

## Effect of Thrombolysis on Symptom Control

On admission to the hospice, the patient continued to complain of mild to moderate dyspnoea but had no pain. He was commenced on regular immediate-release morphine (10 mg QDS) for breathlessness but only required one breakthrough dose of analgesia before his condition deteriorated. The patient died comfortably nine days after thrombolysis treatment.

**Conclusion** Thrombolysis was very effective in controlling pleuritic chest pain and acute severe dyspnoea in this patient with PE and advanced cancer with a limited life expectancy.

# P-86 DOES SOCIOECONOMIC STATUS AFFECT PLACE OF DEATH FOR PATIENTS KNOWN TO SPECIALIST PALLIATIVE CARE SERVICES?

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**Background** Socioeconomic (SE) status can influence where patients die, although no previous studies have investigated whether this is true following referral to specialist palliative care (SPC) services. This study investigated whether SE group influenced place of death for patients known to SPC.

**Methods** Place of death and SE group (using postcode data from the Scottish Index of Multiple Deprivation - SIMD) were examined in 485 patients who had died and were known to SPC services within NHS Lothian. Records were excluded if patients had died in a care home or SIMD data were unavailable. A logistic regression model was fitted with place as a three level factor and SE group as a linear regressor. The significance of differences was tested by a likelihood ratio test and contrasts assessed with Wald tests.

**Results** Statistically significant variation ( $p=0.01$ ) was found in hospital and hospice deaths between patients from the highest socioeconomic group and the lowest, although no variation was found in home deaths. Only 45% (22/49) of patients known to SPC services in the lowest SE group died in a hospice, compared to 60% (97/163) in the highest, while 28.5% (14/49) of patients known to SPC from the lowest SE group died in hospital compared to 12% (20/163) in the highest.

**Conclusions** Even after referral to SPC, statistically significant variation in place of death was found between patients from the highest socioeconomic group and the lowest. Patients from the highest SE group were more likely to die in a hospice and less likely to die in a hospital than patients from the lowest SE group, although no variation in home deaths was found. Further multivariate analysis and investigation of reasons for this variation are required

# P-87 PHYSIOTHERAPY PALLIATIVE CANCER CARE: A CASE STUDY APPROACH

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**Background** Evidence suggests that there is an increasing need for physiotherapists in palliative cancer care services. However, there is a lack of understanding of their role, educational

needs and place within the rehabilitation team. The purpose of this study was to explore a local palliative cancer care physiotherapy service provision in light of best practice recommendations.

**Method** A qualitative approach using a single case study design was chosen as it provided a framework to facilitate the inclusion of multiple perspectives in a complex context within an area of healthcare where little research has been undertaken. Multiple methods of data collection were used from numerous perspectives, which included four data sets: interviews (healthcare professionals [10]); interviews (service users [10]); observations (physiotherapists [2] treating service users [5]); and policy document collection (NICE guidelines; white papers [12]). Data collection occurred from 2008 to 2014 and detailed data analysis was carried out from 2012 to 2014 using a thematic approach within a framework, comparing and contrasting patterns within and across the four data sets.

**Findings** Emergent themes highlighted a number of important aspects relating to physiotherapists including: new ways of working, shift in mindset and treatment planning, emotional adjustment and integration of professional boundaries. This evidenced a metamorphosis of both the physiotherapist's profession and service provision through key competencies, such as entrepreneurial, leadership, policy champion and humanisation skills, which enabled them to meet essential policy recommendations of service quality and innovation.

**Conclusion** This study provides a framework and unique perspective within which the physiotherapy profession can focus its attention on how physiotherapy needs to change in the future. However, a debate is necessary around the need for profession specific or service specific outcomes in this area, and how physiotherapists 'prove their worth' now that they are an integral part of palliative cancer care provision.

# P-88 EVALUATION OF A PILOT SERVICE DESIGNED TO IMPROVE TRANSITION FROM CHILDREN'S PALLIATIVE CARE SERVICES

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**Background** There are increasing numbers of young people (YP) with life limiting diagnoses living into adulthood. When these YP become too old for children's hospice services there is a recognised gap in their care and they often experience challenges when transitioning into adult services. A two year pilot project was developed between a hospice's adult and children's services to try to address this gap and aid transitioning. The pilot involved a day service two Saturdays per month with occasional overnight trips, with two separate groups depending on the YP's ability to communicate.

**Aim** To evaluate the pilot project.

**Method** Three focus groups made up of key stakeholders in the service (YP, their parents and staff) were performed and analysed using an adopted thematic analysis framework.

**Results** Three YP, seven parents and six staff members participated. Five main themes across the three groups were identified;

- Transition is Tough
- Continuity
- Parental Care
- The pilot service helps
- The Future

Participants described the transition period as a difficult time for both the YP and their families, with a perceived lack of adult services available for them. All groups agreed that the pilot project had a positive impact on the YP and their families, with the social benefits highlighted as a key factor. All participants were keen for the project to continue, ideally on a more frequent basis with more overnight stays, and the parents were keen to be more involved in the running of the service.

