

discussed their written accounts with colleagues to identify and record:

- *key words* that characterise the experience of spiritual need; and
- *indicators* (objective and subjective) of spiritual need.

Finally, participants wrote a brief, summary description of the spiritual need, which they further refined with their colleagues.

**Result** The pilot identified refinements to improve the methodology as an effective way of gathering data useful in building a typology of spiritual need.

**Application to hospice practice** With evidence growing that attending to spiritual needs has a beneficial effect on health outcomes (Koenig et al 2012), a clearer understanding of what constitutes 'spiritual need' is likely to have direct impact on patient care and health outcomes.

### P150 DEATH ANXIETY RECOGNITION IN A PALLIATIVE CARE SETTING

Erzsi Nemeth, Ros Taylor, Sarah Russell. *Hospice of St Francis, Berkhamsted, UK*

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**Death anxiety** is the "feeling of dread, apprehension or solicitude (anxiety) when one thinks of the process of dying, or ceasing to 'be'." (1)

**Introduction** Recognition of death anxiety is important in hospice care, but assessment and management is often down to subjective interpretation and personal skills.

There are a number of formal death anxiety scales (2, 3) with an acceptable level of reliability, but these are not routinely used in hospice work. Informal assessment of death anxiety is based on narrative disclosure within a holistic assessment and covert death anxiety is often missed. (4). Generalised anxiety often masks the more specific concerns of 'death anxiety' – and the treatment may differ.

Death anxiety can be managed with psychological interventions specifically aimed at existential distress, spiritual support, and facilitation of open discussions regarding death. These include 'meaning-based' interventions and legacy work.

Standard health anxiety approaches within a cognitive behavioural approach (CBT) have been adapted to treat death anxiety with good effect (5); however a specific death anxiety model is not available.

As part of a Masters Degree in Cognitive Behavioural Therapy I plan to research and design a model of care for death anxiety that can be used in front-line palliative practice. The following work is a baseline survey to underpin the research.

**Aim** To establish current level of understanding, assessment and management of death anxiety at the Hospice of St Francis.

**Method** Inpatient staff completed an anonymous questionnaire to highlight :

- their understanding of the concept of death anxiety
- confidence staff feel in diagnosing and assessing death anxiety.
- subsequent management of death anxiety.

These questions consisted of rating scales and narrative responses.

#### Future work

- To develop an assessment tool to detect death anxiety in a hospice setting,
- To develop a CBT model specifically for the treatment of death anxiety.

### P151 REAL TIME REPORTING PILOT IN END OF LIFE CARE

<sup>1</sup>Jane Bake, <sup>2</sup>Marie Cooper. <sup>1</sup>St Barnabas Lincolnshire Hospice, Lincoln, England, <sup>2</sup>Marie Curie Cancer Care, <sup>3</sup>Help the Hospices, <sup>4</sup>National End of Life Care Programme, <sup>5</sup>United Lincolnshire Hospitals, <sup>6</sup>Lincolnshire NHS Community services, <sup>7</sup>Order of St Johns Care Trust

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**Background** It is acknowledged that to date, capturing meaningful and timely feedback from patients within the last year of life, and their families, remains a challenge.

**Project aim and objectives** The objectives of the project were to ascertain the acceptability and usefulness of a real time survey and reporting system to capture the experience of patients, families and carers receiving end of life care.

Organisations within Lincolnshire were invited to join the pilot and four different care settings, where end of life care is commonly provided were engaged; care home, persons own home, hospice and hospital.

**Approach** Survey questions were tailored to each care setting with volunteers and staff inviting participants to use a hand held 'ipad' device to feedback their experience of care; alternative options, such as web link and paper survey, were also offered.

#### Outcomes and application

- The pilot was successfully implemented across all four different care settings.
- The use of the devices and the length of the survey were acceptable to individual receiving care and their family member.
- The trial of a reworded 'family & friends' question with those at the end of life proved acceptable to the majority of users

The role of the volunteer was instrumental in engaging participants. Volunteers expressed satisfaction and reported back on the added value of one to one engagement with survey participants.

- Anecdotal feedback from the volunteers and staff suggested that patients and carers were happy to participate and expressed enjoyment in taking part. "Patients appreciate the opportunity to speak to someone and to have their voice heard as well as trying new technology"
- Provides timely, concise and meaningful information to service providers
- Provides opportunities for organisations to benchmark end of life care county-wide
- Next phase will seek to inform on further learning for a national roll out

### P152 MAKING USER INVOLVEMENT HAPPEN

Frankie Dee, Jutta Widlake. *St Luke's Hospice, Plymouth, United Kingdom*

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**Background** Stakeholders need a voice that is focussed on the quality of a service rather than numbers. They want to provide feedback and make recommendations developing a true partnership. User involvement can provide this process. A group was set up 3 years ago to develop this and has now moved from "meeting" to "making happen"

