

professionals to recognise the dying person and responding to their needs was inconsistent.

**P-107** **GOOD ENOUGH TO EAT: ENCOURAGING NUTRITIONAL INTAKE AND REAWAKENING APPETITE ON THE IN-PATIENT UNIT**

Nicola Hanmer, Tracy Parkinson. *St Catherine's Hospice, Preston, UK*

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**Introduction** A balanced diet and adequate fluid intake is important, especially for those with a life-shortening condition. In 2016 St Catherine's Hospice formed a Nutrition Focus Group, tasked with ensuring person-centred nutritional care for patients.

**Aims** To develop initiatives to increase food and fluid intake for patients. To re-awaken appetite in patients whose conditions have affected their desire to eat and drink. To widen choices. To modernise the presentation of meals, snacks and refreshments to better reflect the quality of dishes being served. To ensure meals, snacks and refreshments are served in an accessible way. To improve access to nutritious food for families 24/7. To promote the social element of sharing food and drink with loved ones.

**Method** We have made various improvements around three themes:

1. Food/drink/snacks. Extended choice on refreshments trolley to include filter coffee, fruit teas, fruit platters and smoothies. Continue to offer personalised choices alongside daily set menu. Continue to offer suggestions to those struggling to make food choices. Improved the variation in the pureed/soft foods menu
2. Accessibility. Invested in specialist equipment. Opened coffee bar in gift shop selling drinks, snacks and home-cooked ready meals 24 hours a day
3. Socialisation/normalisation. Invested in new trays and cutlery. Introduced linen napkins to improve the experience of having a meal and develop its sense of occasion. Refurbished the conservatory into a comfortable space where patients and loved ones can enjoy refreshments together. Invested in new moulds to improve the presentation of pureed/soft foods.

**Evaluation** Feedback is positive:

*'My appetite has been dire for last 18 months and since being here has vastly improved'*, in-patient.

*'Mum sometimes is not aware of what she wants so ideas are good'*, daughter of an in-patient.

**P-108** **HYDRATION AT THE END OF LIFE: COLLABORATION AND EDUCATION TO EMBED CHANGE IN PRACTICE**

<sup>1</sup>Andrew Fletcher, <sup>2</sup>Kathryn Woods, <sup>3</sup>Louise Dowthwaite, <sup>1</sup>Helen Jones, <sup>2</sup>Stacey Batty, <sup>3</sup>Claire Capewell. <sup>1</sup>St Catherine's Hospice, Preston, UK; <sup>2</sup>Lancashire Care Foundation Trust, Preston, UK; <sup>3</sup>Lancashire Teaching Hospital NHS Trust, Preston, UK

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**Background** 'One chance to get it right' (Leadership Alliance for the Care of Dying People, 2014) and NICE guidance (National Institute for Health and Care Excellence, 2015) highlight the need to ensure appropriate means of providing hydration at end of life is available across care settings,

including the availability of Clinically Assisted Hydration. Across our locality, the processes were not in place to achieve this and there was concern about understanding of the factors informing decision making.

**Aims** Develop procedure for the Administration of Subcutaneous Fluids in Adults at End of Life in the Community. Ensure robust mechanisms in place for monitoring management of hydration at end of life. Develop patient/carer information. Provide multi-professional education and training.

**Methods** Collaborative task and finish group established. Available literature reviewed to develop a patient/carer information leaflet. Multi-professional education and training package developed to enhance understanding of assessment and decision making.

**Results** Procedure for the Administration of Subcutaneous Fluids in Adults at End of Life in the Community was developed and agreed by our local community NHS Trust, hospice and clinical commissioning groups. Associated information contains a flowchart and other guidance. An audit proforma was developed to collect prospective data about the use and impact of subcutaneous fluids at end of life. A patient information leaflet was developed with agreement of partners. Multi-professional education and training was delivered to over 150 clinicians through attendance at GP training afternoons and hospice sessions (Macmillan grant funded).

**Discussion** A procedure has been agreed to ensure methods available to provide hydration support for patients at end of life, not limited by the place in which the person is being cared for. Feedback received from 89 attendees at the hospice education programme – score 1–6, 6 being excellent, 99% of responders scored 5 or 6; 94% recommended the session. Qualitative feedback reflected the need for individualised assessments and staff feeling empowered to support patients.

**P-109** **A MEAL TO DIE FOR**

Vera Mircescu. *Mountbatten Hospice, Newport, UK*

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**Background** Food is at the core of our existence and well-being. It provides familiarity and comfort, it brings families and friends together. In the context of palliative care, food choice can be seen as the sole opportunity for a patient to still make their own choices.

In our relentless pursuit to improve quality of life for our patients we identified the need to make food readily available to our patients throughout the day. Set meal times are not suited to the unpredictable nature of a hospice patient's daily schedule.

**Aim** To provide nutritious, tailor-made, enticing meals and drinks in the form of hotel room-service when our patients and their visiting families or friends want and need them. In addition to an à la carte menu we strive to meet *any* patient request for food, regardless of how difficult to source it may be.

**Method** Consultation meetings carried out with the medical teams. À la carte menu created with nutritionist support. Food service trial sessions carried out involving patients, families and medical. Evaluation of food service trials. Patient survey carried out – feedback provided.

**Results** Improved patient nutrition as meal times were not missed. Increased patient satisfaction recorded as a result of

feedback surveys. Reduced waste as meals are prepared as and when required.

