

The review found little empirical evidence that HCAs are managed in hospices, and concluded that the management of HCAs in hospices is a misnomer. The broad purpose of this study was not to judge infection prevention and control practices in hospices, but to trigger thought and debate, and to develop collaborative approaches to HCAs.

The study recommends further qualitative research based on patient perceptions, on the impact of HCAs, and on infection prevention and control strategies. This knowledge could be used to inform strategies and interventions for palliative care patients.

P-113 SERVICE INNOVATION TO MEET THE INCREASING DEMAND FOR DIETETICS IN PALLIATIVE CARE

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Background Many life-limiting conditions negatively impact on an individual's ability to eat and drink pre-disposing an individual to malnutrition including its adverse consequences. Enjoyment and pleasure from eating and drinking can decline and diet becomes a source of psychological stress and anxiety. Although there exists a sound clinical rationale for dietetic interventions to optimise nutrition and alleviate symptoms dietetic services to hospices remains limited. In our own setting a specialist dietetic post (0.23 w.t.e.) was established in 2012. The service evolved to offer:

- a nutrition component to the patient rehabilitation and carer courses
- one to one consultations for patients with complex conditions requiring specialist dietary advice
- education and training for staff (internal and external).

Demand quickly out-stripped provision and therefore a creative, cost-effective solution was sought to continue to support patients and carers.

Aim To meet growing demand for dietetics with a newly created dietetic assistant post.

Results Following scoping and recruitment to the post, training was provided through case studies, supervision and e-learning. Since recruitment it has been possible to

- Further develop resources including a range of 'Handy Hints' (printed and web-based)
- Provide timely first-line dietetic interventions for patients and carers.
- Better support the specialist nurses.
- Streamline the use of oral nutritional supplements saving costs for the CCG.

A tool to identify patients requiring referral to the specialist dietitian for complex management has been validated and introduced.

Patient feedback in the form of patient evaluation and outcome measures have demonstrated the positive impact of the new service.

Conclusion To our knowledge this is the first hospice-based dietetic assistant post in the UK. Supervised by the specialist dietitian, this post has been better able to meet patient's needs. Similar posts across the UK would assist in meeting the growing demands of clients requiring supportive care who would benefit from diet modifications to maximise quality of life.

P-114 A HOLISTIC APPROACH TO NUTRITION AND DIET IN PALLIATIVE CARE

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Background In response to the Care Quality Commission and NHS contract requirements, a validated screening tool; the Malnutrition Universal Screening Tool 'MUST' was introduced into our hospice setting in 2012. Subsequent research amongst nursing staff confirmed lack of confidence in 'MUST' in identifying and guiding decisions for appropriate nutritional care. A project team was established to investigate how we might achieve appropriate nutritional care taking into account the changing and complex needs of patients and carers in the hospice setting.

Aims To identify nutritional issues experienced and develop a nutrition assessment tool to sensitively determine and deliver nutritional care to meet the needs of patients and carers.

Methods A practice development approach was utilised engaging all stakeholders. The approach included:

- questionnaires to staff
- discussion forums involving members of the healthcare team, patients, carers and catering.
- qualitative interviews with patients/carers.

Findings were used to initiate change and refine and validate a nutrition assessment tool.

Results Results from the questionnaires and forums identified issues affecting the delivery of optimal nutritional care. Solutions were identified and tested, patient and carer participation was a key component. A new approach to menu planning, including 13-day cycles, menu choices and portion size was developed. A new nutrition assessment tool – the 'Patient Led Assessment for Nutritional Care' (PLANC) was developed, tested, refined and validated to identify nutritional issues and determine care taking into account the stage of disease. Nutrition and hydration were integrated into the shared patient record. New pathways and resources were created to address common nutritional problems with triggers for escalation management to a specialist dietitian and dietetic assistant when required.

Conclusion The practice development process for change fitted well with the ethos of the organisation and resulted in practice improvements to enhance care. The 'PLANC' tool for nutrition assessment has been integrated into care across the settings.

P-115 A HOSPICE BREATHLESSNESS MANAGEMENT INTERVENTION SERVICE – A BLEND OF THE OLD WITH THE NEW!

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Background Breathlessness is one of the most distressing symptoms reported in the literature with the prevalence rising with the vast multi-morbidity people are living with. The breathlessness management intervention for patients with a variety of mixed pathologies but they have the commonality of refractory, end stage breathlessness. The approach employs non-pharmacological approaches but clearly can be in tandem to pharmacological agents.