**Conclusion** The key stakeholders in this service were all positive regarding the impact the service has had on the YP and their families, and were keen to see it continue. This pilot models a service that could be adopted by other organisations.

### P-89 RECORDING PREFERRED PLACE OF DEATH: A DYNAMIC PROCESS

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A patient's preferred place of death (PPD) is frequently used as a marker for quality of end of life care. However, surveys of patients with life-limiting conditions indicate that "dying in preferred place" is not their highest priority (Actions for End of Life Care NHSE 2014-2016). As end of life approaches other priorities often take precedence and PPD may change.

**Aim of our audit** To establish how many inpatients referred to our hospital Supportive and Palliative Care Team (SPCT) had PPD recorded, what their preferences were and whether they changed.

**Methods** Data was extracted retrospectively from a database of inpatient deaths referred to the SPCT between July and August 2016

**Results** 63 patients had a PPD recorded - 33 patients at initial consultation and 30 patients at subsequent consultation. Initial PPD was acute hospital (25), home (16), no preference (9), hospice (9), care home (4). 13 patients (21%) changed their PPD during their admission. 6 patients with initial PPD home or hospice changed to acute hospital. 4 people changed their preference to care home (from hospice or home). From 16 patients whose initial PPD was home, this remained their final preference in 7 cases. 6 patients changed their PPD more than once.

**Conclusions** Our data shows that almost half of patients do not discuss PPD at initial consultation but are happy to state preferences subsequently. This could be due to development of rapport and relationship with SPCT members. Interestingly, PPD changed during the hospital admission in one fifth of cases with the majority electing to not spend last days of life at home. This could be due to changes in condition, symptoms and performance status coupled with perceived burden on caregivers. Discussing preferences for place of death should be a dynamic process as care related priorities may change as end of life approaches.

### P-90 PRACTICE IMPROVEMENT PROJECT: PALLIATIVE CARE SERVICE PROVISION FOR PEOPLE WITH DYSPNOEA

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**Background** A scoping exercise and literature review of national and local initiatives highlighted innovation and evaluation as critical elements of change within the healthcare system, where NHS policies require healthcare professionals to research effective ways to deliver healthcare, including evaluation and service improvement. Gaps were identified through reflection in and on practice, within a dyspnoea clinic in a palliative care setting. The purpose of this practice improvement project was to promote patient-centred care, within which care decisions reflected the needs, values and beliefs of the palliative care service users and those providing the care.

**Method** Firstly, a concept analysis approach was used to: a) identify service user needs b) demonstrate that improvement in practice was necessary and c) facilitate change. Secondly, a collaborative nurse/physiotherapist approach was chosen as a model of best practice for the delivery of the non-pharmacological approach to dyspnoea. Finally, an improvement framework which consisted of six elements 1) person-centredness, 2) evidence, 3) improvement processes, 4) enabling and sustaining change, 5) leadership and facilitation, 6) learning and development was used to enable best practice to be implemented into the clinic.

**Findings** The literature review confirmed that the non-pharmacological approach to dyspnoea within a clinic setting continued to be gold standard best practice. It also highlighted that this approach could support people with cancer who were breathless but did not have lung metastases, as well as other chronic lung conditions and those with heart failure. Therefore, the referral criteria, documentation and outcomes for the clinic were revised and widened to include these conditions.

**Conclusion** This evidence based improvement project reflected the needs, values and beliefs of people with dyspnoea and those providing the care meeting policy recommendations and hospice requirements. In doing so it provides information that would help in the future commissioning of dyspnoea clinics.

### P-91 INTEGRATION OF SPECIALIST PALLIATIVE CARE INTO A TERTIARY NON-MALIGNANT SERVICE: EVALUATION OF POTENTIAL GEOGRAPHICAL DISPARITY

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**Background** Idiopathic pulmonary fibrosis (IPF) is a progressive, scarring disease of the pulmonary interstitium. Though emerging anti-fibrotic therapies (Pirfenidone and Nintedanib) are available for selected patients, the symptom burden remains high (breathlessness, cough) and disease trajectories are variable. Resultantly, NICE recommends incorporation of specialist palliative care (SPC) into IPF services.

Only designated IPF centres can prescribe anti-fibrotic medications. This approach generates risk of geographical healthcare inequalities.

IPF services for the North East and Cumbria are delivered by the Royal Victoria Infirmary in Newcastle upon Tyne. SPC support from Marie Curie Newcastle was incorporated in January 2016. We present an initial evaluation of our novel collaborative service.

**Aims** Aims were (1) to map the distribution of patients prescribed anti-fibrotic medications, and (2) to map the distribution of patients who were referred to clinic-based SPC.