

Communication

CARE A two-hour workshop at an introductory level to develop basic skills for communicating compassionately and sensitively with others.

CLEAR A four-hour workshop at a foundation level to develop skills to hold clear, sensitive and honest conversations about care options, explore patient experiences, needs, priorities and choices.

CLEAREST A full day workshop at an intermediate level aimed at qualified clinical staff that develops skills reflecting, analysing and applying communication strategies to ensure effective compassionate conversations in challenging circumstances.

Workshops have been delivered regularly since 2013.

Evaluation Participants completed post workshop evaluations and were observed in practice using their skills.

Outcomes Staff reported increased confidence in having 'big' conversations and supporting people in distress. Feedback from patients and their families indicates staff and volunteers do communicate effectively and compassionately.

Future The demand for workshops from outside the hospice exceeded the capacity to provide them. To address this issue we have worked with our Clinical Commissioning Groups (CCGs) who were looking to provide communication skills education to people working in health and social care. The CCGs are adopting our CLEARER Communication Programme and supporting the training of facilitators to deliver the workshops.

P-210 CLEARER COMMUNICATION COLLABORATION

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The issue The need for high-quality, flexible, cost effective communication skills education for all groups of staff and all levels of experience was identified by the Clinical Commissioning Groups (CCGs) in our locality. In our hospice we deliver our own communication skills education programme (CLEARER Communication) with three levels of workshops – CARE, CLEAR and CLEAREST. These are very well evaluated and fitted the identified need. However, there was not enough capacity to meet the demand.

Why it is important We can provide excellent care when staff have knowledge, skills and confidence to communicate effectively and compassionately with patients, their families and each other. Education at the right level to achieve this must be readily accessible.

What is being done Working with the CCGs, we identified 10 workshop facilitators from partner organisations and planned their training. We successfully bid for funding from the Multi-Professional Education and Training (MPET) budget held by the CCGs to train facilitators, fund administrative support and deliver the workshops. The new facilitators will also build confidence by co-facilitating the CARE, CLEAR and CLEAREST workshops with the programme lead. Then they will each deliver all three workshops each quarter. Evaluation will be via pre and post course questionnaires, evaluation forms and impact assessments.

Expected outcomes Workshop places will increase from 100 per year to 2000. We expect to see an increase in knowledge, skill and confidence of participants. Ways of assessing impact on patient care are under development. Consistency and quality will be monitored by the programme lead.

Sustainability MPET Funding will allow the programme to be delivered free to staff of partner organisations until end 2018. Charging staff from other organisations will provide an income stream to support ongoing provision.

P-211 WHAT DO DOCTORS AND NURSES IDENTIFY AS THE BARRIERS TO STARTING END OF LIFE CONVERSATIONS IN HOSPITALS? A REVIEW

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Introduction Improving end-of-life care is a national priority. Unsatisfactory care persists in acute hospitals, where there is a lack of communication and advance care planning. Although other reviews focus on the patient's perspective or different settings, this is the first systematic review that explores why doctors and nurses in acute hospitals avoid initiating end-of-life conversations with patients.

Method Six electronic databases were searched for evidence published between 2008 and March 2015. Studies were included if they reported on barriers to discussing end-of-life with families or patients, as described by doctors or nurses in acute hospitals, excluding critical care. Study quality was assessed using recognised tools.

Results 12 studies were included in the review. Although there is limited high-quality evidence available, several recurrent barriers were identified: a lack of education and training; uncertain prognosis; cultural differences and institutional restraints such as time and resource; insufficient communication and coherence between healthcare teams; and perceived reluctance of the patient or family.

Conclusions The reviewers recommend a board-level commitment in acute trusts to implement policies and protocols concerning appropriate initiation of end-of-life communication; the integration of the multi-disciplinary team across specialities, particularly empowering nursing staff, and communication training which addresses:

Individual issues: practitioner personal beliefs and managing emotions.

Team issues: shared decision-making and patient-centred communication.

- Practical tools to enable effective communication.

Organisational issues: creating a culture which facilitates communication about end of life care issues.

Further work Health Education Yorkshire and Humber are using the findings to inform commissioning of communication skills training. Further research will be undertaken to understand the barriers to advance care planning within haematology services.

