

**Background** Nearly half of all deaths occur in hospital. Most of end of life care (EOLC) is delivered by non specialist staff. Training is variable and usually not mandatory. How confident are front line staff in delivering EOLC?

**Methods** All inpatient setting healthcare professionals (HCPs) at a general hospital (549 beds) were invited (through email, hospital general bulletin, team meetings) to answer a 10 item questionnaire covering the five Priorities for Care of a Dying Person: their confidence rating on a Likert 1–7 scale about essentials of care and communication.

Scores 5, 6 or 7/7 = confident; scores 1–4 = not confident

All responses were anonymised and inputted via Survey monkey.

**Results** 181 responses were received: 50/181 ward nursing staff, 24/181 junior doctors, 21/181 HCAs, 20/181 consultants. Consultants were most confident; junior doctors and ward staff least. For all the least confident areas were discussing food and fluids and instigating an individualised care plan (Table 1).

**Abstract P-68 Table 1** Percent HCPs confident (n=181)

	All% (n=181)	Junior doctors% (n=24)	Ward nurses% (n=50)
Recognise a dying patient	65	67	64
Answer patients questions	51	50	42
Discuss DNACPR	44	58	44
Discuss food, fluids	35	42	34
Answer relatives questions	54	56	44
Individual care planning	40	38	32
Support patient and family	60	46	58
Symptom control	54	54	52

### Conclusions

- Hands on ward staff report lowest levels of confidence regarding caring for dying patients and their families.
- The least confident area was around discussing provision of food and fluids, which may explain why the NCDHAH 2016 found low levels of discussion regarding fluids (with patients: 18%; with relatives: 39% of cases)
- This questionnaire can identify specific confidence issues and thus be used to plan bespoke teaching sessions.

### P-69 HOSPICE CARE FOR DEPRIVED AREAS – A REVIEW OF THE EQUITY OF HOSPICE CARE IN OUR AREA

Katie Jerram, P J Morey, Steve Plenderleith. *The Rowans Hospice, Purbrook, UK*

10.1136/bmjspcare-2017-00133.69

**Background** In response to the 2015 Marie Curie commissioned document 'Equity in the provision of palliative care in the UK: Review of evidence' which found inequalities in the provision of Palliative Care across a number of domains including social deprivation, I undertook a review of our service in the deprived areas within our area of care.

The Rowans Hospice covers Portsmouth city and South East Hampshire and includes coverage of a number of areas which are within the 20% most deprived in the country.

**Method** I identified all patients referred to the inpatient unit or our Hospice at home service from deprived areas over one year, using Office of National Statistics data, Indices of Multiple Deprivation and computerised records. I noted demographics, diagnosis, referrer, time with service, preferred and actual place of death.

**Results** Compared with the area as a whole, I found that for patients from deprived areas:

- Access to Hospice at Home and inpatient services appears equitable
- Proportion of cancer to non-cancer seems similar
- Average time under the care of Hospice at Home is lower
- Likelihood of being admitted to the Hospice more than once is lower
- Length of inpatient stay is longer
- Chance of a greater than 21 day stay is longer
- PPD is less likely to be recorded
- Dying at home was less likely: but if patients had expressed a wish to die at home they were more likely to achieve this
- More likely than the national average to achieve their PPD

**Conclusions** The findings of this service review were interesting and broadly positive. Exploring some of the differences found with both service users and professionals would be helpful, and a new initiative (The Living Well Centre) may allow us to connect with those who may not engage with the traditional Hospice model.

### P-70 CERVICAL LYMPHADENOPATHY IN YOUNGER ADULTS

<sup>1</sup>Zakia Sultana, <sup>2</sup>Sik kim Ang, <sup>3</sup>Rifat Hasan Mazumder. <sup>1</sup>Broomfield Hospital, Chelmsford Essex, UK; <sup>2</sup>RIPAS Hospital, Bandar Seri Begawan, Brunei Darussalam; <sup>3</sup>Broomfield Hospital, Chelmsford Essex, UK; Supported by: Department of Internal Medicine RIPAS hospital, Bandar Seri Begawan, Brunei Darussalam

10.1136/bmjspcare-2017-00133.70

**Introduction** Cervical lymphadenopathy is a sign that can be presented in many diseases condition. We are presenting a case of fever with cervical lymphadenopathy due to Kikuchi Fujimoto diseases. Kikuchi lymphadenitis is a rare, benign condition of unknown cause usually characterised by cervical lymphadenopathy and fever. While, 40% of patient with Kikuchi disease were initially misdiagnosed as having lymphoma and were consequently over treated with chemotherapy. This pitfall remains an active source of diagnostic error.

**Case** Mr. Am is a 25 years old Malay man initially admitted under Internal Medicine department with history of fever and neck swelling for more than 2 weeks. During admission, his routine blood tests were normal. Chest X ray was also clear. Thereafter patient transferred under Palliative medicine unit for the further evaluation and management. His CT-TAP (thorax, abdomen and pelvis) reported as normal study. He underwent FNAC (fine needle aspiration and cytology) of the cervical lymph node which showed T cell lymphoma. Although, FNAC report did not clinically correlate. Therefore, for the further workup we performed bone marrow aspiration and trephine. His bone marrow showed leukopenia. We started to treat with steroid which showed some clinical improvement. Mr. Am was seen in the NUH (National University hospital) Singapore for second opinion. His working

diagnosis is now Kikuchi lymphadenitis. Unfortunately, he was presented with fever and low WBC count again in September 2014 and went to NUH Singapore and his current working diagnosis is recurrent Kikuchi lymphadenitis with Mycoplasma and Infectious mononucleosis infection. His PET CT scan reported as increased mediastinal masses with low significance. Currently he is under care of Palliative medicine of RIPAS hospital.

