

## 82 IMPROVING SPIRITUAL CARE IN HOSPICE – INTEGRATING THE ‘HOPE’ ASSESSMENT TOOL INTO THE MEDICAL ADMISSION DOCUMENT

Amy Taylor, Jim Armstrong, Clare White. *Northern Ireland Hospice*

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**Background** Junior doctors undertake holistic patient assessments on hospice admission. Although physical and psychosocial needs are frequently comprehensively evaluated, medical staff often lack confidence and training in the assessment and management of spiritual issues. This quality improvement project aimed to improve medical staff confidence in the assessment and documentation of patients' spiritual needs upon hospice admission.

**Methods** An anonymous survey evaluated hospice medical staff opinion on spiritual care. A chart review examined the spiritual assessments documented at baseline and monthly (February to June 2018). Using the 'HOPE' tool, factors assessed were: identification of source of Hope; Organisation/spiritual community; spiritual Practices; desired Effects on healthcare. Interventions included dissemination of a spiritual care journal article, integration of 'HOPE', a spiritual assessment tool, into the admission proforma and junior doctor education by the hospice chaplain. Descriptive statistics were generated using Microsoft Excel.

**Results** Eight medical staff (junior doctors and consultants) completed the survey. Spiritual care was identified as important but often forgotten. 63% believed religious leaders should direct spiritual care, but that all staff should have relevant skills. Over 50% lacked confidence in spiritual aspects, particularly regarding religious minorities.

Completion of spiritual assessment improved from 83% to 94%. Identification of source of hope increased from 50% to 78%, which was sustained. Identification of a spiritual community improved from 6% to 67%, but this was not maintained. Identification of spiritual practices improved from 28% to 75% and discussing effects on healthcare rose from 17% to 67%. These were sustained.

**Conclusions** Introducing a spiritual assessment tool improves identification of spiritual needs on admission, particularly source of hope and spiritual practices. Ongoing targeted education would ensure continuous improvement. Use of this tool across inpatient and community palliative care settings could improve spiritual care by clinicians.

## 83 ASSESSING DEPRESSION ON ADMISSION TO HOSPICE: AN AUDIT

Felicity Wood, Emma Lowe. *Wakefield Hospice*

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**Background** Depression is prevalent but often undiagnosed and undertreated in hospice settings. The aim of this audit was to establish how well depression is assessed and managed on admission to hospice and during the course of admission.

**Method** All admissions to Wakefield hospice between April and June 2018 were examined. The electronic GP notes were accessed to determine if an established diagnosis of depression was recorded. Written hospice notes were then reviewed. Demographic information was collected as well as whether depression was assessed on admission, and whether it was

rated, as per the medical admission proforma. If mood was recorded as low, it was noted whether a plan was in place regarding this. The medical entries during admission were also read to see if depression was assessed during the course of admission.

**Results** There were 87 patients admitted to the hospice during the 3 month period. Data was available on 61 of those. Less than a third of depression diagnoses documented by GP were noted on admission. In 48% of cases depression was assessed on admission. When recorded as being low in mood, there was rarely a plan specified in managing this. In only 6% of all notes was a rating score recorded for depression. This is part of the admission proforma. In 10% of cases, there was some review of mood made during the course of admission.

**Conclusion** Despite depression being prevalent in a hospice setting, an assessment of this was recorded in less than half of cases on admission. Mood was infrequently documented during the course of admission. When depression was noted, there was not often a plan documented for managing or reviewing this. The plan is to update the admission proforma, educate staff on depression screening and re-audit in 6 months time.

## 84 EVOLVING HEALTH AWARENESS AND CARE EXPERIENCES INFLUENCE PREFERENCES FOLLOWING ACUTE ILLNESS: QUALITATIVE ANALYSIS FROM A MIXED-METHODS PROSPECTIVE COHORT STUDY OF FRAIL OLDER PEOPLE

Simon Noah Etkind, Natasha Lovell, Anna E Bone, Laura Cottrell, Fliss EM Murtagh, Irene J Higginson. *King's College London, Cicely Saunders Institute; Wolfson Palliative Care Research Centre, Hull York Medical School*

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**Background** Acute illness may catalyse changes in care preferences, but the influences on preferences are incompletely understood in frail older people following acute illness.

