ASSESSING PAIN IN CHILDREN WHO ARE NON VERBAL USING ONE PAGE PROFILES TO IMPROVE PERSON-CENTRED CARE

Sonia Chand, Sandra Brown, Sheila Popert, Agnes Csikos, Peter Moore, Chris Cutler, Alison Allsopp, Martin Hill, Sonia Chard, Sandra Brown. St Giles Hospice, Whittington, UK; Pain Toolkit, Mindfulness, Relaxation, Cognitive Behavioural Techniques and Seated Exercise.

Background

Many require multiple recurrent transfusions over many months which allows a natural progression from active treatment into palliative services, within an environment which is well equipped to support them as their illness deteriorates. Our patient feedback shows we are running an excellent service for our patients, in a setting they enjoy.

Aim

To pilot and evaluate a holistic PMP tailored to the needs of palliative patients
To reduce use of analgesics
To introduce techniques for self-management of pain.

Design

Patients with a life-limiting illness, complex pain, a Pain Score greater than 5 and a Karnofsky Performance Scale greater than 50% were eligible for enrolment in the six-week programme
Patients were initially assessed by a palliative consultant and a pharmacist to optimise drug regimens
The PMP used a multi-disciplinary rehabilitative approach introducing the Pain Toolkit, Mindfulness, Relaxation, Cognitive Behavioural Techniques and Seated Exercise
Evaluation was by structured questionnaires, the Hospital Anxiety and Depression Scale (HADS) and Pain Scores.

Results

18 patients met the inclusion criteria, nine patients agreed to take part, five patients completed the programme. Age range 32 to 74 years
Patients reported moderate to severe anxiety and depression at the start. HADS scoring showed category improvement by the end
Mindfulness and relaxation were rated as the most beneficial elements
Patients reported group working supportive
Pain scores did not change significantly but patients used less breakthrough medication
Patients were able to employ techniques to self-manage pain.

Conclusion

It can be difficult for palliative patients to attend a six-week programme; however, for those who are well enough the pilot showed benefit, it improves pain self-management and reduces use of analgesics. Wider introduction of modified PMPs could be considered for palliative patients.

P-122 ENABLING PATIENTS TO SELF-MANAGE THEIR PAIN; A PILOT OF A MODIFIED PAIN MANAGEMENT PROGRAMME

Sheila Popert, Agnes Csikos, Peter Moore, Chris Cutler, Alison Allsopp, Martin Hill, Sonia Chard, Sandra Brown. 2St Giles Hospice, Whittington, UK; 2St Clare Hospice, Hastingwood, UK

Background

Despite WHO recommendations for the management of pain the prevalence in palliative patients remains between 62-86% and management remains primarily pharmacological. There is good evidence for the efficacy of Pain Management Programmes (PMP) based on cognitive behavioural principles for patients with chronic pain. They have been shown to improve pain experience, mood, coping, and activity levels. Palliative patients are rarely eligible for inclusion on such programmes.

Method

To pilot and evaluate a holistic PMP tailored to the needs of palliative patients
To reduce use of analgesics
To introduce techniques for self-management of pain.

Design

Patients with a life-limiting illness, complex pain, a Pain Score greater than 5 and a Karnofsky Performance Scale greater than 50% were eligible for enrolment in the six-week programme
Patients were initially assessed by a palliative consultant and a pharmacist to optimise drug regimens
The PMP used a multi-disciplinary rehabilitative approach introducing the Pain Toolkit, Mindfulness, Relaxation, Cognitive Behavioural Techniques and Seated Exercise
Evaluation was by structured questionnaires, the Hospital Anxiety and Depression Scale (HADS) and Pain Scores.

Results

18 patients met the inclusion criteria, nine patients agreed to take part, five patients completed the programme. Age range 32 to 74 years
Patients reported moderate to severe anxiety and depression at the start. HADS scoring showed category improvement by the end
Mindfulness and relaxation were rated as the most beneficial elements
Patients reported group working supportive
Pain scores did not change significantly but patients used less breakthrough medication
Patients were able to employ techniques to self-manage pain.

Conclusion

It can be difficult for palliative patients to attend a six-week programme; however, for those who are well enough the pilot showed benefit, it improves pain self-management and reduces use of analgesics. Wider introduction of modified PMPs could be considered for palliative patients.
in the hospice for a short period of time it is vital that we know what matters to them and what is important to them not just their clinical condition. We are encouraging staff to discuss one page profiles with patients on admission so that staff can get to know their wishes right from the start. Patients can change their one page profiles at any time.

We are receiving very positive feedback from patients that have completed them. Comments include:

‘I feel much more relaxed now that you know what my likes and dislikes are’

‘Suddenly after completing the one page profile I feel I have the strength to talk to my daughter about my wishes’

‘I am happy that my wife will be involved with decisions about my care this means a lot to me’

‘I feel safe and secure that my wish not to be resuscitated has been listened to and everyone will know my wishes’

We have a working group who are undertaking evaluations and will audit this work.

P-124 PREFERRED PLACE OF CARE – ROOT CAUSE ANALYSIS

Introduction Surveys and research indicate that home is the preferred place of care at the end of life for many people (71%), whilst the most commonly recorded place of death remains hospital (53%).

Aim To identify barriers and enablers to the delivery of good end-of-life care for patients.

Methods The project was completed over a six-week period at a hospice in Northwest England. Each week at our multidisciplinary team meeting we discussed deaths of patients known to our community palliative care team and recorded our findings.

Results 48 patients known to the team died during the six-week period. Preferred place of death was achieved in 91% (30/33) of cases when this was home, and 85% (11/13) of cases when this was the hospice. None of our patients expressed hospital as their preferred place of death (PPD). Preferred place of death was unknown in 4.2% (2/48) of patients, a hospital admission was indicated due to acute unexpected deterioration. 77% (21/27) of patients dying in the community had face to face or telephone contact within three days of death. Identified barriers to good end-of-life care were: difficulties accessing oxygen at home for symptom management, one episode of difficulty accessing specialist care advice and challenges communicating directly with district nursing teams. Enablers were: appropriate use of DNACPR forms with no involvement of emergency services at the end-of-life as well as good team-working between specialist and generalist services.

Conclusions The majority of patients known to the team die in their preferred place of care, with a good quality of death as judged by the team. Lessons have been learned from after death analysis and action plans devised. This scoping exercise could be repeated on a periodic basis.