

Year (April–March)	Number of transfusion appointments
2012 – 2013	35
2013 – 2014	72
2014 – 2015	81
2015 – 2016	293

Conclusion Coupled to the significant increase in referral numbers to our service there has been a noticeable increase in the number of patients referred with haematological diagnoses. Many require multiple recurrent transfusions over many months which allows a natural progression from active treatment into palliative services, within an environment which is well equipped to support them as their illness deteriorates. Our patient feedback shows we are running an excellent service for our patients, in a setting they enjoy.

P-121 ASSESSING PAIN IN CHILDREN WHO ARE NON VERBAL OR COGNITIVELY IMPAIRED

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10.1136/bmjspcare-2016-001245.144

Barriers to pain management in infants and children are vast and include inaccuracies regarding pathological mechanisms of pain and deficient knowledge of methods of assessing pain (Srouji *et al.*, 2010). Despite recent advances in our understanding of children's pain, difficulties lie in distinguishing pain from other sources such as anxiety and stress (Voepel-Lewis 2011). The unique challenges assessing pain in children are age, development, communication skills and past experiences of pain (Srouji *et al.*, 2010). These challenges are increased when there is varying levels of cognitive ability, and children with cognitive impairment are at greater risk of under treatment (Clen-Lim *et al.*, 2012). The common problem is the inability to verbally self-report their pain and the frequent exposure to pain due to association of disease pain and the high impact on quality of life (Massaro *et al.*, 2013). Measurement of pain is essential and is assessed to determine the effectiveness of the treatments (Massaro *et al.*, 2013). For children with communication difficulties a valid and reliable tool should always be used (Massaro *et al.*, 2013). The Faces, Legs, Activity, Cry and Consolability (FLACC) behavioural tool developed by Merkel, Voepel-Lewis, Shayevitz, and Malviya (1997) was not originally designed for cognitively impaired children however has shown to be a valid and reliable tool in this population (Massaro *et al.*, 2013).

P-122 ENABLING PATIENTS TO SELF-MANAGE THEIR PAIN; A PILOT OF A MODIFIED PAIN MANAGEMENT PROGRAMME

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10.1136/bmjspcare-2016-001245.145

Background Despite WHO recommendations for the management of pain the prevalence in palliative patients remains between 62–86% and management remains primarily pharmacological. There is good evidence for the efficacy of Pain Management Programmes (PMP) based on cognitive behavioural principles for patients with chronic pain. They have been shown

to improve pain experience, mood, coping, and activity levels. Palliative patients are rarely eligible for inclusion on such programmes.

Aim

- To pilot and evaluate a holistic PMP tailored to the needs of palliative patients
- To reduce use of analgesics
- To introduce techniques for self-management of pain.

Design

- Patients with a life-limiting illness, complex pain, a Pain Score greater than 5 and a Karnofsky Performance Scale greater than 50% were eligible for enrolment in the six week programme
- Patients were initially assessed by a palliative consultant and a pharmacist to optimise drug regimens
- The PMP used a multi-disciplinary rehabilitative approach introducing the Pain Toolkit, Mindfulness, Relaxation, Cognitive Behavioural Techniques and Seated Exercise
- Evaluation was by structured questionnaires, the Hospital Anxiety and Depression Scale (HADS) and Pain Scores.

Results

- 18 patients met the inclusion criteria, nine patients agreed to take part, five patients completed the programme. Age range 32 to 74 years
- Patients reported moderate to severe anxiety and depression at the start. HADS scoring showed category improvement by the end
- Mindfulness and relaxation were rated as the most beneficial elements
- Patients reported group working supportive
- Pain scores did not change significantly but patients used less breakthrough medication
- Patients were able to employ techniques to self-manage pain.

Conclusion It can be difficult for palliative patients to attend a six-week programme; however for those who are well enough the pilot showed benefit, it improves pain self-management and reduces use of analgesics. Wider introduction of modified PMPs could be considered for palliative patients.

P-123 USING ONE PAGE PROFILES TO IMPROVE PERSON CENTRED CARE ON THE INPATIENT UNIT (IPU)

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10.1136/bmjspcare-2016-001245.146

The Inpatient unit are constantly looking at the way in which we work and how we can improve and change practice. One of the current projects we are undertaking is based on person-centred care and One Page profiles.

A one page profile captures all the important information on a single sheet of paper under simple headings. We have produced our own one page profile and named it 'What is Important to You' the headings we are using are:

- How will decisions be made, who will be involved in this?
- What is important to me?
- How to support me and those I love
- What must happen?
- What must not happen?

