

P-129 ANTICIPATORY MEDICATION POCKET CARDS. DO THEY IMPROVE CONFIDENCE AND COMPETENCE IN FY1S?

^{1,2}Cathryn Winnett, ^{1,2}Hazel Coop, ^{1,2}Anna Lock. ¹Sandwell and West Birmingham NHS Trust, Birmingham, UK; ²WM CARES

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Background Many Foundation Year One (FY1) doctors feel anxious and lack confidence in caring for the dying. Prescribing anticipatory medication is one element of this care. Pocket cards with the standard anticipatory medication regimes have been distributed to junior doctors in Sandwell and West Birmingham NHS Trust since 2013. Previous published studies have demonstrated that pocket cards improve confidence and competence in prescribing.

Objective To evaluate the impact of anticipatory medication pocket cards on confidence and competence with prescribing in FY1 doctors at Sandwell and West Birmingham NHS Trust.

Method Distribution of a short electronic survey to FY1 doctors at Sandwell and West Birmingham NHS Trust to assess knowledge of anticipatory medication, use of pocket cards and whether the doctors felt to cards improved their confidence with prescribing.

Results The survey was completed by 17 FY1 doctors across Sandwell and West Birmingham NHS Trust. Four (24%) of respondents possessed a pocket card. Of these four, all listed the anticipatory medication and their indications correctly. The FY1 doctors who did not possess a pocket card, only 62% correctly listed the medication. The main resource used for anticipatory prescribing was the hospital guidelines. For those with pocket cards 100% of respondents found them a useful resource and felt they improved their confidence. Many of the doctors without cards also felt they would be useful if they had access to them.

Conclusion The distribution of pocket cards amongst the FY1 doctors questioned was poor (24%) however of those that did possess a card 100% found it to be useful. The next step is to distribute pocket cards to all FY1 doctors at SWBH and repeat the survey after this intervention.

P-130 IMPLEMENTATION OF ELECTRONIC PATIENT RECORDS – A HOSPICE JOURNEY

Rishi Patel, Philip Lomax, Alison Phippen, Alison Roberts. *St. Ann's Hospice, Manchester, UK*

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Background Electronic patient records were successfully implemented at all sites of St Ann's Hospice in September 2016. A scoping exercise selected EMIS Web, and an implementation group was formed in December 2015.

Method The implementation group consisted of 16 individuals including a project lead, multi-disciplinary healthcare professionals and administrative staff. The project lead was accountable to a board; compromising service managers and executive directors. Implementation group meetings occurred fortnightly in the planning stages, then weekly at the configuration stages until the "go live" date. A medical representative participated in greater than 98% of all meetings.

Results The project was summarised into three phases leading to clinical use as described here. As doctors within the group we draw on our reflections of the process.

Planning - This was regularly revised to provide realistic timeframes whilst incorporating the views of participants. The importance of clinical leadership became clear at the infancy to support the project lead, who had a non-clinical background. Collaboration between professionals was essential to create a working list of documents requiring transition to an electronic format.

Software configuration - We learnt that sound knowledge of software is essential when designing a system, to identify its limitations and identify its potential. Having a clinical leader present with software expertise is crucial to guide non-clinicians through the process of translating documents to an electronic format. Experience of coding is important, given the complexities of data extraction.

Staff training - This created challenges, but the completion of standardised learning objectives was well received alongside role-specific objectives. These are currently utilised for staff induction across all professional groups.

Conclusion The process highlighted strong collaborative working practices and recognised the importance of clinical leadership. We identified areas for development, resulting in improved training programmes. A robust and innovative platform has been created for developing future electronic patient records.

P-131 MEETING THE NEEDS OF PATIENTS WITH PULMONARY ARTERIAL HYPERTENSION: AN IMPORTANT ROLE FOR A HOSPITAL PALLIATIVE CARE TEAM

Rachel Parry, Iain Armstrong, David Kiely, Vandana Vora. *Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, UK*

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Background and aim Pulmonary Arterial Hypertension (PAH) is a rare progressive disease leading to right heart failure and premature death with a prognosis worse than many cancers. Despite this there is very little published data on the disease trajectory during the terminal phase and how hospital palliative care services are accessed. The aim was to assess the reasons for referral, patient outcomes and challenges encountered in one of the largest Pulmonary Vascular Disease Units (PVDU) in Europe serving a population of in excess of 15 million.

Methodology We performed a retrospective review of consecutive patients referred to a Hospital Palliative Care Team (HPCT) from the Sheffield PVDU between 2011 and 2016. Information was extracted from an electronic patient database (Infoflex) capturing details of referral, diagnosis, assessment and HPCT interventions.

Results 30 patients (16 Female), median age 65.6 (range 18–86) were referred; 73% had ECOG performance status 4. The primary reasons for referral were symptom control (mainly breathlessness 71%) and management of end of life care. Given the quaternary nature of the PAH service, 25/30 patients were from outside our local area. During follow-up, 22/30 patients died. 14 patients died during their hospital admission (mean time to death from referral to HPCT 7 days (range 0–27)). For 8 patients the HPCT facilitated and achieved a preferred place of death (3 to local hospice and 5 to own home). The biggest challenge was coordinating end of life care in timely manner due to the geographic locations of patients.

