

patient and staff satisfaction (Cornwell, 2012). A pressure ulcer audit (Hospice UK, 2016) on a hospice inpatient unit (IPU) highlighted the need to improve nurses' skills in the prevention, management and documentation of skin integrity.

Aim To design a comfort round tool specifically for use within the hospice IPU, implement comfort rounds and evaluate the impact on patients and nurses.

Method Nurses on the IPU were consulted regarding the overall concept, naming and design of the tool. Training was provided and following implementation, feedback sought from IPU nurses and patients regarding the impact of comfort rounds on patient care and experience.

Results Nurses' feedback: Healthcare assistants experienced job satisfaction with their involvement in continuity of patient care and evidencing care they provided. They felt areas for improvement included managing time pressures, patient choice, document design, training and team working. Patient feedback: 14 responses, all of whom were positive about the comfort rounds. They felt areas for improvement included communication about the rounds, patient choice and ensuring these discussions are communicated across the team.

Conclusion Comfort rounds have enabled our patients to feel less isolated and provided reassurances to family members. They support the consistent nursing care of our patients, including improving the involvement of the healthcare assistant workforce, optimising hydration and the prevention of pressure ulcers and falls. Initial assessment of patients admitted to the IPU needs to include discussion about the comfort rounds and creating individualised plans of care including the patient's needs and preferences relating to comfort rounds.

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PSYCHOSOCIAL EXPERIENCE OF WEIGHT LOSS IN CANCER CACHEXIA. WHAT CAN HEALTH CARE PROFESSIONALS LEARN?

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10.1136/bmjspcare-2017-hospice.197

Background Up to 80% of people with advanced cancer experience cachexia and of these most have accompanying anorexia, characterised by poor appetite and weight loss. Cachexia has profound psychosocial impact on patients and families including negative emotions associated with reduced food intake and involuntary weight loss, and the social consequences of these symptoms. Weight loss can be unacknowledged by healthcare professionals (HCPs), even in settings where patients are weighed regularly. Little is known about the meaning of weight loss from the patient's perspective, and what support patients expect from HCPs.

Aim(s) • To describe the experience of weight loss in people with advanced cancer and explore what psychosocial support they believe HCPs could provide

- To make recommendations for clinical practice.

Methods Individual, semi-structured interviews with hospice patients diagnosed with advanced cancer and who had expressed distress around weight loss, analysed using thematic content analysis.

Results Nine patients took part. Participants described the emotional impact of weight loss as an indicator of overall deterioration or impending death. Concerns about weight loss were perceived to be unacknowledged by HCPs, and

participants would welcome more opportunities to discuss their fears. Findings were categorised into four themes:

- The meaning of weight loss to the person
- A changed relationship with food
- The experience of being weighed as 'a tick box exercise'
- 'Listen to me' – a message for healthcare professionals.

Conclusions HCPs should acknowledge weight loss in patients with advanced cancer to explore the impact and meaning. Increased awareness of the impact of cachexia and communication skills training may enable these difficult conversations to take place. With appropriate emotional and social support, patients and their families can identify and address what is important to them, which may reduce distress and improve quality of life.

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A ROLE FOR EMOTIONAL FREEDOM TECHNIQUE IN PALLIATIVE PATIENTS? THREE CASE REPORTS

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10.1136/bmjspcare-2017-hospice.198

Background Emotional Freedom Technique (EFT) is a simple and common self-help technique, which is also known as 'Tapping'. It combines elements of exposure therapy, cognitive behavioural therapy and somatic stimulation. It is widespread in the public domain; Meta-analyses show that EFT is effective for anxiety, depression and Post Traumatic Stress Disorder (PTSD). There are no studies examining the effect of EFT for palliative patients.

Case Presentation This case report presents three cases of emotional distress in palliative patients.

Case Management Each patient was treated using EFT. Case Outcome Following treatment using EFT, all of the patients' emotional distress was decreased and within a very short time.

Conclusions EFT is a very simple, effective and safe technique. EFT has the potential to be a powerful tool to improve the care of palliative patients who have distressing emotions. Future research on EFT and its effect on distressing emotions in palliative populations and their families is warranted.

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PERSONALISED CARE PLANNING

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10.1136/bmjspcare-2017-hospice.199

Background It was identified that the hospice in-patient unit records were not as robust as they could be. Despite the patients receiving an excellent level of holistic care, this was not always evidenced clearly in the documentation.

Aim and Implementation To modify existing documentation to clearly evidence the excellent care being received by our in-patients and families, whilst being patient-centred and personalised. The time frame was set for compliance to be complete by the end of January 2017. Weekly audit to ensure the new documentation is fit for purpose and to identify any areas which need further development. Following the guidelines of the NMC code for nurses and midwives specifically sections: 10 – Keep clear and accurate records relevant to your practice ... 3 – Make sure that people's physical, social and psychological needs are assessed and responded to.

