

St Luke's Hospice Basildon, has devised an innovative and unique pathway alongside the acute liver services of Basildon Hospital. This allows patients and their carers with ALD, to have timely access to a range of hospice services and interventions whilst still receiving input and interventions from the acute liver services. Allowing a parallel planning approach to advanced liver disease.

This project has run a successful pilot and attracted significant national interest both in palliative care and hepatology forums. This has resulted in a significant award from The Health Foundation to St Luke's Hospice to develop the work.

This collaborative and multi-disciplinary working between St Luke's Hospice and Basildon liver team seems so far unparalleled on a national level, despite calls to meet this challenging and complex area of need.

The current study is now at its mid-point and early data show that patients and their carers with ALD have complex and unmet needs. Early emergent themes and data are showing the potential for the model to improve quality of life and compliance; to enable more patients to be considered for transplantation and improved and more cost effective paracentesis services when managed by St Luke's Hospice.

The project is due for completion in February 2017 and highlights an innovative approach by St Luke's for patients and their carers with non-malignant disease.

P-147 SPIRITUAL ASSESSMENT – 'HARASSMENT BY QUESTIONING'?

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10.1136/bmjspcare-2016-001245.170

Spirituality is an integral component of holistic care; the initial assessment of a patient's spiritual needs often poses a challenge. I recognised that nursing staff frequently expressed feelings of inadequacy when exploring this area.

It was expected that chaplains would record such assessments; yet it became clear to me that in engaging with patients both in the initial admission process and ongoing conversations this area of a patient's care was in fact being addressed. What was lacking was their recording of this information.

After reviewing literature, exploring the experience of other hospices, and reflecting on our experience, we have developed a holistic assessment recorded as narrative on SystemOne.

The initial recording of the assessment is completed by the admitting nurse as he/she reflects upon their conversation with the patient and/or their carers.

Literature and experience indicate that "relationships" are at the heart of a person's spirituality which therefore forms an integral part of the assessment. On the SystemOne template are found text boxes in which information relating to a patient's relationships with "self", "others", "the world" and "belief system" can be recorded. Guidance on its completion can be found on the template.

Initially there was some resistance to the concept, nurses citing lack of expertise and time constraints as contributing to their unease. To a large degree this has been overcome by provision of internal training and one-to-one support as necessary. Compliance of completion will be checked as part of a records keeping audit this year.

I found that nursing staff are becoming more confident in the completion of the assessment which informs the wider multidisciplinary team and enhances the holistic care offered to patients and their carers.

Take home message; "Spiritual Assessment is not about ticking boxes but rather about listening, reflecting and recording!"

P-148 SPIRITUAL CARE, HUMAN AND DIVINE, AT END OF LIFE – MODELS FIT FOR THE FUTURE

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10.1136/bmjspcare-2016-001245.171

Nelson Mandela is quoted as saying: 'If you talk to a man in a language he understands that goes to his head. If you talk to a man in his language, that goes to his heart'.

Seeking to speak into the heart of all our patients and carers our hospice has moved over the last two years from chaplaincy to spiritual care – not just in name but in philosophy of care. We have been developing a model which overtly honours the spirit human and divine, and cares for each individual as a spiritual person. Patient records and stories demonstrate the relevance of this philosophy of care.

Moreover our vision is that, as spiritual beings, all staff and volunteers – clinical and non-clinical – are spiritual carers and we are rolling out a programme of formal and informal training.

Mindful that the future of hospice care lies in the community and that research states "there is an urgent need to develop policy and practice in community settings to support people dying at home". ('Spiritual Care at the End of Life: a systematic review of the literature', DH 2011, p38.)

...we have initiated three community pilot projects, initially working with church groups, skilling lay people in spiritual care at end-of-life:

structure – flexible eg a single session or series of sessions; working with/supporting individual carers over a period of time; training the trainer, 'pump priming';

timescale – negotiated with each project;

content – exploration and practice of concepts and skills, including caring for 'non-faith' people;

evaluation to include feedback from those 'cared for', carers and healthcare professionals;

next steps

- pilots working through secular agencies
- exploring new models, eg 'telecare'/social media
- 'training trainers'.

