steroids are widely used in palliative care for a variety of indications. However, they are associated with significant side effects and for this reason should be used with care. Their use should be reviewed on a frequent basis to ensure patients are receiving the minimum effective dose for the minimum required time.


Results: Out of 48 identified, 24 patients were inpatients. 24 patient notes & drug chart was analysed from electronic notes. 17 patients out of 24 were admitted on steroids and 7/24 was started as inpatient. Dose was documented clearly in all patients, 17/24 had appropriate dose per their indication. 3 had unclear and 2 was not applicable and 2 had lower dose for their indication. Duration was documented in 14/17. 11/24 had clear documentation of who started the steroids (the admitted on steroids group). 9/17 had documented benefits and 7/17 - no clear documentation of the benefits. The data analysis on those who were started on steroids (T): All had indications identifiable and all had PPI started; 2/7 had identifiable evidence of check of blood sugar. All had evidence of review of steroids. Those patients who were discharged from Hospice on dexamethasone - 2/9 had clear plans and 4/9 had evidence of review after discharge. One had dexamethasone after the admission, but not mentioned in the discharge letter.

Recommendations: We conclude that those who have steroids started as inpatients have indication, review, and plans documented better than those admitted on steroids. However, those who were discharged on steroids lacked in documentation of plan in their discharge letter resulting in lack of follow up. We recommended Improved documentation of duration, dose, started by, benefits, side effects on admission and those who are started. Document plan, review of benefit, side effects, dose in daily review, Document a clear plan for steroids in the discharge letter and Repeat audit in 1 year.

Abstract number: P2-152
Abstract type: Poster

Development and Preliminary Evaluation of a Complex Intervention on Pain Management in Hospitalised Cancer Patients

Alquati S., Tanzi S., Autelitano C., Di Leo S., Costantini M., RCCS Arcipelago S. Maria Nuova, Palliative Care Unit, Reggio Emilia, Italy

Background: Despite the availability of effective assessment procedures and treatments, unrelieved pain in hospitalised cancer patients remains a problem. Many interventions were suggested, without achieving satisfactory results.

Aim: This study was retrospecively set up from a quality improvement programme implemented by a hospital Palliative Care Unit (PCU). It concerns the development and preliminary assessment of an intervention aimed at improving pain control in hospitalised cancer patients.

Methods: This study can be interpreted as a Phase 0–I, according to the MRC Framework for the assessment of the complex interventions. It includes a literature review on interventions for pain management and the identification of the potentially effective components of the interventions. According to the results of the previous steps a new quality improvement intervention was developed, piloted and preliminary assessed in an Oncological ward.

Results: No effective interventions were identified. Five potentially effective components were identified: professional training, daily screening of pain, patient education, specialist PCU consultations, and support from the Hospital Management. The Programme was implemented on the ward throughout 6 months. 75% physicians and 88% nurses participated in the training. After the implementation, daily screening of average pain was performed on 59% of patient-days, and 53% of the patients received the leaflet on cancer pain. All patients with severe pain were referred to the PCU for consultation. The outcome assessment showed 19.3% of patient-days with moderate pain, and 2.6% with severe pain. An external audit was performed by the Hospital Management at 9 months from the end of the intervention.

Conclusion: Results support the feasibility of the intervention and of the its five components. Further studies are needed for assessing the effectiveness of this complex intervention.
A national audit of care in the last hours or days of life was undertaken in the acute hospital setting in England (NCDAH 2013/14) involving 149 sites and 6,580 cases. International consensus exists for the use of 4 key drugs and the use of continuous subcutaneous infusion (CSCI) has been advocated in support of patient comfort at this time. In Round 2 of the NCDAH 2008/09 all patients had CSCI prescribed prior to death (67% of all cancer patients) and 1080 were non cancer patients (46% of all non cancer patients).

Aim: To explore the use of CSCI and any similarities and differences for cancer and non cancer patients in the use of CSCI in the last 24 hours of life, including medications and dosages.

Method: Consecutive, anonymised, retrospective case note review of the last ‘episode of care’ including deaths during May 2013 (excluding acute/sudden/unexpected). Drugs given via CSCI in the last 24 hours of life, combinations and doses, were analysed descriptively via SPSS.

Results: 850 (28%) cases. 722 (46% of all cancer patients) had primary cancer diagnosis, 1128 (32% of all non cancer patients) were non-cancer patients. Non cancer patients were older (83 vs 74 yrs) & had recognition of ‘dying’ earlier (75 hours vs 62 hours prior to death).

The 4 key drugs were regularly prescribed. Most (both groups) received 3+ drugs

Most common 2 drug combination – sedative (usually Midazolam) & opiate (usually Morphine).

Median dose sedative: Midazolam (both groups) = 10mg over 24 hours

Median dose opiate: Morphine – cancer 15mg, non-cancer 10mg; Diamorphine – cancer 12.5mg, non-cancer 10mg, Oxycodone – cancer 20mg, non-cancer 10mg.

Conclusion: Overall, the use of CSCI is around half of that in 2008/9 but in line with this audit patients with cancer are still more likely to die with a CSCI in place. Type of drugs administered was similar in both groups, but the dose of opiates for non-cancer patients was lower on average.

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Ito T.

Laboratory of Molecular Radiology, Center for Disease Biology and Integrative Medicine, Tokyo, Japan

We have already reported its favorable effects on symptom relief.

Carlander I.

Department of Hemodialysis and Apheresis, Tokyo, Japan

To identify and classify the needs of patients who require more resources and devise strategies to optimise resource allocation.

Aim:

The Distrained Masculinity

Berglin SE, Haandou N, Fukui M, Iwasue S, Noin E, Namguk P, Myoga K.

The University of Tokyo Hospital, Department of Palliative Medicine, Tokyo, Japan

A genomic approach; global genome methylation was assessed by determining the DNA hypermethylation was assessed by quantitative methylation specific PCR (qMSP).

Results:

Document:

Background:

Aim:

Raising attention in Japan as one of important strategies for symptom-relief against malignant ascites. We have already reported its favorable effects on symptom relief. Aims:

1.56±8.51×10⁴pg/ml IL-8: 5.10±6.69×10²pg/ml IL-10: 1.63±2.22×10¹pg/ml ). The degree of body temperature after CART, and existence of IL-10 in ascites related to longer survival.

In the first session of each patient, the concentrations of inflammatory and regulatory cytokines including IL-1, IL-6, IL-8, IL-12, TNF-α and IL-10 were measured in original ascites using the System. We evaluated their relation to the side effects of CART and to patients' 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. We conclude that ascitic concentration of IL-6, and 8 correlated with elevation 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.

Results:

10 patients received palliative care for cancer related diagnoses, and were predominantly Chinese (80%). For each patient contact (incoming phone call or unplanned visit), 1 or more patients were identified. There were a total of 94 incoming phone calls and 35 unplanned home visits, making a total of N=129 patient contacts.

Aims:

All 10 patients received palliative care for cancer related diagnoses, and were predominantly Chinese (80%). For each patient contact (incoming phone call or unplanned visit), 1 or more patients were identified. There were a total of 94 incoming phone calls and 35 unplanned home visits, making a total of N=129 patient contacts.

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.

Conclusion:

It is possible to collect biological samples amenable to systematic 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.

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:

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. We conclude that ascitic concentration of IL-6, and 8 correlated with elevation 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.

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Abstract number: P2-158

Abstract type: Poster

Relationship between Cytokine Concentration in Ascites and Effects of Cell-free and Concentrated Ascites Reinfusion Therapy (CART)

Methods:

Aims: The aim of this study is to evaluate cytokine concentration in original ascites and its effect on survival after CART procedure.

Results:

Median survival was 115 days and 51 days for detected group and not detected group, respectively (log-rank = 0.002).

We concluded that ascitic concentration of IL-6 and 8 correlated with elevation 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.

Conclusions: The Distrained Masculinity

Background: The Distrained Masculinity

Abstract number: P2-159

Abstract type: Poster

Assessing the Needs of Patients in the Palliative Home Care Setting: Can We Do Better?

Chan S, Sojic K, Choo WC, Lee A, Lim M, K M

Dover Park Hospice, Singapore, Singapore

University of Newcastle, Newcastle, Australia

The House Call GP, Singapore, Singapore

Tan Tock Seng Hospital, Palliative Medicine, Singapore, Singapore

Abstract number: P2-162

Abstract type: Poster

Palliative Care for People with ID in Europe

Wicki M T.

University of Applied Science of Special Needs Education, Research and Development, Zürich, Switzerland

Abstract number: P2-161

Abstract type: Poster

Biological Changes towards the End of Life: A Feasibility Study


The Marie Curie Palliative Care Institute Liverpool, Liverpool, United Kingdom

Abstract type: Poster

The Distrained Masculinity

Abstract number: P2-150

Abstract type: Poster

The Distressed Masculinity

Carlander I, Ulsellstrom I, Sandberg J, Eriksson H

1Palliative Research Centre, Stockholm, Sweden

Karolinska Institutet, Department of Learning, Informatics, Management and Ethics, Stockholm, Sweden

Umeå University, Campus Norrköping, Norrköping, Sweden

Jönköping University, Jönköping, Sweden

Red Cross University College, Stockholm, Sweden

Dying is a gendered situated experience. 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 8 interviews conducted over 18 months with one man close to death.

The analysis focuses on the interplay between dying and death 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 — strength, the body — revised, the fatherhood — comprised. Setting the priorities straight when time was meted out rewrites norms connected to 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 death is a dispossession 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: Being present seems to involve a range of responsibilities, such as economy, practical and emotional strings even beyond death.

Poster Sessions (Poster Exhibition Set 2)
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/discussion: 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

Deed M.1, Towara A.2, Azoum M.1, Sololomopoulou A.3, Ardasov A.1
1'Saint Savas, Anticancer Hospital of Athens, 1st Department of Medical Oncology, Athens, Greece, 2'Hippokraton' Hospital, Oncology Section, 2nd Department of Internal Medicine, Athens, Greece, 3'Municipality of Limassol, Limassol, Cyprus

Background: Death is a multidimensional phenomenon including physiological, psychological, and spiritual dimensions of human nature. The dimension of grief 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 terminally 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 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 specialists 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**

Thomsen M.H.1, Bucsh C.J.1, Hansen L.E.1
1FUv Løgumkloster, Løgumkloster, Denmark, 2Righospitalet, Copenhagen, Denmark, 3FUv Løgumkloster, Copenhagen, Denmark

**Aims:** The project aims to 1) provide the relevant non-therapeutic bereavement care, 2) document and improve the quality of existing bereavement support groups in the ELCD, and 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. The ELCD holds 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**

Swift B.1, Groves KE.2
1Southport & Ormskirk NHS Trust, Mortuary & Bereavement Services, Southport, United Kingdom, 2Southport & Ormskirk NHS Trust, West Lancs, Southport & Formby Palliative Care Services, Southport, United Kingdom

**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.

**Methods:** Existing facilities were upgraded & practices updated & developed in an area of vital importance to bereaved but largely hidden to the rest of the hospital.

**Results:** Provision of a professional uniform, staff education & development; rebuilding & modernisation of two entire mortuary & bereavement suites (include colour changing lights for skin effects); dignified, respectful transfer of patients in beds with a newly designed bed cover, rather than a concealment trolley & reduction in manual handling.

**Raising awareness for hospital staff helped understanding, reduced fear of the unknown, improved communication with families & adherence to care after death procedures.**

**Updated procedures improved quality of death certification & professionally presented information in specially designed folders.**

**Many, apparently little, touches – quality ‘property bags’ for patients’ effects; last thoughts, words & wishes cards; forget me not’ seeded cards; keepsake pebbles; ribbon ties & muslin bags for hair locks; free parking for those collecting certificates have served to improve a difficult experience.**

**Redesigned, user-friendly bereavement booklets; staff cards with prompts for discussing tissue donation & departmental cultural awareness posters ensure cultural sensitivity to bereaved people.**

**Conclusion:** Realtime feedback from the bereaved feeds further change. This presentation describes the difference that sensitivity & creativity have made to bereaved families’ experiences.

Abstract number: P2-170
Abstract type: Poster

**Development of a Complicated Mourning Screening Protocol**

Carpinio E., Petr C., Coelho C., Gonçalves E.
Centro Hospitalar de S. João, Palliative Care, Porto, Portugal

**Background:** Palliative Care (PC) stands for a holistic approach attending patient and family as a whole and extends care beyond death through bereavement support. To standardise attitudes and identify people at risk for complicated grief we developed a Complicated Mourning Screening Protocol (CMSP).

**Aims:** To develop the CMSP accuracy in identifying carers in risk for complicated mourning, in a PC team.

**Methods:** Prospective analysis of CMSP records related to the patients deceased between November 2013 and August 2014

**Results:** 456 records were evaluated with 295 (65%) of deaths occurring in a hospital setting; 285 (62.5%) were males. According to the CMSP, 131 (29%) were asked for phone contact, 64 (14%) asked for support but 6 were discharged for a median follow up = 53 days and 2.5 appointments and 3 (14%) presented risk factors for complicated grief. Of the 325 cases (61%) designated not to contact (155 because of the scarce contact with the palliative care team), 7 (2%) asked for support but were discharged for not displaying emotional distress related to the loss.

**Conclusion:** Although the vast majority of the carers (85%) had not been contacted by the PC team after the patient death, the CMSP permitted a rapid screening of the carers in risk for complicated grief.

Abstract number: P2-171
Abstract type: Poster

**Population-based Bereavement Grief Data – For Policy and Practice Purposes**

Wilson D.A.M.1, MacLeod R.1, Houtteker D.1, Cahal L.1
1University of Alberta, Faculty of Nursing, Edmonton, AB, Canada, 2HammondCare/University of Sydney, Palliative Medicine, Sydney, Australia, 3Vrije Universiteit & Ghent University, End-of-Life Care Research Group, Brussels, Belgium

A 2014 study sought bereavement grief information to determine if perceived death quality is associated with bereavement grief intensity. After a pilot study, six previously-used questions were added to an annual healthcare telephone survey of adult Albertans (a western Canadian province with 4.1 million citizens). Population-representative data were obtained from a weighed sample of 1208 subjects and analyzed initially for descriptive, comparative, and correlational findings using the SPSS program. Findings: All but 5.4% had experienced bereavement grief one or more times, with most experiencing it many times (mean=8, medians=median=5), 75.9% were currently bereaved to some degree, with the most recent bereavement grief due most often to the death of a parent (21.8%), grandparent (17.9%), or friend (16.8%). Nearly half (45.9%) rated the death quality as bad more than good on a 10 point measurement scale. Bereavement levels varied, with 24.1% reporting no current grief and 18% reporting relatively severe current grief. Perceived death quality was associated with bereavement grief intensity (r=−0.1, p<0.000). Although more in depth analysis is required, these initial findings reveal bereavement grief is a very common and impactful life experience. The bivariate association between perceived death quality and bereavement grief intensity suggests that the prevention of bad deaths is as important or possibly more important for the survivors than the long-standing palliative care focus on the promotion of good deaths. More studies are needed to ensure that the expected increase in deaths due to population growth and aging does not greatly increase the burden of bereavement grief in society.
Communication

Abstract number: P2-173
Abstract type: Poster

Advance Directive in Terminally Ill Patients in Mexico: Family Vision

Allenée S., Venastegui E., Arzate C., Dominguez G., Monreal E., Pérez D.
Instituto Nacional de Cancerología, Cuidados Palliativos, Distrito Federal, Mexico

The Advance Directive (AD) is a personal decision to undergo or not to media, medical procedures or treatments that seek to prolong life when you are terminally and for medical reasons, it is impossible to maintain naturally, protecting at all times dignity through signing the advance directive form (ADF).

Objective: To know the experience of families of cancer patients without cancer treatment and in palliative field to ADF. Telephone survey to 88 families of patients referred to palliative care services for terminally ill is performed. Questions included: AD and its fulfilment, AD format utility and ease decision making.

Results: 86% of the households represented and reported having fulfilled the wishes and desires of the patient during the illness and after his death; 97% the ADF gave them a sense of security for the fulfillment of the desires of wishes of the patient and a minimum percentage were not accepted the AD patient because denial of his or her terminally ill patient despite the ADF. We conclude that the ADF facilitates decision-making and is a guide for meetings the needs and desires of the patient. The palliative care team should encourage the patient and family the ADF to establish their priorities and needs ensuring a good quality of death.

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

Anagnostou D.1, Stoll S.1, Noble S.1, Lester J.1, Byrne A.1, Nelson A.1
Cardiff University, Mater Care Palliative Care Research Centre, School of Medicine, Cardiff, United Kingdom, Velindre Cancer Centre, Cardiff, United Kingdom.
Presenting author email address: anagnostoud@cf.ac.uk

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 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: This is a multiphase study. How treatment pathways are determined and presented to patients is explored via non-participant observation of up to six lung MDT meetings (Phase I) and 20-30 patient-clinician consultations (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: P2-175
Abstract type: Poster

Let’s Talk about Sex, Doubts, Questions and Problems Relating to Sex Life Addressed to Doctors, Nurses, Psychologists and Physical Therapists by Palliative Care Patients

Dęskur-Smolecka E., Chojnicki M.1, Gętłowski1, Bura M., Mozer-Lisewska1.
1Poznan University of Medical Sciences, Department of Family Medicine, Poznan, Poland, 2Southport & Ormskirk NHS Trust, Palliative Medicine, Southport, United Kingdom

The personnel who takes care of palliative carepatients encounters a wide spectrum of problems. Being aware of the progressive illness that limits one’s life causes that spiritual and religious spheres, as well as psychological support, become particularly crucial. In other words, discussions with palliative care personnel also pertain to more physical issues. Learning the religious spheres, as well as psychological support, become particularly crucial. However, being aware of the progressive illness that limits one’s life causes that spiritual and religious spheres, as well as psychological support, become particularly crucial. In other words, discussions with palliative care personnel also pertain to more physical issues. Learning the religious spheres, as well as psychological support, become particularly crucial. However, 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: 100 random deaths Nov/Dec 2013 audited retrospectively against standards developed from LACDP recommendations. Data included conversation documentation, participants, context & time.

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: 39% 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 care only 13% wishes of dying person.

Discussion 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 & document 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 prognosis 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.

Abstract number: P2-176
Abstract type: Poster

Design to Enhance the Usability of Home Health Care Products and Improve Information Transfer to Reduce the Feeling of Insecurity for Patients and their Informal Caregivers

Postma T.
TU Delft, Industrial Design Engineering, Delft, Netherlands

Introduction: As the stage of care shift from the hospitals to home, people will have a greater responsibility to manage their health themselves. In such a change, they would need the right tools, information and access to help and assistance to manage/control their health effectively and with confidence.

Aim: This research aims to reduce the feeling of insecurity and vulnerability by trying to suffice the need for right information and care coordination and focuses to improve the usability of healthcare consumer products.

Research method: Based on the pilot study which was conducted through semi structured interviews and context mapping sessions with 33 Dutch elderly with chronic illnesses and their informal caregivers, it was realized that there lies a constant feeling of insecurity and vulnerability. It was also noted that the information transfer form the hospital to home is inefficient and unclear. Thus, this group needs help to shed the feeling insecurity and realize the responsibility to bring themselves back on their feet to reduce the burden on the healthcare system.

Key concept: A conceptual framework has to be designed to improve information transfer and care coordination in a home care setting. It has been also noticed that using medical devices at home is not an enjoyable thing to do. People need immense motivation and encouragement to face numbers about their body. Hence, the interaction of consumers with such devices has to be drastically improved.

Conclusion: Improving information transfer, care coordination and enhancing the usability of home healthcare products can reduce the feeling of insecurity associated with patients and their informal caregivers.

Abstract number: P2-177
Abstract type: Poster

Avoiding the Inevitable Conversations with those thought likely to be dying and those important to them

Bromby C.E., Grover K.E.
Southport & Ormskirk NHS Trust, Palliative Medicine, Southport, United Kingdom

Presenting author email address: carys.bromby@nhs.net

Background: 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: 100 random deaths Nov/Dec 2013 audited retrospectively against standards developed from LACDP recommendations. Data included conversation documentation, participants, context & time.

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: 39% 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 care only 13% wishes of dying person.

Discussion 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 & document 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 prognosis 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.

The person who takes care of palliative carepatients encounters a wide spectrum of problems. Being aware of the progressive illness that limits one’s life causes that spiritual and religious spheres, as well as psychological support, become particularly crucial. In other words, discussions with palliative care personnel also pertain to more physical issues. Learning the patients’ sex life-related doubts, questions and problems to be solved is also part of the palliative care.

Aim: Learning the questions about sex life most frequently asked by palliative care patients and their problem this sphere addressed to the palliative care person.

Methods: A questionnaire directly addressed to doctors, nurses, psychologists and physical therapists working in palliative care in Poland.

Results: The questionnaire was responded by 54 hospice employees, including 36 doctors, 15 nurses, 8 psychologists, and 5 physical therapists. Most of the respondents (89%) were asked by their patients about patients sex problems during their professional practice. Most of them (52%) claimed that sex was discussed seldom or very seldom (22%). The discussion was more frequently initiated by men than by women (39% vs. 15%) and it was more often conducted as part of the home care service. Only less than 3% of all palliative care employees said that sex questions were the permanent element of the interview. Discussions were initiated by middle-aged (48%), mature (19%) and young (19%) people. The main comment was grief over the loss of sex life, requests to improve their sex life pharmacologically and consent to sex life during the serious illness.

Conclusions: The topic relating to sex life of the palliative care patients emerges in the professional practice of most of the palliative care professionals. Despite of the fact that this topic is discussed rarely, it is essential for people who begin to work in palliative care to be ready to discuss intimate issues.
Abstract number: P2-178
Abstract type: Poster

Developing Online Resources for Palliative Care – The Palliative Hub
Chamilly K.1, Wescott G.1, Connolly M.1,2
1All Ireland Institute of Hospice and Palliative Care, Dublin, Ireland, 2University College Dublin, Dublin, Ireland

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 available to everyone. Providing this information digitally on one website that is easy to navigate 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 innovation and collaboration 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
Bafoussam Regional Hospital, Bafoussam, Cameroon
Presenting author email address: nguetse2003@yahoo.fr

Introduction: Open day celebration (ODC) is a key awareness-raising event for institutions to advertise their Palliative Care. The Bafoussam 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 it 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 information brochures and phone calls (repeated for one week) of different specialists: a gynaecologist, a surgeon and a palliative care specialist. Patients who responded via radio invitation were screened for cervix, breast and prostate cancer and carried out by professionals. Local radio is a key tool to reach particularly people who are thought likely to be dying and 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 published by NHS England in 2013.

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 to a first oncologist consultation before been 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
Domesen Benedetto E.
Cantonal Hospital St Gallen, Center of Palliative Care, St.Gallen, Switzerland
Presenting author email address: francus.domesen@kssg.ch

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 interventions 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 (transcription). 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 relatives) and analyses of in-hospital consultations. Providing this information digitally on one website that is easy to navigate will reduce the burden on individuals trying to navigate the internet and multiple sources of information, which may not be appropriate or relevant.

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 transcribed) and thematic analysis of 8 reflections about palliative care consultations have been completed. Data collection is still going on considering 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
EADIO S.G., Bristowe K., Bailey K., Selman L.E., Murtagh F.E.M.
King’s College London, Cicely Saunders Institute, Dept. of Palliative Care, Policy and Rehabilitation, London, United Kingdom

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 43–95). Major themes related to illness experience were the importance of staying independent, loss of control over health, peer 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
Greaves K.E., Finnegan C.
Ter checkpoint of Burgos Education Centre at Queen Elizabeth, TRANSFORM Team, Southport, United Kingdom, 2Southport & Ormskirk NHS Trust, West Lancs, Southport & Formby Palliative Care Services, Southport, United Kingdom
Presenting author email address: karen.greaves@nhs.net

Background: There is a clear need for precise & unambiguous communication which avoids stigmatization, especially when talking to people who are thought likely to be dying & 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 published by NHS England in 2013.

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 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.

In addition “examples” of individual plans for care for those thought likely to be dying include conversations they would want to have & the plans they have made.

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: Raising awareness of the importance of clear communication has also raised awareness of death & dying in the Trust.
Abstract number: P2-183
Abstract type: Poster

Palliative Care in Patients who Are Not Aware of their Diagnosis

Karamitro S., Myro M., Lázár F., Thano L., Jorgi D.
Konza Palliative Care, Korec, Albania

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:

1. Information received from the patients’ family members during the assessment of the referral and also during their training at “Mary Potter” PC Center.

2. Information collected directly from patients.

Results: 1943 referral formulations are recorded for the period January 2004 – September 2014. 589 were patients living in urban areas and 1354 in rural areas. 1790 patients were not aware of their diagnosis (462 urban, 1328 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 health 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

MacRobbie A.1,2, Beary S.3, Payne S.
Lancaster University, Faculty of Health & Medicine, International Observatory on End of Life Care, Lancaster, United Kingdom, 2NHS Highland, Inverness, United Kingdom

Presenting author email address: alison.macrobbie@nhs.net

Background: Poor symptom management and harm from inappropriate medicines use in the community is well documented. Misunderstandings of medicines use is most commonly caused by poor communication, especially between patients and professionals. Although 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 using medicines safely.

Aim: To identify palliative care patient perspectives of communication barriers, facilitators and preferences for analgesic 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 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: 11 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

Magaya N.1,2, Tikou N.1,3, Strauss F.3
1Cantonal Hospital St. Gallen, St.Gallen, Switzerland, 2ICBSG, Bern, Switzerland

Presenting author email address: natalie.magaya-kalbermatten@kssg.ch

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 oncological 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.

Prior 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 consensual defined them, the procedure was repeated until consensus.

District groups include:

1. pt. med. (e.g. physician [3], relationship [10], hcp staff/system [3], family [3]),
2. general information (cancer care [12], PC [5]) and
3. immediate interactive DC (12).

Palliative Care Patients who Are Not Aware of their Diagnosis

Karamitro S., Myro M., Lázár F., Thano L., Jorgi D.
Konza Palliative Care, Korec, Albania

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.

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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 health care providers. Being aware of the diagnosis increases the reliability of the patient on the palliative care staff.

Abstract number: P2-186
Abstract type: Poster

Advanced Cancer Patients’ Worries Related to End-of-Life and Perceived Communication with Health Care Professionals

Mosoiu D.1, Magayo N.2, Tikou N.1,3, Prediou O.1, Achimas P.3, Curca R.5, Griгоресcu A.6, Achim C.5, Chambaere K.4, Hajós Z.2, Strauss F.3
1Hospice Casa Speranţei, Brasso, Romania, 2Cantonal Hospital St.Gallen, St.Gallen, Switzerland, Oncology Institute Prof. Dr. I. Chiricuţă, Cluj-Napoca, Romania, 3Regional Oncological Institute, Iasi, Romania, 4Emergency County Hospital, Alba Iulia, Romania, 5Institute of Oncology, Bucharest, Romania, 6End-of-Life Care Research Group, Viège Université Brussel (VUB) & Ghent University, Brussel, Belgium

Presenting author email address: danieila.mosoiu@hsu.ro

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 only 42% had a conversation about this with 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 IF P cancer key interventions, demographic (age, gender, marital status, education), clinical (PC needs [DPS], EQ5D), and quality indicators (IQ, inappropriate oncotentment care, aggressive hcp care, quality of dying).

For the key intervention ‘EOL- preparation’ patients were asked if they had 6 specific worries related to EOL (table 1). The table 1 shows the frequency of the worries, the need that 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 with the worry that this worry was addressed where it was addressed

That the illness is spreading 62% 31% 60% 1

That I might have suffering that cannot be relieved 48% 32% 55% 2

That the life time is limited 40% 28% 52% 3

That the family is not prepared to cope with the situation 37% 30% 45% 4

That I will be cared in the future the way I would like 16% 42% 50% 5

That there is unresolved business concerning material aspects 13% 50% 59% 6

[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.

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Poster Sessions (Poster Exhibition Set 2)
**Clinical Management and Care Planning of Patients with Locked-in Syndrome in Palliative Care**

Othello M. S. J., Rocha J. A.

1Hospital Premier, São Paulo, Brazil, 2Hospital das Clínicas, University of São Paulo, Palliative Care, São Paulo, Brazil

**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. The palliative approach to these patients is a challenge, given the fact that most of the patients were at the peak of the intellectual productivity and suffered great functional capacity losses and clinical problems, becoming prisoners of their bodies.

**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, photographed with LIS after TBI, and placed in a hospital in São Paulo. Detailed clinical and biographical history was collected with the family. Based on the data review a reflective discussion about palliative approach in LIS was conducted.

**Results:** In 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 serial clinical examination, imaging tests and multimodal neurophysiological evaluation. It was observed that the access issues to the health services can be worsening factors, as long as in the reported case it is assumed that the lack of early diagnosis and rehabilitation interfered negatively in the process, causing psychological and social suffering to the patient and his family. The care provided by the Palliative Care team could adequately provide emotional support to the patient and family, as well as symptom control, but integration with the Neurology and Rehabilitation was insipient. Further studies to assess a larger number of patients would bring a greater contribution to the management and planning of care for these patients, especially in palliative care, as well as integration among related areas.

**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:** P2-187

**Abstract type:** Poster

**Communicate for a Mutual Understanding: A Study on Training Needs for Palliative Care Professionals**

Verano S., Peghetti B. L., Mesana R. I., Bonzani A. I., Pannuti R. I., Pannuti F. I.

1ANT Italia Foundation, Training and Development Unit, Bologna, Italy, 2University of Bologna, Psychology Department, Bologna, Italy, 3ANT Italia Foundation, Chairmanship, Bologna, Italy

**Presentation author email address:** silvia.varani@ant.it

**Background:** Good communication between patients, caregivers and healthcare teams has assumed great significance in cancer palliative care. Literature shows that effective training may improve physician communication skills but the aspects of communication on which these training should focus has not been extensively researched.

**Aims:** This study aimed to determine communication difficulties experienced by a group of palliative care professionals and to define their main communication needs.

**Methods:** Palliative care professionals' perception of difficulties in communication was assessed using a 22 item questionnaire containing two subscales: communication with the patient and communication with the caregiver. For both subscales has been calculated a cut off to discriminate between professional’s high and low perception of difficulty. Data analysis was performed with nonparametric tests and the Pearson test. P values < 0.05 was considered significant.

**Results:** One hundred forty-six palliative care professionals (81 physicians and 65 nurses) completed the questionnaire. Almost 61% of healthcare professionals experienced low perception of difficulties in communication both with patients and caregivers. The items recognised as the most difficult by the remaining 39% of the sample were: 1) understanding if the patient/caregiver has caught the information given 2) communication to the patient/caregiver of the treatment goals 3) understanding and what and how much information the patient/caregiver want to receive.

**Conclusion:** The results of the current study indicated that palliative care professionals have difficulties in communication, both with cancer patients and caregivers, particularly in understanding the most appropriate way of communication in respect of everyone’s specific needs and values. Patient centered care requires professionals to be formally trained in a set of communication skills enabling them to effectively deliver a real tailored palliative care.

**Abstract number:** P2-190

**Abstract type:** Poster

**Use of Interpreters in Palliative Care – A Practical Four Step Approach**

Tewani K.

**Abstract number:** P2-188

**Abstract type:** Poster

**Use of Interpreters in Palliative Care – A Practical Four Step Approach**

Tewani K., Brook L.

1Singapore University, Singapore, Singapore, 2Alder Hey Children's Hospital, Oncology Unit, Liverpool, United Kingdom

**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 interpreter resource, particularly when interpreters are given a short Exercise in translation before the Family Conference.

**Aims:** 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 and duration of 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 is a cardio voled 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.

**Abstract number:** P2-189

**Abstract type:** Poster

**Use of Interpreters in Palliative Care – A Practical Four Step Approach**

Tewani K., Brook L.

1Singapore University, Singapore, Singapore, 2Alder Hey Children's Hospital, Oncology Unit, Liverpool, United Kingdom

**Abstract number:** P2-189

**Abstract type:** Poster
Kuwait Palliative Care Experience: A Small Country with a Successful Model in the Region Dr Iman Al Dirji

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 have 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 patient on 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 pediatric 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 value. Kuwait model may help many countries in the region to develop their own program.

Abstract number: P2-193
Abstract type: Poster

Collaborative Care – How Can It Be Accomplished?

Bergenholtz H.

