

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

1. Jors K, Tietgen S, Xander C, Momm F and Becker G. Tidying rooms and tending hearts: an explorative, mixed-methods study of hospital cleaning staff's experiences with seriously ill and dying patients. *Palliative medicine* 2017; **31**(1): pp.63–71.)

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DEVELOPING AN EARLY PALLIATIVE CARE SERVICE WITHIN MYELOMA OUTPATIENTS

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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 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.

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PERSONALISED END-OF-LIFE CARE PLANS – A LOCAL REVIEW

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10.1136/spcare-2021-PCC.128

Background The Liverpool Care Pathway was abolished in 2014 following widespread criticism. Since then there has been a focus on local personalised care plans for dying patients.

Objectives The aim of the study was to evaluate the number of patients placed on a personalised end-of-life care plan (PELiCan) during a 5 year period. Then to identify the number of patients removed from a PELiCan. Finally to identify whether removing a patient from an end-of-life care plan was appropriate (the patient was not in the final 7 days of life). By analysing this data we hope to guide and improve our future palliative care practice.

Methods A retrospective study looking at patient information collected from electronic records of all patients started on a PELiCan at The Royal Surrey County Hospital. Inclusion: all patients placed on a PELiCan from August 2015 to July 2020. Patients removed from a PELiCan were evaluated further to assess their outcome.

Results 2465 patients were placed on a PELiCan over 5 years. Overall 2424 patients were included in the study. 94% of patients who started a PELiCan remained on this until death. 157 (6%) patients were taken off a PELiCan. Following removal of PELiCan 28% of patients died within 7 days. Overall the majority of patients had a non-cancer diagnoses. 682 (28%) patients placed on a PELiCan had a primary diagnosis of cancer. Similarly in those removed from a PELiCan 24% had a cancer diagnoses.

Conclusion Number of patients placed of end-of-life care plans has increased within our trust since 2015. A small proportion of patients were removed from personalised end of life care plans. These patients represent a known group of individuals high risk for deteriorating requiring palliative care input and follow up. Based on this we have introduced a palliative review process for these patients.