Oral presentations
Free papers 1 – 3: impact & involvement

[1] INVOLVING FAMILIES AND CARERS IN LEARNING FROM DEATHS

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10.1136/spcare-2020-PCC.1

Background In 2018, the National Quality Board published national guidance aiming to improve how we engage with and support families/carers after death. The guidance requires trusts to ask if families had any concerns about the care their relative received.

Method LTHT formed a multi-professional working group to implement the guidance. A new process was tested and implemented in June 2019 in which families/carers who attend the Bereavement office to collect the medical cause of death certificate (MCCD) are asked if they have any questions or feedback about the care of the person who died. This information is collected and any questions are sent to the Patient Advice and Liaison Service (PALS) to liaise with the relevant department to make contact. If any questions cannot be resolved they are escalated through the formal complaints process. Families are given contact details if they have questions at a later date. All feedback is collated by the end of life care team and fed back to clinical teams on a monthly basis.

Results Since the process was implemented, there were 943 adult deaths. Of those:

- 46 families (4.8% of deaths) had questions which were referred to PALS
- 279 families (29.5% of deaths) had positive comments about care
- 307 families (32.5% of deaths) had no comments
- 49 families fed back areas for improvement but did not want to be referred to the clinical teams through PALS.

Data is being collated to determine how many PALS escalate to a formal complaint and to establish if this new process results in fewer complaints.

Conclusions An unexpected consequence of implementing the new process has been the wealth of positive comments about the care dying patients and their families have received. Further analysis will be needed to monitor the impact on complaints and whether we are better meeting the needs of bereaved families.

[2] DEVELOPMENT OF AN INTEGRATED PALLIATIVE CARE PHARMACIST ROLE ACROSS HEALTHCARE BOUNDARIES

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10.1136/spcare-2020-PCC.2

Introduction The aim of this 3 year project is to develop and evaluate the role of an integrated palliative care prescribing pharmacist, working across different settings to support patients.

Methods The pharmacist works within all areas of the palliative care team, including community, hospital liaison and inpatient palliative care unit (PCU). They contribute to multidisciplinary meetings for each of these teams, accepting referrals for a variety of interventions, including complex symptom management, problematic polypharmacy and medication optimisation. The pharmacist visits the patient (at home, in hospital or on PCU) to discuss their medication, suggest possible changes and come to a shared decision with the patient. The pharmacist then works with teams in primary and secondary care, making interventions and suggestions in order to optimise symptom management, reduce undesirable effects and deprescribe futile medication. The patients are followed up and reassessed throughout their journey, monitoring the response to changes. They also support with the education and training of other members of staff within and outwith the specialist team, as well as contribution and development of policies, clinical guidelines, patient information and quality improvement projects.

Conclusion The development of this role has supported the work of the palliative care service, and increasingly been able to provide independent reviews of patients across boundaries of community, hospital and PCU. Going forward, interventions will be assessed further to determine the impact on patient outcomes.


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10.1136/spcare-2020-PCC.3

Background With few systematic attempts to demonstrate the impact of day-to-day palliative care in clinical services, this study aimed to demonstrate the impact of inpatient palliative care by using routinely-collected outcomes data to estimate the prevalence of symptoms/concerns, and demonstrate improvement in these outcomes over episodes of care.

Methods Secondary analysis of routinely-collected clinical and outcomes data (patients demographics, episodes of care, palliative Phase of Illness, and symptoms/concerns using the Integrated Palliative care Outcome Scale; IPOS) from all admissions to one inpatient hospice unit, between June – November 2019. We defined ‘improvement in outcome’ as any patient with ‘moderate’, ‘severe’, or ‘overwhelming’ IPOS items (scored 2,3 or 4) at start of episode of care, which improved to ‘not at all’ or ‘slightly’ (scored 0,1) by end of episode. Caldicott Guardian approval was received for analysis of this anonymized data.

Results 20,999 contact observations relating to 386 patients receiving 417 episodes of care were analysed. This incorporated 2,307 palliative Phases. Median age was 73 years (IQR 60–83); 82% had cancer.