Background, aims and goals: The Centre for Collaborative Palliative Care in Sweden started 2013, located at a miduniversity. 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 developed 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, methods, 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 caregivers. A collaborative group with patients and family members participate 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 implementation 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 and without suffering. 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

Bergenholtz H.1, Halge-Hazelton B.2, Jonark L.1

Copenhagen University, Copenhagen, Denmark.1 “The Research Unit for General Practice and Section of General Practice”, University of Copenhagen, Copenhagen, Denmark.2 “Danish Knowledge Centre for Palliative Care, University of Southern Denmark, Copenhagen, Denmark”

Presenting author email address: heidi.bergenholtz@gmail.com

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 die in the hospitals, palliative care should be acknowledged and organised equally to other tasks provided by the hospitals. However, little is known about the hospitals’ focus on, organisation of, and evaluation of palliative care. Aim: The aim of this study was to investigate the organisation and evaluation of general palliative care at a Danish regional hospital.

Methods: The study was a cross-sectional study using a large regional hospital as case. The case hospital had three different data sets, which all, in different ways, evaluated the standard and guideline for general palliative care The data were 1. a national survey, 2. an external accreditation and 3. an internal self-evaluation. To investigate the reported and evaluated of palliative care the data were triangulated in order to identify similarities and discrepancies.

Results: When the datasets were compared, the organisation and evaluation of general palliative care, provided by the hospital, did not seem to function in accordance with the nationally recommended approach, neither on the level of the hospital or the departments.

Many discrepancies were seen when comparing the datasets. 24 of 56 departments showed discrepancies on the knowledge and use of palliative guideline.

Conclusions: The results indicate the general palliative care is organised locally within the various departments and appears to function without an overall structure and position. When comparing the three datasets it is apparent that the triangulation is useful for identifying discrepancies in both the organisation and evaluation of the care. However, other methods might be more appropriate to investigate the nature of these discrepancies.

Abstract number: P2-195
Abstract type: Poster

R&D for Knowledge-exchange and Collaboration

Bergstrom A.-M.

Kuwait Palliat vard och ASH Region Skåne, Halmshaw, Sweden

In 2002 several networks formed in North-East Skåne, Sweden, in certain priority areas with a view to increasing knowledge exchange and learning over organisational boundaries, with focus on the needs of the individual patient. 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. Mutual routines for as needed medication in end of life care and for information given 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

Bergenbogaard M., Lauritsen I., Anderson M.H.V., Johnson B.T., Poulsen B.T., Poulsen C.G., Jørgensen L., Knudsen R.D., Hansen S.

Aarhus University Hospital, Department of Paediatrics, Aarhus, Denmark.1 “Sygehus Himmerland I Farsø, Farsø, Denmark.2 Hospice Sjælland, Roskilde, Denmark.3 Hvidovre Hospital, Palliativ Enhed, Hvidovre, Denmark.4 Sygehus Vennysel, Palliativ Team, Hjørring, Denmark.5 Odense University Hospital, Palliativ Team, Odense, Denmark.6 Vejle Sygehus, Palliativ Team, Vejle, Denmark.7 Horsens Sygehus, Palliativ Team, Horsens, Denmark.8 Herlev Hospital, Pallationssenherden, Herlev, Denmark.

Presenting author email address: margrejm@rm.dk

Background: We meet people in need of palliative care throughout the health care system and palliative care goes across specialties and sectors. Denmark was a representative of the Danish Palliative Care Network (DPCN) in 2007-2009. Since then, DPCN has moved from being an association focusing on the establishment to focusing on palliative care so that the individual patient receives the best possible care irrespective of where the care is given.

In conclusion: To strengthen nursing in palliative care and to participate in the debate about education and values in the field of palliative care.

FSP wants to develop the interdisciplinary palliative care at the basic level (home care and hospital departments) and on the specialist level (hospital and specialist 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 geography and specialties.

FSP is active in national and European palliative groups and in public debate.

Result: Membership of European Association for Palliative Care (EAPC) FSP is the second European nursing association as a member of EAPC.

FSP wants to promote a candidate for the Board and is represented by two members of the European Palliative Care Research Collaboration (EAPC) Organising.

Membership of DMCG-PAL: FSP is represented in the DMCG PAL board and has been very active in the making of several national clinical guidelines and educational programs.

Membership of DanSk SygeplejeFællesskab (DASSY): FSP are asked for involvement in national issues that affect palliative care nursing. FSP organise annual 2-day courses and theme seminars with high professional quality.

Conclusion: FSP has moved from being an association focusing on the establishment to focusing on participation in national and international work at a high professional level.

FSP will stick to its core mission: To strengthen nursing in palliative care and to participate in
Timing of Admissions to Specialist Palliative Care Units – A Service Evaluation

Brady L1, Ní Laoire A2, Tempany M3, Balding L4
1Our Lady’s Hospice and Care Services, Harold’s Cross, Palliative Care, Dublin, Ireland
2Marymount University Hospital and Hospice, Palliative Care, Cork, Ireland

Presentation author email address: bernadettebrady@gmail.com

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 3 SPCUs was performed during August/September 2013 & August 2014. On arrival to the ward, patient demographics, time of arrival, reason for admission, source of admission, notice of bed availability, mode of transport & performance status were recorded. Data were analysed using Microsoft Excel. Late arrivals were defined as those arriving after 4pm based on a guide arrival time in units A&B.

Results: Data were collected for 148 admissions. 51% were male. 64% arrived before 2pm, 9% arrived after 4pm. 34% of late arrivals were delayed due to short notice of bed availability, all of whom were offered a bed on day of admission. 31% were delayed awaiting ambulance transfer, 75% of whom were transferred from a hospital. There were significantly more late arrivals in unit C than units A&B.

Conclusions: Time of admission or any of these factors are important to the end user. However, professionals, commissioners, patients and families have different concerns.

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

Breton L1, M1, Chickett J2, Ingleton C3, Gardner C4, Prestley L5, Ward S6, Goyder E7, on behalf of the INTEGRATE-HTA Project Team
1University of Sheffield, School of Nursing and Midwifery, Sheffield, Sheffield, United Kingdom, 2University of Sheffield, School of Nursing and Midwifery, Sheffield, Sheffield, United Kingdom, 3University of Auckland, School of Nursing, Auckland, New Zealand

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-NETHTA 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. 306141).

Abstract number: P2-198
Abstract type: Poster

Outpatient Palliative and Hospice Care for Immigrants in Munich (Germany) – Integrating Multi-professional Service Providers

Rüksel J1, 2
1Hospice Care DaSein, München, Germany, 2Paracelsus Medical University, Endowed Professorship for Interdisciplinary Research in Palliative Care, Institute of Nursing Science and Practice, Salzburg, Austria

Presentation author email address: djruksel@hospiz-da-sein.de

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, hospices, 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 the first phase (2010–11), the nursing and psychosocial support team of Hospice Care DaSein 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: P2-199
Abstract type: Poster

Direct Access from Hospital to Hospice Cutting the Red Tape at End of Life When it Matters!

Burbridge K1
1St Giles Hospice, Lichfield, United Kingdom

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 immediately 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 medic to accept the patient within the hospice setting. The Consultant completes a succinct medical clerking, drug chart and DNR 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 to 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.

Abstract number: P2-200
Abstract type: Poster
Developing Home Based Palliative Care Service for Incurable Patients in the Capital of Moldova: Are There Any Limits?

Carolin M.
Charity Foundation for Public Health ‘Angelus Moldova’, Hospice ‘Angelus’, Chisinau, Moldova, Republic of

Introduction: Palliative care is a new field that was successfully implemented in many countries of the world, but in some states it still remains neglected by the national healthcare systems. In Moldova palliative care has been growing gradually since 2000.

Objectives: To assess the activity of the Charity Foundation for Public Health ‘Angelus Moldova’ about its activity for different categories of incurable patients.

Methods: Review of the annual reports of the Charity Foundation for Public Health ‘Angelus Moldova’ about its activity for different categories of incurable patients.

Results: Charity Foundation for Public Health ‘Angelus Moldova’ is a leading provider of domiciliary palliative care services for incurable patients in the capital of the country. It was started in November 2001 with the mobile palliative care service for incurable cancer and non-cancer adult patients. In November 2008 the home based pediatric palliative care service for incurable cancer children was initiated, and later, 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 oesomy 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 ‘Angelus 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

Corryn M. 1, Sutherland S.1, Campion C.1, Kassey A.2, Wood J.1, Stevens C.1-A.2
1 Royal Marsden Hospital NHS Trust, Palliative Medicine, London, United Kingdom, 2 Royal Marsden Hospital NHS Trust, London, United Kingdom

Abstract type: Poster

Care homes are playing an important role in the care of older people at the end of life. Together, they provide care for 19.6% of the population, rising to 30% of those aged over 85. Each year an average of 41,969 people die in a nursing home and 32,138 in a residential care home (National End of Life Care Intelligence Network, 2010). This poster describes an innovative model of care provision for improving EOLC 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 EOLC for dementia care homes, etc to support critical clinical decisions, research and best practice. The model 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. 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)?

Conway E.1, Mainprize E.2
1 NHS Tayside, Palliative Care, Dundee, United Kingdom, 2 University of Dundee, Dundee, United Kingdom

Abstract type: Poster

Background: Delayed discharges (DD) from hospital have detrimental effects upon patients. Delayed discharge from SPCU can prevent people 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.

Aims: There is very little published research on the prevalence of DD, or what happens to people who are delayed discharges from SPCU. This led to us audit our own experience.

Methods: This was a retrospective case note review. All delayed discharges from our SPCU during 2013 were found via the NHS delayed discharge system. All notes were requested and data was extracted.

Results: Of 391 admissions, 21 patients were on the DD list. Data were available on 14 patients. 6 patients on the DD list were transferred from the unit to another place of care, 6 died awaiting. The mean number of days that patients were on the DD list was 21 (2 – 62), 35% of people (£14 on the DD list lived alone and none were discharged back home if the palliative performance score remained 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).

Discussion: Only 6 patients on the DD list were discharged from the unit. If performance status deteriorated, there was a trend towards lower successful discharge, although this did not reach statistical significance if people live alone at home, a supported discharge home is difficult to arrange in Dundee. The delay in discharging is a challenge, the preferred place of care is home in 14 of 15 cases for making this an important practical consideration for our team and the patients and families care for.

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

Lawson C. 1, Day L.2
1St Catherine’s Hospice, Crawley, United Kingdom

Abstract type: Poster

Background: 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.

We incorporated a rehabilitative approach in order to offer practical solutions whilst using our specialist skills to facilitate excellent end of life care.

Aims: 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, commissionable 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: 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 sector to support patients and carers.

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.

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, A Review Study

d’Genot E.1, Zweer D.1, Uyttehaew G.1, Auecs M.1, Buusen L.1
1 University Medical Center Utrecht, Department of Internal Medicine and Dermatology, Utrecht, Netherlands, 2 Academic Hospice Demeter, De Bilt, Netherlands, 3 University Medical Center, Patient Nursing Care, Utrecht, Netherlands

Abstract type: Poster

Background: Dying on the preferred location is a quality indicator of palliative care (PC). In the Netherlands, most patients prefer to die at home. PC at home is provided by professionals and volunteers, from a variety of primary care organisations. Collaboration in PC at home is a challenge, due to a lack of regular face to face contacts. In a local area, primary care professionals and a high care hospice initiated the Circle Team (CT), a multidisciplinary collaboration of general and specialised PC caregivers to support patients and their families at home.

Aim: To support patients to die at their location of preference and ameliorate PC at home.

Methods: A prospective evaluation study.

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.

The CT collaborates through 2-weekly interdisciplinary consultation and 24/7 out of hours hospice consultation for patients, families and caregivers. All CT patients were registered in a database and a multidimensional patient record, to promote continuity of CT consultation.

Outcome: Concordance between preferred and actual place of death.

Analysis: Descriptive statistics.

Results: A total of 46 patients, 21 men (46%), mean age 72 (SD 12.06), 93% cancer diagnosis, enrolled in CT for 97 days (SD 68.6). In 24 interdisciplinary consultations, patients were discussed 5 times on average.

A total of 35 patients died. 83% (n=29) in concordance and 4% (n=2) not in concordance with their preference. The preference of 4 patients was unknown (inability to discuss death (n=1) and too ill (n=3)). These patients died at home (n=25), in hospice (n=1) and in hospital (n=1, saddle embolism).

Conclusion: Interdisciplinary collaboration and consultation in a local chain of PC generalist and specialised professionals and volunteers, supports patients at home, to die at their preferred location.

Funding: Zonmw
Starting a Hospital-based Palliative Care Program in Sub-Saharan Francophone Semi Urban Setting

Dossouero R.N., Londack C., Tume L., Fette G.T.
Bafoussam Regional Hospital, Bafoussam, Cameroon
Presenting author email address: nguetie2003@yahoo.fr

Objective: To organise a palliative care program is crucial for the effective follow-up and control of pain and symptom in patients suffering from cancer or excruciating pain in the different hospital services during a period of 6 months. We need to ask if medical care is provided for patients suffering from cancer and excruciating pain 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 an internship to the PC unit of the Regional Hospital Bamenda on the use of morphine. Thereafter, a mobile unit of PC was created, in the hospital in July 2013. After 2 years since the creation, 87 patients were supported. The 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 in a hospital setting is possible through innovative collaboration and organised advocacy.

A Map of Active Palliative Care Providers in Slovenia

Zlobec N., Mele M.G., Paholke Golčnik J., Ivanetić M., Zdobnik B., Ebert Molnara M.
1Oncology Institute of Ljubljana, Department for Acute Palliative Care, Ljubljana, Slovenia, 2Oncology Institute of Ljubljana, Department for Medical Oncology, Ljubljana, Slovenia, 3Oncology Institute of Ljubljana, Department for Oncology and Radioterapy, Ljubljana, Slovenia

Background: There are several palliative care providers all over our country, but majority are not well recognised among patients, their caregivers and also among professionals. Many of them are not aware that palliative teams are available in their region as well as they do not know how, when or where to reach them and what kind of support can be expected.

Aims: As a part of Project Butterfly, which was developed for palliative care promotion and recognition among potential users of palliative care our additional aim was to make a list of all active palliative care providers and information on where, when and how they can be reached.

Methods: We have collected information about active palliative care providers from Slovenian Palliative Medicine Society members, Slovenian pain society and Slovenian hospital web pages.

Results: We have recognised 8 palliative teams in hospitals across the country, one specialised only for ALS patient, one for cancer patients and one for paediatric population. All other provide help to any adult palliative care patients. There is one mobile palliative team, 14 outpatient clinics for pain control, 8 hospice home support teams and 1 hospice house. As a part of Project Butterfly all recognised teams are presented on a map, as part of a new webpage www.paliativnaoskrba.si where patients and caregivers can also find the contacts and description of services provided.

Conclusion: The information how to reach any palliative care provider is crucial in sense of getting proper help when a palliative care patient is in need. With a list of active palliative care provider published on a new web page www.paliativnaoskrba.si we have filled that gap.

A map of an active palliative care providers in Slovenia is a part of the project ‘Butterfly’, one of the projects running under supervision of The European Palliative Care Academy.
On the Construction of Design Guidelines for the Architecture of Palliative Care Settings in Denmark

Folk K., Kylenst K.M., Timm H.
University of Southern Denmark / Danish National Institute of Public Health, VHH – Knowledge Centre for Rehabilitation and Palliative Care, Copenhagen, Denmark.

Presenting author email address: kfk@kgs.dtu.dk

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 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 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 what criteria 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

Type: Poster

Improving Emergency Admissions in Palliative Cancer Pathways

Fanna N.C., Tanussen M.M., Akgypensen R.A., Sandbu R.J., Bjelmad M., Hammer S.V.
Vestfold Hospital Trust, Oncology/Palliative, Tønsberg, Norway, Vestfold Hospital Trust, Emergency, Tønsberg, Norway, Vestfold Hospital Trust, Quality, Tønsberg, Norway, Vestfold Hospital Trust, Surgery, Tønsberg, Norway

Background: Patients with advanced cancer are often admitted to hospital emergency departments.

Aims: or goal of the work: The main objective is to ensure equitable and coherent services to palliative cancer patients, were 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 oncologic 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 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 patients with advanced conditions travelling from overall the world. The different cultural backgrounds, characterised by foreign languages, various beliefs and expectations can complicate the therapeutic relationship. These barriers may be further challenged in the event of a desired repatriation for terminal care. The purpose of presenting this care 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.

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

Type: Poster

Physician's Perceptions about Palliative Care Specificities

Flor de Lima M.S.S.O.
Hospital do Divino Espirito Santo de Ponta Delgada, EPI, Pain Unit and Palliative Care Team, Ponta Delgada, Portugal

Presenting author email address: mflordelma@gmail.com

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 the importance of the Medical Ethics. 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.

Abstract number: P2-215

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

Steinset T.J., Amundsen L.
Haraldsplass Deaconal Hospital, Surviva Center of Palliative Care / Rehabilitation Services, Bergen, Norway, Haakon University Hospital, Regional Centre of Excellence for Palliative Care, Bergen, Norway, Haakon University Hospital, Centre for Pain Management and Palliative Care, Bergen, Norway

Presenting author email address: toliff@haraldsplass.no

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 led 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: 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 led by separate executive groups who arrange seminars and have their own web information and competence plans.

Abstract number: P2-214

Type: Poster

Building Bridges – Palliative Care Beyond Borders

Monteverde M., Bommarito P., Pedrazzoli C., Fust S., Schmidhauser T.
KOS-EOC, Palliative Care, Bellinzona, Switzerland

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 overall the world. The different cultural backgrounds, characterised by foreign languages, various beliefs and expectations can complicate the therapeutic relationship. These barriers may be further challenged in the event of a desired repatriation for terminal care. The purpose of presenting this care 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, evaluating both administrative and healthcare aspects, assessing the travel risks carefully.

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.
Patients in Palliative Care (PC) Reluctant to Benefit from Hospital Monitoring: What Type of Collaboration Can General Practitioners (GP) Expect?  

Gevorgyan C., Lawson R., Wild C., Tapson S., Collins S., Badollet M.  
Researches Bayside Palliative Care, La Gardo, France  
Presenting author email address: c.gevorgyan@laspote.fr

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 clear of ambiguous.  

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 home’ structure but not everyone can benefit from such an organisation.  
The PC networks may take part to collegiate 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 interactions are more and more patients to the hospital, together with crowded emergencies departments, is another incentive to develop proper homecare.

When Sociocultural Habits Re-humanize Patient Care: The Experiment of a ‘Wine Bar’ in a Palliative Care Unit  
Guastella V1, Ranque Gamers S2, Donnat C1, Raymond N1  
1Clermont-Ferrand University Hospital, Palliative Care Center, Cebazat, France, 2Manuelle University Hospital, Oncology and Palliative care, France, 3Marseille Université, School of Medicine, EA 3279, Self Perceived Health Assessment Research Unit, Marseille, France  
Presenting author email address: vgastella@chu-clermontferrand.fr

In palliative medical practices, 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 preserve 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 unforeseen by lack of means, family disagreements or sociological isolation. 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 a hospice at home 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 statistician data base with relevance to the impact of this way of care, 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 work of another hospital center proposing the implementation of gastronomical workshops.  
Results: 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. Sensory experience is not only made through wines and food. We use all the sensual dimensions: music, relaxation, essential oils, etc...)

Telephonservice for Nursing Home Residents: A Cost-effectiveness Review  
Guzon S1, Mouchahem P2, Johnston B1  
1University Paul Sabatier, Toulouse, France, 2CHU de Toulouse, Unité Réalisation, Toulouse, France, 3CHU de Toulouse, Gerontopole, Toulouse, France, The University of Nottingham, Sue Ryder Care Centre for the Study of Supportive, Palliative and End of Life Care, Nottingham University, Nottingham, United Kingdom  
Presenting author email address: vincent.guzon@gmail.com

Background: Telemedicine is expected to efficiently 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 telephonic care, could be an efficient adjunct 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.

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  
Harri B.D., Conn D.  
Hospice IDM, Douglas, Isle of Man, Isle of Man  
Presenting author email address: ben.harri@hospice.org.im

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 by 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.  

Sustainable Hospice and Palliative Care Culture in Nursing Homes: Connecting Nursing Homes and Community  
Heimerl K1, Wegleitner K.1, Spicher J.2, Helene G.2, Alexandra T.1, Schönhofer-Nellessen V.1  
1Alpen-Adria University of Klagenfurt, IFT-Palliative Care and Organizational Ethics, Vienna, Austria, 2Caritas Association of the Diocese Aachen, Aachen, Germany, 3Servicestelle Hospiz, Aachen, Germany  
Presenting author email address: katharina.heimerl@aau.at

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 to engage in community care? How was the research process itself should foster 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 denominated one or more interviewees, who carried out 39 qualitative problem-centered interviews and 5 focus groups representing 5 perspectives: Residents, relatives, health professionals, staff and formal and informal support 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: Palliative care culture has been implemented sustainably 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.
My Home Support a Collaboration between Housing and Hospice Care

Hodges E.L., Riches S., Lilley W.
St Giles Hospice, Lichfield, United Kingdom, 1Bromford, Solihull, United Kingdom
Presenting author email address: emma.hodges@stgiles hospice.com

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 support partne...
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Abstract type: Poster

Developing a Strategy for Advance Care Planning: Choosing what Not to Do
Littlegood C.M., Gamble M., Ellershaw J.E.
Marie Curie Palliative Care Institute Liverpool, Liverpool, United Kingdom
Presenting author email address: clemare@ucl.ac.uk

Background: Advance 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 comprising 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, hospice and long term condition provider develop a sensitive and responsive approach to ACP.

Method: A 12 month project is underway to identify strategies for developing ACP including: scoping best practice, clarifying definitions; and making recommendations on resources and educational models, using a top-down and bottom up approach.

Results: Preliminary findings are that key principles needed to be embedded first into everyday practice with emphasis on patient choice. Results will be presented at conference.

Conclusion: Research suggests that understanding ACP process is key to implementation and that good practice can be embedded through recording and sharing conversations alone on standardised documentation. Training and public engagement are fundamental to promoting and maintaining change.

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Abstract type: Poster

Bridging the Gap – How Research-ready Are Palliative Care Services in Sussex?
Moyle A.1,2, Lindsay F.2
1St Wilfrids Hospice, Eastbourne, United Kingdom, 2East Sussex Healthcare NHS Trust, Eastbourne, United Kingdom, 3Sussex Community NHS Trust, Community Palliative Care Team, Brighton, United Kingdom
Presenting author email address: farndam@aol.com

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 stand alone community teams. Survey questions covered items related to service details, service experience and capability, and barriers/factors prompting 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 capacity. Future directions involve inter-regional collaboration between other interested research networks and development of a local research infrastructure to support successful delivery.

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Abstract type: Poster

Development of Continuous and Complete Palliative Care in Zagreb: Improved by the Multidisciplinary and Interdisciplinary Approach and Teamwork
Mandekic D.1, Tomac O.2, Matte B.1,2
1Home Care Centre-Zagreb, Centre for Coordination of Palliative Care, Zagreb, Croatia, 2Franciscan Secular Order Kapitol, Mobile Team of Volunteers in Palliative Care, Zagreb, Croatia
Presenting author email address: renata_mandekic@yahoo.com

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 as 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; a research-based charity as a non-governmental organisations (social workers 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. All these groups work together as a good palliative care 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.
Integrated Community Palliative Care Consultancy – The Active Care in Hungary

Miklós L.1 Agnes C.2
1University of Pecs Clinical Center, Palliative Consultation Service Team, Pecs, Hungary
2Medical University of Pecs, Hospice - Palliative Department, Pecs, Hungary

Background: Cancer patients are seen in a variety of clinical settings. Many evidence describe 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 community support-facilitating 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, advanced 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 phycian, 1 psychologist and 1 palliative nurse coordinator. The palliative nurse coordinator specialist is available 08:00-16:00, 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 prefer 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 patient's discharge time increases.

Supporter: University of Pecs Clinical Center and Pecs-Bánya Hospice Foundation

Abstract number: P2-232
Abstract type: Poster

Introducing a 24/7 Home Care Palliative Service

Philippou K.
The Cyprus Association of Cancer Patients and Friends (PASYKAF), Nicosia, Cyprus

Cyprus has an estimate of 3000 new cancer incidences and about 1200 deaths from cancer each year. All palliative care services are pioneered and operated by the voluntary sector only. The Cyprus Association of Cancer Patients and Friends (PASYKAF) is an NGO dedicated in improving and safeguarding the quality of life of cancer patients and their families. One of our main services is palliative care services at home. In 2013, our multidisciplinary team offered palliative care services at home to 1800 patients.

Our service currently runs from 7am to 6pm so we are implementing a 1-year pilot project in order to develop and provide a 24-hour service beyond our office hours. At the moment no other Association or entity offers this in Cyprus.

We aim to improve our offered health care services, improve the capacity or our nursing staff, transfer the existing knowledge from two partners in this project, the Norwegian Cancer Association and Turkish Cypriot Cancer Association and publicise our new service and make people to feel comfortable to have home treatment. Ideally, with the completion of the project we plan to set up the model for implementing this service across Cyprus.

The key objectives of the project are the following:

To introduce a pilot service of 24 hour service to patients of our organisation in 2 out of 5 districts in Cyprus (Nicosia and Limassol)

To improve health care services, while we reduce costs both for patients and our association through the evaluation of the pilot service

To improve the capacity or our nursing staff through training

To enhance our e-health database of our patients to web-based

To evaluate the project and examine the quantitative and qualitative impact of this service, 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.
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Abstract type: Poster

‘Plus Sport la Vie’ Physical Activities (PA) Program for Patients with Cancer

Ranque Garnier S., Giraudon JM., Salas S., Ruquier P., Duffaud F.¹
¹Marseille University Hospital System APHM, Oncology and Palliative Care, Marseille, France, 2Aix Marseille University, School of Medicine, EA 3274, Self-Percieved Health Assessment Research Unit, Marseille, France, 3Marseille University Hospital System APHM, Cancer Coordination Center, Marseille, France, 4Marseille University Hospital System APHM, Sport Medicine, Marseille, France

Presenting author email address: stephanie.ranque@ap-hm.fr

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, psychological...). 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. Ranque Garnier S.’s 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 3 adapted physical activities per week taught by cancer specialized trainer. From adapted physical lessons in the faculty of Medicine’ 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

Raukkäär M., Krogh Jessen M., Tellenova J.
University of Southern Denmark, PAVI – Knowledge Centre for Rehabilitation and Palliative, Copenhagen, Denmark

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 part.

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 been set up between one to ten beds and mostly housed elderly people with life-threatening diseases. The palliative care provided had a holistic perspective with focus on everyday life; activities, 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 result in treatment of diseases that do 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

Gyllenhaammar E.J., Souts S.F., Forsell C.T.¹
¹ASH - Bylge Gard Palliative Department, Täby, Sweden, 2Stockholms Sjukhusförening, Stockholm, Sweden, 3Lund University, Institute for Palliative Care, Lund, Sweden

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 (NRPPV) and through the archives of the Council.

Results: The Swedish Society for Palliative Medicine (SPFM) was founded in 1997. A curriculum for education in Palliative Medicine, based on the UK and EAPC curricula, was published in 2003. NRPPV was founded 2004 with economical support from the government, and consists of 11 professional PC national organisations. NRPPV 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 at end-of-life care. SPFP – 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 groups for health care. Recommendations to the National Board of Health and Welfare were followed 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.

Conclusion: There has been an increased focus on professional 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.

Abstract number: P2-239
Abstract type: Poster

Experiences and Needs of Relatives of Dying Patients in Switzerland: A Qualitative Narrative Study

Schwarz S., University of Applied Science, IPW Institut für Pflegewissenschaft (Institute of Nursing Science), St. Gallen, Switzerland

Background: In 2010 the Swiss health board approved a national strategy for palliative care. This first qualitative study in Switzerland about the experiences of family survivors after the death of a relative hospitalised in a palliative care ward.

Aim: Presentment of the experiences and needs of relatives of dying patients. These experiences cover the time from diagnosis to hospital treatment, home care and a specific palliative ward, where the patients died at the end. Furthermore, we elaborate the meaning of the professional support for the family members.

Method: Retrospective interviews Twenty-one narrative interviews with bereaved relatives, conducted after the death of their beloved ones on a specialised palliative care ward, were performed using a semi structured interview guideline. The average time of the interviews was 75 minutes, they were digitally recorded. The transcripts were analysed using a qualitative content analysis. Data saturation was obtained after 18 interviews. The study was approved by an independent ethic commission. Results: On the caring level, the relevancy of having a person, as a confidant, was shown as one of the main benefits for the family members. This fact escaped by the remembrance of the professional support for the family members.

Conclusion / Discussion: Palliative Care offers a support resulting in a wide overall satisfaction. The practical and theoretical implications can be seen in the affirmation of the need of extending palliative care on interpersonal aspects. The Study clearly shows that quality of life, plays a major role in the course of dying. Multifaceted interpersonal phenomenon in dealing with the dying and their relatives are more important factors for the remembrance of quality of life than good symptom control.

Abstract number: P2-240
Abstract type: Poster

Innovations in the Transition Process Supporting Young Adults with Life-limiting Illness

Lawson G., Sellars P., Hartley N.
St Christophers Hospice, Young Adults, London, United Kingdom

Introduction: Moving from children’s to adult services can be a difficult transition for young adults and their families. We know that services are poorly coordinated, and this can lead to frustration. Service provision is also inequable and in turn, lead to teenagers, young adults and their parents becoming socially isolated and disengaged.

Method and results: During 2014, we set up a pilot project, funded by the DAISY Foundation. We identified over 40 young adults aged between 17 and 25 who lived in South East London and were being discharged from children’s hospice services from community paediatric services. The project team consisted of a Young Adult’s Coordinator (A Community Nurse Specialist) and an Arts Therapist (2 days a week). Healthcare Assistants and volunteers supported the work when needed and a steering group oversaw the project including representatives from Children’s Hospices as well as other key representatives and a young adult user.

1. We arranged joint home visits between the project lead together with other significant professionals from community services, created a co-ordinated care plan using a newly designed assessment tool. We explored Advance Care Planning and then entered everything onto a central register.

2. We set up regular Young Adult Days, including siblings, friends and carers. We offered support with transport and we involved local schools who provided students who came along to befriend and support the Young Adults.

Conclusion: This poster will outline the project and its success and will also include information regarding future developments, successful funding bids and potential roll-out.
The Impact on Care for Cancer Patients of a Cancer Support Team in a University Hospital in Japan

Sumi H.1, Kobayashi M.2, Mori Y.1, Iwa C.1, Terao M.3, Ishibashi N.1, Nishida A.1, Iwai C.4, Terao M.4, Ishibashi N.4, Nishida A.1, Izawa T.1, Hayashi A.1, Saito S.5, Tsuruoka K.5

1. Kyoto University Hospital, Nursing Department, Kyoto, Japan; 2. Kyoto University Hospital, Department of Hematology and Oncology Graduate School of Medicine, Kyoto, Japan; 3. Kyoto University Hospital, Department of Clinical Oncology, Graduate School of Medicine, Kyoto, Japan; 4. Kyoto University Hospital, Department of Palliative Care, Graduate School of Medicine, Kyoto, Japan; 5. Kyoto University Hospital, Department of Multidisciplinary Cancer Treatment Graduate School of Medicine, Kyoto, Japan; 6. Kyoto University Hospital, Department of Medical Oncology Unit of Policlinico A. Gemelli between January 2013 and August 2013, Simultaneous Care, conducted by the Palliative Care Unit of Hospice Villa Speranza in Rome, Italy.

Aim: 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 the referrals were pain (59%), 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 number of referral in other university hospitals in Japan. This may be due to not only a naming of the team but also well recognition of the team in our hospital. The next challenge is to enhance both the quantity and the quality of the team activity and provide high-quality care to patients with illnesses that are not limited to cancer.

Abstract number: P2-243
Abstract type: Poster

The Possibility to End Life at Home – A Measure of Good Palliative Health Care?

Tocklin L.

ASH, Stockholm Södra, Långbro Park, Stockholms Län Landsting, Nacka, Sweden

Presenting author email address: lars.e.tocklin@sll.se

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 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 their homes at the end of their lives, 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 needs. It also requires that healthcare providers provide information to families in terms of feeling secure and well-care 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 a possibility to live in beauty. Discussions: Is high proportion of deceased patients in the home an indicator of good ASH-care, which implies that the patient and family feel secure, showing strength in the palliative situation? What is an appropriate target for the proportion of ASH-patients who die at home?

