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10 ESTABLISHING A MENTORING SCHEME FOR PALLIATIVE MEDICINE TRAINEES IN WEST YORKSHIRE: A REVIEW OF THE FIRST YEAR

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10.1136/bmjspcare-2019-ASP.33

Background The value of mentoring in helping individuals develop confidence and resilience and focus upon career progression is acknowledged by multiple professional groups. Mentoring is also felt to be beneficial to the mentor.

Recognising this, the West Yorkshire trainees were surveyed about their interest in developing a mentoring scheme. Interest was expressed and thus senior trainees and consultants working in both training and non-training units were approached to become mentors.

Methods Mentors were signposted to mentoring training. First year trainees (ST3s) were mentored by senior trainees and more senior trainees were mentored by consultants.

To distinguish between the mentor and supervisor role, mentoring pairs were allocated to ensure mentors and mentees were not working together clinically. Mentoring relationships began in August 2017 and the scheme was evaluated after the first year.

Results The pairs met between one and five times and the mentees were universally positive about their experience of being mentored. Particular benefits were having an outside perspective and the opportunity to talk openly. Mentees scored their mentoring experience as 8.9/10 for usefulness.

Mentors reflected they had felt well prepared for their role and were happy to continue. The engagement and motivation of the trainee was identified as key in success of the mentoring relationship.

Conclusions The first year of the West Yorkshire trainee mentoring scheme has been well evaluated by both mentors and mentees. Given the acknowledged benefits of mentoring, the relatively short training and challenges of palliative medicine, it is a model which could be considered nationally.

Locally, the scheme continues and there is interest in extending it to consultants in their first year.

11 WE DON'T KNOW WHAT WE DON'T KNOW! KNOWLEDGE AND COMMUNICATION BARRIERS STILL PREVALENT AMONG PALLIATIVE CARE PATIENTS AND FAMILIES

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10.1136/bmjspcare-2019-ASP.34

Background There is a struggle to meet the demands of adequate, let alone high-quality, palliative care, with one in four UK families unable to access the expert palliative care they need. This research uncovered difficulties experienced in accessing palliative care along with insights into why others have not accessed these services at all.

Methods This research is part of a larger ongoing study into palliative care. Data collection began in 2015. To date we have collected almost 2 million words of data from in-depth interviews with palliative care patients and their families

(n=223) and healthcare professionals including GPs, Community Nurses and Hospital Staff (n=22). We also surveyed (n=100) non-users.

Results We find that many of the long-recognised barriers, such as patient and family misconceptions ('the Death House') and lack of knowledge ('I didn't know what a palliative care nurse was'; 'I thought it was just for cancer patients) are just as prevalent as they have always been. There is an acute lack of awareness of wider palliative care offerings (e.g. non-pain physical, psychological, spiritual). Many people believe hospice care is solely for patients with cancer, or just for inpatients, or is private and has to be paid for. Confusion and lack of confidence among healthcare providers are also widespread, particularly when dealing with non-cancer patients. We also found poor integration of healthcare services in the wider ecosystem, often confounded by technological barriers and a lack of effective collaboration between service providers.

Conclusions Palliative and hospice care needs to be rebranded and better communicated to the wider public. Better training is needed to educate and equip healthcare professionals with the knowledge and confidence they desperately need. Champions are needed to improve collaboration and integration among healthcare professionals and their systems.

12 REDUCING PRESCRIBING ERRORS AMONGST JUNIOR DOCTORS AT THE BEGINNING OF THEIR DURING HOSPICE ROTATIONS- A QUALITY IMPROVEMENT PROJECT (QIP)

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10.1136/bmjspcare-2019-ASP.35

Background It is documented within the literature that when transitioning between different forms of prescribing, errors are more likely to occur. This is especially pertinent within Hospice Medicine as many Hospices differ in their prescribing practices to those at Hospitals. This has been noted at Manorlands Hospice, whereby paper prescribing is used, with the local hospital having transitioned to electronic prescribing.

It had been noted amongst staff that a peak in prescribing errors occurred at the beginning of each rotation of new Junior Doctors, many of which resulted in a Datix (incident report). This QIP used the 'PDSA' methodology to look into this phenomenon and try and reduce it.

Methods Datix information regarding prescribing errors that occurred between December 2013 and April 2018 was collected. From this data and conversations with staff, a 'Safe Prescribing Guide' (SPG) was created that was given to new Doctors during their induction. This included information about how to reduce drug errors, and highlighted risky areas.

Results 42 Datix were identified as having occurred within the first month of a new rotation. This resulted in an average of 3 Datix per new rotation. The most common drug errors were due to the prescription of incorrect doses and the omission of medications.

Following the introduction of the SPG in August 2018, no drug errors occurred within the first month of the new Junior Doctors rotation.

