

Abstracts

level. There was evidence that the increased confidence had been sustained.

This project demonstrates how the hospice is engaging with its local community to build capacity and better equip everyone in supporting young people experiencing loss and bereavement.

P141 A REVIEW OF THE MULTI DISCIPLINARY TEAM'S (MDT) PERCEPTION OF THE PSYCHOSOCIAL SERVICES TEAM'S (PST) INTERVENTION ON THE IN PATIENT UNIT (IPU)

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This project considered how counselling is offered, accessed, received and perceived on the In-Patient Unit (IPU) at Hospice in the Weald. Questions were formed about adapting and modifying the existing service to better meet the needs of our service users.

Unstructured interviews were held with professional MDT groups, inviting them to discuss perceptions of psychosocial care and how patients' needs are met on the IPU. Sessions were audio recorded, transcribed and analysed.

A new model of care was proposed. Counsellors rotated through IPU for 6 weeks. At the end of the rotations, each counsellor was interviewed, as was the larger MDT (in one collective group). Interviews were recorded and salient learning points identified. After each rotation, questionnaires were given to IPU staff to identify the benefits, things to change and give feedback.

We learned that traditional methods of referral, assessment and practice of counselling are inappropriate to the specialist setting of in-patient care. Questions about ownership of psychosocial care, referral processes, multidisciplinary aspects of collaborative working, audit/review and IPU admissions for psychological care were asked and partially answered in the study. Interviewing staff after the change in practice revealed much more satisfaction with the counselling service and many advantages arising from the change in practice. Improved MDT working and speed of access to counselling were cited most frequently.

The wider implications include considering how we modify our practice to better meet the needs of our service users. Working differently may lead to investigations about what we call this approach to the provision of psychological support to in-patients and their relatives. For some it's still counselling, for others it's an exciting challenge to expand both their practice and capacity to offer support to those facing the end of a life; particularly those who otherwise reject talking therapy.

P142 DISCUSSING PREFERRED PLACE OF DEATH WITH PATIENTS: STAFF EXPERIENCE IN A PALLIATIVE CARE SETTING

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Aims To qualitatively explore staff members' experiences of discussing preferred place of death (PPD) with patients at the Marie Curie Hospice Edinburgh (MCHE).

Introduction National end-of-life care policies propose that health-care professionals should have regular end-of-life discussions with patients wishing to talk about such issues. In 2007 the process of identifying patient end-of-life preferences was

formalised at the MCHE; and staff now routinely discuss and record PPD. This study explores staff experiences of these discussions.

Method Six members of medical and nursing staff were recruited from the inpatient, day-service and community teams at the MCHE. Participants took part in an in-depth, audio-recorded, semi-structured interview. Interviews were transcribed verbatim and analysed using Interpretative Phenomenological Analysis (IPA), an approach to phenomenology which aims to capture and understand lived experience.

Results Four themes were identified as being integral to participants' accounts: "The importance of discussing preferences at the end of life"- staff recognise the importance of discussing and trying to achieve patients' final wishes; "Identifying how and when to discuss PPD"- staff identify cues from patients to ensure discussions occur at a time and pace suitable for the individual; "Reflecting on the emotional aspects of discussing PPD"- discussing PPD is challenging but important and rewarding; "A journey from expectations to experience"- discussing PPD becomes easier over time through practice and learning from others.

Conclusion These findings highlight that although PPD discussions can be difficult, staff feel that discussing future plans, including place of death, with patients is important and beneficial for both patients and their families. With time, staff members have developed communication strategies that allow them to discuss PPD in an effective, sensitive and patient-centred way.

P143 MEMORIES MATTER: FACILITATING EXPRESSION THROUGH CREATIVITY

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10.1136/bmjspcare-2013-000591.165

Introduction In 2012 the Hospice extended the reach of its traditional family support services with two dedicated events for children and families. Each event was designed to facilitate remembrance, and promote self care and confidence within families whose lives had been inextricably changed through loss.

Aim To create a bespoke event for children and adults (both) independently and collectively through providing a range of creative and therapeutic activities.

To test simple strategies for engagement and interaction, and evaluate the quality of the experience through simple discovery techniques.

To reduce the sense of isolation experienced by children following the loss of someone loved by them.

Method 28 children in total attended the events which took place in July and November 2012. Led by the family support and bereavement care service, and supported by the art therapist and trained volunteers, children and families who had previously engaged in pre-bereavement support, or post bereavement 1:1 or small group support were invited to the events.

A range of activities were developed in consultation with the art therapist with a view to engaging children across a broad range of ages. Some sought to unify children and adult involvement. Activities included:

- Making memory felts
- Making a web of support using a ball of wool to create a shared bond
- Making an interactive advent calendar which featured on the Hospice website throughout December creating a meaningful focus as families faced a first Christmas.