P-212 EVERYTHING IN PLACE: A GOOD DEATH IS A WELL-PLANNED DEATH

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Increasingly individuals are preferring to die at home, eliciting an increased need for good communication, forward planning is more crucial than ever. We need to be better equipped for difficult conversations and more confident in sharing our wishes with others.

The 'Everything in Place' project raises the profile of these taboo subjects, reducing barriers by encouraging conversations and advocates the need to take responsibility for informed decision making. Six sessions included:

- The last taboo
- Wills
- Powers of Attorney
- Advance decisions for health and care
- Funeral planning/poverty
- A strong soul/organ donation.

The project is delivered through local community centres, housing organisations, workplaces and communities of interest. Initially presentations were made to gauge interest, dispel myths, and demonstrate the mass of practical evidence surrounding what constitutes a good death. Once venues were established the project was promoted through posters, leaflets, newspaper and radio, a work book was designed to help with decision making and record thoughts and plans.

Six sessions were delivered in five venues (monthly), five people attended during week one and overall we delivered the equivalent of 82 individual sessions, results below:

As a result of this project :	Yes	No	Not sure
Have your views on death changed?	7	2	1
Are you more comfortable talking about death?	9		1
Are you more comfortable thinking about your own death?	9		1
Are you more able to plan for your own death?	6		4
Are you more confident about availability of home care?	5		5
Were the activities relevant to your own family?	10		
Would you recommend the sessions to others?	10		

Attendance rates might suggest the uncomfortable nature of death, however results would confirm that in the main discussions were beneficial. We believe the project is making an impact and continue our work to make this information accessible.

P-213 DEVELOPING A PALLIATIVE HUB: LESSONS FROM THE ISLAND OF IRELAND

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Background Meeting the information needs of entire community including patients, families, carers, health and social care professionals and researchers is important in a society where online resources are an increasing source of information. Providing this

information digitally in one location will reduce the burden on individuals trying to navigate the internet and multiple sources of information, which may not be appropriate or relevant.

Aim To develop the Palliative Hub, as a gateway for information, education and guidance regarding palliative care.

Method Drawing on the skills and expertise of a range of stakeholders, working groups were established, which represented service users, carers, providers, charities and advocacy groups. The purpose of these groups was to assist with the design and development of the Palliative Hub, as sites to provide information, education and guidance about palliative care. The Palliative Hub whilst providing information also acts to filter and direct the user to the most relevant sources of further information.

Results It is anticipated that this resource will assist with meeting the palliative care information and education needs of the entire community in one place with key signposts to relevant sources and resources.

Conclusion The Palliative Hub has the potential to become an integral element in meeting the palliative care information and education needs of the entire community and is an example of an innovative and collaborative project across the island of Ireland, which could be translated across other jurisdictions.

P-214 TERMINOLOGY RESEARCH – THE WORDS WE USE TO DESCRIBE OUR CARE

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Background There was uncertainty over the words to use to describe the care we provide and type of patients we support, particularly following the transfer of an NHS service to our hospice management in 2015. Other hospices use inconsistent language, so there was no clear direction to follow to create our own language.

Aim In March 2016, we undertook some research to enable us to understand the best phrases to use with supporters, the general public and patients/relatives.

Methods Quantitative research using an online survey was undertaken with 533 supporters and general public; qualitative research through six discussion groups was undertaken with staff, volunteers, patients, carers, supporters and general public; and telephone interviews with seven local GPs.

Results "Illness" was preferred as descriptor, over others like "condition" or "disease".

'Terminal illness' was established as the best phrase for those receiving hospice care and chosen equally by both supporters and general public, but should be softened by saying "living with a terminal illness" to make it more positive and hopeful.

Rejected words: Life-limiting, Life-changing, Incurable, Serious Progressive, Advanced.

'Hospice care' is used our name, so does not to be in the descriptor of the type of care. On its own it can suggest that we only provide care in a hospice building, for in-patients only.

'End of life care' was established as the best phrase to describe type of care, as it was safe, specialised, supportive and inclusive, but we should also include 'Supportive Care', as it suggests that the family are supported as well as the patient, and we also provide non-physical care for the patient.