study of domestic staff but found no research into the experiences of catering staff, a team who play a vital patient-facing role within our hospice.

**Aim** To explore hospice catering staff’s experiences of patient interactions on the inpatient unit (IPU): to better understand these interactions and what support is required.

**Methods** An online questionnaire was sent to all catering staff at our three Hospice IPUs in October 2019. Consisting of 18 closed and 7 open questions, it was adapted from Jors (2017). It was made available for 1 month, with the results then analysed on Excel.

**Results** The response rate was 52% (12/23). All respondents felt providing support for patients was an important aspect of their role. 75% spent at least 15 minutes per shift speaking to patients. 75% spoke to patients about their illness at least once a week, with the same proportion speaking about death and dying at least once a week. However, whilst staff felt confident and well trained to discuss food and drink, the reverse was true when it came to discussing illness or dying. Time pressures and limited communication with the IPU team were highlighted as difficulties.

**Conclusions** Our findings are similar to those of Jors (2017) study of domestic staff. We found that our catering staff have regular patient contact and that they value time spent with patients. These interactions often go beyond addressing nutritional needs, even though this is not a formal part of their role. We will present suggestions for supporting staff when these conversations occur and suggestions for further research into this area.

**REFERENCE**


109 **DEVELOPING AN EARLY PALLIATIVE CARE SERVICE WITHIN MYELOMA OUTPATIENTS**

Rebecca Gemmell, Angela Halley, Mark Ethell, Priya Sriskandarajah, Joanne Droney. Royal Marsden NHS Foundation Trust

10.1136/spcare-2021-PCC.127

**Background** Earlier referral to palliative care is increasingly being utilised in solid tumour oncology to improve quality of life and symptom control. Patients with haematological malignancies have similar symptom burden but are frequently referred later to palliative care. We recently established an integrated early palliative care service for patients with recently progressive or relapsed myeloma within our tertiary referral cancer centre. Patients are seen within the haematology oncology clinic by a member of the palliative care team.

**Methods** We evaluated this new service using a quality improvement PDSA (Plan, Do, Study, Act) framework under domains of proportion of eligible patients reviewed, evidence of patient needs and staff feedback. Demographic details including age were collected from electronic patient records, MyPOS (Myeloma Palliative Outcome Scale), performance status and disease stage. Anonymous feedback was collected from haematology professionals working in the clinic using an online questionnaire.

**Results** Multiple PDSA cycles were completed over 5 months. These generated changes including seeing patients during their haematology review, and patients completing MyPOS assessments on arrival. 58% (25) of eligible patients were reviewed, improving from 43% at the project’s start to 86% at its end. 89% of patients reported at least one severe symptom, and 67% reported at least one overwhelming symptom. Despite this, patients had a median Karnofsky Performance Score of 80. Feedback from haematology professionals reflected a desire for increased co-working and palliative care presence within the department, including 90% rating the value of the service for patients as very positive.

**Conclusion** Early palliative care in myeloma is feasible and allows input for patients not routinely referred to palliative care, potentially enabling shared decision making, advance care planning and improved quality of life. Patients have a significant symptom burden that may benefit from symptom control input.