Abstracts

- Demonstrate the patient’s right to have a say in their care. (NICE, 2004).
- Demonstrate compliance with the End of Life Care Strategy (DoH, 2008).
- Legal imperative for all organisations providing NHS funded services. (National Health Services Act 2006, Local Government and Public Involvement in Health Act 2007, Equity and Excellence: Liberating the NHS, 2008.)

Materials and methods: A steering group was set up incorporating senior members of staff including a Trustee and the Chief Executive. This group identified various methods for involving our stakeholders which included:

- Interviewing patients, carers, volunteers and paid staff
- Listening exercise with carers

Questionnaires: Productive Ward Series
- a template for writing reports on these activities
- a leaflet to hand-out giving an explanation of “Involvement”

Results: As a result of this we are now:

- Piloting Nurse Led Clinics
- Opening Day Care to bereaved carers
- Using a new discharge planning template on the inpatient unit
- Implementing a “Carer’s Break” scheme via Day Care
- Developing a complementary therapy strategy based on user feedback about the value of this service to them

Conclusions: The moving from “meeting” to “happening” has helped to promote the principles of equality, fairness and inclusiveness by actively seeking to engage with our stakeholders including our staff.

The identification of services valued by patients and their carers has ensured that our finances are spent in addressing the needs of our patients rather than what we consider their needs to be.

P153 SERVICE USER GROUP (SUG) - FROM INCEPTION TO BEYOND
Doreen Thompson. Willen Hospice, Milton Keynes, United Kingdom

Background: To establish a SUG giving patients, carers, staff and members of the public the opportunity to engage in improving hospice services.

Involvement covers a range of activities, from consulting service users about their views in partnership, to aid the development of projects or services.

Ensures the views of patients, carers and the public are listened to, ensuring that we continue to maintain excellence within our service now and into the future.

Aims and objectives:

- SUG established to enable the hospice to provide evidence of consultation on matters directly related to patient care.
- SUG involved in consultation on available information for service users.
- Review and approve production of literature to ensure service users receive relevant information.
- SUG involved in fund raising and promotion of hospice services.
- SUG ensures service users input into service provision, promoting standards of excellence in patient care

Approach used:

- IPU Sister identified as project lead.
- Advertised to promote development of Service User Group. Invited participants to join via appropriate communication channels.
- Guest speaker utilised to drive engagement.

Outcomes: The SUG is involved in decision making on hospice improvements and have participated in workshops with a local Cancer Network Group. A service user and the Network group leader were key speakers at the group conference. The SUG have worked on patient feedback and audit tools and information leaflets for patients and families.

The SUG were runners-up in the Patient Experience Network (P. E. N.) awards 2012.

SUG has forged links with the local Hospital patient partnership forum. Representatives attend the meetings of both groups.

With a diverse, growing local population the SUG helps to reflect our local community needs. Their unique input helps the organisation see new perspectives on service development.

P154 FOOD AND NUTRITION IN A HOSPICE: FROM AUDIT TO ACTION

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In 2011, Princess Alice Hospice (PAH) participated in the test phase of the Nutrition and Hydration Audit tool which was created jointly by the Help the Hospices Food and Nutrition Group (FNG) and the National Audit Tools Group (NATG). Since this pilot audit was completed a number of steps were taken to reach standards that were highlighted by the audit:

1. A ‘Nutrition Requirements Tool’ was introduced on the ward. Further work has been undertaken to develop this tool.
2. Understanding the patient experience is at the heart of hospice care. We asked patients on the ward and in Day Hospice to tell us what they thought of our food service. Patients told us that the food and drink service that we provide is excellent. Areas of potential improvement are: protected mealtimes; attending to cultural & religious requirements; allergies and intolerances; special diets; giving written information re: food service; menus and food portions.
3. We provided regular teaching/training sessions for internal and external staff and volunteers. Our training enables healthcare professionals to become more involved in establishing nutrition as part of the patient’s care plan and actively listen to patients and carers, offering support for their needs in relation to foods and lifestyle.
4. An eight-week support and education programme for patients and carers was designed in Day Hospice, offering up-to-date information from our multi-disciplinary team on nutrition and diet, lifestyle and symptom control.
5. Our Nutrition Steering Group meets to promote the role of the multidisciplinary approach to nutritional management and care of our patients.