Abstract number: P2-246
Abstract type: Poster

Integration of Palliative Care Program (Home Care) and Oncology Palliative Program in Advanced Cancer Patients: Clinical Benefit and Quality of Life

Turpinato A.1, Attanasio G.1, Cipollato S.1, Scialo F.1, Sangalli L.2, De Gennaro E.3, Ricciotti MAC.4, Nazionale G.1, Barone C.1,2

1. Hospice Villa Speranza – Universita’ Cattolica del Sacro Cuore, Rome, Italy; 2. Policlinico A. Gemelli, Università Cattolica del Sacro Cuore, Rome, Italy

Background: In the last decades, longer survivals and new treatment side effects in oncology enforce a novel strategy of early comprehensive cancer care including palliative care and anticancer therapy to better meet patients’ needs.

Aim: We report preliminary data of a prospective observational study of Palliative Simultaneous Care, conducted by the Palliative Care Unit of Hospice Villa Speranza in Rome and Medical Oncology Unit of Policlinico A. Gemelli between January 2013 and August 2013, in order to confirm the improvement of QoL with a concurrent approach.

Methods: We considered 21 patients (9 males and 12 females), median age 63 years (35–84), KPS < 50 in 9 patients and ≤ 50 in 12 patients, PAP Score B < 5.5 in 16 patients and 5.6–11 in 5 patients, affected by advanced solid tumors or hematological malignancies. During our observation all patients received palliative care in home setting and cancer therapies as outpatients.

Results: At the time of statistical evaluation, 13 patients were dead but only 1 of them in hospital. The symptom burden was assessed through the Edmonton Symptom Assessment Scale; our evaluation at 1 week (n=19) and 1 month (n=13) registered a positive variation of ESAS score of 4.88% (p=0.34) and 2.24% (p=0.64), respectively. A statistical significance after 1 month was reached for loss of appetite (1.74%, p=0.02).

Conclusions: Our data suggest the effectiveness in terms of QoL of a model of concurrent palliative care. An efficient palliative simultaneous care program offers also a realistic chance to choose the place of death, as demonstrated by the low rate of deaths in hospital, that represents also a better way to allocate resources.

Abstract number: P2-247
Abstract type: Poster
Service Redesign: Development of a 24/7 Triage Service

Twenty C, Level E
St Wilfrid’s Hospice, Eastbourne, United Kingdom
Presenting author email address: colon.twenty@stwhospice.org

Abstract number: P2-247
Abstract type: Poster

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 feedback, 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 exist within the United Kingdom, usually led by nurses operating at an advanced practice level. No extra funding was available for a service development, 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, 594 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
Vejlgaard T.B., Nøttelmann L., on behalf of Palliative Care Team Vejle Vejle Hospital, Leiblach Hospital, Palliative Team Vejle, Denmark
Presenting author email address: tove.velgaard@nyd.dk

Abstract number: P2-249
Abstract type: Poster

An Interdisciplinary Assessment Tool
Venborg A.
Hospice Djuersland, Rande, Denmark
Presenting author email address: annegrete.venborg@hospicedjuersland.dk

A so-called S-analysis supports the interdisciplinary collaboration in a hospice. In this way our work in every aspect is grounded in the knowledge of the patient and satisfies 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. To fulfill this hospice philosophy, data was collected in dialogue with each patient regarding these six categories: Symptom control, Self-determination, Social relationships, Self-Image, Synthesis / summation and Surrender. In the workshop team, each group had one patient, who clarified who the patient is as a person. The concepts behind the six S-categories has its origins in the American psychiatrist, Avery Brundage. He has developed the six S-categories: Symptom control, Self-determination, Social relationships, Self-Image, Synthesis / summation and Surrender. 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.

Cooperation between Nurses and Medical Carers and Other Specialists in Hospices, Nursing Homes and Long Term Care Units in Poland (Pilot Study)
Wisnadowska A., Pawłowski L., Modłinska A., Janiszewska J., Bus T., Lichodziejewski – Niemierko M.
Medical University of Gdańsk, Department of Palliative Medicine, Gdańsk, Poland
Presenting author email address: annawisnadowska@ug.edu.pl

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% respondents cooperated with more than 3 specialists while performing their duties. Almost equal number of participants wanted to be satisfied with the scope of 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

Undergraduate Nurse Education in Cancer Care: Investigating the Impact of an Innovation in Curriculum Content and Delivery

Hopkinson J., Anstrud S., Edwards D., Kelly D.
Cardiff University, School of Healthcare Sciences, Cardiff, United Kingdom

Background: Internationally cancer incidence is increasing and treatments are becoming more complex. Undergraduate nurses need appropriate preparation to deliver the supportive and palliative cancer care of the future. UK policy places importance on person-centred, holistic cancer care that supports self-management for improvement of both clinical outcomes and patient experience.

Aim: This paper reports the findings of a quasi-experimental evaluation of an innovative, educational initiative to enhance undergraduate nurse education in cancer care.

Methods: This investigation is a mixed methods quasi-experimental study of the impact of a new practitioners role. The study participants include a clinical nurse specialist engaged in curriculum development/delivery and two cohorts of undergraduate nurses n1 = 48, n2 = 64 in South Wales, 2014.

Findings: Response questionnaires was 95% at four timepoints. Undergraduate nurses in both cohorts had limited understanding of holistic cancer care and support of self-management. Undergraduates interviewed from the control cohort (n = 35) emphasised the importance of listening to people with cancer and confined cancer and end of life care. All spoke about signposting to patients information services but this was their only reference to supporting self-management. Immediately following exposure to a new model of undergraduate education in cancer care the intervention cohort had improved knowledge, confidence in skills and confidence in their ability to support self-management and influence patient experience. Data collection and analysis is on-going and will be complete by Feb 2015.

Conclusions: The context of cancer care is changing rapidly. This presents a challenge in the educational preparation of practitioners for the future. This project has tested a new model for the delivery of undergraduate nurse cancer education. Preliminary findings are positive.

Funder: Macmillan Cancer Support, Wales

Abstract number: P2-253
Abstract type: Poster

Developing and Evaluating Complex Interventions in Palliative Care: Use of e-learning to Disseminate Research Findings

Benula H., Koffman J., Heggsin J., Evans C.J.
King’s College London, Cicely Saunders Institute, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom

Presenting author email address: hamid.benula@kcl.ac.uk

There is a need to improve research methods to evaluate models of service delivery and complex service level interventions in eULC and identify good practice research to aid future studies. To establish a Teaching End of Life course, a national platform was developed by the UK Medical Research Council (MRC) MORECare built on the MRC guidance on the development and evaluation of complex interventions. We developed evidence-based guidelines on the best methods for the design and evaluation of EACH, with each evaluating EACH focussing on complex service delivery interventions, reconstructions and treatments. We conducted three systematic literature reviews, five transparent expert consultations involving consensus methods of nominal group and online voting, and two stakeholder workshops to identify challenges and best practice in EACHULC research, including: participation, ethics, attrition, integration of mixed methods, complex outcomes and economic evaluation which were published individually. The final synthesis of all the data formed the MORECare statement detailing guidance on best practice to undertake evaluative research on EACHULC.

We are disseminating the MORECare statement and underpinning work by developing, piloting and evaluating a short e-learning course, consisting of six modules: 1) introduction to complex interventions and MRC framework; 2) selection of outcome measures; 3) use of outcome measure; 4) missing data, attrition and response shift; 5) integrating mixed methods; 6) ethics. The e-learning resource is designed for clinicians and researchers. Each module consists of a series of reading material, a formal assessment and an interactive presentation (e.g. formative assessment and reflective activities).

The development of the course consists of 4 stages: 1) development and peer review of e-learning content (e.g. formative assessment and reflective activities). The development of the learning course consists of 4 stages: 1) development and peer review of e-learning content; 2) implementation and beta-testing; 3) piloting (n=15); 4) on learning and utility; 5) first intake and evaluation.

Funding: MRC

Abstract number: P2-254
Abstract type: Poster

Teaching Palliative Care to the Public: The Last Aid Course – An International Multicenter Project from Norway, Denmark and Germany

Boillg G., Abukku N., Last Aid Working Group of the Norwegian Palliative Association, RPAP and Danes Forening for lidrindstid, Institute University of Bergen, Dep. of Clinical Medicine, Bergen, Norway, ‘HELOS Klinikk Schleswig, Dep. of Palliative Care and Pain Therapy, Schleswig, Germany, ’Norwegian Palliative Association, Oslo, Norway, ’RPAP, Institute zur Förderung der Allgemeinen Ambulanten Palliativversorgung, Rendsburg, Germany

Presenting author email address: geo@boillg@helos-klinikk.de

Aims: Palliative Care aims for best possible quality of life for patients with chronic life threatening diseases and their relatives. Many people do need Palliative Care all over the world and the demand is increasing due to demographic changes. The public knowledge approach aims to inform and teach the public about Palliative Care. This approach includes last aid courses and a chain of Palliative Care.

Methods: The curriculum for an Austrian last aid course which consisted of 16 teaching hours was modified and shortened. An international working group from Norway, Denmark and Germany modified the curriculum and reached consensus about the contents of a short basic last Aid course. Members of the working group were experts in the field of Palliative care and belonged to different professions: 1) psychologist, 1) social worker, 1) specialist in palliative medicine, 1) priest, 1) physiotherapist, 1 family medicine physician. in addition to the participants experts from other professions were consulted and gave comments on the curriculum.

Results: The result is a curriculum for a Last Aid course for the public with 4 teaching hours only. It is divided into 4 modules with 1 hour each (each lasting 45 minutes). It is planned to offer the course both as one-day course or on different days with one to or modules at a time suited for different groups of participants. The themes of the modules are: 1. Care at the end of life, 2. Advance Care planning and decision making, 3. Symptom management, 4. Cultural aspects of death and bereavement. Pilot courses start from October 2014 and a first evaluation of the concept will take place in March 2015.

Conclusion: A curriculum for a basic Last aid course was designed by an international working group. The curriculum will be presented. Pilot courses and evaluation of the concept will start in October 2014 and the first results will be presented at the EAPC congress in May 2015.

Increasing the Number of Legal Oral Morphine Prescribers in a Resource Limited Setting

Buyinza N.
Institute of Hospice and Palliative Care in Africa, Kampala, Uganda

Presenting author email address: buyinzan@yahoo.com

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 Merriman, 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 course 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 of 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: P2-256
Abstract type: Poster

Pretending to be Dying

Cameron-Taylor E.L., Byfield N.D., Clark R.
Calvert Mary Newport / University of Newcastle, Palliative Medicine, Newcastle, Newcastle, Australia

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 medical 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 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 a digital palliative care to be tethered 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 terminally ill 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.
E-learning – Doodles, Snippets, Mindmaps and Apps: Keeping up with the New Generation

**Abstract number:** P2-257  
**Abstract type:** Poster

**E-learning – Doodles, Snippets, Mindmaps and Apps: Keeping up with the New Generation**

**Perera J.L.1,2,3 , Downer K.A.**

**Background:** 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 clinical decision making are essential 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 on topics such 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.

**Aim:** To provide local priorities of care training to all staff involved.

**Methods:** 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 hospital & care homes. Strong Trust Executive Board & Clinical Commissioning Group leadership ensures staff are released for training.

**Results:** 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.

**Conclusion:** The 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:** P2-260  
**Abstract type:** Poster

**One Chance to Teach it Right: A Response to One Chance to Get it Right**

**Finnegan C.1, Groves K.E.1,2, Deeming E.2, Godfrey C.3, Southport & Ormskirk NHS Trust, Southport, United Kingdom, 4Southport & Ormskirk NHS Trust, TRANSFORM Team, Southport, United Kingdom, 5Southport & Ormskirk NHS Trust, QI Project Lead, Southport, United Kingdom**

**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-circumscribed 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.

**Methods:** 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 hospital & care homes. Strong Trust Executive Board & Clinical Commissioning Group leadership ensures staff are released for training.

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**Conclusion:** The 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?**

**Free S.L.1, Koffman J.L., Khan S.A.1,3 Guy’s and St Thomas’ NHS Foundation Trust, Palliative Care, London, United Kingdom, 2King’s College London, Centre for Palliative Medicine and Rehabilitation, London, United Kingdom,**

**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 4–8) 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.

**Conclusions:** These 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.

**Sessions (Poster Exhibition Set 2)**
Aim: The European Palliative Care Academy-Leadership Course is a 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 covering one course week 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 course 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 divide into single week modules, run in each of the four courses. The modules comprised 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%). Each of the 20 participants with their personal projects have already ensured that the first course has enriched PC in Europe. Both internal and external evaluations suggest the academic 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 allowed for the achievement of all 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, future funding partners are being sought.

Abstract number: P2-263
Abstract type: Poster

Madrid Training Program: Building Blocks to Bridge and Channel Knowledge and Understanding

Dominguez Cruz A.1, Garcia-Baquero Merino M.T.2, Gil-Hugues E.3, Monleon Just M.2, Cid C.2, García Adrion S.4, Sales I.T.5, Sosa E.6, Barceló Escaro M.7, Alba A.8, Fernández Gómez C.9, Escober Mol N.10

Background: 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.

Methods: 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 achieving the delivery of good care. The lack of discussion 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 emphasises quality of life, therapeutic communication and value patients autonomy.

Results: 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.

Conclusion: 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 recorded increased from 30%-90%; those with other items from 0%-10% patient & carer wishes revised in last days 45% – 100%.

Abstract number: P2-265
Abstract type: Poster

Community of Practice: Developing a Cross-Border Community of Learning for End of Life Care

Deeming E.1,2, Kelly A.1, Collins M.3, Finkenste C.4, Groves K.E.5,6

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.

Aim: To improve the quality & experience of End of Life care for all patients & families, across the trust.

Methods: 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 KCO joined together to meet monthly to learn, enthuse, support one another and to develop their expertise and, encourage the promotion of good End of Life care within their own work areas. All undertaken the End of Life Skill Set Challenge development programme and are auditing End of Life practice within their own areas. 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 Skill Set Challenge, a summary of the End of Life audit results, qualitative & quantitative feedback from participants undertaken independently by local university staff.

Abstract number: P2-266
Abstract type: Poster

Evaluation of Palliative Care Education in Japanese Pharmacy Students

Hisunaga K.1, Naganuma T.2, Matsumoto M.3, Hamaguchi D.1, Hongo F.4, Katayama K.5, Kumagai A.6, Konda A.7, Watanabe Y.8

Teine Keikai Hospital, Palliative Care Team, Sapporo, Japan, Hokkaido Pharmaceutical University, Sapporo, Japan, Teine Keikai Hospital, Sapporo, Japan

Background: Palliative care education for pharmacy students and pharmacists is developing in Japan. We initiated lectures about palliative care pharmacist 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.

Aim: 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.

Methods: 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 levels of education, and the score was decreased from before lectures among some questions about (dyspnea), (psychiatric problems (deleium)), and (gastrointestinal symptoms (nutritions)) before palliative care lectures and after clinical trainings.

Results: The mean total score of PCKT increased from 10.0 (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, the score was decreased from before lectures among some questions about (dyspnea), (psychiatric problems (deleium)), and (gastrointestinal symptoms (nutritions)).

Conclusion: This study showed most of the Japanese pharmacy students had correct knowledge of palliative care philosophy. However, our palliative care educational program that was mainly based on lectures had limitation to teach some specialised knowledge.
Physician Trainees’ Perceptions of Palliative Care Education and Training – An Illuminating Evaluation

Janie R.S.
Cardiff University School of Medical, Medicine Education, Cardiff, United Kingdom

Background: In the UK most palliative care occurs in acute hospital settings, delivered by non-specialist physicians including Core Medical Trainees (CMT). 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 illustrative evaluative 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: Feedback 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.

Abstract number: P2-258
Abstract type: Poster

New Colleagues – Former Students. Spreading Palliative Care Knowledge among Nursing Students

Mjörnberg M., Leveälahti H., Källgren B.
Institute Stockholm Essvik, Essvik’s HUS, EHS – Enhets för FoRskning, Utveckling och Utbildning (Unit for Research, Development & Education), Stockholm, Sweden

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 existent difficult situations and supported their learning 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 terminal illness, existential support, bereavement and teamwork. Daily reflection was an important learning aspect and in the end of practice the students participated in an one hour semi-structured reflection, led by a tutor 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.

Abstract number: P2-269
Abstract type: Poster

Inter-professional Education in Palliative Care. Educating across Sectors in Palliative Care

Kastberg I.
Hospice South, Jutland, Haderslev, Haderslev, Denmark

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 universities or hospitals can afford to send only a few of their staff members to educational enrichment courses. The education programmes offered are often tailored to one specific profession.

Aims: Constructing an education model in which

(1) the courses become a shared experience for different inter-professional professionals, and
(2) that the challenges are embedded in the curriculum and that the students experience palliative care as an inter-professional approach to the patients and their families.

The mixed groups of participants increase their ability to integrate the benefits of the programmes offered are mostly targeted to one specific profession.

The background for the project was the necessity for place people can feel free to go for a consultation with Citizen Partnership, Sapporo, Japan, 4Japan Health Care College, Sapporo, Japan, 5Medical Social Work Research and Development Institute, Sapporo, Japan, 6Hokkaido Sapporo Hospital, Sapporo, Japan, Health Science University of Hokkaido, Sapporo, Japan, 7Nieme Keijiniku Hospital, Sapporo, Japan, KKR Sapporo Medical Center, Sapporo, Japan, Sapporo Hospice Palliative Care Network, Sapporo, Japan.

Methods: We planned the programme in Sapporo’s Underground Pedestrian Space on Saturday. There were 70 volunteers to implement it, including physicians, nurses, case workers, cosmetic camouflage makeup therapists, peer supporters, and Hokkaido prefectural employees. The programme included the following:

1. Information on coping strategies for side effects of therapy
2. Consultations with experts and peer supporters
3. 3.15 minutes lectures about pain relief, home healthcare, and nutrition for cancer patients
4. supplying the brochures to disseminate information on cancer and palliative care

We aggregated participants’ questionnaire responses and the consultation results

Conclusion: We received more attendees come across the street than we expected who required more knowledge of cancer. We realised the necessity for place people can feel free to go for a consultation.

Abstract number: P2-271
Abstract type: Poster

The Role of an End-of-Life Training Workshop for Care Staff in Improving End of Life Care

Welsh T., Donnelly S., Maher H., Keegan O.
1Trinity College Dublin, Dublin, Ireland, 2Irish Hospice Foundation, Dublin, Ireland
Presenting author email address: orla.keegan@hospicefoundation.ie

Formal training evaluation, using a Kirkpatrick framework, of end-of-life (EOL) care for residential care settings would help in improving education approaches. Study aim: To identify if workshop training made a difference over time to participants’ values, practice & sense of job satisfaction. Design etc.

A mixed method design was used. 4 community hospitals were purposefully sampled – in each at least 20 participants attended training in 2012/13, & settings were rural & urban. The following data was collected:

(i) same-day evaluation sheets examined ‘Participant Reactions’
(ii) Questionnaires assessed ‘Learning & On-the-Job Behaviour’ 3–12 months post-workshop
(iii) Focus group discussions (fgds) assessed ‘Learning & On-the-Job Behaviour’ 3–12 months post-workshop
(iv) Interviews with Nursing managers assessed ‘Results’ Impact and Challenges 4–16 months post-workshop.

Descriptive statistics & thematic analysis of interview/fgd data were performed.

Results: EVALUATION SHEETS (151 participants): 85% rated workshop as ‘excellent’ on a 4-point scale (excellent-good-fair-poor), 14% ‘excellent’ as ‘good’.

QUESTIONNAIRES (26/151), 19% respondents reported increased confidence/ more openness to discussing EOL with residents & found format of training workshop very good.

FGDs (% ‘good’)

Training was effective in empowering communication & sensitivity towards residents/families. Staff reported changed attitudes, increased confidence in engaging with residents/families, felt more competent.

CONCLUSION: The response rates to the questionnaire were low. Qualitative report showed training was worthwhile & highly motivating, & led to attitudinal change & behaviour change according to participants & managers.
Palliative Care (PC) Education and Its Importance in Providing a Quality Service

Koço G., Laskolj, Bilybekshe B.
Korca Palliative Care, Koço, Albania

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 care 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 these trainings are patients who are being modestly provided with PC from healthcare professionals trained in MP center.

Conclusions: Education is an important component of PC which needs to develop along with this service. Capacity building of healthcare professionals on PC on has produced a positive impact on the care provided to patients and their families. PC education has contributed to promotion and further development of this service in Albania.

Keywords: Education, Palliative care, Healthcare professionals

Abstract number: P2-273

Abstract type: Poster

For Integration of Palliative Care in Critical/Intensive Care Settings

Kordons D., Chikhladze N., Veliljnovščil M.
IV. Javakhishvili Tbilisi State University, Tbilisi, Georgia

While delivering Palliative Care (PC) in Critical/Intensive Care Settings (CCS) the physicians and nurses usually follow their ‘scant’ knowledge in PC and traditional motivation to cure the patient or postpone death, which leads to neglecting or missing the opportunity to attend the needs and attitudes towards the care of patient’s family and more severely, of the patient himself/herself.

The presented research proves the necessity and importance of special education/training of CCS medical staff. The implementation of PC in CCS in the hospitals of Georgia.

Conducted research was based on the analyses of:

1. Structural interviews of 57 CCS physicians and nurses evaluating their knowledge and skills necessary for adequate PC
2. Semi-structured interviews of 23 individuals aged more than 80 years (age range 83–92 years) and 32 advanced cancer patients (age range 32–78) who still continue active life.

The first study has evidenced that more than 84% of medical staff working in CCS do not have adequate knowledge and skills needed neither to deliver quality PC for patients nor to communicate effectively with patients and their family.

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. Maslow 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 CCS.

The obtained results confirm the importance of education/training in basic PC of medical professionals, working in CCS.

To support these results in CCS, two versions of basic PC modules with both communicative and online-based teaching tools were prepared, accredited and implemented specifically for CCS physicians in Georgia in 2014.

Abstract number: P2-274

Abstract type: Poster

Advanced Training in Palliative Care: 15 Years of Experience in Catalonia (Spain)

Guerrero L., Lomarín C., Albuernequía E., Gómez Batiste X., Bes E., Esa S.
Catalan Institute of Oncology, Training and Education Unit. Department of Persons, Barcelona, Spain; "Catalan Institute of Oncology, The "QUALY" Observatory - WHO Collaborating Centre for Public Health Palliative Care Programmes, Barcelona, Spain; "Universitat de Vic, Chair of Palliative Care, Vic, Spain; "Catalan Institute of Oncology, Barcelona, Spain

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 quantitative results and evolution of advanced training in Palliative care in Catalonia at 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 content 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.

Abstract number: P2-275

Abstract type: Poster

Implementation of an Education Program in Palliative Care among Nursing Students: An Action-research Project in the Outermost Region of Portugal

Lima T., Martin-Pereira S., Mendes-Barreto P.
"University of the Azores, Nursing College of Angra do Heroísmo, Angra do Heroísmo, Portugal; Catholic University of Portugal, Institute of Bioethics, Bioethics Research Centre, Porto, Portugal; "University of Las Palmas de Gran Canaria, Faculty of Health Sciences, Department of Nursing, Las Palmas de Gran Canaria, Spain

Presenting author email address: martinsperiera.sandra@gmail.com

Background: Most courses leading to a nursing degree do not meet the recommendations of the European Association for Palliative Care in palliative care. This may led to difficulties when caring for palliative care needs. In outermost regions, investing in education is a keystone to ensure palliative care provision for all citizens.

Objectives: To study the impact of an optional education program in palliative care among nursing students in their (i) knowledge, (ii) attitudes towards patients and families, and (iii) emotional coping.

Methods: Research-action. Data was collected using the following instruments: pre and post-education program questionnaire; field-notes of the participant students and course leader; written reflections provided by the participant students during the practicals that followed the course completion; focus groups with students after the same practicals. Questionnaires were analysed comparatively; content analyses were done inductively to the transcripts of field-notes, written reflections and focus groups. 24 nursing students participated in this study.

Results: After the course completion, the students exhibited a more accurate and broader concept of palliative care. The major impact of the course on the students’ attitudes towards patients and families referred to an improvement in the students’ ability to identify palliative care needs and to better communicate. The course had a major impact on the awareness of students concerning their emotional capabilities. The students became more able to cope with difficult situations (e.g., end-of-life care and decisions).

Conclusions: The education program in palliative care contributed significantly to students’ clinical practice, namely by terms of the formation of self care for caring for terminally ill patients. By participating in this course, students expanded their knowledge on palliative care, which had an impact also in the development of their competences.

Abstract number: P2-276

Abstract type: Poster

The EAPC Steering Group on Medical Education and Training: Development of Two New Taskforces

Elsner F.1, Mason S.R.2, Centeno C.3, De Coone V.4, Ebershaw J.E.5, Iyichuemru S.8, Filbet M.5, Larkin P.1, Turpinis A.6, European Association for Palliative Care, Steering Group on Medical Education and Training

With Aachen University, Department of Palliative Medicine, Aachen, Germany; University of Liverpool, Marie Curie Palliative Care Institute, Liverpool, United Kingdom; University of Navarra, Institute for Culture and Society, Pamplona, Spain; Fondazione IRCCS Istituto Nazionale dei Tumori di Milano, Dipartimento di Anestesia, Milano, Italy; University of Liverpool, Marie Curie Palliative Care Institute Liverpool, United Kingdom; University Hospital Bern, Centre for Palliative Care, Bern, Switzerland; "University Lyon 1, Palliative Medicine, Lyon, France; "University College Dublin, School of Nursing, Midwifery & Health Sciences, Dublin, Ireland; "Università Cattolica S. Cuore, Hospice Villa Sperranza, Rome, Italy

Aim: The EAPC Steering Group on Medical Education and Training (SG-MET) has been established to overcome a number of specific task forces which look to advance understanding, application and developments in the field. These include: Undergraduate and Postgraduate Curriculum Development; Mapping of Medical Education across Europe; Mapping of the Specialisation of Palliative Medicine; and Research on the preparedness of newly qualified doctors to practise palliative medicine. This paper will outline the development of two new taskforces of the SG-MET.

Methods: Taskforce 1. Development of 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 educate and training to manage the challenge posed by the projected increased morbidity and mortality in Europe and beyond. The development of a multiprofessional curriculum and a separate societal curriculum will draw on the work of previous EAPC Taskforces on the care of the dying, and the findings from the European Union 7th Framework funded OPCARE9 project.

Taskforce 2. International study of Medical Education in Palliative Care - National Assessment (IMP-MEA).

Following the successful pilot work conducted by the IMP taskforce (www.mcpel.org.uk/media/24441/imp%20taskforce_web.pdf), a new Taskforce project will seek to use the existing methodology of the National Home Care Survey Project:assessment of the preparedness of newly qualified doctors to practice palliative medicine in three countries (Spain, Germany and the UK). This project will look to establish an electronic data collection and reporting platform, which can then be expanded to include further countries on completion of the project. In addition, the taskforce will monitor evolving projects in China, India and the USA which are replicating the original IMP pilot work.
**Patients and Families Information Needs Regarding Palliative Care**

Nitou A., Mozziu D.1,2
1Hospice Casa Sperantei, Ediacate, Brasov, Romania, 2Transylvania University Brasov, Brasov, Romania

**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, private 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 (alfa Cronbach=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 (91.7%). 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 68.3%; 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.

**Conclusion:** 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?**

Myers L., Mahoney M.
St Catherine’s Hospice, Education, Crawley, United Kingdom

**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 financiers and service commissioners that the care provision is value for money, specialist and delivered by a competent workforce.

**Method:** 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.

**Results:** Audits indicate levels of knowledge and skills, written assignments demonstrate learning, reflective pieces show progression, portfolios of evidence illustrate acquisition of clinical skills.

**Conclusion:** Some practitioners maximise the opportunities to learn, as shown in well-written assignments and projects that change their own practice and that of their colleagues. Many access the support of the education team to develop self-directed learning skills, with mixed results.

**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**

O’Neill V., Stanan A., Twomey F.
Millford Hospice, Millford Care Centre, Limerick, Ireland

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 enhance the experiences 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. Qualitative data was subsequently analysed independently & grouped into broad themes. 25 questionnaires were returned with substantial representation from 3rd year students (68%, n=17). Despite initial reservations, students largely valued the opportunity to engage with patients and family members attending our day centre and outpatient clinic during their placements. They described an enriched learning experience of multi-dimensional aspects of end of life illness upon their life and pivotal role of interdisciplinary communication and teamwork. 56% (n=14) rated their clinical skills as improved, 60% (n=15) felt their learning would benefit them in examination settings with the majority (88%, n=22) gaining a clearer understanding of the nature of palliative care. 72% (n=18) judged their attitude to hospice care as being positively influenced following placement. Emergent themes included the supportive hospice environment and applicability of learning to other clinical settings. Ongoing learning needs in relation to pain assessment, ethical dimensions of care provision and communication skills were identified as targets for future educational interventions.

Medical students deem hospice placement to be a fulfilling, relevant and worthwhile experience contributing positively towards their clinical knowledge and skill base.

**Abstract number:** P2-280
**Abstract type:** Poster

**Narratives in Palliative Care: Searching for Interdisciplinarity**

Otero M.M.1, Gomes K.L.2
1Hospital Premier, Education and Research, São Paulo, Brazil, 2Faculade de Medicina de Ribeirão Preto, Ribeirão Preto, Brazil

**Palliative Care, the interdisciplinarity becomes critical to deliver a quality care, especially at the end of life, which is so complex. Therefore, in the Postgraduate Course Palliative Care Model for Comprehensive Health Care, developed in São Paulo, Brazil, narratives was used as a teaching strategy. After a multidisciplinary workshop, the students produced the life histories of the institution’s employees. And so, physicians, physiotherapists, nurses and other health professionals interviewed outbursts, housekeepers, construction workers and other non-technical professionals.

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. 36 narratives were produced, which were used to support all the staff. The students drew a poster that contained the story of the interviewee, a photo and a striking phrase from the interview. The posters were displayed in the auditorium and each student made a brief oral presentation. All respondents participated in the presentation that ended with a brief celebration conference. We evaluated that the objectives have been achieved, and a second phase of the project it's been developed in the second half of 2014, focusing on the nursing staff at the technical level.

**Keywords:** interdisciplinary team; life histories; education; Palliative Care

**Abstract number:** P2-281
**Abstract type:** Poster

**Spiritual Care Training Provided to Healthcare Professionals: A Systematic Review**

Paul2), Hebo V., Fred E.
Ludwig-Maximilian-University, Palliative Medicine, Munich, Germany

**Background:** This systematic review is conducted to assess the outcomes of spiritual care training. It outlines the training outcomes based on participants’ oral/written feedback, course evaluation and performance assessment. Intervention was defined as any form of spiritual care training provided to healthcare professionals studying/working in academic or/and clinical setting.

**Method:** Online search was conducted in MEDLINE, EMBASE, CINAHL, Web of Science, ERIC, PsychINFO, ASSIA, CSA, ATLA and CENTRAL to 2013 Week 27 by two independent investigators to reduce error in inclusion. Only peer-reviewed journal articles reporting on training outcomes were included.

**Results:** Primary keyword driven search found 4912 articles, 46 articles were identified as relevant for final analysis. The narrative synthesis of findings outlines following outcomes: (1) acknowledging spirituality on individual level, (2) success in integrating spirituality in clinical practice, (3) positive changes in caring with patients.

**Conclusions:** This study examines primarily pre/post-effects within a single cohort. Due to average study 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.
Nuts and Bolts at the Coalface

Rabbeets, I.K.

University of South Australia, School and Nursing and Midwifery, City East Adelaide, Mount Gambier, Australia

Presenting author email address: lyn.rabbeets@unisa.edu.au

Background: Accessing ongoing post graduate education continues to be a challenge for some nurses working in rural areas despite proliferate online programs 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. 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 complete 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

Ramssamy Venkatadoss M., Cook M.

University of Bedfordshire, Aylesbury, United Kingdom

Background: In England, Clinical Commissioning Groups commissions’ delivery of end-of-life care education programmes for community based health 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 EOLc), 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.