One page profiles are a way of learning and supporting people to achieve things that are important to them. Even if someone is

in the hospice for a short period of time it is vital that we know what matters to them and what is important to them not just their clinical condition. We are encouraging staff to discuss one page profiles with patients on admission so that staff can get to know their wishes right from the start. Patients can change their one page profiles at any time.

We are receiving very positive feedback from patients that have completed them. Comments include:

'I feel much more relaxed now that you know what my likes and dislikes are'

'Suddenly after completing the one page profile I feel I have the strength to talk to my daughter about my wishes'

'I am happy that my wife will be involved with decisions about my care this means a lot to me'

'I feel safe and secure that my wish not to be resuscitated has been listened to and everyone will know my wishes'

We have a working group who are undertaking evaluations and will audit this work.

P-124 PREFERRED PLACE OF CARE – ROOT CAUSE ANALYSIS

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10.1136/bmjspcare-2016-001245.147

Introduction Surveys and research indicate that home is the preferred place of care at the end of life for many people (71%), whilst the most commonly recorded place of death remains hospital (53%).

Aim To identify barriers and enablers to the delivery of good end-of-life care for patients.

Methods The project was completed over a six-week period at a hospice in Northwest England. Each week at our multidisciplinary team meeting we discussed deaths of patients known to our community palliative care team and recorded our findings.

Results 48 patients known to the team died during the six-week period. Preferred place of death was achieved in 91% (30/33) of cases when this was home, and 85% (11/13) of cases when this was the hospice. None of our patients expressed hospital as their PPD. Preferred place of death was unknown in 4.2% (2/48) of patients. 8.3% (4/48) of patients died in hospital. In 50% (2/4) patients, a hospital admission was indicated due to acute unexpected deterioration. 77% (21/27) of patients dying in the community had face to face or telephone contact within three days of death. Identified barriers to good end-of-life care were: difficulties accessing oxygen at home for symptom management, one episode of difficulty accessing specialist care advice and challenges communicating directly with district nursing teams. Enablers were: appropriate use of DNACPR forms with no involvement of emergency services at the end-of-life as well as good team-working between specialist and generalist services.

Conclusions The majority of patients known to the team die in their preferred place of care, with a good quality of death as judged by the team. Lessons have been learned from after death analysis and action plans devised. This scoping exercise could be repeated on a periodic basis.

P-125 HOMEWARD BOUND: RAPID DISCHARGE OF PEOPLE TO THEIR PREFERRED PLACE OF CARE

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10.1136/bmjspcare-2016-001245.148

Following a period of sustained pressure on our local healthcare system, the gauntlet was thrown down from commissioners to the hospice to expedite discharges by providing care at home.

Our hospice, at the heart of the community, renowned for breaking barriers and a positive approach, rose to the challenge of this six-month pilot project.

We rapidly reorganised our community team to release their community support workers to form a team and recruited to expand the workforce.

This newly formed team received a week's robust training in preparation for our crusade to get people home from an inpatient setting.

We met with commissioners and local care providers to plan in partnership how we would work.

Aims of the project

- To respond to local need by developing a reactive workforce to deliver flexible, high quality personal and health care to support people at the end of their life
- Enable rapid response discharges by accepting fast track care requests from Continuing Healthcare within 1.5 hours and commencing care within four hours
- Preventing admissions and decreasing the need for use of acute care by providing and sustaining care at home
- Increase the number of people who choose to live and die in their own homes.

Results

- 100% of referrals were accepted within 1.5 hours
- 100% of these referrals received care within four hours
- 100% of these patients died in their preferred place of care
- We have met the needs of 56% of all fast track care requests.
- 18% were in partnership with local care providers.
- The evidence from the quality survey completed by families, has demonstrated nothing but positive feedback to the excellent responsiveness of the service delivery.

Conclusion It is the intention of the Hospice to continue and expand this service

P-126 AN AUDIT TO DETERMINE IF PEOPLE WITH A LEARNING DISABILITY (LD) AND KNOWN TO THE HOSPICE HAVE ACHIEVED THEIR PREFERRED PLACE OF DEATH (PPD) AND IF THE INITIAL DISCUSSION HAD TAKEN PLACE, WITH AN OUTCOME ESTABLISHED AND DOCUMENTED

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10.1136/bmjspcare-2016-001245.149

Aims and objectives To establish documented evidence of the preferred place of death (PPD) of people with a learning disability (LD) and establish if PPD was achieved and documented. Additionally; to establish where initial conversation took place with regards to PPD. To establish if an "easy read" Preferred