

patient. In contrast, support from management was one aspect of context which assisted with facilitation efforts.

Conclusions In addition to managerial support, establishing a team of practitioners to lead facilitation of the CSNAT intervention and regularly review implementation progress, is vital for implementation success.

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0-4 ENABLING SUCCESSFUL HOSPITAL DISCHARGE TO HOME AT END-OF-LIFE: HOW CAN WE SUPPORT FAMILY CARERS?

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Background Successful hospital discharge and prevention of readmission often depend on carers' ability to support patients.

Aim To investigate how carers are supported during patient discharge from acute care towards end-of-life (EOL) and suitability of using the Carer Support Needs Assessment Tool (CSNAT) to improve carer support at discharge.

Methods Qualitative design: focus groups (FGs) with 40 practitioners supporting patient discharge from three English acute hospital trusts; interviews with 22 carers of patients discharged. 14 practitioners and five carers joined two final workshops. FGs/interviews/workshops explored current discharge processes and potential value of using CSNAT. Thematic framework analysis conducted.

Results Discharge processes were heavily focussed on patients' needs: there was no systematic approach to supporting carers. Practitioners and carers viewed CSNAT as highly relevant and could be used to facilitate much needed EOL conversations which often were absent and to manage carers' expectations of their caregiving role at EOL, including support available (or not) in the community. They also provided advice on feasibility of using the five stage CSNAT approach at discharge.

- Stage 1. CSNAT introduction was seen as crucial, to overcome carer reluctance for support for themselves and to avoid it being viewed as 'another leaflet'
- Stage 2. Carers' consideration of needs: useful to help manage expectations of caregiving, but carers need to be given time to reflect
- Stage 3. Assessment conversation: CSNAT questions seen as a useful trigger, but a separate space and a separate focus from patients needed.
- Stage 4. Action planning: an essential part of the process – giving out the CSNAT was not 'job done'
- Stage 5. Review: challenge in this context is the transition to home, but CSNAT as a carer-held record was a possible solution.

Conclusion CSNAT shows good potential to enhance carer support at hospital discharge and play a role in preventing readmissions towards EOL.

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Conference Papers 2

0-5 COMMUNICATION ABOUT CARDIOPULMONARY RESUSCITATION DECISIONS AT A UK HOSPICE INPATIENT UNIT

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10.1136/bmjspcare-2016-001245.5

Background A 2014 court ruling in the UK established that the only justification for NOT discussing a "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) order with a competent patient is either patient choice or potential "harm" to the patient (not distress).

Aims This study aimed to establish current practice in communication when making DNACPR decisions, the impact of the ruling and the interpretation of "harm".

Methods The records of 150 hospice inpatients admitted after the ruling were screened. An anonymous survey was sent to hospice doctors and hospice nurses trained to complete DNACPR orders.

Results DNACPR decisions were made without discussion with competent patients in 6/150 cases. Reasons documented included: patient choice, the decision was implied from previous discussions, the patient was too unwell. All six decisions were discussed with the family.

Survey response rate was 90% (28/31) with equal numbers of specialist nurses and doctors. 21/28 respondents made DNACPR decisions at least monthly, 6/28 had made these decisions without discussion with a competent patient in the past six months, 20/28 were aware of the ruling and 16/28 felt it would impact on their practice.

Examples of impact on practice included; increased awareness of need to keep up-to-date, forcing earlier DNACPR discussions, pressure to discuss decisions with all patients, increased likelihood of exploring patient choice, increased involvement of family. Interpretations of "harm" included: more than distress, physical harm to self/others, psychiatric disorder, damage to doctor-patient relationship, distress close to the end-of-life.

Conclusions Only a minority of decisions were not discussed with competent patients. Not all relevant health care professionals are aware of the recent court ruling. Of those who were, over half felt it would impact upon their communication practice. There is a need for clarification of what constitutes harm rather than distress.

0-6 DELIVERING INTEGRATED HOSPICE BASED CARE IN MOTOR NEURONE DISEASE

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Background 2016 NICE guidelines on assessment and management of Motor Neurone Disease (MND) recommend that patients should have access to multidisciplinary, integrated care with access to local services and support groups.

Feedback from patients and carers at our hospice-based MND support group highlighted that although the tertiary hospital clinic was important to them, it lacked access to local support, and pre-bereavement care. Often crises and issues arise in between hospital appointments; therefore local services are important in hospital admission avoidance where possible.

Aim To develop a satellite MND MDT clinic at our hospice incorporating the regional and local MND expertise.