Results: Clinical practitioners and educational providers were highly positive about the existing end-of-life care education provision. Focused education on facilitating choice around place of care during the last days of life reported to led reduced hospital admissions particularly from care homes at community level. Yet, lack of academic credit and non-protected time for completion of this educational provision were viewed as challenges by healthcare professionals.

Conclusion: Commissioning for continued educational and clinical support in end-of-life care provision is essential to enable clinical practitioners to uphold quality in end-of-life care provision. This study found that without continued funding, service providers perceived that the provision of education to support end-of-life care would lose its current momentum and be detrimental in the longer term in achieving quality in provision of end-of-life care at community level.

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

Abbas A.1, Bird M.1, Khan N.1, Boultadpole L.1, Stewart J.1, 2, Reed N.1, 3

1Heart of England NHS Foundation Trust, Birmingham, United Kingdom, 2University of Birmingham, Birmingham, United Kingdom, 3Milligan S.1, Wotherspoon I.1, 2

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 integrate 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.

Aim: 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 provision. This new level 7 Masters course was developed commensurate with the level of qualification and the online delivery methodology.

Results: The programme of study is now delivered fully online and is available to all members of the multi-professional team who work in 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.

Abstract number: P2-285

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, Milligan S.1, Wotherspoon I.1, 2, 3

1University of the West of Scotland, School of Health, Nursing and Midwifery, Paisley, United Kingdom, 2NHG 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 integrate 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.

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Abstract number: P2-286

Abstract type: Poster

Building Bridges of Knowledge ‘Palliative Care’ – A Collaborative Project between Hospice and Nursing Homes

Rosenbæk M.1, Hansen K.B.1, 2

1Hospice Sydvestjylland, Esbjerg, Denmark, 2Municipality of Varde, Health Department, Varde, Denmark

Abstract type: Poster

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 terminal ill and dying needs specialised care at the hospice, which underlines the importance of maintaining a certain level and the least palliative care in the municipality.

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 improved the collaboration with relatives and colleagues. This is a prerequisite for them to be 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: P2-287

Abstract type: Poster

Poster

Sessions (Poster Exhibition Set 2)

Poster

Sessions (Poster Exhibition Set 2)

Presenting author email address: marianne.rosenbaek@hospice.rsyd.dk
Evaluation of Multi-medical Staff Education for Death Related Care in Rural Areas

*KK Sapporo Medical Center, Sapporo, Japan, Sapporo City University, Nursing Course, Sapporo, Japan, Akita Medical College, Palliative Medicine, Asahikawa, Japan, *Palliative Clinic Eniwa, Eniwa, Japan, T*Teine Keiinjku Hospital, Palliative Medicine, Sapporo, Japan, T*Hokkaido Gavenment, 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 due to complicated cultural issues involving EOL treatment. Our aim in this study was to acquire rural based medical and allied health professionals about the benefits of using palliative care in EOL treatment by starting a dialog through workshops and meetings.

Methods: 1. Two communities in 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 workshop 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 and 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 utilizing palliative care.

Participants in both communities stated that communication between medical professionals and patients is a barrier in the caring 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.

Conclusion: Palliative care was widely received by medical professionals and caregivers. More information and opportunities for 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., Stobboat-Rowlands M.
The Gold Standards Framework Centre, Shrewbury, 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 increased 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.

Result: We report on the outcomes of about 100(M51) 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.

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-JWilson J., Edgar C.
Gold Standards Framework, Shrewbury, United Kingdom

Background: In response to the growing challenges of the ageing populations and whole system areas of end of life care one of the key factors is to develop an integrating 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 to 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 such as the Delphi dashboard, 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 improve 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 (LVS). DSpAM has the responsibility for defining the theoretical and clinical demands for obtaining the title ‘Field of Competence Specialist in Palliative Medicine’ (FOCIPM), and for acknowledging the specialists. DSpAM has 145 members. Thirtyseven Danish doctors have passed the NCSFC to this date.

Aim: To describe the first application- and acknowledgement procedures and details about the physicians who applied and who those who testified the title FOCIM in the first application round.

Methods: Demands for FOCIPM:
- Full specialist training in relevant specialty
- NCSFM 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 deadline 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: Anaesthesiology 16, General Medicine 14, Oncology 4, Other 4. None. 1 theoretical course: NSCPM 24, Cardiff Diploma in PM 4, MSc in PC 1.

24 doctors were acknowledged as FOCIPM, 3 had a conditional acknowledgement (insufficient clinical training). 11 were rejected, 1 was uncertain.

Discussion: The possibility to apply for FOCIPM 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


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 patients 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

Putzier S.1, Zumiwelch C.1, Meyer Koulouki L.1

Community Palliative Care Unit, Division of Primary Care, Carugio, Switzerland. 1imad, Geneva, Switzerland, 2Yale University, New Haven, Connecticut, USA.

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 AD in outpatients. Describe the current involvement of medical and nursing staff in supporting patients to write AD.

Methods: One hundred and sixty five inpatients and outpatients who completed their ADs 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 27 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 or 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’s 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. 18/21 nurses that completed the survey systematically asked the patients if they completed AD. 2 supported the patients to complete AD. 4/6 physicians that completed the survey systematically asked the patients if they completed AD.

Conclusion / Discussion: Motivations of the minority of patients that completed their AD are very individualistic. 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.

The Role of Emotion in the Process of a Good Death

Keane L.M.

Pain, None, None, Ireland

Presenting author email address: lynnmkkeane@eircom.net

This paper articulates an Aristotelian approach to the correct role of emotions, in particular of fear, in the process of dying. An attempt to resolve the controversy that surrounds Aristotelian catharsis, results in the claim that it is a practical emotional therapy. The process of catharsis is a process of emotional movement to cure emotional movements. In an endeavour to provide a plausible proposal for how emotions are to be balanced in the process of dying I argue that Aristotelian catharsis provides a good model for this, as it allows in a safe context for the expression of one’s extreme fear of death and dying, which results in the alloying of this fear and the restoration of emotional health that allows for a peaceful death. Hence, Aristotel’s cathartic process is one in which one is enabled to feel one’s fear, in such a way as to thereby lessen one’s fear, and thereby come to feel it more appropriately. The greatest opposition to this Aristotelian approach is Stoicism about death. Whereas I take the challenge of dying well to involve achieving an appropriate balance of emotions like fear, the Stoics take the challenge involved the eradication of fear through a rational education.

Nevertheless, narratives of dying taken from both factual and fictional literature demonstrate that a cathartic development of emotion is natural to the dying process. They also, however, provide cases in which the overwhelming fear of death prevented the person from dying well. Real case narratives reveal how psychotherapeutic techniques are used by medical practitioners in extreme cases to help relieve the emotional suffering of their patients so they can die well. And while these psychotherapeutic approaches do not describe the emotional process in cathartic terms, it is clear that what occurs is a cathartic development of emotion. A good death, therefore, involves an engagement with fear and not the extinction of fear as the Stoics would have it.

Palliative Care and Quality of Life in the New Italian Code of Medical Ethics

Cunnetto G., del Bon P., Buzzi E.M., Conti A.

Fondazione Campiani - Dorius Salus, Palliative Care Unit, Brescia, Italy. 1University of Brescia, Departments 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 ‘ Person’. This is explicitly 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 a brief analysis of the most prevalent dementia 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 hospital.

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Abstract number: P2-297
Abstract type: Poster

Advanced Care Planning in an Acute Geriatric Unit
Cabrera M., Hernana S., Salies E., Villanino M., diazeter G., Torrente L., Collot N., Lynd F., Nuñezas A., Parc Taui University Hospital, CSS Albada Health Center, Sabadell, Spain

Background: Advanced care planning (ACP) allows one to face the health problems of the elderly offering better care in accordance with their needs and preferences.

Aims: To assess the prevalence, degree and type of ACP in patients admitted to our Acute Geriatric Unit (AGU) and describe the variables associated with ACP.

Methods: Descriptive retrospective study of patients admitted to the AGU between May and June 2014 by reviewing the case histories.

Results: During the period 188 patients were admitted to the AGU of whom 92 (48.9%) had ACP. Barthel Index prior to admission in the AGU showed severe or complete dependence (Barthel < 35 or < 20) in 41 patients (45.1% of the ACP 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 in the 19 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 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 (13.5%) 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 to ICU and give priority to comfort.

Abstract number: P2-298
Abstract type: Poster

Ultimate Time of Life
Chazot I., Chvetzoff G., Perach M., Centre Leon Berard, Supportive Care, Lyon, France

Presenting author email address: isabelle.chazot@lyon.unicancer.fr

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 reflection concerns this ultimate time: what about this time? 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: nonsense of a life which cannot 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?) persist? 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 words describing a more serene real life experience. Their life keeps a sense only if they are not suffering and are able to live in relationship with others. This time which tells itself the present, connected with a past and turned to a future?

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
Woods S., Newcastle University, Policy, Ethics and Life Sciences Research Institute, Newcastle upon Tyne, United Kingdom

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 influenced. Now is an appropriate time to reflect upon the values which underpin palliative care.

Care is at risk of becoming mere technique devoid of values.

There is no consensus on the appropriateness of care across the illness trajectory.

Conclusion: Now is an appropriate time to reflect upon the values which underpin palliative care.

Abstract number: P2-300
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

1University of Navarra, ICS, Programa ATLANTES, Pamplona, Spain, 2University 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 moral 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 solution of the ethical dilemmas in palliative care (PC) and EOL decision-making.

Aims: 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 opportunely 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.

Conclusions: 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:** P2-302  
**Abstract type:** Poster

**Family and Caregivers**

**Abstract number:** P2-303  
**Abstract type:** Poster

**Background:** What Do Proxies Direct in Advance? 
**Abstract type:** Poster

**Methods:** The pooled ADBPs of two nursing home studies (n = 46) were analysed with regard to formal criteria, validity, and directions regarding life-sustaining treatments. 

**Results:** (preliminary analysis): The residents’ age reached a median of 86 (range 50–101) years. The ADBPs were 1 (range 1–7) years old, 6.5 (0.25–5) pages long, and had been signed by 1 (0–5) persons. In 37%, the proxy’s legal status was not clear; in only 2 ADBPs a facilitation by a physician was documented. 85% were free texts (28% of which were in the nursing charts) and were regionally used forms. 63% contained information about the (justifying) foundation of the directives: earlier oral comments, 30%, the impaired (17%) or suffering (15%) state of the resident, as judged by the proxy, or the resident’s behaviour (11%). With 3 exceptions, the ADBPs were confined to treatment exclusions, mostly for the case of complications arising from the actual (rather than a future hypothetical) state of health (any: 52%, cardiopulmonary resuscitation: 20%, hospital: 67%, tube feeding: 37%). In 28% of the ADBPs, palliative care was explicitly requested. 

**Conclusion:** (German) ADBPs are mostly handwritten documents that typically regulate crises that may occur from the given state. The signee was often not recognisably legitimised, a physician’s consultation was rarely documented, the ethical legitimation of the ADBP was fragmentary and varied extremely. There is a great need for formal, content and ethical standards for ADBPs.

**Abstract number:** P2-305  
**Abstract type:** Poster

**Background:** A lot of research shows that information to loved ones is important. To ensure that the loved ones really are informed of the patients illness and treatment during the hospital stay the palliative care unit have started a project to evaluate how the information to loved ones can be improved. 

**Aim:** To continuously inform the patient’s loved ones about the progression of the illness and the daily treatment. 

**Method:** The patient gives permission to the nurse that once a week give the loved ones information about recent treatment and planning. At a conference the team agrees on what information should be given. The nurse then contacts the loved ones, either when they visit the patient or by telephone. The nurse fills in a questionnaire, like a diary, about the method’s advantages and weaknesses. 

**Result:** A pilot project has been started and the result so far is that the loved ones feel more involved in the patient’s illness. Knowing what is going to happen and what is planned also make them feel safe.

**Abstract number:** P2-306  
**Abstract type:** Poster

**For the Palliative Care Unit’s Health Professionals, what Role to Play and how to Deal with the Patients in the Agonic Phase and their Close Family Members**

**Methods:** This study was descriptive, multicentric and interprofessional. Preliminary semi-directed discussions were carried out. A protocol of validation was built with the assistance of two psychologists, eight doctors and eight caregivers of eight different PCUs. In addition, an oral test was carried out. 

This survey was conducted among the different professionals of 123 French PCUs in April and May 2013, using a questionnaire of 19 closed or half-open questions.

**Results:** 341 exploitable questionnaires were collected. The health professionals prove sensitised to taking care of the patient’s body: analgesia (87%), body position 4 per day (80%), hydration (75%) and respiration (80%).

They focussed on the importance to take into account the close family members and to listen to them regularly about pain (96%), prognosis (94%), nutrition/hydration (70%).

Caregivers are mainly against euthanasia (92%). Three guidelines come out from this study: comprehensive approach of the patient in agonic phase, listening in conjunction with therapeutic alliance, inter professionnality as a support of the emotions. 

**Conclusion:** These results make it possible to have a better knowledge of this significant and mysterious time which is agony. In the long term, this approach would aim at considering a harmonised specific training, improving the support of the health professionals.
The Influence of Life Experiences with People at the End of Life on Attitudes towards Death and Dying

Modriska A.1,2, Kulikovskaja I.2, Wyszadko A.1,2, Pawlowski L.1, Lichodziejewska Niermko M.1, Bult I.1
1Medical University of Gdansk, Department of Palliative Medicine, Gdansk, Poland, 2St Joseph's Hospice, Sopot, Poland, 3 Medical University of Gdansk, Nursing Faculty, Gdansk, Poland

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 grandparent(s) 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 was possible to turn back time they would do it. The Coaches and Coordinator report enjoying 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 fulfilment, 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.

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Abstract number: P-307
Abstract type: Poster

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Abstract number: P-307
Abstract type: Poster

Poster Sessions (Poster Exhibition Set 2)
Abstract number: P2-312
Abstract type: Poster

The Design & Dignity Project. Transforming End of Life Care in Hospitals, one Room at a Time

Lovegrove M.1, O’Sullivan G.1, Lynch M.1, Keegan O.1, Rose-Roberts R.2  
1Irish Hospice Foundation, Dublin, Ireland, 2RONAN Rose-Roberts Architects, Wicklow, Ireland

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 over €1.5m in capital grants to hospitals in Ireland.

Approach: Public hospitals in Ireland were invited to submit applications for grants to renovate areas 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 family rooms 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 cluttered rooms and dreary facilities were transformed into tranquil spaces where families gather to be with each other and their deceased family member. Testimonies 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 included 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
Shanagher D., Lynch M., Keegan O., De Sam A.  
Irish Hospice Foundation, Dublin, Ireland

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 prominent themes. The themes to emerge are: ‘General Support’, ‘Psychological Distress’, and ‘Decision Making’. 

Results: The literature indicates the following:
1. Family carers providing 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 around 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. Healthcare 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 leaflets for 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 To Terminally Ill Patients Facing Death Experience Comfort? A Differentiated Understanding of their Network
Matthewen H.N.1, Delmar C.2  
1Aarhus University Hospital, Palliative Team, Oncology Department, Aarhus, Denmark, 2Aarhus University Hospital, Department of Public Health and Department of Clinical Medicine, Aarhus, Denmark

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 individual in-depth interviews with six terminally ill cancer patients. The interviews were based on patients’ life stories to obtain a more detailed understanding of the subject following Kvale and Brinkman’s theory of analysis. 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-sufferer feeling sorry for the patient and displaying the same identity characteristics sent by the terminally ill patient. The ‘active comfort’ 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 a 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
Henriksson A.1,2, Molcher U.1,2  
1Estia Skondal University College and Estia Hospital, Palliative Care Research Centre, Stockholm, Sweden, 2Capio Geriatric, Dalens Hospital, Palliative Care Unit, Stockholm, Sweden, Estia Hospice, Stockholm, Sweden

Background: Teenagers are greatly influenced by a parent’s illness and death. How do they reason about their parent’s recent death and their life without the parent.

Aim: To explore how teenagers reason about their parent’s recent death and their life without the parent.

Methods: The study has a descriptive-interpretive design using qualitative content analysis. Ten teenagers (14-19 years), seven boys and three girls, participated through repeated interviews that were carried out as free conversations.

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 opened 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 over 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.

Conclusion: Teenagers want to be included and present around the time of their parent’s death. All teenagers in the study appreciated the chance to talk about their parent’s illness and death and many had never talked about it before. Adults in their social network as well as 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
Mitchell G.K.1,2, Goggin A.1,3, Avra M.1, Sibbett D.1, Burridge L.H.1, Senior H.E.1  
1University of Queensland, School of Medicine, Herston, Australia, 2University of New South Wales, School of Medicine, Sydney, Australia, 3Ingham Institute, Translational Cancer Research Unit, Sydney, Australia, 4Curtin University, Faculty of Health Sciences, Perth, Australia, 5University of Technology, Faculty of Health, Sydney, Australia

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 self assessed by the carer.

Methods: Prospective randomised controlled trial. Intervention was a self-reported checklist completed by the carer following consultation with the GP. The control group received usual care. The checklist comprised two questions: ‘Are your current GP’s needs being met’ and ‘Are your current GP’s needs being met’.

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 anxious at baseline (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

Nordin M.1,2, Henriksson A.1,3
1Capio Geriatrics, Dalens Hospital, Palliative Care Unit, Stockholm, Sweden, 2Erstå Sköndal University College, Stockholm, Sweden, 3Erstå Sköndal University College and Ersta Hospital, Palliative Research Center, Stockholm, Sweden

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 effects and meanings for patients when their family caregiver participate in a psycho-educational intervention during ongoing palliative care.

Method: An interpretive 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 feelings 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 knowledge and even if no effects could be 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

Polo García L., Mínguez Covacho M.A., Coleman Mengual S., Rodríguez Calderón J.L., Mínguez Morín M.
Hospital San Juan de Dios, Madrid, Spain

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 show a humanistic and encouraging point of view of how is taking care of 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 checking out the current bibliography and the daily work-care, we have verified that caregivers are that 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

Bregón C.1, Pau-Ribero J.L.1, Novellas A.3,4, Gonçalves E.5
1Faculty of Psychology and Educational Sciences, Porto, Portugal, 2University of Hull, Hull York Medical School – SEDA, Hull, United Kingdom, 3University of Barcelone, Barcelona, Spain, 4Institut Català d'Oncologia, Observatori 'QUALY', Barcelona, Spain, 5São João Hospital Centre, Palliative Care Service, Porto, Portugal

Variables of well-being and exhaustion are generally related to family caregivers in palliative care (PC). Few studies which focus specifically on interventions aimed at their treatment – a practical preventive interventions to enhance the internal/external resources of the patient and families.

To create a program named Self-care Practice Ability Program (SPA Program) to increase the well-being and reducing exhaustion of the caregivers by combining skill 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 prepere 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 questionare; 4) Repetition of step 1 and 2. Criteria: oncologic PC caregivers, > 16 years; verbal and writing comprehension of Portuguese language.

In 2013 a PC Service (in Oporto) treated 641 patients, 85% of whom had an oncologic diagnosis (follow up median-17 days). The P who addressed the Practical module (N=4) had registered a positive value at the end of the sessions. Five P who worked the Emotional module, 6 had increased their capability in this field. In the Relational module only 2 out of 5 P concluded the program. However, this dimension registered positive values in the other groups, despite not having addressed this theme directly. 7/11 P presented exhaustion prior the start of the program; at the end these levels had decreased significantly. We conclude that P levels of well-being, social quality and quantity of the SPA program. The number of P is a limitation which may be related to the oncologic prognosis of the patients that continue to arrive too late to PC treatment thus affecting the family empowerment. Therefore, we propose that this type of program should focus mainly on non-oncologic patient's caregivers.

Abstract number: P2-320

Abstract type: Poster

Sleep among Bereaved Caregivers of Patients Admitted to Hospice: A 1-Year Longitudinal Pilot Study

Slåtten K.1, Gay C.2, Sagghaug E.A.3, Grov E.K.1, Normann A.1, Lee K.A.4, Lerdal A.5
1Lovisenberg Diakonale University College, Oslo, Norway, 2Lovisenberg Diakonale Hospital, Oslo, Norway, 3Lovisenberg Diakonale Hospitals, Oslo, Norway, 4Oslo and Akershus University College of Applied Sciences, Institute of Nursing, Oslo, Norway, 5University of California, San Francisco, CA, United States, 6Lovisenberg Diakonale Hospital, Oslo and Akershus University College, Oslo, Norway

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. Sleep was measured at 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 stable 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

Satomura E.1, Takada H.1, Kojima R.1, Jagni K.1, Shutou C.1, Sabo O.1, Matoba M.2
1National Cancer Center Central Hospital, Palliative Medicine, Tokyo, Japan, 2National Cancer Center Hospital East, Chiba, Japan, 3Aomori Prefectural Central Hospital, Aomori, Japan

Presenting author email address: okires@gmail.com

Background and aim: Parents who are diagnosed cancer have much psychological distress and several problems for family, especially children. Palliative care team supports 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 patients who have young children (under 20 years) about patients' demography, support need, interviews and activities.

Results: 60 patients (mfV 27/33, age 43y) 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 patient 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 realised one of important supports in oncology. Further study should needed to effective support by team to reduce their distress.
Abstract number: P2-322
Abstract type: Poster

Care Competence and Caregiving: A Profile of Caregivers Supporting Advanced Cancer Patients Receiving Home-based Palliative Care

Varesi S.1, Peghetti B.1, Bonazzii A.1, Messana R.1, Piccinelli E.1, Pannuti R.1, Pannuti F.1
1ANT Italia Foundation, Training and Development Unit, Bologna, Italy, 2University of Bologna, Psychology Department, Bologna, Italy, 3ANT Italia Foundation, Health Department, Bologna, Italy, 4ANT Italia Foundation, Chairmanship, Bologna, Italy

Background: Diagnosis of cancer has a significant impact not only on patient, but also on their caregivers. In Italy many 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 analysed with chv-square tests and Fisher’s exact tests.

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<0.008). Caregivers with lower education tended to have lower communication competence (p=0.02). Therefore, significant correlations were found between competence in reporting patients’ needs and competence in providing basic care (p<0.001) or competence in providing specific care (p<0.001).

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 Caregivers’ Experiences of Supporting a Person with Palliative Heart Failure: A Mixed Methods Study

Whittingham K.1, Barnes S.1, Dawson J.1, Gardner C.1
1University of Sheffield, School of Health and Associated Research, Sheffield, United Kingdom, 2University of Sheffield, SCHARR, Sheffield, United Kingdom, 3University of Sheffield, Sheffield, United Kingdom

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 48 caregivers 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 gatekeepers 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.

International developments

Abstract number: P2-324
Abstract type: Poster

Palliative Care in Egypt: The Experience of the Gharbiah Cancer Society

Hablos M.A.
Gharbiah Cancer Society, Tanta, Egypt

Background and context: The need for palliative care in middle and low resources countries, including Egypt, is emerging. The Gharbiah Cancer Society (GCS) is a nonprofit, nongovernmental hospital, located in Tanta, the Capital of the Gharbiah governate in the mid-Nile Delta. The Society provides acute care to patients with cancer including surgery, chemo-, and radiotherapy. Review of nine year-data of Gharbiah population-based cancer registry from 1999 to 2007 revealed 3460 cancer cases/year, with Age Standardised Rate (ASR) of 161.7/100,000 for males & 120.8/100.000 for females.

Aim: About 70% of cases present in advanced stages (IBBIV) with liver cancer the most frequent cancer in male and breast cancer as the most frequent cancer in females. The GCS started a comprehensive palliative care service in April 2011 with 10 bed inpatient unit and six days/week outpatient clinic. All palliative care equipment were provided by public donations.

Strategy/Tactics: Through collaboration with Cancer Institute in USA, a fellowship training program was developed for a medical oncologist in palliative medicine and End-of-Life Care training course for nurses.

Programme/Policy process: The program succeeded in convincing local health authorities to increase the recommended opioids dose and to allow more physicians to prescribe opioids for cancer pain. In a period of 24 months, symptom management and palliative care were provided to 195 patients with advanced malignancies. The opioids consumption was increased by 30 folds.

Outcomes/what was learned: The Major challenges for the program were inadequate public and health professionals awareness of palliative care services and lack of vehicles and finances to cover home visits. The initial results of the program warrant allocating more resources for coverage of a large number of trainees and instituting a home visits program.

Abstract number: P2-325
Abstract type: Poster

The Importance of Continuing Medical Education (CME) in the Diffusion and Adoption of Best Practice Palliative Care Protocols in Six Northern European Countries (non-empirical)

Hoefler J.
Dickinson College, Political Science, Carlisle, PA, United States

Aims: Continuing Medical Education (CME) has been touted as an important means for propagating best practice protocols for palliative care in the physician population, but there is little research on this important assumption. This study aims to assess the impact of CME training — or lack of CME training — has on palliative care in six northern European countries: Denmark, Finland, Norway, Sweden, Great Britain, and Germany.

Research design: Analysis will involve a comprehensive review of the literature on (1) CME policy and practice and (2) the sophistication of palliative care provision in the selected countries.

Results: It is too soon to report results as work on this study is still in progress.

Conclusions: Conclusions will be drawn about the impact CME education has had on palliative care provision, with an eye toward making recommendations about how much and what kind of palliative care CME might be indicated to bring all countries (those in the study and even others) up to standard in this important area of medicine.
Abstract number: P2-326

Type: Poster

International Palliative Care Network Conference: Free Participation and Access

Bharadwaj P., Kaur S., Hennu S.¹
¹Sentara Healthcare, Virginia Beach, VA, United States, ²UCLA, Los Angeles, CA, United States, ³MD Anderson Cancer Center, Houston, TX, United States

Abstract number: P2-328

Type: Poster

Dying in Prison: A New Form of Shameful Death

Peacock M., Turner M.
Lancaster University, Faculty of Health and Medicine, Lancaster, United Kingdom

Impact of 'Life before Death' Movie in Raising Awareness for Palliative Care

Corbu S., Mosovu D.²
¹Spitalul Judetean, Sectia Oncologie, Oradea, Romania, ²Transylvania University Brasov, Brasov, Romania

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Abstract number: P2-327

Type: Poster

Preliminary Findings from the Stakeholder Advisory Panel Meetings with Experts and Families in a Project Health Technology Assessment – INTEGRATE in Poland

Laport W.¹, Stachowiak A.¹, Koszela M.², Breereton L.³, on behalf of the HTA-INTEGRATE
¹Poznan University of Medical Sciences, Chair and Department of Palliative Medicine, Poznan, Poland, ²Sue Ryder House, Pallmed, Bydgoszcz, Poland, ³Sheffield University, Sheffield, United Kingdom

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. Each meeting was led by a moderator, and the discussions were recorded and transcribed. At least two moderators led the discussions.

Results: The SAPs 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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Reasons for, Appropriateness and Avoidability of End-of-Life Hospital Admissions: Results of a Survey among Family Physicians
Reyniers T.1, Houttekier D.2, Cohen J.1, Pasman H.R.1, Vander Stichele R.1, Sijnaeve B.1, Deliens L.1,2
1End-of-Life Care Research Group, Vrije Universiteit Brussel (VUB) & Ghent University, Department of Family Medicine & Chronic Care, Jette, Belgium, 2EMGO Institute for Health and Care Research, VU University Medical Centre, Department of Public and Occupational Health, Amsterdam, Netherlands, 3Hôpitaux Universitaires de Genève, University Hospital, Geneva, Switzerland, 4University Hospital Ghent, Department ICT, Ghent, Belgium, 5Department of Medical Oncology, Ghent University Hospital, Ghent, Belgium

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 physician (FP).

Methods: A retrospective survey was used among 139 FP 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 causes 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 avoidable 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 of 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 according to 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
Abstract type: Poster

Staff’s Understandings of Cross-cultural Interaction in End-of-Life Care: A Focus Group Study
Milbergs A.1,2, Torres S.1, Ågård P.1
1Linköping University, Palliative Education & Research Centre and Dept of Social and Welfare Studies, Norkoping, Sweden, 2Linköping University, Dept of Advanced Home Care and Dept of Social Welfare Studies, Norkoping, Sweden, 3Uppsala University, Dept of Sociology, Uppsala, Sweden

Presenting author email address: anna.milberg@liu.se

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: Six focus group interviews were performed with eight palliative care professionals 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 ethnic-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 ethnic-cultural minorities, and also 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 ethnic-cultural backgrounds, and to consider these 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
Abstract type: Poster

Applying Health Promotion Methodology to Reach out to Populations Recently on an Admission of Palliative Care
García-Baquerizo Miro M.1,2, Santamaria Morales A.2, Gallardo Pino C.2, Sastre Paz M.2, Pliego E.2, Lorenzo Palomar E.2, Molla R.1, Martínez Rodríguez S.2, Yace J., Champañeres P.1, Chen C.1,2
1Servicio Madrileño de Salud, Coordinadora Regional de Cuidados Paliativos, Madrid, Spain, 2Master of Epidemiology and Health Public. URJC, Promoción de la Salud, Madrid, Spain

Presenting author email address: msantamaria.garcia@salamadrid.org

Background: Large proportion of European populations have complex needs and yet, they are unaware of the possibility of receiving high-quality responses to these needs. Health Promotion approaches can promote changes to facilitate social progression by educating people.

Health services research
Abstract number: P2-333
Abstract type: Poster

Inequality in Admittance to Specialised Palliative Care (SPC) of Referred Cancer Patients? A Study from the Danish Palliative Care Database (DPD)
Arboe J.1, Thygesen L.C.1, Sjogren P.1, Neergaard M.A.1, Jensen A.B.1, Damkier A.1, Groenvold M.1,2
1Sbispebjerg Hospital, Research Unit, Department of Palliative Medicine, Copenhagen, Denmark, 2University of Southern Denmark, National Institute of Public Health, Copenhagen, Denmark, 3Aarhus University Hospital, Department of Oncology, Aarhus, Denmark, 4Odense University Hospital, Palliative Care Team Funen, Odense, Denmark, 5University of Copenhagen, Department of Public Health, Copenhagen, Denmark

Background: Few previous studies of admittance to specialised palliative care (SPC) have taken the actual need for SPC into account. Physicians refer patients they judge have a need for SPC. To be admitted to SPC, the physician must be convinced that care is better in the hospital. How, knowledge and understanding.

Methods: Using the Danish Palliative Care Database, all adult cancer patients referred to SPC who were deemed eligible by a SPC unit, and who died in 2010-12 were identified (n = 21,474). Associations between the explanatory variables (sex, age, diagnosis, geographic region, referral unit, year of death) and the outcome variable admittance to SPC were investigated using logistic regression analysis.

Results: The overall admittance proportion was 83.1%. A sex difference was found with higher odds of admittance to SPC for women (OR=1.16, 1.07–1.26). The admittance decreased strongly with increasing age. The odds of admittance to SPC were over five times higher for the youngest (18–40 years old) compared to the 80+ years old (OR = 5.38, 3.21–9.08). Patients with non-Hodgkin lymphoma (OR=0.56; 0.37–0.83) and leukemia (OR=0.55; 0.41–0.75) had the lowest odds of admittance to SPC. A difference in admittance was found based on geography, with the lowest odds of admittance in the Capital Region of Denmark and Region of Southern Denmark.

Conclusion / Discussion: In this first nationwide study of admittance among patients referred to and eligible for SPC, we found an inequality in admittance to SPC in Denmark, disfavouring older patients, patients with haematological malignancies and those living in two of the five Danish geographic regions.
Research Priority Setting in Palliative and End of Life Care: The James Lind Alliance Collaboration Projects

Abstract type:
Trends and Characteristics of Inpatient Palliative Care for Cancer Patients

Abstract number:
10 Scottish Partnership for Palliative Care, Edinburgh, United Kingdom, 11 National Research Priority Setting in Palliative and End of Life Care: The James Lind Alliance (JLA), sought to identify and prioritise questions that are important to palliative care populations. The Palliative and end of life care Priority Setting Partnership (PeolcPSP), facilitated by the James Lind Alliance (JLA), sought to identify and prioritise questions that are important to palliative care populations. The process has challenges. Although difficult it must be ensured that patients', carers' and professional views are represented throughout. Research priority setting methods are evolving; it is hoped our experience can help future projects.

