Pilot studies guide the development of research plans to ensure that the methods and ideas which are being proposed will work in practice (Kim, 2010). This pilot study was undertaken to explore the feasibility of a proposed Doctorate study designed to answer the research question: 'What is the family experience of bereavement when a family member has dementia and what might this mean for the provision of support?' using constructivist grounded theory (Charmaz, 2014).

The pilot explored the family bereavement experience from the perspective of one family member and focused on the use of unstructured interviews and research diaries as tools for quality data collection, and a process of data analysis involving process coding and memo writing (Saldaña, 2016).

Tentative theoretical understanding of the data emerged including:

- Experiencing a spiritual dimension
- Being a bereaved carer
- Family functioning
- Relationship between bereavement and dementia.

These early findings will be integrated into the main study through the constant comparison process consistent with grounded theory methodology (Charmaz, 2014; Urquhart, 2013).

Carrying out and reflecting on the pilot highlighted several issues including the researchers' role within the interview and data analysis process, the design and use of a diary for data collection and the ethical dilemma of involving or excluding people with dementia within the study. Learning from this pilot will help shape future study plans.

Communication, voices and stories

P-14 EXPLORATION OF SUPPORT WORKERS' AND VOLUNTEERS' INITIATION OF QUALITY OF LIFE CONVERSATIONS

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10.1136/bmjspcare-2018-hospiceabs.39

Background Through being a pilot site for NHS England exploring Personal Health Budgets (PHBs) in end of life care, Treetops Hospice Care became aware that there needed to be more focus on conversations around what was important to patients. There appeared to be barriers around developing these conversations, possible reasons were lack of healthcare professionals' time and clarity as to whose role it was. Resulting from this highlighted need, Treetops Hospice Care and the University of Derby are undertaking a research project to explore the outcomes of developing support workers and volunteers in initiating conversations around quality of life. Policy drivers have acknowledged that there is a much greater need and demand for person-centred care than professionals in health and social care can meet (Health Education England, Skills for Health & Skills for Care, 2017). This follows the principles of a 'public health' approach to end of life care, and that a 'de-professionalisation' of supportive care, involving volunteers and support staff engaging in these conversations, could result in being able to include more individuals (Abel & Kellehear, 2016).

Aims Exploring participants' involvement and perceptions of patient-centred conversations to improve end of life care experiences.

Methods/conclusion Qualitative interviewing will be undertaken before and after a new educational training approach is delivered, along with a pre and post Likert evaluation tool capturing self-perceived confidence and competence. The new approach will focus around the mnemonic L.I.S.T.E.N (developed by Treetops Hospice Care) supporting these conversations around preferences and wishes, within a person-centred approach.

We anticipate that with the appropriate support and training, unregistered healthcare professionals/volunteers feel more enabled in having these conversations, empowering them to offer more timely conversation opportunities with palliative care patients. Resulting outcomes will inform future training.

P-15 BESPOKE HOSPITAL DISCHARGE SUMMARY GUIDES COMMUNICATION OF PATIENT PREFERENCES AT END OF LIFE

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10.1136/bmjspcare-2018-hospiceabs.40

Introduction Identification of patients approaching end of life, and advance care planning (ACP) with them, can improve patient outcomes and reduce hospital deaths.

Methods The essential items that should be included in any initial ACP discussions were agreed by a working group (COTE doctor, palliative care doctor and nurse, GP and Patient in Partnership Group). Some items were mandatory and some dynamic. Items included:

1. Dropdown menu: prognostication (based on SPICT)
2. Yes/No: elements of discussions had, e.g. regarding prognostication, resuscitation status during stay, Preferred Place of Care, Preferred Place of Death
3. Free text: e.g. ceilings of care.
4. These items were added to the usual hospital discharge summary template (EPRO) by the Trust's IT department. Patients were identified as appropriate for invitation to ACP discussion by using a modified Surprise Question (found to have 61% sensitivity and 88% specificity in this group), which was used as standard during COTE MDT discussions. Following a short training session to COTE team, at discharge the modified discharge summary was used for appropriate patients.

COTE discharge summaries were surveyed using a standardised proforma to quantify recording of ACP preferences (n=40 at baseline and n=20 10 weeks after new template introduced).

Results The new ACP template improves frequency of documentation in discharge summaries from baseline of: resuscitation status (10% to 100%) information regarding prognostication (0% to 100%) and any mention of patient preferences for care (8%–100%).

Conclusion Specific items added to the hospital discharge summary at no extra cost improves ACP information sharing from secondary to primary care. Staff fed back that the ACP discharge summary fields were easy to use. The teams continue to engage with the process as they see improved cross