Method The novel hospice-based clinic includes the hospital MND specialist nurse, an MND Association representative, and the hospice therapy team. New referrals are seen in the next monthly clinic.

The pilot will run for 12 months and be reviewed at six and 12 months.

During the year, clinic activity data, patient and carer feedback and a patient reported outcome scale (IPOS) will be collected as part of the service evaluation. This service is being set up within existing hospice budgets.

Results Preliminary analysis of IPOS and qualitative feedback data indicates that patients and carers prefer not having the burden of travelling to the tertiary hospital and value the opportunity to have more time to discuss their care and access the local services available to them. Frequent reviews and expedited access to hospice services has allowed more timely management of arising issues, preventing interval hospital admissions.

Conclusions By implementing the 2016 NICE Guidelines in MND care through our novel hospice-based clinic, we have a new service which rates very highly in satisfaction with patients and carers. It is also preventing crises in MND care falling upon tertiary centres by diversion to palliative care within local services.

0-7 IMPROVING PRACTICE THROUGH AUDIT: ASSESSING AND MANAGING CONSTIPATION WITHIN A HOSPICE SETTING

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10.1136/bmjspcare-2016-001245.7

Background Constipation is a common problem in palliative care, affecting approximately 50% of patients admitted to hospices and causing a wide range of symptoms. It is important to identify, treat and document constipation systematically in order to provide immediate symptomatic relief and to prevent complication occurrence.

Aims To identify if there is documented evidence that constipated hospice inpatients are being adequately assessed, monitored and managed, and to implement improvements where necessary.

Methods Retrospective audit of constipation assessment and management in twenty consecutive patients admitted to a hospice inpatient unit, against local and national standards. Data collected included documentation of bowel habits, oral laxative prescribing and administration, and rectal interventions.

Results A number of areas for improvement were identified in both medical and nursing documentation and clinical practice. Particular areas for improvement included standardisation of documentation, the creation and implementation of appropriate care plans, review and upward titration of oral laxatives, rectal

medication administration, and obtaining verbal consent and offering a chaperone prior to bowel examination or intervention.

Conclusions Lack of optimal assessment, management and documentation of constipation in hospice inpatients, will impact negatively on their physical and psychological symptom burden. In order to rectify this, a 'Constipation Working Party' was established comprising management, nursing and medical staff. Phase 1 of the improvement plan was the implementation of a 'Bowel Template' on the electronic patient record, on which all aspects of bowel care can be recorded. This has resulted in constipation documentation being more consistent, accurate and easily accessible. Phase 2 involves the development of hospice constipation guidelines, which are currently underway. Following completion and implementation of the new guidelines, a re-audit of constipation will be conducted to assess the extent to which the interventions have improved documentation and clinical practice.

0-8 USABILITY AND ACCEPTABILITY OF AN ELECTRONIC PAIN MONITORING SYSTEM FOR ADVANCED CANCER: A THINK ALOUD STUDY

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Introduction Pain experienced by advanced cancer patients is often poorly controlled due to inadequate monitoring or assessment. There is growing interest internationally in the development and implementation of remote monitoring technologies to enhance pain assessment. The aim of this study was to test an electronic pain monitoring system (PainCheck) with advanced cancer patients and health professionals and to explore how the system could be integrated into clinical practice.

Methods The think aloud method was used to gain an understanding of how patients and health professionals might use PainCheck. Twenty-nine participants (advanced cancer patients (N = 13), GPs (N = 4), community nurse specialists (N = 4), district nurses (N = 3), palliative care doctors (N = 5)) completed PainCheck while thinking their thoughts aloud. Patients completed the PainCheck assessment and explored their personalised feedback. Health professionals accessed a research version of PainCheck which contained reports from simulated patients. All participants were given minimal explanation of the system and were asked to use it as they would in their role as patient/health professional. After the think aloud, both groups were asked about their experiences. Think-aloud and semi-structured interview data were analysed using framework analysis.

Results Health professionals were able to use PainCheck easily without instruction and were quickly able to consider its application into clinical practice. Patients needed a little more support when using PainCheck. Both groups identified potential benefits of using PainCheck such as improved monitoring and quicker access to advice and support. There were, however, some concerns about the potential burden and impact on time for patients and health professionals and fears that problems may be overlooked if PainCheck was not routinely monitored.

Conclusion PainCheck is acceptable to patients and health professionals but guidance on its use and the expectations of its users need to be clarified before it is integrated into clinical practice.