

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

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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

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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

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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

interesting to determine whether this confidence will be maintained at three months and one year.

It is hoped that improved staff confidence scores will be achieved and maintained with resultant increased use of the handheld fan and improved management of the symptom of breathlessness.

Conclusion It is hoped that the anticipated results will demonstrate improved confidence and improved management of the symptom of breathlessness. Future plans will be centred on making the training available in other care settings and teams with resultant up-skilling of the workforce in non-pharmacological management of breathlessness in palliative care.

P-113 EVALUATION OF A FATIGUE AND BREATHLESSNESS PROGRAMME BY HOSPICE ISLE OF MAN

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Background A programme was developed at Hospice Isle of Man to provide support for people who are experiencing extreme tiredness and/or breathlessness. The programme involves exercise, relaxation and education.

Aim To evaluate the programme using validated outcome measures and the views and experience of the participants.

Methods We used the Self-reported Chronic Respiratory Disease Questionnaire (Chauvin, Rupley, Meyers *et al.*, 2008) which is a quality of life measure designed for those with respiratory problems. It asks individuals to rate their current state on four dimensions: dyspnoea, fatigue, emotional function and mastery (feeling of control over disease) using a seven point scale. This is done for their five most important activities in which they have been limited by symptoms, giving a total score for each dimension. Previous validations (Chauvin, Rupley, Meyers *et al.*, 2008) have identified that the minimum clinically important difference in the score for each activity is about 0.5 while 1.5 and 2.0 would identify moderate and large positive changes and negative values would indicate decline. Individuals rated themselves at the beginning of the programme and again at the end.

Results to date We have only completed 10 cases so far. Of these, one person had a large improvement in dyspnoea, one a moderate improvement and two a small improvement; one person deteriorated. For fatigue, three reported a large improvement, one moderate and three a small improvement; no-one deteriorated. For emotional function, there was one large improvement, two moderate and one small and one person deteriorated. For mastery, one person had a large improvement, one a moderate improvement and one a small improvement but five deteriorated.

Conclusion This is only a small sample so far but the evaluation continues. The improvement in dyspnoea and fatigue is encouraging and we hope that over time there will be more improvement in mastery.

P-114 SINGLE NURSE ADMINISTRATION (SNA) CONTROLLED DRUGS – A PHASED APPROACH

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Background Controlled drugs (CDs) are used extensively in end of life care and need to be administered in a timely way. Two staff nurses to check and administer CDs has implications on time, autonomy and person-centred care.

Aims To empower staff to work autonomously in the administration of oral CDs, reduce CD incidents, free nursing time to care and prevent delay in the administration of medication.

Methods SNA would be considered a significant change to process therefore the first step was to introduce this proposed change as part of staff's annual medications training. This consisted of revisiting;

- policy and procedure for CDs
- mapping the process using a medications incident to demonstrate the risk of a two– nurse process.

Root Cause Analysis and human factors were considered. A phased approach was utilised to role out this innovative change over a six months period. Phase 1 consisted of Band 6 staff and nurses that had volunteered to participate. Phase 2 were staff who were initially reserved regarding the SNA but encouraged by the initial success of Phase 1. Phase 3 took longer as this was a fluid group of staff who were new and lacked experience, had confidence issues due to a previous drug error or needed additional support due to concerns.

Results SNA of CDs showed a reduction in incidents from 72.7% with two nurses administering to 28.5% with SNA. Staff reported more autonomy, release of time to care and speed of reaction to patient need.

Conclusion SNA demonstrated a positive impact on person-centred care for all.

P-115 IMPLEMENTING SINGLE NURSE CONTROLLED DRUG ADMINISTRATION. A PRACTICE DEVELOPMENT APPROACH

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Background In a hospice inpatient unit (IPU), registered nurses (RNs) raised concerns about time taken to administer controlled drugs impacting on patient waiting time for pain and symptom control and limiting the time available for other RN activities.

Aim To enhance person-centred practice around pain and symptom control by using a practice development (PD) approach to implement single nurse controlled drug administration (SNDA) in a hospice IPU.

Method A Practice Development approach using collaboration, inclusion and participation (McCormack, Manley & Titchen, 2013) was used throughout.

Preparatory phase

- A literature review and staff engagement sessions to elicit an overview of values and beliefs informed policy, procedure and risk assessments.
- A programme of education was developed in collaboration with the MDT including facilitated critical reflection.