Conclusion This QIP has highlighted the importance in recognising the new challenges faced by Junior Doctors due to the rapidly changing clinical environment as a consequence of new technologies. Following the implementation of the SPG

drug errors have been reduced. However this could be due to a number of factors and ongoing data collection is required to identify the trend. The SPG has now been disseminated to Sue Ryder Hospices nationally.

13 ASSESSING THE IMPACT OF A ONE DAY ADVANCED COMMUNICATION SKILLS COURSE FOR QUALIFIED AND UNQUALIFIED NURSES IN A HOSPICE SETTING

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10.1136/bmjspcare-2019-ASP.36

Background Trinity Hospice, Blackpool run an internal advanced communications course for qualified and unqualified nursing staff working across inpatient and community settings. Groups of up to 8 participants undertake role play with a facilitator and an actor, using commonly encountered communication scenarios. This project assessed the impact of the course on participants' confidence in communicating in difficult situations and the emotional burden associated with undertaking the course.

Methods Pre- and post-course questionnaires were filled in by all participants, and then retrospectively analysed.

Results 45 people were trained over 18 months, including 27 qualified and 18 unqualified staff-members. 1 questionnaire was incompletely filled out giving a total sample of 44.

84% of participants described negative emotions (e.g. nervous, unsure) before the course.

82% described positive emotions (e.g. relaxed, confident, energised) after the course.

50% of participants showed improvement in confidence in a challenging conversation with a patient or relatives

68% showed improvement in confidence in a challenging conversation with a colleague.

50% showed improvement in confidence in handling strong emotions.

34% showed improvement in confidence in identifying a patient or relative's concerns.

59% showed improvement in confidence in challenging problematic behaviour by a patient or relative.

98% of the participants reported that the course had met their needs, and scored the course as being interesting, informative, useful, enjoyable, respectful and safe.

Conclusion The subjective response to the course was positive, with a shift from negative to positive emotional responses. At least half of participants improved in all but one area of communication. We feel this project supports the validity of the advanced communication skills course for development of confidence in challenging areas of communication, for both qualified and unqualified nursing staff.

14 PHASE OF ILLNESS SURVEY

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10.1136/bmjspcare-2019-ASP.37

Background Phase of Illness (POI) is one of the measures in the Outcome Assessment and Complexity Collaborative (OACC) suite of measures, and describes the current stage in the patient's illness according to the care needs of the patient and their family. The phases are: stable, unstable,

deteriorating, dying and deceased. POI is documented at every patient clinical contact by a range of healthcare professionals (HCPs); therefore consistency of phase assessment is important. The aim of this survey was to assess the consistency of POI assessment.

Method A survey was emailed to all clinical staff and had two peer reviewed fictional case studies evolving over time. They were asked to select the POI that best described the patient's situation at various time points.

Results Fifty-one HCPs completed scenario 1 and 41 completed scenario 2. The range of HCPs included nurses, doctors, physiotherapists, occupational therapists, counsellors, social workers and complementary therapists.

Scenario 1 – Mrs A with metastatic lung cancer, and six phase assessments. There was majority agreement across all phase assessments. The phase assessment with least agreement was Q5 stable 63%; unstable 1%; deteriorating 35%. All other assessments had >70% agreement with a particular POI.

Scenario 2 – Mr B with Motor Neurone Disease (MND), and seven phase assessments. There was less agreement across the phase assessments. Three POI assessments had <70% majority agreement: Q3- Stable 10%, Unstable 45%, Deteriorating 45%; Q4 – Stable 68%, Unstable 7.5%, Deteriorating 24.5%; Q7 – Stable 7.5%, Unstable 55%, Deteriorating 37.5%.

Conclusion There was less consistency of POI assessment in the MND patient scenario, particularly in terms of unstable and deteriorating phases, compared to the cancer patient scenario. This disparity may reflect the different disease trajectories and HCP familiarity with each condition. This has led to further multidisciplinary team training focusing on POI assessment in non-cancer conditions.

15 EXPLORING THE USE OF INNOVATIVE TECHNOLOGY TO DELIVER JUNIOR DOCTORS INDUCTION AT THE HOSPICE

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10.1136/bmjspcare-2019-ASP.38

Background There is a paucity of published evidence evaluating the effectiveness of induction methods for trainee doctors. In any 12 month period 17 trainees (3 foundation doctors, 8 core medical trainees and 6 specialty trainees) will rotate through our hospice, resulting in the medical induction programme being repeated at least 8 times per year.

Methods Considering prudent healthcare principles, the aim was to evaluate the current induction programme and to scope alternative, more efficient delivery methods. Feedback on the induction of 16 trainees was analysed in addition to feedback from 29 medical students who had experienced virtual reality (VR) palliative care teaching methods locally as well as an online survey sent to 33 previous trainees at the hospice to ascertain their views on alternative delivery methods.

Results Amongst the cohort who had experienced VR, the feedback was generally positive. There was however a general reluctance to consider new techniques amongst past trainees of the hospice who, unanimously, valued the face-to-face induction they had received, this is consistent with positive GMC trainee survey responses at the hospice to the induction question.