Aim The intervention aims to reduce the resultant distress from breathlessness whilst improving functional capacity with improving the activities of daily living ability and the overall quality of life.

Method The intervention was compiled using available evidence from published data specifically geared at refractory breathlessness in advanced disease.

Results The group developed a set of objectives, referral criteria and a service specification to replicate across the organisation. Evidence from the literature supports carers managing the “dyspnoea crisis” and inclusion with exploration of their feelings, concerns and expectations and education. Recent work suggested that low intensity (one session) breathlessness management was as effective as high (three sessions) intensity but the wider remit of this intervention and its proposed outcomes, three sessions were employed.

Sessions comprise of components of education with regard to physiological changes that occur during breathlessness, why exercise is important and why breathing control works. Anxiety management including the carer is a fundamental component in managing the dyadic units response to “dyspnoea crisis”. Finally goal setting in terms of the 3Ps (pacing, planning and prioritising) are key to enabling functional improvement. Objective and subjective assessments are completed to help track changes over time for patients/carers and professionals.

Conclusions This breathlessness management intervention has been clearly articulated in a pathway to help internal and external professionals understand the process and the components involved whilst meeting the need for commissioning bodies to see evidence of activity linked to meaningful patient outcomes.

P-116 ANXIETY MANAGEMENT IN PRACTICE; DEVELOPING A RELAXATION CD

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Background The impact of living with a life-limiting illness and the effects of living with physical and psychological symptoms and impact can create high levels of anxiety for both the patient and their carer. The most common issues that can exacerbate anxiety are breathlessness, pain, fatigue and the anticipation of what the future holds.

An occupational therapist, complementary therapist and hypnotherapist provide supportive interventions to patients and carers. Evaluation of these services reports a positive impact of anxiety reduction after sessions but this often reduces over time.

The therapists were eager to find ways of increasing the efficacy of these sessions and support the individuals to feel empowered to support themselves outside their sessions using the techniques gained.

Aims To produce a relaxation CD with different styles of relaxation to support and develop their ability to relax in their everyday lives.

Method A search established what relaxation CDs were available. There was no appropriate relaxation CD with mixed relaxation styles available. We focused on four approaches:

- Guided imagery
- Progressive muscular relaxation
- Autogenic relaxation
- Mindfulness.

A local composer offered to record our own CD for free. From experience we knew some people prefer music and others only the spoken word. We piloted the CD with 20 people. Overall the feedback was positive with some modifications suggested.

Findings Two people didn't like the CD but the others continued to use the CD regularly reporting a reduction in insomnia, breathlessness and anxiety.

Conclusions The CD has been very well received and has been reported to improve relaxation using a non-invasive approach.

Implications for practice The CD is now used in the breathlessness group, with our patients and carers and is available on the ward for patients and staff and for sale in our shops.

P-117 “BREATHE BETTER”: EXPLORING THE POTENTIAL IMPACT OF SUPPORT GROUPS FOR PEOPLE WITH END-STAGE COPD

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Background The Breathe Better group (BBG) has been running from Marie Curie Hospice Bradford (MCHB) since 2008. It aims to reduce dyspnoea, improve quality of life and mastery of illness for patients with end stage COPD. It uses four methods: education, exercise, pharmacological management and individual consultations. We aimed to ascertain the impact of the BBG.

Method A retrospective longitudinal study was performed on patients referred between August 2010 and June 2013. Data were collected on shuttle walk distance, mastery, Hospital Anxiety and Depression Scores (HADS), advance care planning (ACP), and mortality. Outcomes were analysed using a paired t-test.

Results Data from 56 patients was analysed. Mean shuttle walk distance increased by an average of 10.8m which was statistically significant ($p = 0.05$). Total HADS score improved by 2 points. 65% of patients had an ACP after the group, compared with 24% prior to commencement. 76% patients died with two years of the group. Place of death (below) demonstrates an increase in rates of hospice death when compared with regional and national COPD data.

Place of Death (n = 45)

Care home	11%
Home	7%
Hospital	38%
Hospice	31%
Not recorded	13%

Discussion Results suggest that BBG improves shuttle walk distance and recording of ACP which appears to influence place of death. Missing data means conclusions are based on a small sample size. Improved data recording is a local priority in order to render future evaluations more meaningful.

Implications Other hospices may wish to consider pilot schemes especially as often this patient group are unable to access current NHS schemes such as Pulmonary Rehabilitation due to their poor health. A larger study with a control group of patients who did not attend will allow more accurate evaluation.