

Aim Breaking bad news to patients is difficult for healthcare professionals. As part of my reflections and learning from studying Loss and Grief (University module) at the hospice I wanted to explore how we might improve this.

Method Within the day unit we identified a need to support patients throughout this time. I drew inspiration from Worden's Tasks of Mourning (1982) along with an awareness of the social context of loss and grief. I gathered ideas about how we might enhance practice and have been piloting a new approach to delivering bad news to patients.

Results This new approach focuses on a celebration of life, bringing all patients together in a safe environment where they are told about the loss. An 'I remember' discussion (led by day unit staff with support from volunteers, spiritual and social care teams) is held, which is a positive interaction to share memories through reminiscence. Throughout suggestions are made about how to celebrate the memory of the deceased, which includes music, singing and lighting candles.

Conclusion Initial results suggest that patients are not left low in mood. In fact, their memories bring positive emotions such as laughter. We believe that by encouraging patients to communicate after loss will enable them to speak more freely about their own diagnosis and wishes.

Communication, life stories and the digital age

P-10 ADVANCE CARE PLANNING WITH PATIENTS WITH DEMENTIA

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10.1136/bmjspcare-2017-hospice.37

Introduction Advance Care Planning (ACP) is high on the government's agenda for all patients with life limiting illnesses. This is particularly difficult for patients with dementia due to the long and unpredictable illness trajectory affecting their capacity. ACP has been shown to have positive impact on end of life care and is important to ensuring that the patient voice is heard and removing burden from family members. Applying policy to practice however is challenging with confusion over which professionals are responsible for the role.

Aims and Objectives The aim of the study was to determine which professionals are best placed to undergo ACP with patients with dementia. Health care professionals' views and experience of the process were explored with regard to personal beliefs, professional roles and working practices.

Method A qualitative approach was adopted using semi-structured interviews. These were recorded and transcribed verbatim and analysed using guidance from the Framework Method.

Results 11 professionals were interviewed, representing a broad spectrum of multidisciplinary community healthcare practice. Two major themes were developed: ACP and working practices and combined complexities of dementia and ACP. Overall it was found that ACP with patients with dementia is complex and challenging, with numerous barriers to successfully implementing the process. Each professional group has different issues making this difficult. This therefore impacts on the concept of one group taking ownership of the process.

Conclusion Which professionals should be responsible for the role remains unclear, with differing opinions as to whether it

should be the role of one group of professionals, a new role or a shared responsibility. Barriers need to be overcome and use of the Gold Standard Framework needs to be more focused on patients with dementia early in the illness trajectory.

P-11 PROMOTING ACCESS TO PALLIATIVE CARE AND ADVANCE CARE PLANNING FOR PEOPLE WITH DEMENTIA

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10.1136/bmjspcare-2017-hospice.38

Dementia is one of the most severe and devastating disorders that we face as a society (DH, 2009) and is now the leading cause of death in Britain (Office for National Statistics, 2015). However, while it is widely recognised that dementia is a terminal condition, there is a lack of coordination or philosophy that embraces the principles of palliative care which are beneficial at all stages of dementia (Ashton et al., 2016; Lloyd-Williams & Payne, 2002; Mitchell et al., 2004; Mitchell et al., 2007; Sachs, 2004). This results in missed opportunities to access interventions such as advance care planning (ACP) along with the psychosocial and spiritual support that is so important in promoting resilience and self-management (Conroy, 2009; Dempsey, 2013; Ashton et al., 2016; Murray et al., 2017). Thus reducing the risk in the latter stages of dementia, of people being subjected to escalations in care that they have expressed a preference not to receive and reducing the incidence of avoidable hospitalisation (Brinkman-Stoppelenburg et al., 2014; Conroy, 2009; Ashton et al., 2016; Murray et al., 2017). This poster will explore the local collaborative initiative in Lincolnshire of a joint ACP policy document across the health and social care economy and how this is being supported to be used in practice, underpinned by current advanced communication skills education.

The Aim To empower staff and subsequently people with dementia and those important to them, to participate in recording their wishes and preferences within a single ACP document, that will be used and recognised by all the local organisations involved in the person's care and documented on the Electronic Palliative Care Coordination System (EPaCCS) (Public Health England, 2013).

P-12 TALKING MATS: AN APPROACH TO SUPPORT CONVERSATIONS IN A HOSPICE SETTING

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10.1136/bmjspcare-2017-hospice.39

Background Professionals who work in palliative care settings strive to provide person centred care (NICE, 2011). Finding out what is important to patients and families is core to this (Henry, 2015). People who use hospices often have specific difficulties communicating their thoughts and feelings because of advanced illness and emotional factors. Talking Mats is a visual framework which has been shown as an effective method to enable people to express their views, especially when their ability to communicate is compromised, for

example because of cognitive, physical or emotional difficulties (Murphy et al., 2013; Murphy & Boa, 2012; Murphy, 2009). **Aims** We aimed to introduce and use Talking Mats in a hospice setting and to develop a symbol set to support conversations relating to Advance Care Planning (ACP).