Princess Alice Hospice is committed to delivering safe and high quality nutritional care to people with life-limiting illnesses.
their families and carers. We are keen to share our results and experience with others and to improve further our service.

**P155** MAKING SENSE OF SHADES OF GREY!: IMPACT OF A PALLIATIVE CARE INTERVENTION FOR PATIENTS WITH LUNG CLINIC TO MEET THE NEEDS OF PATIENTS WITH COPD

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**Background** Patients with advanced disease require transportation to hospital for ultrasound identification of abnormal fluid and location marking. This is not only exhausting, but introduces service delays, increases work for an already overburdened hospital radiology service and reproducing the exact position of original scan is difficult.

**Aim** Does the introduction of portable ultrasound improve patient, carer & health professional experience and co-ordination of care?

**Method** Two hospice doctors underwent the necessary ultrasound scanning training for non radiologists. Following a selection process, an appropriate portable ultrasound machine was purchased, and support agreed with one of the local radiologists.

**Results** A retrospective review of thirty months ultrasound use was undertaken. One hundred and four patients have had one hundred and sixty eight separate scanning episodes resulting in eighty five procedures. Uses have included confirmation of presence & location of abdominal ascites prior to paracentesis, confirmation of location of pleural fluid prior to aspiration, confirmation of full bladder prior to catheterisation (urethral or suprapubic), monitoring the growth of large intra-abdominal malignant cyst, confirmation of hydrenephrosis, biliary stent placement & locating nerve in real time neural blockade. The poster includes detailed analysis of use.

**Conclusion** On each occasion a definitive clinical question was answered. Patients report greater satisfaction from a speedier service, families feel that patients are less fatigued by the interventions and staff feel able to give a better, more responsive, safer service, adhering to current best practice guidance. Being able to ultrasound patients in the home or in outpatients has prevented unnecessary admissions where the cause of abdominal distension had previously been in doubt.

**P156** LUNG CLINIC TO MEET THE NEEDS OF PATIENTS WITH NON MALIGNANT LUNG DISEASE AT GARDEN HOUSE HOSPICE

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10.1136/bmjspcare-2013-000591.178

**Introduction** In 2011 the Department of Health Outcomes strategy for COPD suggested that the needs and preferences of patients for care at the end of life were not being met.

The model of Day Hospice did not meet the needs of this group of patients; therefore a proposal was put forward with the support of the local chest physicians to provide a service accessible to COPD patients and their carers.

A pilot clinic was set up for twelve months. Staffed by a nursing Sister, a physiotherapist and trained volunteers.

**Aims** The aim was to develop an accessible multidisciplinary service that met the individual needs of the patients, family and carers. This included transition to palliative care services, psychosocial support, symptom management and advanced care planning.

**Method** During the pilot and the following year the numbers of patients attending was monitored. Also the source of referrals was examined. Some anecdotal feedback was gained from the referrals. The service was adjusted overtime to maximise accessibility for the patients.

A qualitative questionnaire was produced in December 2012 to find out the perceived benefits for patients attending the clinic and if there was anything else that could be provided. Nine questionnaires were completed.

**Results** The results of the questionnaire suggested that the patients were fearful of attending the hospice beforehand, however, once attendance had commenced their psychosocial and symptom control needs were being met. The results of the questionnaire will be made available.

**Conclusion** The clinic is meeting the patients’ needs, therefore it will continue in its current format. There is a need to discuss and consider strategies to educate the referrers on Hospice philosophy and the aims of the clinic so they can help change the fearful expectations of the patients on referral.