**Discussion** Our case illustrates a significant role of palliative medicine for the complicated clinical case. Which could be achieved by meticulous history taking and symptoms assessment and relevant investigations. Hence, integrated palliative care service could prevent the miss diagnosis, and ensures a better outcome.

#### P-71 EVALUATION OF A RAPID DISCHARGE PATHWAY FOR DYING PATIENTS

Sally Hall. *Royal Surrey County Hospital, Guildford, UK*

10.1136/bmjspcare-2017-00133.71

**Background** The rapid discharge pathway for the dying patient is an integral part of the Department of Health's End of Life Care Strategy. It is aimed at patients who are thought to be in the last 72 hours of life, although there is no clear guidance about identifying such patients.

The aim of this prospective service evaluation was to review the outcomes of patients started on the rapid discharge pathway for the dying patient.

**Methods** Data was prospectively collected on all patients started on the rapid discharge pathway during a six month period (February – July 2016) at a medium sized district general hospital with associated cancer centre. Data collected included: date of referral for rapid discharge; date of discharge; date of death; place of death; readmissions; demographic details.

**Results** 24 patients were referred for the rapid discharge pathway, 23 were thought to be appropriate for RDP (9 patients with non-malignant disease, 14 patients with cancer). 18 patients were discharged home, whilst 5 patients died in hospital (all within 72 hours). Of the 18 patients discharged 16 have died (7 within 72 hours, 9 after more than 72 hours). In total 17 out of 23 patients died within 72 hours. No patients were readmitted to hospital.

**Conclusion** The rapid discharge pathway can help facilitate discharge home for patients in the last days of life. However prognostication can be challenging, especially differentiating between patients who will die within 72 hours (more difficult) than patients who will die within 1 week (less difficult).

#### P-72 'PLACE BONDING' IN CHILDREN'S HOSPICE CARE

<sup>1,2</sup>Helena Dunbar. <sup>1</sup>De Montfort University, Leicester, UK; <sup>2</sup>Rainbows Hospice for Children and Young People

10.1136/bmjspcare-2017-00133.72

As the number of children in the UK with life-limiting and life-threatening conditions are increasing, providers of palliative care services, such as children's hospices are considering how best to support families. However, evidence suggests that

only a small percentage of parents of children with such conditions choose to access hospice services.

This exploratory study examined parents' perspectives of existing hospice services, the types and characteristics of hospice services parents wanted, the barriers and facilitators to accessing services, and how best these services could be delivered to meet the needs of the population of children with life-limiting and life-threatening conditions in one region in England.

A two phase qualitative study underpinned by a constructivist grounded theory methodology was employed. In Phase 1 focus groups were used to collect data from twenty four parents of children accessing services at the hospice. In Phase 2 in-depth semi-structured interviews were conducted with seven parents of children who did not use services at the hospice and with a further seven parents who had either previous experience of the hospice or were using a hospice outside of the region.

Findings showed the desire, the sense of searching that parents had in seeking out a place, other than their actual home, where their child could access a caring environment and the parent/s receive some respite from caring. Over time affective bonds developed between parents and the hospice. Finding a place where they belonged and where they felt at 'home' made the decision to accept help in caring for their child with a life-limiting condition more manageable.

A theory of place bonding was developed which has the potential to influence practice for children's hospices and also provide a platform for service development for other respite situations for children and young people with life-limiting conditions.

#### P-73 IMPROVING PALLIATIVE DEMENTIA CARE – EVALUATION OF A NEW EDUCATION PROGRAMME

<sup>1,2</sup>Clare White, <sup>3</sup>Clare McVeigh, <sup>1</sup>Sue Foster, <sup>4</sup>Lynn Dunwoody, <sup>1</sup>Max Watson. <sup>1</sup>Northern Ireland Hospice, Belfast, Northern Ireland; <sup>2</sup>Belfast HSC Trust, Northern Ireland; <sup>3</sup>Queens University Belfast, Northern Ireland; <sup>4</sup>Ulster University, Northern Ireland

10.1136/bmjspcare-2017-00133.73

**Background** Globally, dementia is a growing healthcare problem. Both the life-limiting nature of the illness and the clinical manifestations of the disease warrant patients and their families being able to access a palliative approach to care. Due to the complex symptomatology associated with dementia, providing optimal holistic care can be challenging and healthcare professionals (HCPs) need the appropriate level of knowledge and skills in both palliative and dementia care. The European Certificate in Holistic Dementia Care (ECHDC) is an 8 week, multidisciplinary home study programme designed to help meet this need. The course was created by palliative and dementia specialists. The aim of this research was to evaluate the effectiveness of the course in improving the knowledge and skills of HCPs regarding a palliative approach to dementia care.

**Methods** A prospective mixed methods longitudinal cohort study was conducted to evaluate the education program. The first phase incorporated baseline knowledge and self-efficacy assessments prior to commencement of the course. The second phase encompassed post course knowledge and self-efficacy assessments, and focus groups exploring participants' experiences and perceptions of the course in enhancing their knowledge and skills in relation to palliative dementia care.