Methods Sixteen staff from the multidisciplinary team were trained to use Talking Mats and successfully used it with patients in the hospice. A sub-group of staff attended a workshop to discuss the potential use of Talking Mats to support conversations relating to ACP. Topics and options were agreed. These were then presented to a wider forum of staff from another Hospice for validation and checking. Three main topics to support ACP conversations were identified: Affairs; Care and Personal Values and are currently being trialled with a range of patients in the hospice setting.

Results Staff trained in the use of Talking Mats found that they could use it with a range of patients for a variety of purposes: getting to know someone; identifying goals; discharge planning and enabling ACP discussions.

Conclusion Talking Mats can be used by trained staff in a hospice setting to support people to express their views and help them plan for the end of life.

P-13 IMPROVING ACP UPTAKE BY UNDERSTANDING AND ADDRESSING BARRIERS FACED BY HOSPICE STAFF

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10.1136/bmjspcare-2017-hospice.40

Background ACP is a key means of improving care for people nearing the end of life. Enables better planning and provision of appropriate care (End of Life Care Programme, 2008). Although recognised as important, ACP conversations are not always carried out, confirmed by baseline audit (2015) of ACPs by patients with brain tumours. Results suggested some ACP occurring but scope to improve.

Methods Exploratory study to consider attitudes, enablers and possible barriers for hospice staff engaging in ACP. Need for good understanding of ACP and assistance with communication skills highlighted.

Following study, ACP Steering Group formed, actions included:

- ACP workshops for clinical staff.
- Review of an appropriate ACP paper document for patients to supplement oral information.
- New ACP template for hospice electronic records.

ACP workshops:

5×2 hour, at hospice, attended by hospice MDT (March – September, 2016). Consisted of presentation covering various aspects of ACP then time allowing staff opportunity to practice communication in role-play using ‘fish bowl’ technique.

Results Attendees:

Doctors (4), IPU nurses (9), CNS (community) (9) Pharmacy (4), Day Hospice (3), MDT (4) Administrator (1)

100% attendees: workshop met training needs, most appreciated ‘fish bowl’ exercise some requested additional training most requested further opportunities to practice challenging conversations. Feedback on new electronic template: allows clear recording, easy to find recorded conversations, raises ACP profile. Follow up ACP audits: December 2016, April 2017. Results include 95% patient records: evidence of complex discussions about ACP with hospice HCPs. Given the

popularity of experiential training and recognising the need to assist staff with communication, further communication skills workshops arranged. Feedback: assist in increasing confidence and skills in addressing challenging conversations including ACP discussions.

Conclusion Hospice staff need training and support with ACP. Understanding and addressing needs in a variety of methods results in both an increase of ACP conversations and more confident staff.

P-14 ADVANCE CARE PLANNING FACILITATOR

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10.1136/bmjspcare-2017-hospice.41

Background It is recognised within the national framework that palliative and end of life (EoL) care must be a priority. Empowering individuals to think about their wishes and what is important to them is an extremely important and developing part of healthcare. The Advance Care Planning (ACP) Facilitator role was developed to support ACP within local care homes. After a three year project the role became permanent receiving full funding from the local Clinical Commissioning Group.

Aims The aim of the role is to support local care homes with ACP. Supporting them to achieve the national ambition that states everyone approaching EoL must be given the opportunity to plan. The role provides care home staff with support and education regarding EoL care. This allows them to work towards improving outcomes wherever the setting, which is a priority within the national framework.

Methods ACP support has been provided to care home staff and residents. Free educational sessions have been delivered on subjects relating to palliative and EoL care. Work has been undertaken within the local community to enhance their knowledge and understanding on ACP. A good working relationship has been developed with the multidisciplinary team to encourage a pro-active response to ACP.

Results Increased use of ACP documents has been noted within care homes. Good attendance and evaluations from the educational sessions have been recorded through registers and feedback forms. Verbal feedback has been received from numerous individuals with gratitude of the support provided.

Conclusion The role has shown to benefit residents, their loved ones and the staff. Residents are given the opportunity to discuss and record future plans which are in accordance with their wishes. Residents’ loved ones are able to access various services the hospice offers. Care home staff have expressed feeling more confident with ACP and EoL care.

P-15 THINKING AHEAD: COMPLEXITIES OF RESUSCITATION DECISIONS WITH DIVERSE COMMUNITIES IN LEICESTERSHIRE

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10.1136/bmjspcare-2017-hospice.42

Background Advance care planning (ACP) supports people who are seriously ill to be cared for in the way, and in the place that they prefer. However, evidence suggests there are