Results Children and families unanimously placed a high value on the quality of the event in terms of:

- Therapeutic value
- Facilitating dialogue which acknowledged the loss of the person who had died
- Making meaningful memories
- Reducing the sense of isolation within families

Staff and volunteer experience was enriched through their involvement.

P144 MEET MR FOUL! AN INNOVATIVE APPROACH TO GET TO THE HEART OF DISTRESS: A THERAPEUTIC TOOL TO WORK WITH PATIENTS IN 'EXTERNALISING' ILLNESS, SYMPTOMS AND THEIR CONSEQUENCES

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Context Introduced to the field of family therapy in the 1980s, 'externalising' practice aims to enable people to realise that they and the problem are not the same thing. Externalising the problem encourages a separation from the problem - 'the person is not the problem, the problem is the problem' (White 2007:9). A space is created between the person and whatever is troubling them. Often problems become 'internalised'; with patients seeing illness as something wrong with them, that they or something about them is problematic.

In Practice Externalising helps us to shift self-blame. A patient living with Parkinson's disease said 'I'm so pathetic, so incompetent and such a burden...'. Externalising questions helped to reshape the relationship with Parkinson's e.g. 'How long has Parkinson's been influencing you?', 'What does Parkinson's tell you about yourself?', 'When is Parkinson's not so strong?'. Questions enabled collaborative exploration of the effects and tactics of problems and helped to reduce their influence.

This encouraged separation from the problem, the patient began to see her symptoms as external to herself. Contributing to this process was her renaming Parkinson's as 'Mr Foul Disease'. Self-blame decreased and 'Mr Foul' became more manageable and less powerful. A sense of relief was experienced as the patient realised she was not the problem and became more able to reconnect stories about herself as 'capable, insightful and determined'.

Discussion Externalising conversations can be flexible, creative and encourage patients to use their own problem-solving strategies, skills. They provide palliative practitioners with a tool, which positions them alongside their patients' problems, jointly exploring of new ways of relating to illness and symptoms rather than a position of expertise.

P145 LIFE STORIES: REBUILDING SELF ESTEEM THROUGH SHARING AND RECORDING BIOGRAPHICAL STORIES

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Introduction In 2012 we were approached by a local storyteller. We experimented with a simple programme, offering patients the opportunity to tell their stories on an informal basis and produced a series of summaries of the stories they told. We are now piloting a closed group version of Life Stories offering a 5 – 6 week course of story sharing sessions to day patients and

patients in the community. The results observed to date have been overwhelming – we want to share these with you.

Aims The aims of Life Stories are to provide a space for reflection and story telling for patients who are low in mood or anxious.

Methods The weekly 1.5 hour sessions are facilitated by the storyteller and attended by the social worker. Each session is structured using common life experiences, e.g. seasons, senses, celebrations. Using a mix of group, individual and pair work, all participants are invited to explore the theme and its meaning for them before sharing a related life story with a session partner. Next the stories are shared out loud with the whole group giving the facilitator a chance to record them all.

Results The reaction of the patients and their families to this experience is very positive; patients visibly brighten and do not want to leave. They report enhanced feelings of wellbeing, happiness and a generally improved quality of life. A family member reported: "my mother is talking again and painting again – thank you".

Conclusion Positive feedback from patients, their carers and hospice staff suggest that Life Stories workshops should be made available as part of a patient's individual care plan and be a regular part of the hospice day services.

P146 WHO MATTERS TO ME? - USING ECOMAPS IN PATIENT ASSESSMENT & CARE

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When doing good quality assessments for patients at St Joseph's Hospice it was recognised that genograms did not tell the whole story – so I looked to Ecomaps

Dr Ann Hartmann developed the ecomap as part of her social work practice in 1975. Initially it was used as a tool to show family life but Dr Hartmann then recognised that it was a useful tool to show a diagrammatic picture of a person's life and helped clients view their situation from an outside perspective.

The term eco is derived from the Greek ecology - the pattern of relationships between plants, animals & people to each other & their surroundings.

The ecomap is a graphical representation of an individual or family and their interaction with other people & their environment. It is underpinned by the Systems Theory as described by Pincus & Minahan (1973)

- Informal Systems e.g. family, friends & neighbours. Providing emotional support & advice.
- Formal systems e.g. clubs, societies & other groups that can provide support.
- Public systems e.g. hospitals, schools & local government.

The systems theory is useful in looking at an individual's systems (their support network) to recognise & promote strengths and to sustain relationships that are under strain, it is at the heart of person centred planning. It is therefore used for assessment, planning & intervention.

The ecomap is as individual as the person and a positive is that it can show spiritual domains that are very important to the person to help cope with illness this can include transpersonal beings (angels, demons, ancestors).

Ecomaps are now included in St. Joseph's Hospice Core Assessments & each patient's ecomap will be displayed in our