#### Aim

- Help in identifying areas requiring improvement

- Demonstrate the patient's right to have a say in their care. (NICE, 2004).
- Demonstrate compliance with the End of Life Care Strategy (DoH, 2008).
- Legal imperative for all organisations providing NHS funded services. (National Health Services Act 2006, Local Government and Public Involvement in Health Act 2007, Equity and Excellence: Liberating the NHS, 2008)

**Materials and methods** A steering group was set up incorporating senior members of staff including a Trustee and the Chief Executive. This group identified various methods for involving our stakeholders which included

Interviewing patients, carers, volunteers and paid staff  
Listening exercise with carers

**Questionnaires** Productive Ward Series

a template for writing reports on these activities  
a leaflet to hand-out giving an explanation of "Involvement"

**Results** As a result of this we are now:-

- Piloting Nurse Led Clinics
- Opening Day Care to bereaved carers
- Using a new discharge planning template on the inpatient unit
- Implementing a "Carer's Break" scheme via Day Care
- Developing a complementary therapy strategy based on user feedback about the value of this service to them

**Conclusions** The moving from "meeting" to "happening" has helped to promote the principles of equality, fairness and inclusiveness by actively seeking to engage with our stakeholders including our staff.

The identification of services valued by patients and their carers has ensured that our finances are spent in addressing the needs of our patients rather than what we consider their needs to be.

### P153 SERVICE USER GROUP (SUG) - FROM INCEPTION TO BEYOND

Doreen Thompson. *Willen Hospice, Milton Keynes, United Kingdom*

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**Background** To establish a SUG giving patients, carers, staff and members of the public opportunity to engage in improving hospice services.

Involvement covers a range of activities, from consulting service users about their views in partnership, to aid the development of projects or services.

Ensures the views of patients, carers and the public are listened to, ensuring that we continue to maintain excellence within our service now and into the future.

**Aims and objectives**

- SUG established to enable the hospice to provide evidence of consultation on matters directly related to patient care.
- SUG involved in consultation on available information for service users.
- Review and approve production of literature to ensure service users receive relevant information.
- SUG involved in fund raising and promotion of hospice services.
- SUG ensures service users input into service provision, promoting standards of excellence in patient care

**Approach used**

- IPU Sister identified as project lead.
- Advertised to promote development of Service User Group. Invited participants to join via appropriate communication channels.
- Guest speaker utilised to drive engagement.

**Outcomes** The SUG is involved in decision making on hospice improvements and have participated in workshops with a local Cancer Network Group. A service user and the Network group leader were key speakers at the group conference. The SUG have worked on patient feedback and audit tools and information leaflets for patients and families.

The SUG were runners-up in the Patient Experience Network (P. E. N.) awards 2012.

SUG has forged links with the local Hospital patient partnership forum. Representatives attend the meetings of both groups.

With a diverse, growing local population the SUG helps to reflect our local community needs. Their unique input helps the organisation see new perspectives on service development.

### P154 FOOD AND NUTRITION IN A HOSPICE: FROM AUDIT TO ACTION

<sup>1,2</sup>Eleni Tsiompanou, <sup>1</sup>Teresa Day, <sup>1</sup>Andrew Knight. <sup>1</sup>Princess Alice Hospice, Esher, UK, <sup>2</sup>Kingston Hospital, Kingston, UK

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In 2011, Princess Alice Hospice (PAH) participated in the test phase of the Nutrition and Hydration Audit tool which was created jointly by the Help the Hospices Food and Nutrition Group (FNG) and the National Audit Tools Group (NATG)<sup>1</sup>. Since this pilot audit was completed a number of steps were taken to reach standards that were highlighted by the audit:

1. A 'Nutrition Requirements Tool' was introduced on the ward. Further work has been undertaken to develop this tool.
2. Understanding the patient experience is at the heart of hospice care. We asked patients on the ward and in Day Hospice to tell us what they thought of our food service. Patients told us that the food and drink service that we provide is excellent. Areas of potential improvement are: protected mealtimes; attending to cultural & religious requirements, allergies and intolerances, special diets; giving written information re: food service; menus and food portions.
3. We provided regular teaching/training sessions for internal and external staff and volunteers. Our training enables healthcare professionals to become more involved in establishing nutrition as part of the patient's care plan and actively listen to patients and carers, offering support for their needs in relation to foods and lifestyle.
4. An eight-week support and education programme for patients and carers was designed in Day Hospice, offering up-to-date information from our multi-disciplinary team on nutrition and diet, lifestyle and symptom control.
5. Our Nutrition Steering Group meets to promote the role of the multidisciplinary approach to nutritional management and care of our patients.

Princess Alice Hospice is committed to delivering safe and high quality nutritional care to people with life-limiting illnesses,