Outcomes Success to date has been extremely positive with outcome measures exceeding expectation across all areas.

Application into Hospice Practice An action plan was developed and implementation commenced of the recommended actions. The new documentation was rolled out on the 30 November and is now being used for all patients who are admitted to the in-patient unit. Care plans were redesigned to encourage planning and documentation of personalised care. Records audit was then done every week, all patients records are audited without exception.

Feedback from issues found through audit is given directly to the staff member involved as soon as possible either face to face or by email and clinical supervision documentation is completed for evidence of feedback. Compliance of feedback is checked the following week whilst doing the weekly audit. The nurse coordinators' role defined to include monitoring of documentation following admission to ensure compliance sustaining improvements. There remained a need to continue weekly audits until staff have adapted and familiarised themselves with the documentation, by March 2017 following evidence of sustained compliance to the audit requirements, the audit was conducted fortnightly for three months and if remains stable will then be downscaled to monthly. Documentation is clearer and evidences patient and family engagement and consent in personalised care planning. Documentation compliance has improved.

P-175 AN AUDIT OF DOCUMENTATION OF MENTAL CAPACITY ASSESSMENTS AT ST JOSEPH'S HOSPICE

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10.1136/bmjspcare-2017-hospice.200

Introduction Since the introduction of the Mental Capacity Act (MCA) in 2005, there has been much debate what constitutes an adequate MCA assessment. It is important to keep comprehensive documentation of MCA assessments as they can be challenged. Hospices (along with other healthcare services) need to ensure their staff are competent in conducting MCA assessments and that their documentation is clear and consistent.

Aims To evaluate the quality of MCA assessment and documentation for patients under the care of the hospice.

Methods All MCA assessments conducted in a 34-bed hospice over a six-month period were reviewed retrospectively using an audit tool developed by the British Psychological Society.

Results and Recommendations 44 assessments for 20 patients were analysed. Assessments were generally well documented: the rationale was clear (91%); the decision to be made was clearly stated (95%) and the diagnostic and functional tests were specifically addressed (91%). Areas where practice could be improved included: assessing capacity for one decision at a time; documenting any communication difficulties and how these are overcome; clearly documenting recommendations as a result of the assessment; and identifying the need for repeat assessments. As part of a multidisciplinary discussion, amendments have been made to the MCA assessment documentation template. Results have been disseminated and an education session held to increase awareness, and the hospice documentation template updated, prior to re-audit in August 2017.

Conclusions MCA assessment documentation was generally clear and appeared to show staff understood the basic

principles of the MCA. It is hoped that updating the documentation template, in addition to staff education, will address the areas requiring improvement.

Service development, models and collaborative working

P-176 I WANT TO DIE ALONE NURSE, I WANT TO DIE AT HOME

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10.1136/bmjspcare-2017-hospice.201

Supporting a patient with limited family and financial resource to die alone at home, when some people were profoundly uncomfortable with their end of life wishes proved a difficult, but not insurmountable, challenge.

Background The concept of a 'Good Death' (Ko et al., 2015) is widely accepted, dying alone is seen as an aspect of 'bad death'. The Mental Capacity Act (2005) makes it clear, people have a right to make informed choices; these choices should not be measured against those others might make. Patients who want to die alone are not always able to do so – well-meaning friends, neighbours and professionals can create barriers to prevent lone death including detailing safety, medicines and vulnerable adult concerns.

Results The patient died at home, alone, what did we do ?

- Enabled the patient to be explicit about their choices, and communicate them to friends, neighbours and professionals effectively
- Recognised that dying alone was a valid choice, made with capacity, and fully in tune with the context of this person's life
- Reflected on our insecurities, helped carers to do the same, recognising that our fear can create a barrier to patient choice
- Brought together the widest multidisciplinary team including social services, carers, neighbours, helping them to understand the patient's viewpoint, right to autonomy and self-determination
- Honestly addressed risks to patient safety, safeguarding, medicines management, access to patient's home – minimising those risks using technology, equipment adaptations and creative problem solving
- Rapid response hospice team involved.

Conclusions The biggest challenge was to overcome preconceptions of what is a good death to enable the patient to have their choices honoured. Creating common understanding with good communication, having a clear plan, and taking a degree of shared risk empowered real patient choice at end of life. An alone death is not necessarily a bad death.

P-177 DISCHARGE BUDDIES – FEELING SAFE GOING HOME

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10.1136/bmjspcare-2017-hospice.202

Background When patients are discharged from a hospice inpatient unit many report feeling vulnerable and abandoned;