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SUPPORTIVE CARE OF ORAL MUCOSITIS IN HAEMATOLOGY PATIENTS: SERVICE EVALUATION AND IMPROVEMENT PROJECT

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In haematological malignancy high dose chemotherapy or bone marrow transplant commonly cause oropharyngeal mucositis. At Sheffield Teaching Hospitals NHS Foundation Trust (STH) there is joint working between palliative care (PCT) and haematology to manage these patients. The aim was to evaluate the service, implement improvements and re-evaluate.

Initial evaluation was performed against the STH Standard Operating Procedures (SOP) for haematology patients suffering with mucositis and referred to PCT. Convenience sampling was used and data collected between April-October 2015. Case notes of 19 patients referred to PCT with mucositis were reviewed. The SOP recommends referral to PCT if third line interventions fail. The results of the initial evaluation showed that most patients, 18 and 17 patients respectively, had antacid-oxceitacaine and lidocaine mouthwashes prescribed. Only 1 (5%) had the treatment fully optimised; i.e. alternating four hourly and to swallow. Fifteen patients (79%) were referred to PCT before completing third line treatment without systemic treatment with opioid being initiated.

Intervention An education programme and simple flowchart for prescribing was developed with a new SOP.

Final evaluation was performed on the next 11 sequential haematology patients with mucositis from February-April 2016. All patients had the mouthwashes prescribed with appropriate frequency and route. Six patients required systemic PRN or regular opioids. Four patients (67%) had PRN opioids prescribed appropriately. All transdermal patches (buprenorphine or fentanyl) were prescribed and titrated appropriately. One patient (9%) was referred to PCT team earlier than the flowchart recommended compared to 79% previously. A survey of staff reported increased confidence with prescribing and improvement in patient experience, with PCT only reviewing those with specialist needs.

Conclusion This service evaluation and improvement project has enhanced prescribing and the confidence of haematology team in managing those with mucositis.

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A SURVEY OF JUNIOR DOCTORS' CONFIDENCE IN PROVIDING END OF LIFE CARE

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Background Palliative care is increasingly incorporated into undergraduate curriculums in UK medical schools. Training needs of junior doctors who frequently provide care for dying patients, however, are less well elucidated.

Aim We set out to assess junior doctors' confidence in various areas of End of Life Care in order to identify specific training needs.

Method We adapted the University College London Hospital Care of the Dying Confidence Questionnaire to focus on areas of End of Life Care relevant to junior doctors. We distributed

a paper and online version of this questionnaire to trainees in acute, surgical and medical specialties at the Royal Free NHS Foundation Trust. The statistical significance of the difference between Likert scale medians was determined by Kruskal-Wallis tests.

Results We received 95 survey responses from doctors in foundation (71%), core (19%) and specialty registrar (10%) training years. Unsurprisingly, higher training grade was associated with increased confidence in providing End of Life Care, in particular in discussing dying and ceiling of care with patients and their family members. All trainees were confident (Likert median=6) in verifying death and writing death certificates. Trainees reported low confidence (Likert median=4) in discussing the discontinuation of nutrition and hydration as well as in caring for a dying patient who becomes unconscious.

Conclusion Junior doctors are confident in skills routinely taught and tested during medical school. There remains a need for additional End of Life Care training, in particular for foundation trainees. To optimise the End of Life Care provided by junior doctors this training should focus on areas of low confidence such as discussing nutrition and hydration.

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THE PERSONAL, PROFESSIONAL AND INSTITUTIONAL IMPACT OF BEING A MENTOR TO A PALLIATIVE CARE TEAM IN A LOW-INCOME COUNTRY

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Background Global access to palliative care is improving but inadequate. In 2011, only 58% of countries had one or more palliative care service. Palliative care expertise and successful service models exist in low-income countries but the scale of demand indicates a role for additional international support to aid service expansion and training. Global health partnerships aim for mutual benefits; research shows that international health volunteering benefits volunteers and employers by developing professional and leadership skills. Health-related mentorship research in higher-income countries recognises wide-ranging benefits to mentors themselves. Less is known regarding the professional and institutional impacts of short-term international mentoring or if being a mentor in a low-income country offers transferable benefits for UK palliative care.

Aim To ascertain the personal and professional impact of being a mentor to a palliative care team based in a low-income country and identify transferable benefits for UK healthcare institutions.

Method UK-employed, palliative care clinicians: four consultants, two specialty trainees, and a nurse, were recruited from an international palliative care initiative incorporating mentorship. Semi-structured telephone interviews were recorded and analysed using interpretive phenomenological analysis.