P-149 WHAT DO WE MEAN BY SPIRITUAL CARE? AN ETHNOGRAPHIC APPROACH

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10.1136/bmjspcare-2016-001245.172

Patients, families, staff and volunteers will be asked to give their views as part of a qualitative study with an ethnographic approach to ascertain the values and beliefs in relation to the definition of spiritual care and what it means for the patient experience. The study will be evaluated against the following outcomes:

1. Design and implement a research project using a qualitative methodology
2. Present the descriptions of spiritual care from the perspective of staff and volunteers and patients/families in the form of an organisational statement and strategy
3. Identify patterns and subsequent themes which emerge from the staff and volunteer perspective
4. Identify and share relevant findings to support the introduction of the spiritual care champion role
5. Identify and share relevant findings to support the introduction of feedback from patients and their families about their experience
6. Design an introduction to spiritual care for the induction of all staff and volunteers
7. Implement a spiritual care assessment tool for staff
8. Share this research with the wider community through connecting with the multi faith network surrounding a UK Hospice and thus increase (community) engagement via this network
9. Share learning within the hospice movement.

P-150 GATHERING REAL-TIME PATIENT SATISFACTION FEEDBACK USING AN ELECTRONIC TABLET-BASED APPLICATION

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10.1136/bmjspcare-2016-001245.173

Background Hospices are increasingly expected to collect data from service users in order to demonstrate the quality of the care provided. However, there can be challenges in gathering feedback from patients who may be too ill or fatigued to complete lengthy surveys. Additionally, by the time paper-based surveys are processed, important issues and concerns may have been missed. Many hospitals are now using portable electronic devices to obtain patients' views, but this approach is seldom used in hospices.

Aim To use a short electronic survey to gather feedback from hospice in-patients and day patients.

Method Patients use a tablet computer to rate statements about their care using a standard scale. The statements are based on the National Institute for Health and Care Excellence quality standards for end of life care. Patients complete the survey either by themselves or with assistance, simply touching the screen to indicate their responses. A free text box allows patients to make comments. Results are transmitted wirelessly to a relevant staff member within two minutes of the survey being completed.

Results Between January 2015 and April 2016, 200 in-patients and 46 day patients completed a survey. The results show a generally high level of satisfaction with care. The real-time nature of the feedback allows us to act quickly on any issues – for example, comparing the time and date of any negative feedback about nurse response times with the actual call times and staffing levels for that day. Results are used to inform future planning and contribute to staff training. Patients find the survey easy and quick to complete.

Interpretation and conclusions We continue to gather data using the survey on an ongoing basis. It enables us to continually monitor patient satisfaction, covering a large percentage of our in-patients and day patients, and address problems swiftly.

P-151 THE CHERRY ON THE CAKE: WORK WITH A SERVICE USER GROUP MAKING A REAL DIFFERENCE TO PERSONALISED CARE

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10.1136/bmjspcare-2016-001245.174

Involving users in the development and evaluation of services is an indispensable way of ensuring quality healthcare provision (Help the Hospices, 2013). Our aim was to create a Service User Group that would become an important resource for the hospice and to try to identify the extra things that would make a difference for our patients' experience.

Over the last 18 months our group has been pivotal in introducing the following new initiatives:

- Just in Case folders – Patients are now discharged home with a folder for district nurses that contains injectable medication, a prescription chart, advice on medication and a satisfaction survey.
- Personalising the bed space – patients asked for a way to personalise their bed space with photos and personal items. A magnetic board is now at each bedside for patients' personal use.
- Patient Information Booklet – a detailed information booklet of who's who and daily hospice life is now at each patient's bedside, this has been written by the user group.
- Mugs – Our hospice mugs for patient and visitors were very plain; we now plan to introduce a variety of styles of mugs.
- A medication chart – is currently under development, to help patients to monitor their medication on discharge.

Our recommendations from working with this group are:

- Start small and build on this, even if you only have one service user their contribution can be invaluable
- The user group needs to be promoted locally via web page, Facebook, Twitter and the local press
- Create a lively useful agenda with speakers
- Ensure actions are taken forward and fed back at the next meeting
- Ensure the group remains in the forefront of colleagues' minds as they create new leaflets or change their services.

P-152 TALK TO US, A PARTNERSHIP APPROACH TO UNDERSTANDING THE EXPERIENCES OF CARE DURING THE LAST YEAR OF LIFE

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10.1136/bmjspcare-2016-001245.175

The National VOICES survey of bereaved people told us that for many people in Lincolnshire palliative and end-of-life care was not meeting expectations.

In 2012 a bereaved person began conversation with Lincolnshire West Clinical Commissioning Group about the care his wife had received. His insight highlighted how vital a good understanding of patient experience is to informing and influencing system wide change.

An earlier study using St Barnabas volunteers evidenced that the use of volunteers in collecting data, in a peer to peer exchange, provides unprecedentedly rich information.

In November 2014 we drew this learning together to launch the Public and Patient Participation Project, latterly referred to as