Abstract number:
P2-335
Abstract type:
Poster

Italian Palliative Care Services: The Role of Patients' and Professionals' Views in Health Technology Assessment Scope Development

Saccomi D.1, Refolo P.1, De Nicola M.1, Bremont L.M.1, Spagnolo A.G.1, INTEGRATE-HTA Project Team

1Università Cattolica del Sacro Cuore, Institute of Bioethics, Rome, Italy, 11University of Sheffield, Sheffield, United Kingdom

Background: Palliative care services are growing, but vary across Europe. Palliative care is being used as a case study to test the methodology developed within the INTEGRATE-HTA Project. The project aims to develop methods to enable an integrated assessment of complex technologies by involving patients and carers.

Methods: Fifty-six consecutive attendees (33 patients and 23 informal caregivers) of the PMC were included. For the whole group, the difficulty of the patient to attend the PMC regularly to collect opioids was rated as none by 18 (32%) attendees, mild by 3 (5%), moderate by 11 (19%), and severe by 24 (41%). The reasons of difficulty reported by the attendees were: difficulty mobility in 23 patients (41%), difficult transportation in 7 (13%), financial reason in 4 (7%), pain in 2 (4%), hospitalisation in 1 (2%) and social reason in 1 (3%). Caregiver attendees were more likely to rate the difficulty of regular attendance by the patient as moderate/severe (p=0.011). Among the studied variables, the only one associated significantly with moderate/severe difficulty was an Eastern Cooperative Oncology Group performance status of 3–4 (p<0.001).

Conclusion / Discussion: Attending an Egyptian outpatient palliative medicine clinic (PMC) to collect opioid analgesics is difficult for the majority of advanced cancer patients. The physical presence of advanced cancer patients in the clinic should not be a prerequisite to dispense opioid analgesics. Finding alternative ways to assess patients, like home visits, would save travel distance for patients. The JLA methodology should be tested in a different context.

Implementing Advance Care Planning Across a Healthcare System: Identifying Local Barriers and Facilitators

Hagen N.A.1, Shaugh M.N.1, Hofveldt L.G.1, Holroyd-Leduc J.M.1, Biondo P.D.1, Simon J.E.1, Foxheller A.1,2

1University of Calgary, Departments of Oncology, Clinical Neurosciences, and Medicine, Calgary, AB, Canada, 2University of Calgary, Departments of Medicine and Community Health Sciences, Calgary, AB, Canada, 1University of Calgary, Department of Medicine and Community Health Sciences, Calgary, AB, Canada, 1University of Calgary, Oncology, Calgary, AB, Canada, 1University of Calgary, Division of Medical Oncology, Calgary, AB, Canada, 1Covenant Health, Edmonton, AB, Canada

Background: Advance Care Planning (ACP) is a process of reflection and communication of a person’s future healthcare preferences. Promotion of ACP is a priority for many healthcare systems. However, it is a complex process that is not yet well understood. An ACP tool or a system that is easy to implement is needed to assist in the implementation of ACP. The project aims to identify local barriers and facilitators to the uptake of ACP across the publicly funded provincial healthcare system in Alberta, Canada, and to identify mitigation strategies relative to the local context.

Methods: We surveyed 100 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 Michie Theoretical Domains Framework patient/relatives in healthcare provider behavior in the uptake of best practices.

Results: Fifty-one of 88 SCNs (58%) completed the survey. Insufficient public
Poster Sessions (Poster Exhibition Set 2)

engagement/understanding; conflict among different provincial health service initiatives", and 'lack of infrastructure' were identified as the most important local barriers. From a health practitioner perspective, 32% of the time was spent on 'coping processes', and 'inadequate electronic reporting systems' were identified as significant barriers. Mastery of the skills needed; and emotional discomfort with initiating the ACIP/GLO protocol were also highlighted. These barriers were then explored through a semi-structured interview with key informants, who identified mitigating approaches.

Conclusion: Identifying and addressing local barriers to the uptake of innovation has been described as a core element of successful knowledge translation. Identifying and addressing local barriers to ACP uptake and identifying mitigating strategies through discussion with key informants was successfully undertaken through a brief survey and group discussion.

Abstract number: P2-339
Abstract type: Poster
Title: Effectiveness of Psychosocial Teams’ Intervention: A Randomized, Open, Controlled, Multi-centred Phase III Study
Authors: Mateo-Ortega D.1, Martínez-Muñoz M.1, Limonero J.T.2, Maté-Méndez J.3, González-Barboteo J.4, Mateo-Ortega D.5, Mateo-Ortega D.6
Affiliations: 1Catalan Institute of Oncology, The ‘Qualy’ Observatory – WHO Collaborating Centre for Psycho-Oncology, Hospitalet de Llobregat, Spain, 2Catalan Institute of Oncology, Psicology Unit, Hospitalet de Llobregat, Spain, 3Catalan Institute of Oncology, Palliative Care Services, Hospitalet de Llobregat, Spain, 4la Caixa’ Foundation, Social Area, Barcelona, Spain, 5University of Vic, Chair of Palliative Care, Vic, Spain
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.
Methods: A randomized, open, controlled, multi-centred, phase III study. 80 subjects (cancer patients to be included by the PCCPAD-CF, being > 16 old and giving informed consent) are randomised in a 1:1 ratio to Am A: psychosocial intervention every 3 days (days +2 and +6) during a period of 7 days in combination with conventional intervention or Arm B: conventional intervention.
Psycho-social 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 or severe (DED≥13). Test for two proportions will be used to determine if hypothetic 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: To evaluate efficacy of psychosocial teams’ intervention within PCCPAD-CF has been designed and implemented.

Abstract number: P2-340
Abstract type: Poster
Title: The Cost of Palliative Care in Breast, Colorectal and Prostate Cancer
Authors: Halton O.1,2, Farkkila N.V.1,2, Tsai R.1,2, Rome R.P.1, Stinton L.3,4, Hanninen J.1, Lehto J.T.5, Saarto T.1,6
Affiliations: 1University of Helsinki, Helsinki, Finland, 2GlaxoSmithKline, Espoo, Finland, Helsinki University Central Hospital, Helsinki, Finland, 3National Institute for Health and Welfare, Helsinki, Finland, 4University of Eastern Finland, Kuopio, Finland, 5Terhiolaki Hospice, Helsinki, Finland, 6Tampere University Hospital and University of Tampere, Tampere, Finland
Presenting author email address: ohi.halton@finnnet.fi
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 (Terhiolaki). Resource use, demographics and cost data at death were extracted from patients’ electronic 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 palliative care patients 43 (61%) were males, the median age was 70 (range 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. The last two weeks of life comprised 27% of the total HCC. The costs of palliative care were highest in patients living alone (Table). This was especially true for inpatient care (1103 vs. 4879 euros, p<0.01).

<table>
<thead>
<tr>
<th>Informal care</th>
<th>Productivity cost</th>
<th>Direct health care cost</th>
<th>Total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living alone</td>
<td>354 (2)</td>
<td>241 (4)</td>
<td>16 (1)</td>
</tr>
<tr>
<td>Living alone</td>
<td>589 (2)</td>
<td>396 (2)</td>
<td>174 (2)</td>
</tr>
<tr>
<td>Non-patients</td>
<td>6136 (27)</td>
<td>420 (16)</td>
<td>1270 (34)</td>
</tr>
</tbody>
</table>

(Mean cost of palliative care in euros).%)

Conclusions: Costs of palliative care are substantial but only a relatively small proportion of the costs is caused by direct health care resource utilisation. These costs are highest during the last two weeks of life. Living alone is clearly associated with higher costs and more inpatient days. Therefore, the support should be arranged for patients living alone to enable end-of-life care at home.

Abstract number: P2-341
Abstract type: Poster
Title: Because Trust and Justice Matter: Perceptions of Health Professionals Providing Palliative Care in Primary Care Services
Authors: Hernandez-Marrero P.1,2, Martinez Perez S.1, Lopes T.P.2,3,4, Flett D.H.1,5 on behalf of Project LIDER and QualIDP
Affiliations: 1University of Las Palmas de Gran Canaria, Medical School, Department of Nursing, Las Palmas de Gran Canaria, Spain, 2Catholic University of Porto, Institute of Bioethics, Bioethics Research Centre, Porto, Portugal, 3Hospital Santo Espirito da Ilha Terceira, Angra do Heroísmo, Portugal, 4Universidade dos Açores, Ponta Delgada, Portugal, 5University of New Brunswick, Faculty of Business Administration, Fredericton, NB, Canada
Presenting author email address: phmarrero@gmail.com
Background: Organisations’ true sustainable advantage is 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 macro-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 larger multi-center survey study, a random sample of 289 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 psychological 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=-.229, p<.01) 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 process) that facilitate teamwork and promote empowerment in primary care settings, contributing to the quality of care provided.

Abstract number: P2-342
Abstract type: Poster
Title: Burnout in Palliative and Intensive Care Units: Does it Make a Difference?
Authors: Martinez Perez S.1, Hernandez-Marrero P.1,2, Toxena C.M.1,3, Carvalho A.S.1
Affiliations: 1Catholic University of Porto, Institute of Bioethics, Bioethics Research Centre, Porto, Portugal, 2University of Las Palmas de Gran Canaria, Faculty of Health Sciences, Department of Nursing, Las Palmas de Gran Canaria, Spain, 3Department of Business Administration, Fredericton, NB, Canada
Presenting author email address: phmarrero@gmail.com
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 Haslach Burnout Inventory was used. Data collection took place 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 (PCCU) and 300 in intensive care units (ICUs). Univariate and multivariate logistic regression analyses were performed. OR side-effect with 95% CI were calculated. Results: While 23% of the professionals working in ICUs exhibited burnout, only 3% of those working in PCCUs exhibited this syndrome. Univariate logistic regression analysis showed that burnout was inversely associated with working in PCUs (OR= 0.19, 95% CI=0.12-0.31) and 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, 161–976 95% CI). Higher levels of burnout in ICUs were related to a burnout score >49 (OR= 1.84, 95%CI: 1.029-3.312) and experiencing conflicts (OR=2.170 95% CI=2.181-3.86).
Conclusions: Burnout is inversely associated to working in PCUs. Work-related experiences (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.
Acknowledgments: Fundação Grunenthal and Fundação Merck, Sharp and Dohme.
Empowering Leader Behaviours: Impact on Health Professionals' Empowerment and Commitment

Hernández-Marreño, J.1, Martínez Pérez, S.1, López, T.1,2, Fáñez D.H.1, on behalf of Projects LiDERA and QuoLiDERA.

1University of Las Palmas de Gran Canaria, Faculty of Health Sciences, Dep. of Nursing. 2University of Las Palmas de Gran Canaria, Spain.

Aims: To test a model linking leader-emowering behaviours to health professionals' perceptions of workplace empowerment and commitment in primary care.

Methods: As part of a larger multicenter study, a random sample of 209 professionals (nurses and physicians) providing palliative care in primary care settings in two Spanish regions was drawn. Pre-validated scales were used to measure leader-emowering behaviours, empowerment and commitment. Multiple regression analyses were conducted to test the mediation model.

Results: Over all, perceptions of workplace empowerment were significantly related to all dimensions of leader-emowering behaviours. These dimensions were correlated with empowerment and commitment (r = 0.31 to 0.63). Empowerment at least partially mediated the relationships between leader-emowering behaviours and commitment. Empowerment had a significant impact on commitment (β = -0.64, p < 0.05).

Conclusion: The conclusions of this study highlight the importance of facilitating leaders in creating empowering work environments. Recommendations can be made to ensure that healthcare managers leading primary care teams can facilitate the implementation and delivery of palliative care in these settings by promoting professionals' empowerment and commitment. This study provides encouraging empirical support and guidance for healthcare leaders interested in creating high-quality work environments that benefit both patients and professionals who care for them within current turbulent healthcare organisations.

Abstract number: P2-344

Type of paper: Poster

The Organisational Landscape of Generalist Palliative Care in Danish Hospital Departments

Jørgensen L.1, Tomm H.2

1University of Southern Denmark, PAVI, Knowledge Centre for Rehabilitation and Palliative Care, National Institute of Public Health, Copenhagen, Denmark. 2University of Southern Denmark, PAVI, Knowledge Centre for Rehabilitation and Palliative Care, National Institute of Public Health, Copenhagen, Denmark.

Background: In Denmark, 48% of all deaths take place in hospitals. Many die from chronic progressive diseases, often preceded by frequent hospital stays. Obviously, the need for palliative care (PC) should be addressed in the patients’ encounter with the hospital system, as a routine in the daily clinical work. If, and how, the departments have organized their provision of PC, is by large unknown.

Aims: To examine Danish hospital departments’ organisation and focus on PC.

Methods: A survey was sent to managers of the 410 hospital departments in Denmark, who treat patients. The survey addressed whether PC was prioritised and implemented at the organisational level in the departments (depts).

Results: A total of 318 (78%) depts responded, 85% had palliative patients among their clientele, 15% of depts had 40% or more of their patients who died of cancer. Among medical (N=80), surgical (N=95), psychiatric (N=40) and children's (N=14) depts, 93%, 77%, 43% and 71% could provide PC, respectively. Half of the depts would refer palliative patients to specialist PC to a greater or lesser extent (32% answered ‘always or often’), 33% of the depts had a policy for PC, 17% had allocated resources to PC, and 11% had used the specialised PC teams to increase the staff’s palliative skills. Whether the depts had guidelines for PC, was among these 33% vs. 39% (p<0.05).

Conclusion / Discussion: The majority of managers of hospital depts confirmed they had a focus on PC. However, focus did not seem to equal a policy or organisation of PC in the depts as recommended by the health authorities and the hospital’s national accreditation process. This survey has pinpointed some areas to address in the depts’ provision of PC; e.g. sparse allocation of resources, unawareness of guidelines and scant use of specialist PC teams to implement PC in the depts. It is imperative to know the depts’ awareness towards PC and organisation of PC in general PC in the hospitals shall be promoted and improved.

Abstract number: P2-345

Type of paper: Poster

Is Emergency Department Attendance Associated with Factors Relating to Preferences for Place of Death? A Population-based Mortality Follow-back Study

Klausen Schiebé,1 Galanwas N,1 Koffman J.,1 Hall S.,2 McGinnon J.J.,2 Gomes B.1

1Kings College London, London, United Kingdom. 2Centre for Palliative Care, Policy and Rehabilitation, London, United Kingdom.

Background: Emergency Department (ED) use is considered an indicator of poor quality end-of-life care and increases the risk of dying in hospital but it is unclear whether this reflects patient preferences.

Aims: To examine the association between factors related to preferences for Place of Death (PoD) with ED attendance by cancer patients in the last 3 months of life.

Methods: Population-based mortality followback survey with 596 bereaved relatives of adults who died of cancer (QUALYCARE study, London 2009-10, response rate 39.3%). 582 respondents and corresponding cancer registration data were analysed using bivariate analysis to compare patients who attended the ED to those that did not in terms of hospital stay and death, and factors relating to preferences for PoD.

Results: 56% of patients visited the ED once or more in the last 3 months of life (median 1, range 1 to 8 visits). ED attenders were more often admitted to hospital (93.8% vs. 52.7%, p<0.001), were hospitalised for longer (median 14 vs. 0 days, p<0.001) and more often experienced a hospital death (17.1% vs. 3.9%, p=0.001). Moreover, ED attenders were less likely to have discussed their preference for PoD with family (54.8% vs. 66.5%, p<0.005) or health professionals (50.4% vs. 65.5%, p<0.002). Their preference for hospital death was no different from those who did not attend ED (15.7% vs. 19.3%, p=0.49). Mean intensity scores were: pain 1.86, depression1.30 and anxiety 1.51.

Conclusion: ED attendance is common (more than 2 experience this) and associated with longer hospital stay, and more hospital deaths. This has cost implications as health systems struggle with funding and ED closures. Our results also suggest that ED attendance may reflect poorer planning and patient choice for PoD. This prompts policy and practice to improve community palliative care and facilitate discussion of preferences.

Funding: Cicely Saunders International

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Type of paper: Poster

National Perspectives on Dying and Bereavement – Ireland 2004 and 2014

Weaver J.1, Keenan F.1, Foley S.2, Mc Galloway S.3

1Weaver Research Associates, Dublin, Ireland. 2Irish Hospice Foundation, Dublin, Ireland. 3University of Maynooth, Maynooth, Ireland

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.

Aims: To examine current 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 did not believe their preference will be available to them (53% up from 45% in 2004). More than half (53%) experienced the death of someone close in the previous two years & 26% of these deaths were at home. Wishes for end-of-life care were consistent with 2004 & international surveys - to be surrounded by people you love, and free from pain. Nevertheless, most (two thirds) did not have others direction on their preference or written advance plans. Organ donation and writing a will are the exceptions. Suicide and accidental death were thought to be in the top three causes of death by 47% and 35% in fact these causes account for only 5% of death in Ireland annually.

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.

Abstract number: P2-347

Type of paper: Poster

The Orkdal Model: Establishment of an Integrated Oncology and Palliative Care Outpatient Clinic to Improve Collaboration and Care – Who Are The Patients?

Lølø BE1, Bremé A-Y.1, Brunell C-Y.2, Roasa S.3, Knudsen A.K.1

1Norwegian University of Science and Technology / St. Olavs Hospital, Trondheim University Hospital, European Palliative Care Research Centre (PRC), Trondheim, Norway, 2Norwegian University of Science and Technology, European Palliative Care Research Centre (PRC), Trondheim, Norway, 3Fondazione IRCCS Istituto Nazionale dei Tumori, Palliative Care, Pain Therapy and Rehabilitation Unit, Milano, Italy.

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 cancer 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 cancer care. It consists of a standardised care pathway coordinating care within specialties- and community care across the two levels; an educational programme 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 outpatient cancer 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 24%. 33% had pain at diagnosis. Among the 119, 48% had experienced the death of someone close in the previous two years. 101 patients had more than one registration. 31 patients died in the study period; among these 33% died at home. Mean intensity scores were: pain 1.92, dyspnoea 2.46. 2.

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.
Focus-groups with Family Practitioners (FP) on How to Deliver High Quality Palliative Care (PC)

Leysen B., Van den Eynde B., Wens J., Research Group Palliative Care, University of Antwerp University of Antwerp, Primary and Interdisciplinary Care Antwerp, Antwerp, Belgium
Presenting author email address: bert.leysen@uantwerpen.be

Abstract number: P2-348
Abstract type: Poster

Background: Palliative care (PC) is a rewarding but difficult task for each family practitioner (FP). The knowledge and skills required for effective care of patients with palliative care needs are challenging. FP usually work with a good team, whether in the nursing home or in home care. Patients at the end of life require continuous engagement with primary and secondary care professionals. PC patients deserve a higher level of continuity of care compared to others. Facilitators for this ideal of delivering PC are: - working with a good team, whether in the nursing home or in home care - working in a group practice - a health care culture accepting the concept of advance care planning - instruments helping FP to discuss the patient’s prognosis and PC needs with the patient and with colleagues - financial support measures for PC patients at home Barriers to provide high quality PC are: - the taboo of ‘palliative care’ is diminishing slowly, but it is still present also in family doctors - the understanding of PC as ‘care for the dying’ - fragmented care in home care compared to care in the nursing home

Conclusions: The main issue to improve the quality of PC seems to be its taboo nature.

Abstract number: P2-349
Abstract type: Poster

Case Conferences between General Practitioners and Specialist Palliative Care Teams in End Stage Heart Failure or Lung Failure Reduces Service Utilisation

Mitchell G.C., Zhang J., Burrell L.H., Senior H.E., Young S., Donald M., Jackson J.L., NHMRC Centre for Excellence in Primary Secondary Care Integration University of Queensland, School of Medicine, Herston, Australia
Presenting author email address: g.mitchell@uq.edu.au

Background: Non-malignant diseases cause many more deaths than cancer, but most palliative care service patients have cancer. Determining how to manage the end of life phase of non-malignant disease is still uncertain. Australian General Practitioners (GPs) can collaborate well both with patients and informal care givers, and with primary and secondary care professionals. PC patients deserve a higher level of continuity of care compared to others. Aims: To determine the effectiveness of formal case conferences between General practitioners and specialist teams to develop care management plans for end stage heart and lung disease patients.

Methods: Patients are identified by hospital heart failure and lung health nurses. A single case conference between the nurse, the patient’s GP and a Palliative Medicine specialist was conducted using a structured format to produce a care plan with clear responsibilities negotiated. Patient and carer needs are discussed. Chart audit of hospital records and GP records to determine service utilisation rates before and after the case conference, and adherence to the recommendations raised in the case conference.

Results: Twenty-four patients eligible, 20 case conferences with 21 GPs conducted between November 2011 and November 2012. One GP refused to participate. Ten patients died, three at home. Of 82 management recommendations made, 55 (65%) were enacted. ED admissions fell from 13.9 per annum (pa) to 2.1 (difference 11.8, 95% CI 2.2–21.3, p = 0.001); ED admissions leading to discharge home from 3.9 to 0.4 pa (difference 3.5, 95% CI -0.4–7.5, p = 0.05); hospital admissions from 11.4 to 3.5 pa (difference 7.9, 95% CI 2.2–13.7, p = 0.002); and length of stay from 7.0 to 3.7 days (difference 3.4, 95% CI 0.9–5.9, p = 0.007). Participating health professionals were enthusiastic about the process.

Conclusion: Case conferences appear to improve service utilisation markedly. This appears to be due to comprehensive case review, better interdisciplinary communication and clear role delineation. A formal RCT will be conducted to confirm the finding.

Abstract number: P2-350
Abstract type: Poster

Qualitative Study of Australian GPs and Palliative Care Practitioners on the Role of General Practice in End-of-Life Planning and Care

Rhee J.1, Mitchell G.C.1, Senior H.E.1, Chee Kong T.2, Clayton J.1 UNSW Australia, School of Public Health & Community Medicine, UNSW Sydney, Australia, 1University of Queensland, Brisbane, Australia, 2University of New South Wales, Sydney, NSW, Australia
Presenting author email address: s.nishiyama@ashya-hosp.com

Background: To understand which facilitators and barriers are perceived by FP to deliver high quality PC. Methods: The CPPC is implemented in 5 Belgian areas (2 Dutch-speaking areas, 2 French-speaking areas and the bilingual Brussels area). Per area and before implementation, a focus group with FP will discuss facilitators and barriers for FD to deliver high quality PC. Results: Focus groups have been done in 2 areas, more are planned in November 2014, March and September 2015. Main results of focus groups in 4 areas will be presented during the conference. Many FPs define high quality PC as communicating the PC status ‘timely’ to stakeholders, having a good knowledge of symptom control and collaborating well both with patients and informal care givers, and with primary and secondary care professionals. PC patients deserve a higher level of continuity of care compared to others. Facilitators for this ideal of delivering PC are: - working with a good team, whether in the nursing home or in home care - working in a group practice - a health care culture accepting the concept of advance care planning - instruments helping FP to discuss the patient’s prognosis and PC needs with the patient and with colleagues - financial support measures for PC patients at home Barriers to provide high quality PC are: - the taboo of ‘palliative care’ is diminishing slowly, but it is still present also in family doctors - the understanding of PC as ‘care for the dying’ - fragmented care in home care compared to care in the nursing home

Conclusions: The main issue to improve the quality of PC seems to be its taboo nature.

Abstract number: P2-351
Abstract type: Poster

A National Wide Survey of Medical Rehabilitation Professionals Staffing in Palliative Care Teams of Core Cancer Treatment Hospitals in Japan

Nishiyama N.1, Abe P.K.2, 1Ashiya Municipal Hospital, Rehabilitation, Ashiya, Japan, 2Hiroshima University Graduate School of Biomedical & Health Sciences, Hiroshima, Japan, 3Chiba Prefectural University of Health Sciences, Rehabilitation
Presenting author email address: n.nishiyama@ashya-hosp.com

Background: In Japan, based on cancer control act 2006, palliative care is provided with cancer treatment concurrently. The cancer core treatment hospitals (CCTHs) which started in 2006 should take a leading part of cancer treatment all over Japan, totally 197 hospitals at 2013, one of the criteria of patients set up with palliative care team (PCT). That shows needs of Palliative care for cancer patients. Aims: To investigate staffing about medical rehabilitation professionals (MRPs), in PCT of Japanese CCTHs in 2013. Methods: We accessed 397 CCTHs' homepages to collect data about staffing of MRPs in PCT at the end of December 2013. Then, we analysed the data statistically. Results: We found out they have 196/397(39.9%) of MRPs and 394/397(99.2%) of PCT in CCTHs. The CCTHs take not only cancer patients but also others, such as CVA, Fracture, SCL and so on. 145/397(36.5%) of CCTHs have posted MRPs as a member of PCT. Focusing on Japanese associations of cancer centers (JACC), 9/32(28.1%). JACC started in 1965, their experience is older than CCTH. Discussion: In this survey, the ratio of MRPs in PCT are 28.1% of JACC, and 36.5% of CCTH. In other survey reported by Abe at 13th world congress of EAPC, the ratio was 58.8% of hospital (231/393). So, the more hospitals specialise in cancer treatments by top-down theory, the less MRPs in PCT. In other words, the more hospitals based on the needs of the patient and community by bottom-up theory, the more MRPs in PCT. PCT registration of JSPM has increased to 491 hospitals in May 2014, and the ratio of MRP in PCT is still 60%, the tendency has been similar. Conclusion: We conclude MRP staffing in PCT does not meet the needs of cancer patients in Japan.
Using Emotional Touchpoints to Explore Attendees' Experiences of Specialist Palliative Day Services

Steven E., Dewar B., White C.A.1

University of the West of Scotland, School of Health, Nursing and Midwifery, Paisley, United Kingdom, 1University of the West of Scotland, School of Health, Nursing and Midwifery, Hamilton, United Kingdom

Poster

Abstract number: P2-356
Abstract type: Poster

Aim: To Explore the Impact of Attending SPDS on Attendees' Wellbeing.

Methods: This is the qualitative phase of a larger mixed-methods study. Using a phenomenological framework 15 SPDS attendees from two different SPDS took part in a single audio-recorded ET interview. The data was then subjected to interpretative thematic analysis to explore the impact of attending SPDS on wellbeing. Member checking, in the form of providing each participant with a copy of their story, took place to ensure accuracy of the research's understanding of what was said.

Results: The final interpretation of the data will be ready to report in January 2015. From early analysis it would appear that attending SPDS makes attendees feel safe and allows them to talk openly to fellow attendees and staff about issues that people who are not ill and are 'in the outside world' do not want to hear about. It would also seem that seeing other people who are 'in the same boat' coping with illness or being helped by expert staff helps attendees face their own future which in turn reduces anxieties.

Conclusions: These will be drawn from the final data analysis which is ongoing.
Challenges in Preparing Advance Directives and Advance Care Planning for Dementia Patients: Summary of Issues for Policy Discussion in Japan

Tsunoda A.1, Kadoma S.1
Japan Medical Association Research Institute, Tokyo, Japan. 2Kyoto University Graduate School of Letters, Kyoto, Japan
Presenting author email address: mispimpko@umin.ac.jp

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 a person’s death is a cultural norm. However, there are few data on dementia-related ADs and ACP in Japan. Aim: To achieve dementia-specific issues in Japan with dementia patients and their families and care providers. Methods: Comprehensive literature review. PubMed and EBSOhost databases were searched and relevant public reports and academic guidelines were added. Results: Four major challenges were identified:
1. Dementia-specific medical issues (delays in diagnosis; perception that dementia is a life-limiting disease and the opposite perception);
2. Capacity for decision-making;
3. Difficulty maintaining or improving Quality of Life (acknowledging dementia to be a loss of personhood/inequitable provision of palliative care); and
4. Dependency on others, including family and proxy decision makers.

Abstract number: P2-358 Abstract type: Poster

A New Framework for Palliative Care in Switzerland: Getting a Common Basis for the Implementation of Palliative Care within the National Strategy for Palliative Care

Sychmüller S.1, von Worthing E.2
1Swiss Palliative Care Association Palliative CH Bern, Switzerland. 2Center for Palliative Care, University Hospital Bern, Bern, Switzerland. Federal Office of Public Health, Health Policy Directorate, Bern, Switzerland

There is an ongoing discussion worldwide on what palliative care really is. This complicates the implementation of palliative care into health services: how can a new system be set up, financed and made operational if it cannot actually be described? As part of the Swiss National Strategy for Palliative Care, a Framework for Palliative Care has been developed. It is intended to build a common thread running through all areas covered by the National Strategy, from health services issues to education, finances, awareness and research. In a first step we reviewed literature with specific focus on attempts to give a clear definition of palliative care and their requirements. In a second step, working group was set up, composed of fourteen members with background in different disciplines. The document was drawn up in three full-day sessions including chaired group discussions. An online questionnaire has been set up and will determine the extent to which the framework is used and how it is perceived.

The framework describes the implementation of palliative care in four different domains:
• the specific target groups of palliative care and their requirements
• the service offers and interventions necessary to meet the needs of each target group
• the care structures required to provide these services
• the competencies required to accomplish these tasks in high quality

We defined three levels of expertise in each domain which partly differ from the EAPC white paper: palliative care awareness, general palliative care and specialist palliative care. A major point is the systematic integration of the population as a specific target group. The framework for Palliative Care in Switzerland provides a mapping system to locate the wide range of different tasks in palliative care. It provides guidance and can serve as a working tool for all persons and institutions involved in the implementation of the National Strategy for Palliative Care. Results of the online questionnaire will help to specify its impact.

Abstract number: P2-359 Abstract type: Poster

The Place of ‘Place’ of Death in the Netherlands

Koekoek B.U.1, Knoppers A.E.2, Halloekamp C.3
1Palliatief Network Sailand, Denvertor, Netherlands. 2Utrecht University, Administrative and Organizational Science, Utrecht, Netherlands. 3Utrecht University, Law, Economics, Management and Organization, Social Sciences, Pedagogical and Educational Sciences, Utrecht, Netherlands. 4VPTZ Nederland, CD Bunnik, Netherlands

Background: Most (73%) of the Dutch population prefers to die at home; yet only 32% were able to do so in 2006. Since then, the number of palliative terminal beds and the provision of public information about the possibilities of palliative care have greatly increased.

Aims: This study explored shifts in the selection of places of death from 2004 to 2013 and the meanings assigned to individual agency and illness that play a role in these shifts. The purpose of this study is to contribute to the dialogue between professionals, scientists and policymakers about the concept of autonomy and personal choice about the place of death.

Mixed methods:
Quantitative:
National survey (n = 1881)
Palliative care patients in hospices (n = 41)
Central Bureau of Statistics: mortality statistics of people with chronic illness (not sudden death)
Qualitative:
Retrospective study: semi-structured interviews with survivors (n = 20)

Analysis:
Chi-square test; the Spearman Rank Correlation Coefficient

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 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.

Conclusions: 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 to 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
Who Are Demanding Changes in the Russian Public Agenda?

Usenko O. 
Palliative Care Initiative, Kemerovo, Russian Federation
Presenting author email address: usenko_olga@mail.ru

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: 2,024 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 access to opioids, and the Ministry of Health displayed an interest in 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 on 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 Khorinak were catalysts in altering the public’s attention to access to 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.

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 the same time that the democratic institutions in Russia do not work properly, a World Health Organization investigation on the availability of opioids for pain relief is vital.

Public health and epidemiology

Is Cancer Patients’ Admittance to Specialised Palliative Care Related to Sex, Age and Cancer Diagnosis? A Study from the Danish Palliative Care Database (DPD)

Asdrubali M.1, Thygesen L.C.C.1, Neepgaard M.A.1, Jørgensen P.F.2, Jensen A.B.3, Gromov M.1,4
1Bispebjerg Hospital, Research Unit, Department of Palliative Medicine, Copenhagen, Denmark, 2University of Southern Denmark, National Institute of Public Health, Copenhagen, Denmark, 3Aarhus University Hospital, Palliative Team, Department of Oncology, Aarhus, Denmark, 4Rigshospitalet, Copenhagen University Hospital, Section of Palliative Medicine, Department of Oncology, Copenhagen, Denmark, 5Aarhus University Hospital, Department of Oncology, Aarhus, Denmark, 6University of Copenhagen, Department of Public Health, Copenhagen, Denmark

Background: Denmark has no national guidelines for referral of patients to specialised palliative care (SPC) and little is known about the referral patterns. A previous Danish study of advanced cancer patients found no major differences in symptoms and problems in relation to sex, age and diagnosis. Therefore, one could hypothesise equal admittance to SPC in relation to sex, age and diagnosis.

Aim: To investigate whether admittance to SPC in Denmark varies for adults dying of cancer in relation to sex, age and diagnosis.