Results All mentors described positive personal, professional and institutional impacts of international mentorship, whilst acknowledging the need to address challenges and complex emotions. Personal impact stemmed from exploring one's own value: fulfilling a humanitarian drive, working through challenges and rationalising lived experiences. Professional impacts resulted from experiential learning regarding management, leadership and mentoring; stimulating reflection on own UK

practice; and renewing holistic perspective. Perceived institutional impacts occurred through mentors' professional development influencing both their approach to patient care and supporting colleagues.

Conclusions Being a palliative care mentor in a low-income country provides unique opportunities for personal and professional development benefiting individual clinicians and potentially, UK institutions. Identified benefits outweigh negative impacts. Acceptability of and opportunities for international mentoring and volunteering should be expanded.

P-35 WILL I EVER BE ME AGAIN? THE SUPPORTIVE CARE NEEDS OF PATIENTS ATTENDING A CANCER OF UNKNOWN PRIMARY OUTPATIENT CLINIC

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Background Cancer of unknown primary (CUP) is associated with clinical uncertainty, limited treatment options and a short prognosis. Guidelines recognise that patients need the input of dedicated multidisciplinary teams. Yet there is little evidence about their care needs to guide service configuration.

Aim To identify the supportive care needs of patients attending a CUP outpatient clinic as part of service evaluation.

Methods Between January and July 2016 patients attending clinic were offered an Integrated Palliative Care Outcome Scale (IPOS) as a holistic needs assessment. Patients stated their worse problems in free text and scored concerns on a 0–4 scale of increasing severity.

Results Of 57 patients 37 (65%) completed an IPOS. Tissue confirmation of malignancy occurred in 34 (92%) patients. A primary was identified in 14 (38%), and 20 (54%) retained a CUP diagnosis despite histology. Overall 13 (35%) were for best supportive care, ten of whom kept a CUP diagnosis. Chemotherapy was given to 16 (43%) patients. It was delivered to treat CUP in ten patients and six received chemotherapy after identification of a primary. Problems with the highest mean scores were: family anxiety (2.7), patient anxiety (1.9), weakness (1.8), not being at peace and poor mobility (1.7). Family anxiety and patient anxiety were present most of the time to always for 24 (73%) and 13 (39%) patients respectively. Weakness was severe to over-whelming for 12 (38%) patients. Thirty patients described their worse problems. Weakness/fatigue was identified by 12 (40%), concern about the future by 11 (36%), pain by 10 (33%) and distress by 7 (23%).

Discussion CUP services need to be configured to address family and patient anxiety and the weakness/fatigue associated with metastatic cancer. This cohort represents patients who are fit enough to undergo outpatient workup and biopsy. It may not reflect the needs of frailer patients who are not candidates for systemic cancer therapy.

P-36 A PERSONAL NARRATIVE OF HOW A JUNIOR DOCTOR IN THE POST OF EDUCATION FELLOW APPROACHED THE DESIGN AND IMPLEMENTATION OF A MULTIDISCIPLINARY END-OF-LIFE CARE PILOT TRAINING PROGRAMME AT A LONDON HOSPITAL FOUNDATION TRUST

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Background Junior doctors often have limited opportunities to develop the professional skills required to manage educational projects. As a junior doctor, I describe how in the role of education fellow, I approached the design and implementation of a multidisciplinary end-of-life care pilot training programme for non-specialist palliative care healthcare professionals (HCP) at a London hospital foundation trust.

Methods During this post, I designed, implemented and coordinated a pilot programme consisting of seven half day training sessions. Preparation including a literature search, liaising with educators for advice and arranging meetings with healthcare leads within the Trust helped lay the foundations of the programme. I also elected to undertake a PGCert in Medical Education in order to further develop my understanding of pedagogical theory. Working with a steering group, key challenges were identified and strategies devised, which led to the team-based simulation course design. Following the pilots, important considerations have been sustainability and continued development.

Results A total of 57 participants consisting of 15 consultants, 11 registrars, 14 therapists and 17 nurses attended the course from a range of medical and surgical specialties. Preliminary feedback has been positive and further sessions will run in 2017.

This task posed an entirely new set of challenges to me and resulted in improved problem-solving and management skills which contributed to the success of the pilot.

Conclusions Key priorities for pilot training programmes include participant recruitment and achieving expected learning outcomes. Having been successful in these domains future challenges for this programme will be ensuring sustainability and continued improvement.

Posts such as this, pose different challenges to those seen in junior doctors' traditional clinical roles. Project planning and associated tasks provide valuable experiences that aid in the development of other essential skills required at more senior level. These initiatives also provide unique opportunities that could influence the direction of many future careers.

P-37 GENERAL PRACTITIONER PERCEPTIONS OF CURRENT SERVICES FOR HEART FAILURE PATIENTS: A QUALITATIVE STUDY

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