P-205 BISPHOSPHONATE TREATMENT IN BONE METASTASES:
AN INTERVENTIONAL OUTPATIENT CLINIC MODEL

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Background Patients with bone metastases can suffer from considerable pain and reduced quality of life, in addition to complications such as pathological fracture and spinal cord compression. Bisphosphonates can be used as an adjunct to treat pain in addition to conventional analgesia and radiotherapy.

Aims Our outpatient bisphosphonate infusion service at the hospice was set up in 2008, in conjunction with our local acute NHS trust oncology unit. The pilot service initially accepted patients with bone metastases from hormone refractory prostate cancer when pain was not controlled with conventional radiotherapy and analgesia.

Method Patients benefit from an outpatient appointment with a doctor and nurse to assess current symptoms using IPOS (Integrated Palliative care Outcome Scale), followed by bisphosphonate treatment on the same day. Referral into other services within the hospice, such as physiotherapy, occupational therapy, rehab services and our FAB (Fatigue, Anxiety and Breathlessness) clinic, can be made when needed.

Results Following review of the service we now accept patients earlier in their disease trajectory and treat patients with bone involvement from other diagnoses such as myeloma, sarcoma or renal cancer. Our referral numbers continue to increase on a yearly basis.

We have successfully treated patients with recurrent hypercalcaemia in the day case setting by monitoring levels closely and treating early with a bisphosphonate before they are symptomatic; thereby reducing morbidity, preventing the need for inpatient admission and reducing pressure on acute hospital services.

Conclusion Future expansion of this interventional outpatient clinic might include breast cancer patients who currently receive denosumab injections in the hospital. We could use this model of service to allow early integration of these patients into palliative care services and allow them to benefit from the diversity of therapies and services the hospice can offer at an earlier stage in their illness.

P-206 REACHING THE WIDER NEED – A PILOT – THE ORCHARD SUPPORTIVE CARE CLINIC

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Hospice care continues to meet the needs of only a minority of patients who have specialist palliative care needs, either because prognosis is uncertain, patients themselves are not ready to accept ‘hospice’ or referrer/referee do not directly consider palliative care needs or prognosis. Indeed, many patients with non-cancer diagnoses will never see a palliative care specialist despite complex symptomatology and psychological morbidity. Recognising this gap, St Wilfrid’s Hospice developed a pilot clinic to bridge a gap in provision: accepting any patient with complex physical or psychological symptoms needing specialist clinical support/advice -associated with a chronic life-limiting illness of any diagnosis (or its treatment related symptom burden.) Prognosis could exceed 12 months (unlike hospice criteria) or be established/uncertain. The clinic aims were to promote proactive management- including self-management of symptoms, provide information for both patient and carers, offer an advance care planning course and breathlessness/fatigue management course, and provide general emotional support. The multidisciplinary team included a palliative care consultant, 2 CNs, occupational and physiotherapy, a complementary/art therapy and a volunteer.

65 patients were referred (9 declined input, one died before seen, six were too unwell, 40% of these had non-cancer diagnoses. 60% of referrals came from secondary care (commonest specialities-respiratory, neurology and urology.) Of the 49 patients seen in OSCC, 21 were later transferred to the main hospice caseload as their illness progressed; 12 then died once under the care of the main hospice, all of whom had completed advance care planning before transfer. Patients able to self-report symptoms completed Edmonton Symptom Assessment Scores (ESAS)

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at initial and follow up consultation. Most striking was the significant degree of psychological distress reported by 83% of the patients and cited as the main reason for referral. This was reflected in higher ESAS scores in the psychological domain and an impact on wellbeing scores.

In 2013 one of our volunteers (Jenny) voiced concerns that hospice clients attending a MS seated exercise class were finding the session less useful due to disease progression. Their weekly visit had proved to be invaluable to their wellbeing. Since becoming a volunteer with the hospice Jenny had done some basic complementary therapy training – reiki, “M” technique and chair massage. In conjunction with colleagues Jenny developed a 12 week programme for both clients and carers. The hour’s session started and finished with a relaxation/visualisation 10 minutes – and the middle section offered a different therapy each week. Jenny recruited trained therapists to gift their time and deliver a range of therapies. For example; massage, reiki, mindfulness, sound baths, reflexology etc.

From the outset the volunteers and therapists involved with the group were encouraged to facilitate a rehabilitative and enabling approach “to actively support patients to integrate self-management behaviours into their daily lives”. (Tiberini, Richardson Pg. 32) Group members evaluated their pain, mobility, general wellbeing and concentration. Also the effect of the session, both immediately and whether it had a longer lasting effect and helped them during the week.

The group has evolved into a sustainable cost effective programme. Every second week Jenny offers a therapy, either with or without additional therapists. On the alternate weeks the group focuses on mindfulness, either with Jenny of if she is unavailable one of the group puts on a mindfulness CD and the group runs itself.

Mindfulness was particularly popular and the Spiritual Coordinator has piloted an eight-week programme. Group members have discovered for themselves what therapies they benefit from and therefore might incorporate into their lives. Three group members went on to enrol on a complementary therapy course. Clients say the group experience generates fantastic positive “energy”.

Social Media, Communication and Technology

**P-209 COMMUNICATION – HOW TO MAKE IT CLEARER**

Elizabeth Bailey, Denise Williams. East Lancashire Hospice, Blackburn, UK

The Issue: We needed cost effective in-house communication skills education to suit all levels of staff and volunteers to ensure they had the knowledge, skills and confidence to communicate effectively with patients, their families and with each other.

Why it is important: All of our staff and volunteers will at some time be supporting people in distress. Clinical staff often have ‘big’ conversations with their patients – breaking bad news etc. They can only do this if they have the right communication skills and the confidence to use them.

What was done: We developed a three-tier programme of interactive communication skills workshops called CLEARER.

**P-208 THE VALUE OF TRAINING VOLUNTEERS IN ENABLING COMMUNITIES: MINDFULNESS AND COMPLEMENTARY THERAPY GROUP**

Julie Nicholas, Jenny Waite, Nikki Archer, Martin Hill. St Giles Hospice, Lichfield, UK

10.1136/bmjspcare-2016-001245.229

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