Methods: The study is a register based study on Danish adult patients who died from cancer in 2010–12 (N = 44,548). Data sources: The Danish Register of Causes of Death, the Danish Cancer Registry and the Danish Palliative Care Database. The associations between the explanatory variables (sex, age and diagnosis) and admittance to SPC were investigated using logistic regression.

Results: More than one third (37 %) of the patients who died in cancer in 2010–12 in Denmark were admitted to SPC. Women were more likely admitted to SPC than men (OR=1.23; 1.17–1.28). The odds of admittance decreased with increasing age, the odds of admittance to SPC were over six times higher for the youngest (18–40 years old) compared to the 80+ years old (OR=6.44; 5.19–7.99). In relation to diagnosis, the highest odds ratios were found for individuals with sarcoma (OR=1.90; 1.52–2.38), pancreatic (OR=1.77; 1.61–1.94) and stomach cancer (1.69; 1.50–1.90) and lowest for the haematological malignancies (OR between 0.33 and 0.50) compared to the average of all diagnoses.

Conclusion / Discussion: In this first national register based study of admittance to SPC, we found that admittance to SPC varied in relation to sex (lowest for men), age (lowest for the 80+ years old) and cancer diagnosis (lowest for haematological malignancies).

Place of Death is Influenced Not Only by Cause of Death, but Also by Age and Gender – A National Cohort Study

Jørgensen L., Jørgensen P.F., Tvern H.
1University of Southern Denmark, PAVI, Knowledge Centre for Rehabilitation and Palliative Care, National Institute of Public Health, Copenhagen K, Denmark, 2University of Southern Denmark, PAVI, Knowledge Centre for Rehabilitation and Palliative Care, National Institute of Public Health, Copenhagen, Denmark

Background: In the health care system’s organisation of palliative care, it is of interest to know which factors influence place of death. In Denmark, a nationwide registry for causes of death allows for epidemiological analyses in the whole nation.

Aims: To investigate whether causes of death were evenly distributed among persons dying in hospitals or at home, and to analyse which factors play a role in place of death in the Danish adult population.

Methods: A cohort study using the national registry for causes of death during the period 2007 – 2011. All natural causes of death in hospitals and at home, among persons aged 19+, were included (N=195,158), except rare causes (N=5,358). The outcome for the analyses was death in hospital compared with death at home.

Results: The major cause for death was cancer (32% among all). For persons younger than 86 years, 69% died in hospitals, and 37% died from cancer. For 86+ years, 58% died at home, 27% died from heart disease, and 11% from cancer. Infectious and respiratory diseases had significantly higher odds-ratios for hospital death, compared with cancer; 3.35[3.06;3.67] and 1.29[1.21;1.33] respectively, while heart diseases and psychiatric causes were significantly lower; 0.80[0.78;0.83] and 0.19[0.12;0.30] respectively. Male gender was an independent factor for hospital death (odds ratio 1.33[1.11;1.55]). Age influenced death in hospitals, regardless of cause or gender, with odds-ratios of 1.32[1.29;1.35], 1.38[1.26;1.51] and 0.50[0.49;0.51] for age groups; 60–64, 65–69, and 80+ years (ref: age 65–69).

Conclusion / Discussion: The causes of death had a major impact on place of death. However, both age and gender independently influenced place of death. It seems obvious that the cause of death plays a role in place of death, and these results can help the dimensioning of palliative care initiatives. However, it is suggestive that both age and gender are independent factors for place of death – which seems to call for more qualitative explanations.

Building Bridges with the General Public: Palliative Care and Media

Uhlir M.1, Dvorakova M.2, Votruba L., Usenko O.3
1Cesta domu, Prague, Czech Republic, 2Center for Palliative Care, Prague, Czech Republic

Aim: 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.

Methods: The analysis of information on 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 Khorinak were catalysts in altering the public’s attention to access to 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.

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 the same time that the democratic institutions in Russia do not work properly, a World Health Organization investigation on the availability of opioids for pain relief is vital.

Poster Sessions (Poster Exhibition Set 2)
Ten-year Trends in the Risk of Hospital Death for Conditions Needing Palliative Care: A Death Certificate Study

Gómez B, Pinheiro M, Lopes S, Sartoris LP, Ferreira PL, Barro M, Higginson IJ, Goodhead AF

Objectives: To examine the risk of hospital death for conditions needing palliative care over a 10-year period in deaths certified on death certificates.

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 neurodegenerative diseases, dementia, Alzheimer’s disease, or HIV/AIDS. For this group, we studied trends and factors associated with dying in hospital using multivariate logistic regression.

Results: 273,454 (70.7%) of deaths met the criteria for needing palliative care. Median age at death was 73.6 years (IQR 65.4–83.8). 61.8% of these deaths occurred in hospital, 36.8% of which is outside the patient’s municipality of residence. The rate of dying in hospital increased by year (AOR 1.04, 95%CI 1.04–1.04), with age- and gender-standardised percentages ranging 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, 1.31–1.83), liver (1.49, 1.44–1.55) 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 (0.40, 0.40–0.44) diseases, dementia/alzheimer’s disease (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 for this group. Findings are consistent with similar studies in other countries and suggest an increasing trend of hospital death.


Håkanson C, Höhne T, Drenning S, Kjellén J

Purpose: To establish the characteristics of patients who could benefit from early access to palliative care services earlier, and measure the timely utilisation of these services within a population of patients at risk of dying within six months.

Methods: Data from the national Swedish Clinical Classifications database (Census Classification Software), which was linked with the Cause of Death Database, and the Palliative Care Register. The sample comprised patients registered in the Palliative Care Register between 1 July 2013 and 30 June 2014.

Results: Of 12, 421 people 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 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 at home. The geographical and socioeconomic distribution of place of death calls 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.

P2-368 Common Attributes of Patients with Advanced Chronic Disease Who Would Benefit from Palliative / Hospice Care

Snow RJ, VogeLKL, Creggton A, Edwards D, Hamold B, Vanderhall B, Goodhead AF

‘OhioHealth, Clinical Transformation, Columbus, OH, United States,’OhioHealth, Palliative and Hospice Care, Columbus, OH, United States,’OhioHealth, Chief Medical Officer, Columbus, OH, United States’

Presenting author email address: f.snow@ohiohealth.com

Abstract: 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 software, 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 1.347–1.607; 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.

P2-369 Spirituality

Goodhead AF, Kenny J, St Christopher’s Hospice, London, United Kingdom

Abstract: To examine the risk of hospital death for conditions needing palliative care over a 10-year period in deaths certified on death certificates.

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 neurodegenerative diseases, dementia, Alzheimer’s disease, or HIV/AIDS. For this group, we studied trends and factors associated with dying in hospital using multivariate logistic regression.

Results: 273,454 (70.7%) of deaths met the criteria for needing palliative care. Median age at death was 73.6 years (IQR 65.4–83.8). 61.8% of these deaths occurred in hospital, 36.8% of which is outside the patient’s municipality of residence. The rate of dying in hospital increased by year (AOR 1.04, 95%CI 1.04–1.04), with age- and gender-standardised percentages ranging 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, 1.31–1.83), liver (1.49, 1.44–1.55) 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 (0.40, 0.40–0.44) diseases, dementia/alzheimer’s disease (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 for this group. Findings are consistent with similar studies in other countries and suggest an increasing trend of hospital death.

P2-370 Innovation in Cancer Management Spiritual Care and Changes in Receptor Gene Expression in Breast Cancer Patients

Akbari ME, Lotfi Kashani A, Amanah G, Hossien L

‘Cancer Research Center, Tehran, Iran,’Islamic Republic of,’Shahid Beheshti University of Medical Science, Tehran, Iran,’Islamic Republic of,’National Institute of Genetic Engineering and Biotechnology, Department of Medical Genetics, Tehran, Iran,’Islamic Republic of,’Shahid Beheshti University of Medical Science, Cancer Research Center, Tehran, Iran,’Islamic Republic of

Abstract: 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 consequences such as heart disease, cancer and death. Also, there is a confirmed relation between psychiatric conditions and changes in receptor gene expression in depression anxiety and social dysfunction. Different studies demonstrated the role of spiritual experiences in occurrence and progression of cancers. 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 DRD2-DRD4 in intervention group PBMC decreased compared to the control group and even lower than those of healthy individuals. Moreover, real-time PCR data indicated significant promotion in expression of SHT3AR and SHT2AR in PBMC in breast cancer. Our results indicated significant reduction in expression of SHT3AR and SHT2AR in intervention group compared with the control group but there were no findings of changes 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: P2-371
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
Abrahms PM 1, Groves K.E.2
1Southport & Ormskirk NHS Trust, Chaplaincy & Spiritual Care Services, Southport, United Kingdom, 2Southport & Ormskirk NHS Trust, West Lancs, Southport & Formby Palliative Care Services, Southport, United Kingdom
Presenting author email address: martin.abrams@nhs.net

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. 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.

Method: The method employed for baseline and post intervention audits was to visit hospital wards 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 by the distribution of posters and a chaplain doing a weekly ward round with the End of Life Facilitator.

Discussion:
Spiritual care leaflets were inserted into all individualised Plans for Care
Staff actively encouraged to make a spiritual assessment & acknowledged for doing so
Education offered to staff on spiritual assessment and the Trust's spiritual care policy
Input has been given on the re-writing of new documentation to support staff.

Abstract number: P2-374
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
Hansen FT 1, Hansen H.2, Lilkevang I.3, Lange L.4
1Aalborg University, Communication, Aalborg, Denmark, 2Aalborg, Denmark, 3Værker Fjord Hospice, Hvide Sande, Denmark
Presenting author email address: frithjof@hum.aau.dk

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 (Wright, 2005) it is surprising how little research there has been on the relevance of the practice of philosophy and philosophising 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-inquiries’ came out. The results 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 Socratic 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-the-other in spiritual care.
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**

van Meijl L.1,2, Engels V.1, Groot M.M.1,2
1Radboud University Medical Center, Expertise Center for Palliative Care, Nijmegen, Netherlands; 2Heine Dowlings Institute, Research Department, Bithoven, Netherlands

Presenting author email address: jacqueline.vanneurs@radboudumc.nl

**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 assisted 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 recognize 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 content of spiritual care of the palliative care consultation team was recorded along with several nurses in their daily work (3-6 shifts). Due to this participant observation technique, in which she wears a doctor’s white coat, the careattitude 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 analyzed 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 and thereby contribute to complete and integral 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**

Best M.1,2, Button P.1, Olvert L.2
1University of Sydney, Sydney, Australia; 2HammondCare, Palliative Care, Greenwhich, Australia; 3Cancer Council Australia, Sydney, Australia

Presenting author email address: megan.best@sydney.edu.au

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 described 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 patient care.

Abstract number: P2-377
Abstract type: Poster

**Hospice Philosophy in Practice – Spiritual Care in a Hospice Setting**

Gowen P.1
1Aalborg University, Department of Sociology and Social Work, Aalborg, Denmark

Presenting author email address: vbkebe@socsci.aau.dk

**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 often regarded as high important to 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 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 Western society.**

The method used in this research is phenomenological and hermeneutic and utilizes phenomenological practice as a tool for enabling hospice nurses to articulate and reflect upon their experiences of delivering spiritual care to dying persons. A phenomenological hermeneutical 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?**

Abstract number: P2-378
Abstract type: Poster

**Sacred Music and Spiritual Well-being of Bereaved Family: A Randomized Clinical Trial**

do Silva P.A.1, da Silva M.J.P.1, Study Group on Alternatives or Complementary Health Practices
1School of Nursing of the University of São Paulo – EESP, Postgraduate Program in Adult Healthcare Nursing, São Paulo, Brazil, 2University of São Paulo – USP, School of Nursing, São Paulo, Brazil

Presenting author email address: vilma@araujo_silva@usp.br

**Aim:** Evaluate the effect of passive listening of sacred music in the levels of spiritual well-being of bereaved family. **Methods:** Randomised clinical trial conducted at home of bereaved family registered in the Health Network of Cancer Care from Maringá, Brazil. Thirty families, bereaved from 1 to 12 months were randomly allocated to: group 1: experimental with sung music (n=10), group 2: experimental with instrumental music (n=10), or group 3: control (n=10). In the experimental groups four musical sessions were performed lasting 20 minutes each, one session a week. The Spiritual Well Being Scale (SWBS) was used to measure and evaluating spirituality before and after the intervention. In the control group, the SWBS was applied twice, with an interval of one month. The songs ‘Your presence makes living’, ‘Prayer for the world of God of IICF’, and ‘When the pain approaches’, which make up the album ‘Life Now Always’ from the label COMEF were pre-selected by investigator (nurse and musician). The music delivery method was live with voice and acoustic guitar or alto recorder and acoustic guitar. **Results:** The means and standard deviations of the scores of the SWBS, of the Religious Well-Being subscale and of the Existential Well-Being subscale before the intervention were: 101,1 (12,5), 55,6 (6,5) e 45,7 (7,3) in group 1; 101,2 (16,4), 55,8 (8) e 45,9 (12,1) in group 2; 102,1 (15,6), 56,5 (5,6) e 46 (7,2) in group 3. **Conclusion:** The experimental groups showed a slight increase in the scores of the SWBS, especially in the scores of the Existential Well-Being subscale. The increase was greater in the group 2. The control group showed a slight decrease in the scores of the SWBS. The passive listening of sacred music can improve the levels of spiritual well-being of bereaved family.

Abstract number: P2-379
Abstract type: Poster

**The Church Guest Book – Landscape of Spirituality in a Danish Hospital**

Nielsen M.N., Mørk L.B.
Rigshospitalet, København Ø, Denmark

**Background:** Danish spirituality is often described as individualised, privatised, secularised, and somewhat diffuse. Furthermore Danish people are described as modest in ways of expressing spirituality. Meanwhile new research find that spirituality plays an important role for a great number of people when they are diagnosed with a life threatening illness. It is therefore essential, for caregivers in palliative care, to acknowledge that patients and relatives might have thoughts regarding spirituality, and they must also be able to venture dialogue about it and thereby improve the quality of life, as described by WHO. **Aim:** An investigation of the empirical data from 24 Church Guest Books (CGB) (4011 written messages) to find out how patients and relatives express their spirituality in the context of a Danish hospital. **Methods:** The 4011 messages were retyped and compiled into categories in order to make a demographic overview of people using the CGB and b) an interpretation of the data using a hermeneutic approach, focusing on spiritual themes represented in the books; e.g. people’s representations of God. **Results:** The project discovered that as many as 1523 of the messages were written by relatives and 909 by patients. It also reveals that people express their spirituality in very different ways some approach a direct God, others a much more personal God, and yet others a rather spiritualised God, an interpretation of God. Some people write to relatives for support. Finally a guideline on how to be church at a hospital was produced. **Conclusion/ Discussion:** The study illustrates how some patients and relatives have a need to express their spirituality, when facing illness. It also illustrates that some people need another discourse than the medical and biological focus on healing. They desire one that includes the religious and existential discourse in their life. The role of the religious is to equip caregivers in palliative care, to acknowledge that patients and relatives might have thoughts regarding spirituality and to also be able to venture dialogue about it and thereby improve the quality of life, as described by WHO.

Abstract number: P2-380
Abstract type: Poster

**Spirituality in Palliative Care – What Are We Talking about? The Role of Clinical Pastoral Care in Promoting a Better Interdisciplinary Understanding of Spirituality in Palliative Care**

Wethé M.1, Sebel K.1,2, Xander C.1, Becker G.1,2
1Ostena Klinikkum Offenburg-Gengenbach, Offenburg, Germany, 2Medical Center – University of Freiburg, Department of Palliative Care, Freiburg, Germany
Background: Caring for patients’ spiritual needs is considered a central part of the provision of palliative care (PC) and therefore concerns the work of all PC professionals. However, the term ‘spirituality’ remains unclear or even controversial within the interdisciplinary practice of PC as well as within the scientific discourse.

Aim: To conduct a literature review regarding the question: is there a common interdisciplinary understanding of the term ‘spirituality’? In detail: a) How is ‘spirituality’ defined in PC literature in general? b) How is ‘spirituality’ defined in German PC literature?

Methods: Papers were obtained from searches a) of Medline and PsycINFO (2003–2013) and b) of Protestant concepts of clinical pastoral care in Germany for both searches for the search terms ‘spiritual and palliative’ ‘spiritual and cancer’ as well as ‘spiritual and end-of-life’.

More than 4000 publication titles contained the word ‘spirituality’, 56 were included.

Results: A clear definition of spirituality that is shared by all professionals involved in PC could not be identified – neither in general PC literature nor in the clinical pastoral care literature. The most frequently listed elements of spirituality were: ‘meaning and purpose’, ‘connectedness’ and ‘something transcendent’.

Conclusion: To define the term ‘spirituality’ is required in order to achieve an adequately individual and beneficial assessment of patients’ spiritual needs. As ‘spirituality’ is a concept in flux, only snap-shots are possible. Finding a common and contemporary concept of ‘spirituality’ needs to be a collaborative and ongoing process. The role of pastoral care in this process should be to offer a Christian definition of spirituality and to initiate and maintain an open and self-reflective interdisciplinary discussion on spirituality.

Abstract number: P-238
Abstract type: Poster

Evaluation of a Spiritual Care Curriculum for Hospice Volunteers

Grunz M1*, Roser T1, Kittelberger F1, Paal P2

1University of Muenster, Department of Practical Theology, Muenster, Germany, 2University Hospital of Munich, Department of Palliative Medicine, Professorship in Clinical Pastoral Care, Munich, Germany, 3Protestant Academy Tuting, Director of Studies on Ethics in Medicine and Healthcare, Pastoral Psychology and Spiritual Care, Tuting, Germany

Presenting author email address: margrit.gratz@uni-muenster.de

Background: The spiritual care (SC) curriculum content was arranged based on a discussion with hospice coordinators and available literature. Eleven themes were included in the curriculum draft. Training aims and methods for each theme were specified in detail.

Aim: The aim of this study was to test the practicability of the curriculum designed to teach spirituality and SC for hospice volunteers.

Methods: 21 participants were trained using the curriculum draft. During the two day training the participants were asked to evaluate the training aims, content, and provide feedback on curriculum’s feasibility. The SSPS 21 was used to analyse the quantitative data. The thematic content analysis was used to analyse the feedback.

Results: The curriculum was estimated to be able to prepare hospice volunteers for their duty (mean=3.6; range 1–5; sd=0.676). It was also seen to be helpful for educationalists to arrange a training programme (mean=3.9; range 1–5; sd=0.964). Following themes became ranked as top content: firstly, spirituality, spiritual needs, distress, promises and resources; secondly, spiritual care: presence and communication; and thirdly, spiritual care: staying put and holding up. Detailed comments were received regarding the training aims and themes for each section. The results indicated that the selection of teaching methods needs significant improvement.

Conclusion: The final curriculum will assist hospice home care services to create an end-of-life care training for volunteers that integrates spirituality and SC in an agreement with their institutional agenda. For educationalists the curriculum may serve as a detailed mandate or a guideline.

Abstract number: P-238
Abstract type: Poster

Social care and social work

‘A Museum with you’. Pictures from Movies in a Hospice

Milo A1, Basano R1, Pesenti D1, Ventresce S1, Valle A1

1Fondazione Assistance e Ricerca in Oncologia, Torino, Italy, 2Museo Nazionale del Cinema, Torino, Italy, 3Fondazione FARO onlus, Torino, Italy

A professor of history of cinema was admitted and died in our hospice in spring 2014. In his last days 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 excessive joyous scenes or those with nude actors or too sad to be displayed. The pictures are nice and pleasant and are showing a positive and creative 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 obserbative and narrative approach this paper presents an meaningful 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’, ‘highlight the whole personal history of the patient and the family’, ‘foster the image of a protector’ were looked at and as a result this paper was written.

Abstract number: P-238
Abstract type: Poster

Professional Competencies of Social Workers in Palliative Care Specialized Services – The Romanian Experience

Aniana P

Fundatia Hospice Casa Sperantei, Brasov, Romania

Background: In Romania the competencies for Social workers (SW) in palliative care has 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 reflective 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: situational assessment, decision making, care planning, 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 (98=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 capacity to support and promote the patient’s and family’s care. In support for the patient and family’ domain: 95% saw extremely important for the SW to demonstrate the capacity 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’.

Conclusion: The patient and the family are relying on the social worker for representation, global assessment, support in finding solutions, counselling, advice and guidance.

Abstract number: P-238
Abstract type: Poster

Social Needs for Adult Patients with Cancer

Pop C

Fundatia Hospice Casa Sperantei, Education and National Development, Brasov, Romania

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. Aims: 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 leisure. Assessing their financial situation, 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=81,26%). Respondents were women 177 (54,8%), men 142 (44,6%), 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 44,6% of 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.

Abstract number: P-238
Abstract type: Poster
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

Sarafraz S., Voss S., Loof F., Akin M.E., Hessem L.
Cancer Research Center, Shahid Beheshti University of Medical Sciences, Tehran, Iran, Islamic Republic of

Purpose: The purpose of this study was to compare the perception of mother’s 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’s role, women with mastectomy 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 taring apart. In parent-child relationship two different aspects of relationship was seen; one was a dependant relationship and 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, Perception, 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

Hossein L., Alkan M.E., Loof F., Sarafraz S.
1Shahid Beheshti University of Medical Science, Tehran, Iran, Islamic Republic of, 2Shahid Beheshti University of Medical Science, Cancer Research Center, Tehran, Iran, Islamic Republic of

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 effect(s) 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 IP. 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 Delirium: A Systematic Review

Guerrero-Torrelles M.1,2, Monforte-Royo C., Tomás-Sábado J., Balaguer A.
1,2, Monforte-Royo C.1,2, Tomás-Sábado J.3, Balaguer A.1,2
1WeCare –End of Life Care, Sant Cugat del Vallès, Spain, 2Nursing Department. Facultad Medicina i Ciències de la Salut, Universitat Internacional de Catalunya, Sant Cugat del Vallès, Spain, 3Escola Universitària d’Infermeria Gimbernat, Universitat Autònoma de Barcelona, Sant Cugat del Vallès, Spain, 4Facultad Medicina i Ciències de la Salut, Universitat Internacional de Catalunya, Sant Cugat del Vallès, Spain

Purpose: 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).

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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

Rodriguez G., Vensaeghe E., Aitorde S.
Instituto Nacional de Cancerología, Cuidados Paliativos, Distrito Federal, Mexico

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 and clinical can be underdiagnosed 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 40% 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 (Confussion 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, 23 (38.3%) met diagnostic criteria for delirium; of these 56.5% were hyperactive, hyperactive 4.3% and 39.1% mixed.

Conclusions: The population in our palliative care unit behaves in the range reported in the literature, with 38.3% of the population with delirium and the hyperactive type is the more prevalent.

Abstract number: P2-389
Abstract type: Poster

The Role of Psychologists for Prevention Syndrome Professional Burnout of Hospice Workers

Bratsyun O.1, Andryushyn L.-O.1
1National Medical Academy of Postgraduate Education, Dept Palliative and Hospice Medicine, Kyiv, Ukraine, 2Regional Clinical Palliative Care Centre, Ivano-Frankivsk, Ukraine

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 distance 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.
Psychological Distress in a Hospice In-patient Unit

McCorry N.K., Sadler A., Wilkinson P.i-2
1Marie Curie Cancer Care, Marie Curie Hospice Belfast, Belfast, United Kingdom, 2Belfast Health & Social Care Trust, Belfast, United Kingdom

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 disclose 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 terminal care. 41% of patients were able to complete both the DT and HADS, and 59% were either not offered (did not meet the eligibility criteria) or were unable to complete the questionnaires. Of those patients who completed the assessments, 83% scored 4 or above on the DT, and endorsed sources of distress including worry, loss of interest, sadness and fatigue. 61% and 75% of patients scored 8 or above for HADS anxiety and HADS depression scales respectively.

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.

The Need for Social Contact during the Dying

Mockova M.i, Lazarkova M.i, Skalova A.i, Mockova M.i
1Pardubice of University, Department of Midwifery and Health and Social Work, Pardubice, Czech Republic, 2Masaryk University, Department of Medical Ethics, Brno, Czech Republic, 3Neuro-Centre, Liberec Regional Hospital, Liberec, Czech Republic

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 by parts as 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 have 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.
Positive Emotions as Predictors of Cancer Patients’ Functioning

Ziętalewicz U.1, Fidalgo F.2,1, Skov Benthien K.1,2, Johansen C.1,3, Kjellberg J.4, Timm H.5, Von Der Maase H.1, Gørgen E.1, Stypula-Cuda B.2
1University of Southern Denmark, Denmark, 2Faculty of Health and Medical Sciences, Copenhagen University, 3Danish Cancer Society Research Center, Copenhagen, Denmark, 4The Danish Institute for Local and Regional Research, Copenhagen, Denmark, 5Danish Knowledge Centre for Palliative Care, University of Southern Denmark, Copenhagen, Denmark, 6Copenhagen University Hospital, Section of Palliative Medicine, Department of Oncology, Copenhagen, Denmark, 7Copenhagen University Hospital, Multidisciplinary Pain Centre, Copenhagen, Denmark

Abstract number: P2-396
Abstract type: Poster

‘Rémémance’: Portraits in Palliative Care

Georgantelis C.1, Fidalgo F.2
1Reseau de Soins Palliatifs RIVAGE, Toulouse, France, 2Photograph, Toulouse, France

Presenting author email address: c.georgantelis@laposte.net

Aims: To offer to patients a representation of themselves distinct from the one associated with the disease. The aim was to assess whether the resulting portraits can improve the quality of care.

Methods: Patients’ photographic 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 vision of themselves as not having the disease. As wished, they wished to share these pictures with their family.

Conclusions: The developed procedures are feasible and could be expanded in palliative care units.

Poster Sessions (Poster Exhibition Set 2)

Negative Emotions as Predictors of Cancer Patients’ Functioning

Ziętalewicz U., Kudra M.1, Gørgen E., Stypula-Cuda B.2
1University of Southern Denmark, Denmark, 2Faculty of Health and Medical Sciences, Copenhagen University

Abstract number: P2-394
Abstract type: Poster

Need for Psycho-oncological-Social-care of Oncological Inpatients: A Pilot Survey Using Hornheider Questionnaires

Sumnitch P.
LÖH Hohenems, Academic Teaching Hospital Feldkirch, Feldkirch, Rankweil, Austria
Presenting author email address: petra.sumnitch@lhk.net

Aim and object: The aim of this survey was to identify psycho-oncological and psycho-social needs in the 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. The patients were asked to fill out the questionnaires, and their answers were analyzed.

Results: Overall, 149 patients returned complete questionnaires (75%, 68 women and 81 men, 74 ± 5 years and 75 ± 65 years). Hornheider scores ≥ 4 were considered to indicate psycho-oncological and psycho-social need. The results indicate that minimisation of negative emotions, especially anxiety, improved their physical, emotional and social functioning. The study included 50 women and 72 men (mean age 57 years) with a diagnosis of cancer. The patients were followed for six month and several symptoms, psychological and treatment results were 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, respectively.

Conclusions: 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: P2-397
Abstract type: Poster

Status on the DOMUS Study: A Randomized Clinical Trial of Accelerated Transition from Oncological Treatment to Palliative Care at Home

Nordby M.1,2, Skov Benthien K.1,2, Von Der Maase H.1, Johansen C.1,3, Kjellberg J.4, Timm H.5, Fidalgo F.2,1, Paulou Kanta O.2,4, Seygen P.2,4
1Copenhagen University Hospital, Department of Oncology, Copenhagen, Denmark, 2Faculty of Health and Medical Sciences, Copenhagen University, 3Danish Cancer Society Research Center, Copenhagen, Denmark, 4The Danish Institute for Local and Regional Research, Copenhagen, Denmark, 5Danish Knowledge Centre for Palliative Care, University of Southern Denmark, Copenhagen, Denmark, 6Copenhagen University Hospital, Section of Palliative Medicine, Department of Oncology, Copenhagen, Denmark, 7Copenhagen University Hospital, Multidisciplinary Pain Centre, Copenhagen, Denmark

Presenting author email address: mjuul.nordby@region.dk

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 or no limited antineoplastic treatment options and ECOG Performance status 2-4 at a comprehensive cancer centre. 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 months 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 y). 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.

Discussion: The slow inclusion of patients has required measures to optimise study development. The main objectives 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 removed, which may implicate earlier intervention and an analysis of reasons for refusal is ongoing. The changes have been reported to clinicaltrials.gov.

Funded by the Danish Cancer Society and Trygfonden.

Poster Sessions (Poster Exhibition Set 2)
The Attitudes and Experiences of General Practitioners towards Nurse Independent Prescribing of the Nurse Independent Nurse Practitioner in Palliative Care in the Community

McGillivray E1, Swift E1, Nelson A2
1Cardiff University, School of Medicine, Cardiff, United Kingdom, 2Marie Curie Hospice Cardiff and Vale, Penarth, United Kingdom, 3Marie Curie Palliative Care Research Centre, Cardiff, Cardiff, United Kingdom

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, 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, and the role of CNSs is arguably better positioned to respond to the needs 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 rated these factors in a way which was positive, with advantages to patient care identified including saving CNSs’ and patients’ time, greater autonomy for the CNS and being of benefit to working relationships. The purpose of the study was to identify barriers, benefits and support available and as a result inform future practice.

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 Attrition in a Multicenter Longitudinal Observational Study of Patients with Advanced Cancer

Pérez-Cruz PE, Shamsat O, Paxton C, Kieron JM, Muckaden M, Bruera E, Hui D
1Pontificia Universidad Católica de Chile, Internal Medicine, Santiago, Chile, 2King Hussein Cancer Center, Amman, Jordan, 3Barretos Cancer Hospital, Barretos, Brazil, 4Rangiyong Sacred Heart Hospital, Hallim University College of Medicine, Seoul, Korea, Republic of, 5TATA Memorial Hospital, Mumbai, India, 6MD Anderson Cancer Care and Rehabilitation Hospital, Houston, Texas, USA

Background: Attrition 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 6 weeks after enrollment. We compared baseline characteristics among patients who returned for follow-up visit and those who dropped out of the study.

Results: 744 patients with advanced cancer were enrolled. Mean age was 57 years (range 20–90); 61.1% were female and 38.9% were male. Mean age at enrollment was 61 years. The average time between patients’ death and caregivers’ interview was 57.3 days (range 26–176). The mean burden was 2.5 (range 0–7). 71.5% reported law to arrange burden (0–6) and 5% indicated severe burden (8–10) on a numerical rating scale.

Concluding the study, 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 participate by phone (n=1). In case of immediate consent, they took part in a planned face-to-face 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%), in middle ages (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 0–7). 71.5% reported law to arrange burden (0–6) and 5% indicated severe burden (8–10) on a numerical rating scale.

Concluding the study, 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 participate by phone (n=1). In case of immediate consent, they took part in a planned face-to-face interview at the PCU or in their private home.

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

How Research Governance Challenges Ethnography in Palliative Care

Lowley LL1, Sampson EL2, Higgins P2
1UCL Division of Psychiatry, Marie Curie Palliative Care Research Department, London, United Kingdom, 2UCL Division of Psychiatry, London, United Kingdom

Presenting author email address: h.lowley@ucl.ac.uk

Context: Ethnography is a key approach in medical anthropology and sociology. It seeks to understand people’s experiences, beliefs, logics and perceptions over extended 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. As 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 within a Welsh context.

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 correspondences 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 way of conceptualising statements on 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 Rates

Stal J1, Heckel M2, Ruzsome I3, Weber M4, Ostgathe C1
1University Hospital Erlangen, Friedrich-Alexander Universität Erlangen-Nürnberg, Department of Palliative Medicine, Erlangen, Germany, 2University Hospital Erlangen, Friedrich-Alexander-Universität Erlangen-Nürnberg, Comprehensive Cancer Center, Erlangen – EAN, Erlangen, Germany, 3University Medical Center of the Johannes Gutenberg University of Mainz, Interdisciplinary Palliative Care Unit, III. Department of Medicine, Mainz, Germany

Presenting author email address: stephanie.steljk@uk-erlangen.de

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 enlarge knowledge on recruitment strategies and participation rates when inviting 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 researcher earliest 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%), in middle ages (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 0–7). 71.5% reported law to arrange burden (0–6) and 5% indicated severe burden (8–10) on a numerical rating scale.

Concluding the study, 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 participate by phone (n=1). In case of immediate consent, they took part in a planned face-to-face interview at the PCU or in their private home.