By the end of the episode of care:
PROGNOSTIC COMMUNICATION WITH FAMILIES OF PATIENTS AT THE END-OF-LIFE IN A HOSPICE: A QUALITATIVE INTERVIEW STUDY

Rebecca J Anderson, Joseph TS Low, Steven Bloch, Patrick C Stone. University College London

Background Research has consistently shown that patients at the end-of-life and their families value honest communication about prognosis. In the final hours and days of life, communication with families is particularly important, as at this point patients are often unable to communicate. This study aims to understand experiences of end-of-life prognostic communication from the perspective of hospice clinicians and relatives of patients.

Methods Semi-structured interviews and a focus group were carried out with five senior hospice clinicians and twelve relatives of patients who died in the same hospice in the previous 3–6 months. Thematic analysis was used to identify relatives’ and clinicians’ perspectives on what is important to them during end-of-life prognostic communication.

Results Clinicians suggested that as long as the family was aware that the patient was dying, it was not always necessary to raise prognosis. They felt repeatedly talking about timelines could cause families to become fixated on prognosis. When they did raise prognosis, this was often for practical reasons, such as ensuring relatives could stay overnight to be present if they did raise prognosis, this was often for practical reasons, to raise prognosis. They felt repeatedly talking about timelines aware that the patient was dying, it was not always necessary and clinicians’ perceptions of the patient’s deterioration to help them understand the prognosis, and emphasised the importance of being honest about the uncertainty. Relatives appreciated this honesty and were aware that it would not be possible to be given an exact timeline. Some described information on what to expect during the dying process as helpful, but others felt this information was lacking.

Conclusions Relative and clinician accounts of prognostic communication were generally aligned, with a focus on providing an awareness that the patient was dying whilst highlighting prognostic uncertainty. Clinicians should be aware that some relatives want further information about what changes to expect in order to be reassured that the patient’s symptoms are a part of the natural dying process.

Quality Improvement - Development of an Interactive Staff Education Session to Raise Confidence in Discussing LGBTQ+ Issues in the Hospice Setting

Vicki Ewart, Kate Morris, Tina Abberline, Donna Wakefield. Marie Curie Hospice Newcastle

Background People who identify as LGBTQ+ are at an increased risk of certain serious health conditions including types of cancer and so it is vital that this group of people feel able to access palliative care services. In 2014, Marie Curie commissioned research which highlighted a lack of evidence about LGBTQ+ people’s experience of palliative care. A recent study identified that individuals may feel unable to spontaneously disclose their identity to healthcare staff due to prior experience of discrimination. Therefore, it is important that all staff feel confident in talking to patients about sexual orientation.

Method Review of patient records to identify how many patients admitted to hospice over the past 6 months have been asked their sexual orientation. Development of a 3-hour interactive LGBTQ+ staff training programme. Review of written feedback from these sessions to analyse how this was received by staff.

Results Over the past 6 months, 146 patients were admitted. 52% had been asked about their sexual orientation. Small group LGBTQ+ teaching sessions were provided, where interactivity was promoted with activities such as a quiz and word-search. Feedback indicating that this was a valuable learning opportunity for staff. Quotes included, ‘more aware of LGBTQ+ terms that patient may use and what they mean’, ‘increased awareness and has made me more confident to ask’, ‘session highlighted the importance of continuing to treat patients as individuals’.

Discussion Marie Curie has made great strides both locally and nationally to ensure LGBTQ+ patients feel welcome. New training sessions have been provided to ensure that all staff feel confident in being able to openly discuss LGBTQ+ issues and feedback from this has been extremely positive. We plan to re-review the data in 6 months to ensure that more patients are being offered the opportunity to disclose their sexual orientation on admission.

Bridging the Gap – An Educational Initiative to Improve Communication and Decision Making at End of Life Care at a District General Hospital and Its Local Area


Background and introduction North Middlesex University Hospital (NMUH) is a district general hospital that serves the culturally and ethnically diverse London boroughs of Haringey and Enfield. In a May 2018 questionnaire, NMUH staff reported that spiritual, religious and cultural factors frequently