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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