**Conclusions** Working in end of life care you develop an appreciation early on that every meal prepared has to be the best. It could very well be the last meal a patient has. Evaluation of the room-service catering shows a positive contribution. We have also learnt how much our input can mean and matter to relatives and friends of patients. Seeing a loved one being cared for, not just through exceptional medical/nursing care, but through a dedicated catering team trying their hardest too, may just help to ease the pain they experience as well.

**P-110 LOVE ON A PLATE: A QUALITY IMPROVEMENT PROJECT EXPLORING NUTRITIONAL CARE**

Sharon Twigger, Suzanne Davies. *Compton Care, Wolverhampton, UK*

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**Background** Good nutritional care is essential to the delivery of excellent palliative care. In addition to our bodies' physical needs, nutrition can have social, psychological and spiritual importance to patients. Despite this historically nutrition has not always been well supported in palliative care organisations (Help the Hospices Food and Nutrition Group, 2009).

**Aim(s)** To examine the current nutritional care provision within our organisation; to compare this to national standards; to explore where deficiencies existed and how these could be overcome.

**Methods** A full review of nutritional care was undertaken in 2017 across the organisation. Five key functional areas relating to nutrition were explored: catering management; patients' nutrition; communication; governance; and others' nutrition. Tools used included direct observation of catering processes, talking to key members of staff, seeking feedback from patients, completing the Hospice UK Nutrition and Hydration Audit Tool and visiting other local hospices delivering excellent nutritional care.

**Results** The review produced a number of recommendations for improvement across the five key functional areas. A Nutritional Care Steering Group was set up to ensure recommendations were delivered in a coordinated way and that strong governance structures underpinned this. Changes being implemented are already directly impacting positively on patient care.

**Conclusions** Delivery of excellent nutritional care requires a whole system approach where each aspect of the service is explored and improved cohesively.

**P-111 CAMBRIDGE BREATHLESSNESS INTERVENTION SERVICE: IMPACT ON HOSPITAL ATTENDANCE**

<sup>1</sup>Chloe Chin, <sup>2</sup>Efthalia Massou, <sup>1</sup>Julie Burkin, <sup>1</sup>Sara Booth, <sup>1,2</sup>Anna Spathis. <sup>1</sup>Cambridge University Hospitals NHS Foundation Trust, Cambridge, UK; <sup>2</sup>Department of Public Health and Primary Care, University of Cambridge, Cambridge, UK

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**Context** Cambridge Breathlessness Intervention Service (CBIS) supports patients with intractable breathlessness due to a variety of conditions. This evidence-based, multidisciplinary, complex intervention promotes self-management of symptoms using predominantly non-pharmacological techniques. Successful self-management reduces Emergency Department

attendance (EDA) and inpatient admissions. This service evaluation aimed to investigate the impact of CBIS on hospital attendances, in terms of EDAs and inpatient admissions.

**Method** The number of EDAs and the number and length of admissions in the six months before, and six months after, first clinical contact with CBIS were recorded for all patients referred during four specific months. Costs of £138/EDA and £306/inpatient bed day were assumed. Other than in cost calculations, a 'bed day' was defined as either an EDA or an inpatient bed day. 'Avoidable attendances' were EDAs or admissions due to breathlessness alone without an underlying cause requiring intervention in hospital.

**Results** Data from 74 patients were analysed. There was a significant 43% absolute risk reduction in hospital attendances ( $p=0.001$ ). There were 3.0 fewer bed days for each patient seen. Avoidable attendances also reduced significantly ( $p=0.023$ ). The odds of an avoidable attendance was three times lower after receiving CBIS (OR 0.31,  $p=0.049$ ), and the odds of an avoidable bed day dropped significantly (OR 0.24,  $p<0.001$ ). The five fewer EDAs and 214 fewer inpatient bed days saves £65 484 or £894/patient.

**Discussion** CBIS significantly reduced hospital attendance.

The intervention costs £119/patient, suggesting potential overall cost savings. Interestingly, all types of hospital attendances were reduced, not only those deemed potentially avoidable. CBIS supports patients to develop self-efficacy, and improves physical and psychological wellbeing. Therefore, the service may impact hospital attendance for a range of reasons, not only breathlessness. Further work is needed to gain insight into, and increase confidence, in these findings.

**P-112 INCREASING STAFF CONFIDENCE AND USE OF A HANDHELD FAN IN THE MANAGEMENT OF BREATHLESSNESS**

Margaret Kerr. *Western Health and Social Care Trust (WHST), Derry/Omagh/Enniskillen, UK*

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**Background** Using a handheld fan has been identified in the literature as useful in the palliation of breathlessness (Luckett, Philips, Johnson *et al.*, 2017). There is continuing evidence that the handheld fan should be recommended to all breathless patients as an evidenced based management strategy for their symptoms (Galbraith, Fagan, Perkins *et al.*, 2010). It is also a useful intervention to recommend without qualification to any clinician or healthcare worker who sees breathless patients (Booth, Moffat & Burkin, 2011). Yet we know within the WHST within palliative care settings where breathlessness is a symptom, it is not being commonly considered or used.

**Aim** To increase staff confidence in identifying, providing and teaching use of the fan. To increase the use of the handheld fan in the palliative care inpatient settings within the WHST (palliative care in-patient unit and hospice in-patient unit).

**Methods** Training package developed including educational video and practical teaching session and delivered to nursing staff. Staff confidence measured pre- and post- training, at three months and at one year post training. Numbers of fans provided monitored.

**Results** Training is currently on-going in both locations and will be completed by 30/06/2018 when pre- and post- training confidence scores will be collated. To date, initial data shows 100% of high confidence scores post training. It will be most