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 Integrated Palliative Care

van der Eerden M1, Hughes E2, Buss C3, Kiss V2, van Beek K1, Hasselsaar J3, Colks A4, Groot M1
1Radboud University Medical Center, Anesthesiology, Pain, Palliative Medicine, Nijmegen, Netherlands, 2International Observatory on End of Life Care, Division of Health Research, Lancaster, United Kingdom, 3Universitätsklinikum Bonn, Bonn, Germany, 4University of Pécs Medical Center, Pécs, Hungary, 5University Hospital Leuven, Leuven, Belgium, 6Radboud University Medical Center, Nijmegen, Netherlands

Background: Conducting an international, mixed methods study in integrated palliative care (IP) 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 IP 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 facilitated to communicate. 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 no material 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 compatibility. The study’s results were meaningful to the core research aims.

Conclusions: To achieve consistent and reliable results in an international IP study, a uniform core methods has to be combined with clear and frequent communication of the study aims is essential. An international platform is useful to discuss and overcome challenges faced in IP research.

Funding: EU FP7 grant #335555
Exploring of Factors Affecting Recruitment in a Longitudinal, Multicentre, Observational Study of Key Interventions Palliative Care Cancer (KiPCC)


Background: A longitudinal observational study in Romanian and Swiss (CH) cancer centres measures patients’ (pts) needs for KIPCC, perceived delivery, reported outcomes and quality indicators. Data collection consists of an interactive baseline and monthly follow-up interviews for 6 months. CH recruitment rates differ from Romanian rates.

Aim: To systematically analyse recruitment and characteristics of un-/willing pts and understand reasons for unwillingness of pts to report their palliative care needs/outcomes relevant for understanding representativeness.

Method: Review of applied recruitment processes included staff training, identifying/minimising of gate keeping and unrequired staff engagement and adaptation of pts/staff communication and recruitment scope. Independent analysis of screening logs by study nurses to identify potential systematic categories (step 1). Step 2: semi-structured interviews (SIs) with a sample of included/not included pts (20/20) and 1–2 focus groups of staff in the catchment areas.

Results: So far 1290 pts of 3 catchment areas of a CH tertiary cancer centre were screened. 230 pts were eligible (stage IV cancer, prognosis ≥ 1 month, no cognitive impairment, ECOG 1, 2 or 3). Despite all applied recruitment optimisation, S1 (22%) refused to complete the IPOS (integrated palliative outcome scale) during screening and 39 (51%) of pts with completed IPOS and criteria fulfilled refused after having received verbal study information.

Reasons for refusal in step 1 were mainly related to a) autonomy of CH pts; b) burden of symptoms/situation; c) unwillingness/self-perceived incapacity to deal with an emotional topic.

Conclusions: Despite substantial recruitment effort/improvement in CH, further research and analysis is needed to gain insight into possible systematic recruitment bias and related factors and highlight alternatives in reaching refusing pts. Funding: SNP and Romanian partners.

Volunteering

Palliative Terminal Care by Specialized Volunteers in Nursing Homes

Somsen J.

Volunteers Palliative Terminal Care Netherlands, Bunnik, Netherlands

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 carers.

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 home’s/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 organising 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 easier recognised and discussed ‘care for the carers’ who are more open about their own emotions and needs high satisfaction of residents and their families (8.8 on a 10-point scale) and staff (9.8) with the support given by the volunteers

Conclusion / lessons learned: The collaboration between specialised volunteer 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 NutsOva (NL).

Abstract number: P2-405

Abstract type: Poster

Bridging – Walking – Mapping the Activity of Palliative Care Volunteers in New South Wales

Nansen L., Hunter A.

Palliative Care New South Wales, Strawberry Hills, Australia

Background: Palliative care volunteers regularly feature in the media and in policy documents, but their nature and location remain unclear. Independent analysis of a survey of services in New South Wales (NSW).

In 2014 a detailed study of the participation and management of volunteers in palliative care services in NSW was undertaken for the first time.

Aims: The aim of the study was to map the activity of palliative care volunteers across NSW from which to develop the capacity of palliative care volunteer services and to raise public awareness of their work. This is part of a plan to develop a state-wide framework for palliative care volunteer services over the next 3 years.

Method: A total of 44 Volunteer Coordinators, clinicians and other health service staff were surveyed across 34 services mostly by telephone and face-to-face meetings using a 21 question survey which measured quantitative and qualitative data. The findings were published in October 2014.

Results: The survey found that 1,188 volunteers participated in the services with 77.4% actively involved at any given time. Volunteers are supported by 22 Volunteer Coordinator roles state wide with an average of 54 volunteers per Volunteer Coordinator. Palliative care volunteers contribute 110,400 hours per year to their services. About 63% of services involve volunteers within community settings, and 63% within inpatient settings.

Conclusion/discussion: Not all services included palliative care volunteers, raising issues of equity of access for service users.

The challenge for local health districts and policy makers is to prioritise palliative care volunteers within their service and policy groupings.

Given the emergent nature of palliative care practice there are precedents for the inclusion of palliative care volunteers and Coordinators more extensively within communities of practice at strategic, policy and operational contexts.

Abstract number: P2-407

Abstract type: Poster

Palliative Care Teams: How to Motivate Volunteers

Fern-de-Lima M.T.F.D., Coutinho M.I., Amado R.S.M.V.

‘Hospital do Divino Espírito Santo EPE, Multidisciplinary Pain Unit / Palliative Care Team, Ponta Delgada, Portugal, ‘Hospital do Divino Espírito Santo de Ponta Delgada, EPE, Multidisciplinary Pain Unit / Palliative Care Team, Ponta Delgada, Portugal, ‘Associação Seniores de São Miguel, Ponta Delgada, Portugal

Presenting author email address: mfaldeilma@gmail.com

Background: The art of adding quality to care in the last phase of life through the Volunteering is recognised by many organisations, such as Palliative Care Associations, World Health Organization. Also studies have demonstrated the job of people who humanises care of patients, families, caregivers and the personal skills, especially the communicative skills and organisational aspects.

The task force on volunteers of the European Palliative Care Association states that in some countries in Europe, volunteers have historically had a long involvement in hospice and palliative care, sometimes even started it, and will have a significant role to play in the delivery of services in the future.

Aims: The authors aim to identify the integration of volunteers in our teams and to find strategies to enhance the motivation and opportunities for the development of Volunteering in Palliative Care.

Methods: We asked about volunteers in 24 Palliative Care Teams registered in the National Association: 11 Palliative Care Units, 5 Community Support Teams, 6 Support Teams in Hospitals, 2 combined Teams.

Results: From the total of 24 teams, only 13 (54%) have volunteers: 9 Units, 3 Support Teams in Hospitals and 1 combined (Unit and Community Team). From those, 8 (62%) have specific education and 4 (31%) have education in thematic areas (communication, bereavement or oncology). The number of volunteers varies from 1 (3 teams) to 10 (1 team).

Discussion: These results ask for strategies to find more motivated volunteers, innovative organisations and education programs in Palliative Care contributing as recognised support to the well-being of patients and their families.

Conclusion: Due to the complexity and vulnerability of patients and the emotions of carers, families and the volunteers they have to deal with, Volunteering in Palliative Care calls for more reflection on personal motivation and intentions of the volunteers.

Abstract number: P2-408

Abstract type: Poster

Enabling the Voice of the User/Carer for Palliative Care Research

McIntrack S.1, Blaney P1

1University of Ulster, Belfast, United Kingdom, 2All Ireland Institute of Hospice & Palliative Care, Dublin, Ireland

Presenting author email address: s.mcintack@ulster.ac.uk

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 comprised 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 focused on: challenges; skills & knowledge and organisational aspects.

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 one-time 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.
Abstract number: P2-409
Abstract type: Poster

Development of a National Programme for Volunteering in Palliative Care

Hurdusco A1, Rigo R2, Manoel B1, Botta A1, Sass D1, Lungu D1, Janowicz A1, Mosoiu D1,6
1 Hospice Casa Sperantei, Educatie, Brasov, Romania, 2 Hospice Casa Sperantei, Bucuresti, Romania, 3 Hospice Emanuel, Oradea, Romania, 4 Casa Lumina, Bacau, Romania, 5 Like To Help Foundation, Gdansk, Poland, 6 Transylvania University Brasov, Brasov, Romania

Background: Volunteers have a unique position in palliative care (PC). By offering informal and formal care (e.g., PC teams). In Romania, volunteering is a new concept and the few volunteers in PC are mainly involved in administrative activities. Aim: To develop volunteering at national level by creating a network of volunteers coordinated by recruiting and training opinion leaders and clinical volunteers for PC services in minimum 40 communities.

Method: The project extends over two years (April 2014–April 2016) and has four stages:
1. Set up an expert group to develop curriculum for volunteers coordinators, opinion leaders and clinical volunteers in PC and to define the portfolio of the volunteer in PC services.
2. Recruitment and training volunteers’ coordinators and developing a national network of them.
3. Recruitment and training of opinion leaders that will raise awareness about volunteering in PC.
4. Recruitment and training for clinical volunteers.

Results: At present the first stage has been finalised; one expert group of seven members was set up; after presenting the project, several organisations expressed interest in being involved in the project as advisory group; a curricula with 68 hours was developed (48 face to face training and 20 hours of individual study) containing 21 topics (from legal aspects, operational procedures, PC volunteer profile to speaking with media, organising campaigns and how to talk about PC in community); four Polish PC services with expertise in volunteering visited during the one-week exchange visit in Poland; PC Volunteer Portfolio was developed; 45 volunteers coordinator have been recruited and will go through training in May 2015.

Conclusion: The project was well received, activities are in time frame, education programme and materials and selection of future volunteers’ coordinators was done, it seems the project for developing such a programme.

Cancer

Abstract number: P2-410
Abstract type: Poster

Outcome after Palliative Percutaneous Transhepatic Drainage in Malignant Biliary Obstruction

Astradsson E1, Heimdahl P-A1, Blomquist K1, Sjödlad R1
1 Palliative Education & Research Centre in the County of Östergötland, Vrinnevi Hospital, Norrköping, Sweden, 2 Regional Cancer Centre, Southeast, Sweden, 3 University Hospital of Linköping, Surgical Clinic, Linköping, Sweden, 4 Department of Experimental and Clinical Medicine, Linköping University, Linköping, Sweden

Presenting author email address: eva.astradsson@regionostergotland.se

Background: Percutaneous Transhepatic Drainage (PTD) has traditionally been used to decrease hyperbilirubinemia in malignant biliary obstruction with the aim of symptom alleviation and prolonging life. New endoscopic methods have gradually been listed as treatment options with the result that PTD nowadays often is a second choice. Still many PTDs are performed with possible benefits for some patients and possible risks for others. This study aimed to analyse the outcome of PTD in palliative care.

Method: Retrospective, structured, demographic journal review of 140 patients (75 male, 65 female, median age 70) receiving PTD at Linköping University Hospital from September 2008 until June 2013.

Results: The vast majority (126/140 patients) had a remaining PTD and in 90%, there was no documented medical information to the patient about the intervention before the PTD. For 44% the hyperbilirubinemia was the initial symptom of malignancy. 56% had a previously known cancer mostly originated from the upper gastrointestinal tract. The biliary obstruction was often intrahepatic in 16 and mixed in 60. The median value for bilirubin was 237 before and 103 after PTD. 34 of 126 (27%) suffered from itching before the intervention. Tenovus

Poster Sessions (Poster Exhibition Set 2)
Arm, two studies a worsening and nine studies stable scores. Seven studies found significant differences in pain outcomes between treatment arms. Improvement in mean pain score from baseline was examined in six studies and observed in seven. Change in weight was assessed as weight change, but few details were reported. No studies found significant differences favoring one treatment arm, and only a small number of patients gained weight from baseline. Of the four studies reporting a significant self-efficacy difference in pain scores between treatment arms, three reported of a corresponding difference in HRQoL and/or pain outcomes.

Conclusion: Chemotherapy can maintain HRQoL and improve pain control in patients with advanced pancreatic cancer. Improved survival does not come at the expense of deterioration of HRQoL or pain. Conclusions about effects on cachexia cannot be drawn.
Background: If age of cancer patients affects the quality of end-of-life (EOL) care has been insufficiently studied.

Aim: To explore age-related 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 during 2012-2016 were categorized in five age groups: 18-39 yr (G1), 40-59 yr (G2), 60-74 yr (G3), 75-84 yr (G4), 85 yr or age (G5). Odds ratios (ORs) with 95% confidence intervals were calculated as references.

Results: Young patients were more often informed about imminent death, ORs 3.85 (G1), 2.24 (G2), 1.74 (G3), 1.4 (G4), 1.25 (G5), and more likely to be offered bereavement support, ORs 4.56 (G1), 2.33 (G2), 1.6 (G3), 1.29 (G4). Prescriptions as needed (PRN) against 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). G1 had significantly more unmet needs in the ‘Information and education’ domain. Support, ORs 4.56 (G1), 2.33 (G2), 1.6 (G3), 1.29 (G4), was more frequent in young patients.

Conclusion: Age impacts on several quality aspects of EOL care for cancer patients in Sweden. The oldest group (G5) as reference.

Abstract number: P2-420
Abstract type: Poster

Phoenix RETRO: A Retrospective Study of Chemotherapy in Palliative Intent (CT) Patients with Advanced Cancer with a Reduced Performance Status (PS) on an Accredited Integrated Palliative Care (PC) Unit

Maggioni N, Blum D, Hejji D, Frueh M, Stroesser F
Kantonsstip St. Gallen, Oncology, St. Gallen, Switzerland

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 unexplored although it is a common practice.

Aims: Our aim was to analyze in a retrospective review the current practice, experiences and outcomes of CPI patients with PS2/3 at a PC unit in a tertiary centre in cancer.

Methods: Charts of cancer patients with advanced cancer (PS2/3) with newly started CPI (contacted tumours and non metastatic patients) were analyzed in the period 2011–2012. CPI Live Data: 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 strategy and result data, especially, Systematic pain assessment was done in all patients in the main groups of young patients, ORs 1.61 (G1), 1.45 (G2), 1.37 (G3). Severe pain (ORs 2.5–1.1 for G1–G4), breathlessness (OR 2.2–1.1 for G1–G4) and anxiety (OR 3.4–1.2 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 oldest group (G5) as reference.

Abstract number: P2-421
Abstract type: Poster

Renal Failure in Patients with Advanced Cancer Sent to Palliative Care

Moreno E, Allende S, Verastegui E, Danielia M, Dominguez G, Perez D
Instituto Nacional de Cancerología, Cuidados Palúticos, Distrito Federal, Mexico

It is difficult to quantify the extent of renal complications associated with malignancy because renal dysfunction may occur before to the oncology discovery, simultaneously with the diagnosis and even after the treatments used. The objective was to estimate the prevalence of renal failure in patients with advanced cancer sent to Palliative Care Service of 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. Were studied 380 patients, of which only 18% of the patients had a glomerular filtration of glomerular filtration rate 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% had a creatinine clearance and patients have hypoalbuminemia and hypalbuminemia, space by reduced intake or excessive loss and bleeding. The appropriate water management of patients can slow the progression of chronic kidney disease morbidity initial 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 Participants Study (CaNCERS)

National Cancer Institute of Singapore, Singapore, Singapore, 2Dukes University-National University of Singapore, Centre for Quantitative Medicine, Singapore, Singapore

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 treatments with intact cognition. The CNAT was administered with the help of an interviewer, to assess 7 domains of unmet need namely ‘Information education; ‘Psychological’; ‘Healthcare staff; ‘Physical symptoms;’ ‘Hospital facilities/services; ‘Spiritual/religious support’ and ‘Practical support’. Unmet need was rated as nil, mild, moderate or severe.

Results: Altogether, 173 inpatients 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) had 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. There were significant differences in the percentage of moderate or severe scores for specific CNAT domains and tumour types.

Conclusion: Significant unmet need occurs in the minority of patients with advanced cancer with Malay (minority) 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

Nwogu I, van Boeijen C, Grypdonck M, Kecke AV, Verhaeghe S
1Ghent University and Daaconessenshu Dieren, Leiden Department of Public Health, Gent, Belgium, 2Ghent University, Gent, Belgium
Presenting author email address: canierop@diaconessenhuis.nl

Background: Palliative patients may have strong hope, even hope for a cure, despite awareness of prognosis. This hope features prominently and positively affects their relations and quality of life. Healthcare practitioners hope strongly influence their hope and quality of life. The meaning of hope in palliative care patients has hardly described and understood. 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) and their relatives. Results: Palliative 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: patients hope because they cannot forsake it and because they benefit so much from it. Hope can spring from many sources and can even over time to 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 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

Nwogu I, Martinez M, Quintas C, Urroz J, de Santamaria A, Monge D, Hjermstad MJ
1Karolinska Institutet, Stockholm, 2Karolinska University Hospital, Solna, Stockholm, Sweden, 3Karolinska Institutet, Stockholm, Sweden

Purpose: To compare differences in performance status, symptom control and medication delivery between patients assisted by a PC Consultant Team (CT) and Hospice (H) patients.

Methods: We conducted a secondary analysis of the prospective data collected from the European Palliative Care Cancer Symptom study (EPCCS). Differences in performance status at admission (T1) and second evaluations (T2) after four weeks were assessed in the Karolinska Index (KPS) (Man–Whitney test), symptom control using the Edmonton Symptom Assessment System (ESAS-r) (Mann–Whitney test), medication delivery with a check-list specifically designed for this study, and the percent of patients with loss of weight ≥5% in the last 3 months (Mann–Whitney test).

Results: Patients were recruited by the CT and 58% of patients in both evaluations: T1 H group M 2 vs. CT 0 (p < 0.00), and T2: H M 2 vs. CT 0 (p < 0.001). No differences in opioid prescription.

Conclusion: Patients assisted by a CT had better performance status. Medication prescribed in H in both evaluations. T1 H group M 2 vs. CT 0 (p < 0.00), and T2: H M 2 vs. CT 0 (p < 0.001). No differences in opioid prescription.
Disparities in Hospitalized Cancer Patients Receiving Palliative Care Consultation

Smith C.B., Omotewo K., Stefanis L., Meier D.E., Morrison R.S.
Icahn School of Medicine at Mount Sinai, New York, NY, United States

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 included 166 patients receiving PC from 2 hospitals. We reviewed inpatient records to identify the presence or absence of a specialty palliative care consultation. We compared patient characteristics and inpatient outcomes of minority and non-minority patients.

Results: 181 (97%) patients received PC. Of those, 166 (86%) were minorities and 418 (72%) non-minorities. Mean days to PC was 4.4 vs. 3.2 in non-minorities and minorities, respectively (p<0.05). 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<0.05). 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<0.07), DNR completion (p<0.02), proxy assignment (p<0.22) and taking pain medications (p<0.22) when compared to non-minorities.

Conclusions: In patients with advanced cancer, minorities with worse baseline health assessments.

Poster Sessions (Poster Exhibition Set 2)
Incidence of Diabetes Induced by High-dose Glucocorticoid Treatment in Cancer Patients

Schulte H., Kristensen P.L., Engenhalm S.A., Harder E., Pedersen-Bjergaard U.1
1NorthJyllands Hospital Hillerkilde, Department of Endocrinology, Hillerkilde, Denmark, 2Rigshospitalet, Copenhagen University Hospital, Department of Oncology, Copenhagen, Denmark, 3Nordjyllands Hospital Hillerkilde, Department of Oncology & Palliation, Hillerkilde, Denmark

Abstract number: P-430
Abstract type: Poster

Incidence of Diabetes Induced by High-dose Glucocorticoid Treatment in Cancer Patients was 11.1 mmol/l (WHO criteria). Secondary endpoint is diabetes needing glucose-lowering therapy — according to local guidelines — to control plasma glucose levels. Results: Reduced AUC c from 46–87 years were 27% (p = 15–19 mmol/mol). kg/m2, daily dose of prednisone 27% (100–156 mg). A total of 27 of included were diagnosed with diabetes (41%, 95%CI 29–54%). Seven patients with diabetes (11%, 95%CI 4–21%) needed treatment with insulin. In the logistic regression analysis only HbA1c made a significant contribution to prediction. Odds ratio for needing insulin treatment for diabetes during prednisone exposure increased by 1.1 (1.2–2.0) per unit (mmol/mol) HbA1c (p = 0.08). Conclusions: Almost half of patients with MSCC undergoing radiation therapy and high-dose glucocorticoid treatment developed diabetes and one fourth of the diabetic patients needed insulin only. Only baseline HbA1c was positively associated with risk of needing antidiabetic treatment. These results underline the importance of systematic screening for glucocorticoid-induced diabetes.

Non-cancer

Dignity Therapy: A Supportive Psychological Intervention for People with Motor Neurone Disease and their Family Carers

Aoun S.M.1, Chochinov H.M.2, Kristjanson L.J.1
1Curtin University, Western Australia, Australia, 2University of Manitoba, Winnipeg, MB, Canada, 3Swinburne University of Technology, Melbourne, Australia

Abstract number: P-432
Abstract type: Poster

Dignity Therapy is a short psychotherapy intervention shown to alleviate distress for people with life-limiting illnesses.

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.

Sessions (Poster Exhibition Set 2)

14th World Congress of the European Association for Palliative Care, Copenhagen, Denmark, 8 May – 10 May 2015
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

da Silva M.G.N.1,2, Fragoso A.1,2, Rodrigues N.1,2, Pires G.1,2, Almeida J.2,2, Agostão T.2,2, Moretto P.2,2, Lawler P.3,4, Viscarra J.M.4,5, da Costa A.G.1,2

1Hospital General de Santa Maria and Mechanical Medicine 2, Lisbon, Portugal, 1APCP, Lisbon, Portugal, 2Hospital Santa Maria, Renal Department, Lisbon, Portugal, 3Hospital Santa Maria, Internal Medicine 2, Lisbon, Portugal, 4Hospital de Santa Cruz, Renal Department, 5Carneiro, Portugal, Faculy of Medicine, University of Lisbon, Visiting Professor in Dialytic Care, Lisbon, Portugal

Presenting author email address: mnjunesdaiva@gmail.com

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. 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. Data included their Karnofsky Performance Status (KPS) and Berlin Comorbidity Index (BCI).

Results: Of our study sample (N=185) 57% were male, 50% were diabetic, 47% were 75 years or older (75+), 51% were admitted to Internal Medicine wards and 35% to a Renal ward. Mean follow-up was 1265 months; 35% died, 47% during their first hospitalisation. Mortality was associated with age 75+ (p<.001), KPS<50 (p=.03), confusion and dementia (CMDS) (p=.01), ECI (p=.05), GAD (p=.05), heart failure (HF) (p=.02), coronary artery disease (CAD) (p=.25), and CKDEPI (p=.01). Mortality predictors in a Cox-regression model were: 75+ (HR 3.42, p=.003), HF (HR 1.9, p=.033); CAD (HR 1.6, p=.033); CMDS (HR 2.3, p=.003); and CKDEPI (HR 1.98, p=.001). The 75+ patients (n=11) who were referred early to hospital palliative care (HPC) and KPS<50, and met standard CM criteria benefited less with dialysis: 6 died and 1 recovered renal function.

Conclusions / Discussion: CM and KPS status were useful in predicting mortality. Dialysis use among patients with high comorbidity decreased 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

Raimakers N.L.H.1, Hofsteede J.M.1, van der Heijde L.2, Franke A.L.1, de Vre A.3, NIVEL, Netherlands Institute for Health Services Research, Utrecht, Netherlands

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 438 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=61) and with frailty (n=182) both reported more negative experiences regarding expertise of the healthcare professionals, involved in cancer care respectively OR 9.95%CI 1.8–5.29 and OR 4.59% CI 0.9–15.1. Furthermore, patients with frailty had less frequent access to a counsellor for spiritual problems compared patients with cancer (n=215), OR 5.49%CI 0.22–14.30, 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 presence of bereaved 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

Dunn R.G.1, Heijsja Y.1, Verhagen S.1, Dekhuijzen R.2, Vissers K.C.P.1, Engels Y.1

1Radiobudumc Nijmegen, Anesthesiology, Pain and Palliative Medicine, Nijmegen, Netherlands, 2Radiobudumc Nijmegen, Pulmonology, Nijmegen, Netherlands

Presenting author email address: ria.duenk@radboudumc.nl

Background: Proactive palliative care is not yet common practice for patients with COPD. Important barriers are who are at risk for 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 at risk for poor prognosis 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: The objectives of PROLONG study are:

1) to 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 indicators receive additionally regular consultations with a specialised palliative care team.

Results: The primary outcome measurement is time to 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 needs to better understand the conditions of the treatment to start 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

Eriksson H.M.1, Milberg A.1, Hjelm K.2, Axelsson B.2, Fredrichsson M.3

1Linköpings University, Department of Social and Welfare Studies, Norrköping, Sweden, 2Linköpings University, Campus Norrköping, Department of Social and Welfare Studies, Linköping, Sweden, 3Linköpings University, Department of Social and Welfare Studies, Norrköping, Sweden

Background and purpose: Stroke causes suffering in patients, but there is limited knowledge on the quality of palliative care for patients dying from stroke. The most 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 of 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 deceased 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 whether the patients in the stroke group had a 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 families 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

Freeman N.1, Le L.W.1, Zimmermann C.1, Colman R.1E, Singer L.1G, Wentlandt K.1
1Windsor Regional Hospital, Windsor, ON, Canada, 2Princess Margaret Cancer Centre, University Health Network, Toronto, ON, Canada

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 PC in the non-malignant setting.

Methods: 115 patients awaiting lung transplant were referred to the OPC team from December 1st, 2011 to March 1st, 2014. Patient demographics, diagnoses, reasons for referral to the OPC team, palliative 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 consultation and follow-up. Using paired t-tests, changes in symptom scores were assessed.

Results: 93.4% 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 (60-85) at time of consultation. 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<0.45), appetite +0.3 (P<0.4), wellbeing -0.1 (P<0.47), 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).

Conclusions: The initial consultation by the OPC team achieved significant improvements in sleep. Further investigation into the role of palliative care in the ESLD population awaiting transplant is warranted.

No official funding received.

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Abstract type: Poster

Perceptions of Healthcare Professionals Regarding the Transition to a Palliative Approach to Care in Advanced Heart Failure

Gadoua A., Chen H., MacLeod U., Johnson M.
University of Hull, Hull York Medical School, Hull, United Kingdom
Presenting author email address: amy.gadoua@hymus.ac.uk

Background: National and international consensus guidelines recommend a palliative care approach in heart failure, but this has not been widely implemented and clinicians find it hard to identify when a transition to palliative care should occur.

Aims: To explore healthcare professionals’ perceptions of decision making and communication regarding the transition to a palliative approach to care in heart failure.

Methods: [design, 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 specialty. Interactions 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.

<table>
<thead>
<tr>
<th>Cardiology</th>
<th>Primary care</th>
<th>Specialist palliative care</th>
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<tbody>
<tr>
<td>Recognition of transition to palliative care</td>
<td>‘Don’t think everyone knows the exact kind of patients’</td>
<td>‘Worries for heart failure you don’t have such a dear message from the specialist’</td>
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<tr>
<td>Comparison with cancer</td>
<td>‘You’ve diagnosed with cancer, people expect you to do the unbelievably’</td>
<td>‘It’s very streamlined, oncology, palliative, Macmillan’</td>
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<tr>
<td>Importance of integrated palliative care</td>
<td>‘If we look at the weight charts, at the blood pressures, we mess about with the drugs and do not actually deal with what the patients have a problem with’</td>
<td>‘Importance of heart failure nurses’</td>
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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 coordinate care.

No official funding received.

Abstract number: P2-442
Abstract type: Poster

Bridging Disciplinary and Professional Gaps: Psychologist as Key Worker within MND

Salsas T.1, Marín S.1, García-Baquero Merino M.T.1, Mora J.1, Quina Navas E.1, Pinedo F.1, Santos Puebla D.1, Gómez Arévalo J.1, Molina Cara C.1
1Servicio Madrileño de Salud, Coordinación Regional de Cuidados Paliativos, Madrid, Spain, 2Servicio Madrileño de Salud, Coordinación Regional de Cuidados Paliativos, Madrid, Spain.

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 patient 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 reports. Retrospective evaluation of research 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.

Abstract number: P2-443
Abstract type: Poster

Financial Implications for People Dying with Advanced Dementia in Care Homes in England

Gola A., Davis S.1, Elliott M.1, King M.B.1, Kapuli N.1, Leahey G.1, Moore K.1, Morris S.1, Nazareth I.1, Omar R.12, Sampson E.11, Jones L.1
1UCL Division of Psychiatry, Marie Curie Palliative Care Research, London, United Kingdom, 2UCL Division of Psychiatry, London, United Kingdom, 3Bamford Centre for Mental Health, Health, Wellbeing, London, United Kingdom, 4UCL, Epidemiology and Public Health, London, United Kingdom, 5UCL, Primary Care and Population Health, London, United Kingdom, 6UCL, Statistical Science, London, United Kingdom

Background: The Care Act 2014 framework enables a local authority to decide how much to charge, but this has not been widely implemented and clinicians find it hard to identify when a transition to palliative care should occur.

Aims: To explore financial dimensions of well-being among people dying with advanced dementia in care homes in England.

Methods: 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 £734 (std dev £163). In our sample of 70 residents (median age 85, 79% female, 79% White British/Irish, FAST score 7a- 7c 68%, 7d-7f 32%), almost 1/4 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 £23,250 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 wealth 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-11-1) administered in partnership with Cancer Research UK.
Poster Sessions (Poster Exhibition Set 2)

Abstract number: P2-444
Abstract type: Poster

Patient-reported Outcomes in Primary and Acute Settings in South Africa: The IMPAQ T Study

Harding E., Geyhert L.T., Da Sa A.N., Magono P.O., Selman L.T.
King's College London, Cecily Saunders Institute, Palliative Care, Policy & Rehabilitation,Brighton United Kingdom, 2University of Cape Town, Public Health & Family Medicine, Cape Town,South Africa, 3University of Cape Town, Cecily Saunders Institute, Palliative Care, Policy & Rehabilitation,London United Kingdom.

Presenting author email address: richard.harding@kcl.ac.uk

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 patients attending primary care.

Methods: Consecutive patients with stage III/IV CHF or IV COPD breathlessness were invited to participate. Each gave self-report data using the POS (Palliative Outcome Scale), with worst score=0, best=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 POS 7.1 (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 worse sharing pain, symptom and worry scores.
3) Over 4 months, there were n=662 primary care contacts, n=525 outpatients, n=567 other HCW and 2,002 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 findings multidimensional burden of 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

Hennessy C., Lawton A., Whyte B., Wallace E., Tienan E.
1St. Vincent's University Hospital, Dublin, Ireland, 2Marymount University Hospital and Hospice and Cork University Hospital, Palliative Medicine, Cork, Ireland, 3St. Vincent's University Hospital, Palliative Medicine, Dublin, Ireland, 4Our Lady of Lourdes Hospital, Louth

Health Specialist Palliative Care Services, Drogheda, Ireland

Presenting author email address: camhennessy@gmail.com

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 records and both the hospital and the SPMS’s Patient Administration System (PAS) and collated on Excel. Data was analysed using SPSS.

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<0.0000). 2012 saw a marked increase in the referral of patients with neurological conditions such as motor neurone disease, stroke and dementia, as well 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 infusion 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 accessed on the basis of need rather than diagnosis. Our service is adapting to the rising tide of referrals.

Keywords: Non-malignant, palliative medicine, referral patterns, symptoms, end-of-life care

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Abstract type: Poster

Managing Parkinson’s Disease in the Last Days of Life – A Guide for Clinicians

Jackson TA., Ahearn D.J., Bourne D., Fountain A., Pickard J., Doonan K.
1Salford Royal Foundation Trust Department of Palliative Care, Manchester, United Kingdom, 2University Hospital South Manchester, Manchester, United Kingdom, 3Royal Manchester Children’s Hospital, Manchester, United Kingdom

Presenting author email address: tim.jackson@srft.nhs.uk

Background: Current guidance for the management of Parkinson’s disease patients in the last days of life is limited, particularly with regard to pharmacological treatments when patients are unable to swallow reliably.

Aims: To produce specific guidance for symptom control and use of anti-parkinsonian medications in patients with Parkinson’s disease in the last days of life.