Conclusion Patients are often referred very late in the terminal phase of their disease process. Whilst the specialist PAH team provide basic symptom control and support, earlier referral and proactive involvement of the HPCT as part of a multidisciplinary team would help address advanced care planning, complex symptom control and end of life care.

P-132 COMBINED ONCOLOGY & PALLIATIVE CARE CLINICS; WORKING IN PARALLEL

¹Beccy Benham, ¹Anna Broadbent, ¹Amman Mader, ²Joanne Palmer, ^{1,3}Deborah Stevens, ^{1,2,3}Carolyn Campbell, ^{1,2}Rachel Newman, ^{1,2,3}Jane Gibbins. ¹Exeter Medical School, UK; ²Royal Cornwall Hospital Trust, UK; ³Cornwall Hospice Care, St Austell, UK

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Background Early Specialist Palliative Care (SPC) introduced to patients with advanced lung cancer has recently been proven to enhance quality-of-life and improve survival.¹

Combined Oncology and Palliative Care Clinics (COPCC) have been carried at Royal Cornwall Hospital Trust for over two decades, to enable patients to be reviewed by Palliative Care Consultants (PCC) whilst attending Oncology Outpatient review; enabling the two specialities to run in parallel to improve patient care. The aims of this project were to explore the types of patients seen and content of consultations.

Methods A retrospective review of the current PCC consultation letter of 150 consecutive patients reviewed between 01/2016-06/2016. Data collected by three medical students.

Results Of the 150 patients, 49% had on-going/planned palliative oncological options (POO), 20% optimal supportive/symptom control (SSC), 18% radical treatment and 13% treated with curative intent. 75% had stable disease, 23% deteriorating and 2% in their last month of life.

The main focus of the consultation was symptom control (95%), followed by discussions around aims of palliative/oncological treatment (71%).

For patients who were considered POO or SSC (n=104), 66% were referred/known to the community SPC nursing team. The median number of consultations per patient was 2.9, and patients were known to the service for up to 5 years and 2 months.

Conclusion COPCCs appears to facilitate collaborative working between disciplines to enable optimal symptom control, information sharing and forward planning to patients attending oncology clinics. Unsurprisingly, PCC focus on symptom control and early referral to SPC services in the community. Many patients are seen when they are 'stable' suggesting the service is proactive in approach. COPCCs remove the need for a 'referral' to SPC, and allows patients to be seen who perhaps wouldn't otherwise be referred to SPC.

REFERENCE

1. Temel JS, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *NEJM* 2010;**19**:733–42.

P-133 COMBINED ONCOLOGY & PALLIATIVE CARE CLINICS; HOSPICE IN-PATIENT STAYS AND PLACE OF DEATH

¹Anna Broadbent, ¹Amman Mader, ¹Beccy Benham, ²Joanne Palmer, ^{1,2,3}Carolyn Campbell, ^{1,2}Rachel Newman, ¹Deborah Stevens, ^{1,2,3}Jane Gibbins. ¹Exeter Medical School, UK; ²Royal Cornwall Hospital Trust; ³Cornwall Hospice Care, St Austell, UK

10.1136/bmjspcare-2017-00133.132

Background Early Specialist Palliative Care (SPC) introduced to patients with advanced lung cancer has been proven to enhance quality-of-life and improve survival.

Combined Oncology and Palliative Care Clinics (COPCC) at Royal Cornwall Hospital Trust enable patients to be reviewed by palliative care consultants whilst attending for oncology review; facilitating the two specialities to run in parallel to improve patient care. The aims of this project were to explore the use of inpatient hospice facilities of all patients, and place of death those for those patients who died.

Methods Retrospective case-note review of 150 consecutive patients between 01/2016-06/2016. Data collected by three medical students.

Results Admissions to hospice: 18/150 patients (12%) had at least one hospice admission, with the most common primary reason for admission being symptom control (83%). Total number of admissions of any one patient ranged from one to seven. Length of stay range; one to 46 days, with a median value of nine days. Patients were known to the hospice up to 65 months prior to death. 11/18 patients died during their last hospice admission, and seven were discharged home.

Place of death: 29/150 (19%) patients died at the time of data collection; 12 (41%) died at home, 11 (38%) died in a hospice, 3 (10.5%) died in acute 3 (10.5%) or 3 (10.5%) community hospitals.

Conclusion Access to SPC in COPCCs appears to enable early contact with inpatient hospice units, and enable more patients to die in hospices and at home. 38% of this study's deceased patients died in a hospice; a 2.3 fold increase compared to hospice deaths of cancer patients specifically (16.4%).² The number of deaths is small and warrants follow-up studies.

REFERENCES

1. Temel JS, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *NEJM* 2010;**19**:733–42
2. National End of Life Care Intelligence Network.

P-134 SHOULD SIM MAN DIE? FINAL YEAR MEDICAL STUDENTS' BELIEFS AND ATTITUDES REGARDING DEATH IN SIMULATION

^{1,2}Lowri Evans, ^{1,2}Joseph Hartland. ¹Swindon Academy, Great Western Hospital, Swindon, UK; ²University of Bristol

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Background Learning to deal with death is an essential for medical graduates but there is no educational consensus whether sim man should die in undergraduate simulation. Concerns include being too distressing for students or