Approach: A literature review was undertaken for the use of anti-parkinsonian medications in the last days of life. In conjunction with this, existing regional and national UK clinical guidance was evaluated. Summary of product characteristics information was examined and local professional consensus sought. A multi-disciplinary working group including consultant physicians, specialist pharmacists and clinical nurse specialists subsequently worked to produce detailed written clinical guidance.

Results: A detailed account has been produced with guidance on the use of all common anti-parkinsonian medications in the last days of life. This includes information on dose and formulation of medications given orally or 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

Kane P.M., Margush F.E., Ryan K., McQuillan R., Higgonson L.J., Dawson B.A., on behalf of Build4CARE
1King's College Hospital, Cecily Saunders Institute, Department of Palliative Care, Policy and Rehabilitation, London, United Kingdom, 2St Francis Hospice and Mater Misericordiae University Hospital, Dublin, Ireland, 3St Francis Hospice and Beaumont Hospital, Dublin, Ireland

Presenting author email address: pauline.m.kane@kcl.ac.uk

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. Progress is difficult to predict and treatment decisions are complex. Patient-centred care (PCC) recognises the external and internal factors influencing the 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.

Aim: To identify PCC interventions and outcomes for patients with CHF.

Methods: Searches were undertaken in Medline, Embase, PsycINFO, Cinahl, Assa, the Cochrane Library, clinicalgiv, 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. Care 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 care 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

Kool B.
1RNL, Nijmegen, Netherlands

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 hospital 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 are 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

Lavello F.J.A., Murphy C., Macmillan D., Fallon M., Sattar N., Mcmurphy J.

University of Edinburgh, Edinburgh, United Kingdom, Norwegian University of Science and Technology (NTNU), Trondheim, Norway, University of Glasgow, Glasgow, United Kingdom

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 (e.g. 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 (16.2–92.9). 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=0.045), 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?

Lovell N., Elliott C., Vinen K., Thien S.J., Higgsmon L., Murtagh F.E.M.

Singly College London, Ceiety Saunders Institute, London, United Kingdom, ‘York’s College Hospital, London, United Kingdom

Presenting author email address: natalia.lovell@kcl.ac.uk

Background: There are increasing numbers of younger people living with a chronic condition. Chronic disease has been highlighted as a priority (NHS Outcomes Framework), 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 24 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.

Establishing and Addressing the Palliative Care Needs of People with Advancing Neurological Disease (AND)

DeSulian A., Weaver J.L., Rodgers M., Lynch M., Shanagher D., Keegan O.

Irish Hospice Foundation, Dublin, Ireland, ‘Welf Research Associates, Dublin, Ireland, Neurological Alliance of Ireland, Dublin, Ireland

Background: Within Ireland, there is a lack of consensus and direction with regard to the palliative care needs of people with AND. Staff members and volunteers of organisations that are members of a neurological umbrella organisation informed this study. The population total was fourteen.

Aims: This study aims to:
  i) Investigate neurological organisations’ understanding of palliative care.
  ii) Investigate how organisations identify and respond to the palliative care needs of their members.
  iii) Provide a greater understanding of the palliative care needs of people with AND.
  iv) Give direction to the supports, resources and developments required to respond to needs identified.

Methods: A literature review and a series of qualitative interviews were carried out. Interviews were recorded and analysed using NVivo to identify themes.

Results: i) The literature review and interviews identified that ambiguity exists around the terminology of palliative care. Palliative care is primarily associated with specialist services.
  ii) The following issues arise for organisations:
    • Difficulty accessing palliative services.
    • Uncertainty when palliative care begins.
    • Planning Ahead.
    • The requirement for training.

Conclusion: Collaboration among all stakeholders is required to ensure the palliative care needs of those with AND are adequately addressed.
Deactivation of an Implantable Cardioverter Defibrillator (ICD) – How Do Professionals Decide?

HAW L.M.1, McClellan S.J.1, Taylor B.J.2, Dixon L.3, Cole B.R.4, Fizemore D.4

1University of Ulster at Jordanstown, Institute of Nursing and Health Research, Belfast, United Kingdom, 2British Heart Foundation, Social Care Trust, Cardiology, Belfast, United Kingdom, 3University of Ulster/AlIreland Institute of Hospice and Palliative Care, Institute of Nursing and Health Research, Belfast, United Kingdom, 4University of Ulster at Jordanstown, Social Work, Belfast, United Kingdom

Background: The therapeutic benefit of an Implantable Cardioverter 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. Aims: 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 14 professionals (8 cardiologists, 3 palliative care nurses, a pharmacist, a psychologist and an ICD specialist) in 7 data. Data were combined to identify and conceptualise factors affecting decision making

Results: Nine factors (italics) 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 data showed that many patients were reluctant to engage in a discussion through-out their illness until at death/death (49 year female). Frequent shocks prompted patients to consider deactivation and was viewed by professionals as indicative of a discussion. Professionals mentioned number of hospital admissions as a sign of clinical deterioration Ethical and legal considerations dominated in clarifying treatment intent. Patients felt ill-equipped i.e. ‘Woame 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 (e-morbidity) they were less likely to engage in a discussion.

Conclusion: It is 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

Moussa C.A.1, Timm H.2, Kirkvold M.3, Lomborg K.4

1Aarhus University, Department of Public Health, Section for Nursing, Aarhus C, Denmark, 2School of Health Sciences, VIA University College, Randers School of Nursing, Randers, Denmark, 3University of Southern Denmark, PNAV – Knowledge Centre for Rehabilitation and Palliative Care for People with Lung disease, Naestervig, Denmark, 4University of Oslo, Institute of Health and Society, Department of Nursing Science, Oslo, Norway, 5Aarhus University, Department of Clinical Medicine, Aarhus, Denmark

Background: Patients with chronic obstructive pulmonary disease (COPD) are under-served in the primary sector and receive less palliative care than patients with other diseases with comparable symptoms and prognoses.

Aims: 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 homecare districts in Denmark and the interviews were analysed descriptively. Five major questions were discussed during the interviews: i) what is palliation and who needs palliative care; what are the challenges for professionals 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

Nobal M1, Palomar C.2, Aguila M.2, Michons B.2, Caroll L.1, Trujillo L.1

1Hospital Universitario Amaro de Vilanova, Palliative Care Team, Lleida, Spain, 2Hospital Universitario Amaro de Vilanova, Pneumology, Lleida, Spain, 3Hospital Universitario Arnau de Vilanova, Palliative Care Team, Lleida, Spain, 4Hospital Universitario Amaro de Vilanova, Intensive Care Team, Lleida, Spain

Aims: To determine the feasibility of embedding PM consults in the HD unit during HD runs.

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. Medical records were reviewed for documentation of advance directive status, advance directive discussion and time after PM intervention. Pre and post analysis was done using McNemar’s test.

Results: 10 patients were eligible. 91 patients attending the outpatient COPD clinic were alive. They were unable to take part after informed consent. Two independent blind assessments were done by pneumologists and palliative care physicians. At the COPD clinic, a part from the routine Global Respiratory Assessment including BOLB, BODE index was 3.94 (p>0,01). BODE index more than 5 can identify patients needing palliative care and helps in the decision making.

Conclusion: BODE Index can be used by pneumologists to refer patients to palliative care teams.
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

Beatty S., O’Riordan J., Martugghia C., Mannion E.
Galway Hospice Foundation, Palliative Medicine, Galway, Ireland, *Galway Hospice Foundation, Galway, Ireland*

Background: Dementia is a progressive degenerative disorder causing severe cognitive impairment, behavioral disturbances, and loss of ability to perform activities of daily living. The median survival time from onset of dementia to death is 4-15 years for men and 4-12 years for women. Survival data does not correspond to < 90 yrs. Nausea, infections, and eating problems are the most common causes of death. Awareness of palliative care needs in these patients lead to the EAPC white paper on Dementia.

Methods: Purposeful sampling employed for retrospective chart review of patients with end stage dementia (2010-2012). 11 domains identified by the EAPC paper used as gold standard for comparison.

Results: 23 cases reviewed from 2010-2012, average age 84yrs; median PPS 30(10–60); 91% patient’s non-home care. 52% in nursing homes at admission. EoL/EoL care 17days (1–117days). 78% patients died. Each EAPC domain was assessed and data recorded. Patients presenting at end of life with multimorbidity and increased symptom burden. On review, clear evidence of targeted symptom control, holistic approach, family involvement as proxy decision makers, equitable access. Key targets for development include the inclusion of validated assessment tools to aid prognostication), improved liaison with psychiatry and gerontology, proactive care planning to address patient preference for place of care, nutrition and transfers, and increased education for staff within the unit.

Conclusions: Dementia is a debilitating terminal illness with features demanding a tailored approach to effective and proactive care provision. The EAPC paper provides a framework on which to build effective and proactive practice. A clinical practice guideline incorporating validated assessment tools was developed to guide palliative care provision to patients with dementia.

Abstract number: P2-459
Abstract type: Poster

Dying in Nursing Homes: A Focus Group Study Exploring Health Care Professionals’ Attitudes

Bükki J.1, Pölz P.1
1Hospice Care DaSein, München, Germany, 2Paracelsus Medical University, Endowed Professorship for Interdisciplinary Research in Palliative Care, Institute of Nursing Science and Practice, Salzburg, Austria, *Munich University Hospital, Spiritual Care, München, Germany*

Background: While palliative and end of life (EoL) care needs of nursing home residents are widely acknowledged, little is known about health care professionals (HCPs) views, concerns, and specific requirements regarding EoL care in these facilities. The aim of this study was to explore factors and barriers that possibly interfere with providing palliative care.

Methods: In a German 300-bed nursing home, 3 focus group interviews were performed with the following pre-defined groups:

(A) nurses/nurse aides, (B) nursing managers, and (C) physicians. Participants were recruited by a trained palliative care facilitator.

The group discussions were audiotaped, transcribed, and analysed for relevant themes.

Results: There were 10 participants in group (A), 9 in (B), and 3 in (C). Common themes emerging were: lack of training, and resources limiting appropriate EoL care, dissatisfaction with communication (both among HCPs and with families), high motivation to provide good EoL care, responsibility for residents until death, high confidence and familiarity with EoL care, usefulness of defining a palliative care phase, existential questions, and lack of team support measures such as supervision. Group-specific themes were: experience of being discouraged by management (A), ‘giving life to palliative/EoL care, benefits of a mobile palliative care team (B), legal concerns regarding decision making, and limited benefit of a mobile palliative care team (C).

Conclusions: Despite numerous existing guidelines that regulate EoL care in long term care facilities, various issues related to structure and process have to be addressed. HCPs needs may differ among professions. Common terminology regarding palliative/EoL care and feasible criteria that trigger palliative care interventions should be adopted.

Abstract number: P2-460
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ZULIDAD – Zurich Life and Death with Advanced Dementia Study

Eicher S.1,2, Theill N.1, Geschwindner H.3, Bieri G.3,4, Wettstein A.1, Martin M.1,2, Hock C.5, Wolf H.5,6, Riese F.5
1University of Zurich, Center for Gerontology, Zürich, Switzerland, 2University of Zurich, Research Priority Program Dynamics of Healthy Aging, Zürich, Switzerland, 3Pflegenzentren der Stadt Zürich, Zürich, Switzerland, 4Städtische Gesundheitsdienste Zürich, Zürich, Switzerland, 5University of Zurich, Division of Psychiatry Research and Psychogeriatric Medicine, Zürich, Switzerland, 6German Center for Neurodegenerative Diseases, Bonn, Germany

Background: Due to the ageing of the Swiss population dementia is an increasing challenge for both individuals and the health care system in general. However, key questions in the health care delivery for patients suffering from dementia, many of which live and die in nursing homes, remain unanswered.

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-MDS), ZULIDAD-A prospectively collects health status and mortality data from residents (n=20‘000+) of several hundred nursing homes in Switzerland. ZULIDAD-B is an in-depth prospective study of nursing home residents with advanced dementia (n=1500) 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 consists 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/ discussion: 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.

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Bridges to Advance Directives – Readiness to Sign, among the Elderly

Ein-Gill S.1,2, Shvartman P.1
1Ben-Gurion University of the Negev, Community Health, Beer Sheva, Israel, *Funding: The Israel National Institute for Health Policy Research (NIPH), Tel Aviv, Israel*

Background: In the 2005 the Israeli 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 withdrawal of treatment, when faced with a life-threatening condition.

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). 336 subjects (mean age 79.2 SD 8.9, 78.5% females) filled in validated questionnaires that included socio-demographic factors, knowledge, attitudes, choice of treatment and quality of life.

Results: 1. 126 (37.2%) 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: 3.3, p=0.01), previous discussion of subject (OR: 1.49, p=0.002), arguments for signing (OR: 2.42, p<0.001) and arguments against (OR: 0.245, p<0.001). 3. 60.6%–81% wanted to forgo life-saving treatments and invasive therapies, while only 17.7%–44% wanted to forgo palliative treatments during terminal stages. The factors predicting the avoidance of fluid and nutrition drip feed: actual signing of AD (OR: 2.1, p=0.002), arguments for signing (OR: 1.59, p=0.002) and arguments against (OR: 0.608, p<0.001). 4. 51.7% decide for themselves to fill AD forms, while only 24.1% thought that health care professionals could influence them.

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 conversations 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.
Predictors of Tube Feeding in End Stage Dementia, in European Long Term Care Facilities

Finne-Sørensen U.H.1, Nara A.2, Szczerbicka K.1, Onder G.1, Bembenek R.1, Topinkova E.1, Andreasen P.1, Gindt J.1, van Houw M.H.1, SHELF 7th Floor work

Background: Tube feeding causes discomfort but does not prevent aspiration, prolonging life, or improve nutritional status, in patients with end stage dementia. Aim of this study is to investigate occurrence and predictors of tube feeding (TF) in end stage dementia in long term care facilities (LTCFs).

Methods: Data originates from the EU-funded SHELTER database, collected from 59 LTCFs, in 7 European countries, from 2009-2011. The assessment was performed by trained nurses using interRAI-LTCF form (www.interRAI.org). Multiple X²-tests, and logistic regression analyses were performed to find out the independent predictors of TF.

Results: Of the 4156 LTCF residents, 701 individuals were 65 years or older and fulfilled the criteria for end stage dementia: diagnosis of dementia, severe cognitive impairment (Cognitive Performance Scale 5–6), and dependent or fully dependent in ADLs (ADL hierarchy Scale 5–6). Mean age of these residents was 86.1 years (65–110), and 88.7% were female. Forty eight residents had either nasogastric tube or PEG (6.9%). In three countries, there were no tubes found. In the logistic regression analysis, female sex (OR 3.95% CI 1.28–11.7), difficulties with secretions in airways (OR 3.5 95%CI 1.64–7.62), afasia (OR 2.9 95% CI 1.41–6.06) and stroke (OR 2.8 95%CI 1.38–4.93), and presence of end stage dementia were independent predictors for TF. Of the care procedures only number of physician's visits (OR 2.5 95% CI 1.2–5.45) and positioning/turning program (OR 8.3 95% CI 3.34–20.1) were significant, when country of residence had been taken into account.

Conclusion: Tube feeding seems not to be prevalent, in end stage dementia, in Europe. However local differences may exist.

Abstract number: P2-464
Abstract type: Poster
Self-management Support Interventions for Informal Caregivers of People with Dementia: A Systematic Meta Review

Huys in het Veld J.1, Verkaik R.2, Mistjon P.1, van Meijel B.1, Francke A.1

Background: Dementia is a life-threatening disease, requiring a palliative care approach where supporting informal caregivers in managing the symptoms and problems related to the dementia should be part of. However, it is not clear which self-management support interventions are most effective. Aim: To synthesise evidence from previous systematic reviews on self-management support interventions for informal caregivers of persons with dementia.

Methods: This systematic meta-review followed the PRISMA Statement. Searches were conducted in PubMed, CINAHL, Cochrane Library, Embase and PsychINFO. 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 classification of self-management, covering 5 intervention targets: (1) relationship with family, (2) maintaining an active lifestyle, (3) psychological wellbeing, (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 on the 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 well-being, 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.

Abstract number: 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

Froggatt K.1, Finne-Sørensen U.H.1, Morbay H.2, Payne S.1, Szczerbicka K.1, Van den Noortgate N.1, Van den Block L.3

Background: Older people are increasingly dying in long term care facilities (LTCFs) due to aging populations and growth in non-cancer causes of death. Palliative care (PC) is well organised in many countries and provision diverse, but PC in LTCFs is a recent development. Comparing the effectiveness of Palliative Care for Elderly people in LTCFs in Europe (PACE) is an international study on the state of current provision. Aim: To map provision of PC in LTCFs in Europe.

Methods: Extending an earlier LTCF EAPC 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 identified and key common 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/organisational level initiatives in Central and Eastern European countries. Relevant national policy level PC developments are reported, with limited focus on LTCF. Interventions across Europe are 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.

Conclusion: 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.

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Inter-disciplinary Perspectives on Palliative Care Provision for Older People: Barriers and Facilitators

Froggatt K.1, Albers G.2, Pautex S.3, Nele Van den Noortgate N.4, Van den Berghe P.2, Van den Block L.1, Gambassi G.1

Lancaster University, Lancaster, United Kingdom, 2Federation of Palliative Care Flanders, Vilvoorde, Belgium, 3Hôpitaux Universitaires de Genève, Geneva, Switzerland, 4Université Ziekenhuis, Ghent, Belgium, 5Vrije Universiteit Brussel, Brussels, Belgium, 6Università Cattolica del Sacro Cuore, Rome, Italy

Abstract type: Poster
Qualitative Study on the Perception of Hospice Nurses in Relation to the Palliative Sedation in Adult Cancer Patients

Gognola A

Università degli Studi di Milano, Cernusco sul Naviglio, Italy

Background: In September 2013, the Marzouza Foundation, EAPC, and the EUSOMA 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. Aim: To identify: (1) collaboration between palliative care and geriatric care and (2) barriers and facilitators to on-going collaboration.

Methods: A descriptive exploratory study was undertaken. Four discussion groups were held in two groups at each organisation’s annual conference. Analysis was undertaken using a 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.
How Do Older People with Incurable Cancer Experience Daily Living? A Qualitative Study in Norway

Kjersti Haug S.L., Danbolt L.L., Krige K.G.1,2, Delmarinis V.1 1Inlandet Hospital Trust and MF – The Norwegian School of Theology, Center for Psychology of Religion, Oslo Metropolitan University College, Institute of Nursing and Mental Health, Department of Public Health, Elverum, Norway, 2Ynesa University College, Institute for Nursing Education, Elverum, Norway, IMPACT Research Program, Public Mental Health Promotion, Upplåsa University, Inlandet Hospital Trust, Center for Psychology of Religion, Uppsala, Sweden

Presenting author email address: snyderhelene@kjorven.haug@nyheuslet.inlandnet.no

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Abstract type: Poster

Background: In Western countries, an increasing proportion of patients in specialised healthcare contexts are older people living with incurable cancer as a chronic disease, requiring palliative care for shorter or longer periods of time. The aim of our study was to describe how they experience daily living while receiving palliative care in specialised healthcare contexts.

Methods: Qualitative research study with a phenomenological approach called ‘systematic text-conditional’. Twenty-one participants, 12 men and nine women aged 70–88, were interviewed with a semi-structured guide. They were recruited from two somatic hospitals in southeastern Norway.

Results: The participants experienced a strong link to life in terms of four subthemes: to acknowledge the need for close relationships; to maintain activities of normal daily life; to provide space for existential meaning-making; and, to name and handle decline and loss. They also experienced that specialised healthcare contexts strengthened the link to life by providing person-centred palliative care.

Conclusion: Discussions: The main finding demonstrates that older people both had a wish and an ability to continue with life-oriented daily living. Though a central subtheme in itself, existential meaning-making was seen as an enriching process for older people. Insights into these processes are seen as useful in order to increase the understanding of how older people adapt to adversities, and how their responses may help to protect them from some of the difficulties in aging. Healthcare professionals can make use of this information in treatment planning and for the identification of psychosocial and sociocultural resources to support older people and to strengthen the person’s own life resources.

When Influences the Transfer of Nursing Home Residents to Emergency Service during their Inpatient Stay in an Acute Hospital Setting

Møs S.1,2, Erenbra H.1,2, Øhlandtuneng E.1,2, Wallace E.1,2, O’Gorman A.1,2 1Royal College of Physicians of Ireland, Dublin, Ireland, 2Our Lady of Lourdes Hospital, Drogheda, Ireland

Presenting author email address: siboma@rcpi.ie

Background: Optimisation of quality of life for patients with advanced life-limiting illnesses is a key goal of specialist palliative care. Hospitalisations of nursing home (NH) residents can be associated with deterioration in quality of life. We reviewed the number of NH residents referred to the hospital specialist palliative medicine service (SPMS) with an established plan of care.

Methods: The palliative care database was used to identify all NH patients referred to the SPMS from June–September 2013. Data collected from patients’ medical records included: reason for admission, source of referral, readmission within 30 days, length of admission, reason for SPMS referral and established ceiling of care. Data was analysed using Excel. Results: 22 patients were available for analysis. 20 (91%) had a non-malignant diagnosis and respiratory infection was the main reason for admission in 11 (55%). No patients had a care plan for discharge. Discussion: End of life (EOL) care was the primary reason for referral to the SPMS in 10 (46%). 14 (63%) residents were referred to hospital by nursing staff in the NH. 9 (41%) were readmitted within a 30 days. Mean length of stay was 13 days (range 1–33). Seven (32%) referrals died in hospital, which included 4 (9%) of the 46 referrals readmitted within 30 days. Of the 15 referrals subsequently discharged back to the NH, 6 (40%) had a ceiling of care established.

Conclusion: Plans and ceilings of care are essential in optimising patient comfort towards EOL and may help decrease unnecessary hospital admissions. Communication regarding the discussions with doctors, patient/family, NH staff and GP is essential. Our service is adapting to strengthen links and provide increased support to NH staff and GPs in providing high quality EOL care in the NH setting.

What Influences the Transfer of Nursing Home Residents to Emergency Service during their Inpatient Stay in an Acute Hospital Setting

Møs S.1,2, Erenbra H.1,2, Øhlandtuneng E.1,2, Wallace E.1,2, O’Gorman A.1,2 1Royal College of Physicians of Ireland, Dublin, Ireland, 2Our Lady of Lourdes Hospital, Drogheda, Ireland

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Breast Cancer Survivors Aged 60 and Older with Dragonboat Paddling

Posner M.M. 1Institute for Palliative & Hospice Training, Inc, Alexandria, VA, United States

Presenting author email address: posner@comcast.net

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 % of the survey respondents.

AIMS: The goal of this study was to have the breast cancer survivor 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 submission of information in this survey and creating a private, individual data record. The only identifying data collected was a birth date.

Results: Women 60–66 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, 83%.

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 all ages support each other to deal with challenges of life after cancer; illustrating the potential of dragonboating as a beneficial support program.

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

Penders W.W.A.1,2, Van den Block L.1,2, Donker G.A.1,2, Deibens L.1,2, Ouwateko-Philippens B.1,2, EUROMORT, 1Vrije Universiteit Brussel (VUB) & Ghent University, Family Medicine and Chronic Care, Brussels, Belgium, 2Netherlands Institute for Health Services Research, MIVEL, Primary Care Database – Sentinel Practises, University Medical Center, Medical Oncology, Ghent, Belgium, VU University Medical Center, EMGO Institute for Health and Care Research, Amsterdam, Netherlands

Presenting author email address: w.w.a.penders@vub.ac.be

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 (58% versus 53%, odds ratio=2.8, 95% CI=1.4–5.1). Those living at home experienced transfers between care settings more often (odds ratio=2.8, 95% CI=1.4–5.1) as well as hospitalisation in the last three months of life (odds ratio=2.9, London CI=1.0–6.1) were more likely to die in hospital (odds ratio=1.3, 95% CI=1.0–1.6) than those in a residential home.

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.

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Hospice and Palliative Care in Long Term Care Settings: The Relatives’ Perceptions of Sustainability

Reitinger E., Homert K., Schuchter P.
Alpen Adria University of Klagenfurt, IFF - Palliative Care and Organizational Ethics, Vienna, Austria

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 German speaking countries with high commitment during the past 15 years. Therefore it is necessary to find out factors supporting the sustainability of these projects.

Aims: The aim 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 settings varied concerning place, provider organisation and composition of participants. Analysis of data was process 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 ‘in between’ living and dying 2) 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

End of Life Care in Advanced Dementia – Choice or Necessity?

Sampson E.L., Fordham University, New York, NY, United States, 2Memorial Sloan Kettering Cancer Center, New York, NY, United States

Method: A qualitative methodology was used. Two workshops (WS) were held. WS1: 5 people with early dementia who retained capacity, MMSE>19, 2 male/3 female, age 76-91 years, living at home supported by family. WS2: 5 family carers, 1 male/4 female, all children of people with early dementia resident in a care home. Workshops were facilitated by a researcher following a topic guide; an observer took detailed notes. Data analysis followed a grounded theory approach. Themes were developed iteratively and inductively.

Results: WS1: Participants preferred to receive care in their own home. Two had initiated power of attorney documents and had limited discussions with family members regarding future care. None had made advance care plans, all expressed confusion as to the meaning of these documents. Responses suggested discussion about future care preferences are unlikely to occur without focused support.

WS2: All family carers had tried to support their relative at home but reported that care home admission had been a necessary due to concerns regarding unsafe behaviours. They described feelings of relief on care home placement. Experiences within care homes were mixed but all expressed concern about a perceived lack of staff training and ability to manage symptoms of advanced dementia or end of life care needs.

Conclusion: People with dementia while they retain capacity may be unlikely to choose or plan for support in a care home. However, despite family support, in advanced dementia placement within a care home may be a necessary due to needs that cannot be safely met in their own home.

Depression and Neuropsychological Functioning in Inpatient Palliative Cancer Care

Spencer L.1, Kolbe E.1, Rosenfeld B.2,3
1Foamham University, New York, NY, United States, 2Memorial Sloan Kettering Cancer Center, New York, NY, United States
Presenting author email address: rjames11@fordham.edu

Cognitive functioning and mood disturbances have been closely linked across settings. 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. Participants included 55 terminally ill cancer patients and 50 community-dwelling adults (age 50-89). Subjects completed a series of NP tests and the Hospital Anxiety and Depression Scale (HADS). Standard scores across 8 NP tests were collapsed into 4 NP indices: Processing Speed (PS), Verbal Learning (VL), Executive Functioning (EF), and Verbal Fluency (VF). Statistical analyses explored the relationship between NP domains and depression and anxiety, and differences by setting.

As expected, inpatients performed significantly worse on all NP domains and were more depressed than community-dwelling participants. However, while EF and VF were significantly correlated with depression in controls, there were no significant associations between NP functioning and anxiety or depression in inpatients. In a regression accounting for basic demographics, only EF was a significant predictor of depression. Results were consistent even when looking only within controls. Inpatients had more depression and more significant cognitive impairment than community-dwelling older adults. Levels of anxiety were equal across groups. However, the relationship typically observed in controls between anxiety and depression was not observed. Possible explanations include the impact of pain management, as most inpatients were actively receiving pain medications that might impact cognition and/or mood. Similarly, we were not able to control for cancer treatment history and therefore the relationship between cognition and mood might have been altered due to treatment side effects.

Hospice and Palliative Care in Nursing Homes – Transfer to Hungary

Pissarek A.H.1, Schaffer J.2
1Hospiz Austria, Wien, Austria, 2Hungarian Hospice-Palliative Association, Budapest, Hungary

Background: Many residents of nursing homes suffer from multiple terminal illnesses, many suffer from dementia. As a result an expertise in hospice and palliative care is highly required on all levels.

Aims and questions: Hospice Austria has started a successful project to integrate hospice and palliative care to nursing homes in 2006. The main question was how to transfer this expertise to Hungary.

Methods: Hospice Austria presented the three key elements of the Austrian project (guidelines for quality of palliative care in nursing homes, a model organisational development process, a 36hrs curriculum in Palliative Geriatrics) to the Hungarian team of an EC funded project called Nazzres. In cooperation with the Hungarian Association of Hospice and Palliative Care and the local project team the guidelines and the organisational development process were adapted to the Hungarian conditions. The trainer workshops introduced Hungarian professionals to this organisational development and the special curriculum.

Results: The cooperation shifted the attitude concerning PC in the Hungarian social sphere: 2 Hungarian model homes in Zalaegerszeg realised the integration of hospice and palliative care. They focus now on symptom therapy, consult PC providers, improved the communication with patients and relatives and created memorial ceremonies. 4 other nursing home intend to start.

Free social section in the XI. HHPA Congress with 50 participants.

Education:
Train the trainer workshops (see above)
4 National HP workshops in nursing homes and hospitals (50 participants)
2 HP courses of 40 hrs with 16 social workers from nursing homes, accredited for 3 yrs.
Conclusions: The Austro-Hungarian cooperation initiated a dialogue between PC and the social sphere, between nursing homes and PC providers, thus improving the care for residents, their families and supporting carers. It proved equally essential to have an advisory board with all relevant policymakers and to cultivate networking.
Researching Non-kin-Care Relationships in End-of-Life care – Methodological Challenges

Woolley P.1, Pechenger S.2
1UMIT Health & Life Sciences University, Institute of Nursing Science, Vienna, Austria, 2Paracelsus Medical University Salzburg, Institute of Nursing Science and Practice, Salzburg, Austria

Abstract withdrawn

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 individuals’ 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 worthwhile to be discussed.

Method: A qualitative design included narrative interviews in retrospect with non-kin-carers (n=15) 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.

Palliative care in children and adolescents

The Experience of Teenagers and Young Adults (TYAs) Having Cancer Treatment in an Adult Setting: A Systematic Review of the Literature

Marshall S., King’s College Hospital, Palliative Care, London, United Kingdom
Presenting author email address: steven.marshall3@nhs.net

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 should be treated on specialist adolescent units, of which there are now 27 in the UK. These units are intended 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 upon strict eligibility criteria, 14 studies (4 qualitative, 9 quantitative 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/clinical 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.
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Specialized Paediatric Palliative Home Care in Germany – Different Models of Service Provision  
Kremel Ke,1, Sander A,2, Mainzer K,3, Weikand R,3, Reinhardt D.1,4  
1Netzwerk für die Versorgung schwerkranker Kinder und Jugendlicher e.V, Hannover, Germany; 2Hannover Medical School, Paediatric Haematology and Oncology, Hannover, Germany; 3KinderPacT-Hamburg e.V., Hamburg, Germany; 4Clinic for Pediatrics III, Essen University Hospital, Paediatric Haematology and Oncology, Essen, Germany  
Presenting author email address: kremelke@kmh-hannover.de  
Background and aims: Since 2007, the children's right to specialised paediatric palliative home 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, 25 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) 3 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) 1200 km²; 3) 5,000 km².  
Number of patients (2012 & 2013): 1) 60 + 66; 2) 50 + 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.

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Creativity Required – Apply within Evaluation in a Children’s Hospice  
Shirvian M1, Stewart L2, Blain A1, Scott R,3  
1university of the highlands and Islands, Inverness, United Kingdom, 2children’s hospice association scotland, robin house children’s hospice, balloch, united kingdom, 3children’s hospice association scotland, rachel house children’s hospice, kinross, united kingdom  
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: the 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.  
The 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, embodied 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.  
The 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 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.

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Bridging the Gap for Young People in Transition between Children’s and Adults Services  
Studley D,1, Chambers L.J.2  
1Together for Short Lives, Transition Taskforce, Bristol, United Kingdom, 2A 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 ‘push’ 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 and 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 individual child; and, Individually, to work with young people to listen to their views and to ensure that young persons’ centred approaches 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.

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Development and Validation of the APCA African Children's Palliative Outcome Scale (C-POS)  
Namasango E1, Alteno M1, Powell R.A2, Ali Z1, Marston J1, Meiring M1, Kasture I1, Harding R1,2  
1African Palliative Care Association, Kampala, Uganda, 2Global Health Researcher, Nairobi, Kenya, Kenyan Hospice and Palliative Care Association, Nairobi, Kenya, International Children’s Palliative Care Network, Bloemfontein, South Africa, 3University of Cape Town, Department of Paediatrics and Family Medicine, Cape Town, South Africa, 4Mildmay Uganda, Kampala, Uganda, 5Cicely Saunders Institute, King’s College London, London, United Kingdom, 6Makere University, Kampala, Uganda  
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.  
Aims: 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 & proxy). 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 and reliable tool & its development is an important step forward in the measurement of outcomes in children's palliative care.
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