**Aim** To explore influences on the care preferences of frail older people following acute illness.

**Methods** Prospective cohort study utilising a concurrent dominant status (quan + QUAL) mixed-methods design with six month follow up. Inclusion criteria were: age  $\geq 65$ ; Rockwood clinical frailty score  $\geq 5$ ; recent acute illness requiring secondary care assessment or admission. Of a study sample of 90 participants, 18 purposively sampled participants contributed both survey responses about their preferred care outcomes and serial in-depth qualitative interviews with a topic guide exploring influences on preferences. Patterns of preference stability identified in the survey responses of these 18 participants were explored during thematic analysis of interviews.

**Results** Median patient age 84 (inter-quartile range (IQR) 81 – 87), 53% female. Median frailty score 6 (IQR 5 – 7). Evolving awareness of deteriorating or uncertain health trajectories tended to influence preferences away from 'extending life', towards 'staying out of hospital', 'being comfortable', or 'improving quality of life'. Care experiences influenced preferences more prominently than time during the study, particularly affecting place-of-care preferences. Health status changes did influence preference stability, but those with close support from family reported that family considerations were more important than health status changes as an influence on preferences, as family gave them 'something to live for'. The

presence of prominent longstanding personal values, often relating to independence, supported stability of preferences.

**Conclusions** The stability of care preferences is influenced by experience, evolving awareness and family considerations, but is less influenced by time or health changes in this population. By exploring health awareness and care experiences with patients, clinicians may be better able to elicit preferences and deliver care responsive to preferences following acute illness.

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#### CULTURAL RESPONSES TO PROSTATE CANCER IN GHANA: MASCULINITY AND STIGMA

Yakubu Salifu, Kathryn Almack, Glenys Caswell. *University of Nottingham, University of Hertfordshire*

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**Background** Almost two-thirds of cancer deaths occur in developing countries. In resource-poor countries where there are no well-developed institutional-based palliative care services or where those facilities are in limited supply, family home-based care is a critical element of providing comforting care for patients whose prostate cancer has spread to other parts of the body (advanced). One in 8 men in the UK develops prostate cancer.

**Method** The study adopted a qualitative repeat in-depth interview approach to explore the complexity of viewpoints. A total of 23 patients with advanced prostate cancer (APC), 23 family caregivers, and 12 health care professional yielded 68 interviews to get a holistic understanding of such care. Patients and their caregiver(s) participated in two interviews either individually or as joints across a period of up to 6 months. The interviews were transcribed and an inductive thematic analysis approach was used to explore relevant content and contexts of commonly recurring themes regarding the experiences stigma and how prostate cancer impacts on men's masculinity.

**Findings** Physical changes, impotence, incontinence, and loss of social status impacts on what means to be a real man. APC affects masculinity results in changed identity that affect the masculine role as leaders, breadwinners, and head of households. This together with impotence made the men felt 'not man enough' and 'living dead' thereby impacting on their social statuses. APC is stigmatised as a promiscuous disease. The cultural response to prostate cancer should guide any self-management services for men living with prostate cancer.

**Conclusion** This study has identified the cultural response to prostate cancer and how it influences their quality of life and dignity. This study provides rich experiences about living with prostate cancer issues around cultural responses that may hinder health-seeking and quality of care.

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#### MOVING TOWARDS AN ENHANCED COMMUNITY PALLIATIVE SUPPORT SERVICE (ENCOMPASS): IMPACT OF USING MOBILE TECHNOLOGY TO SUPPORT DELIVERY OF COMMUNITY PALLIATIVE CARE

Paul Taylor, Susan Mawson, Steven Ariss. *University of Sheffield, St Luke's Hospice Sheffield*

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**Background** Models of community palliative care delivery are typically dependent on specialist nursing and medical staff acting independently. This study, part of the EnComPaSS project, appraises the impact of eShift, a technological system created by Sensory Technologies. eShift supports a delegated model of care, facilitating visiting staff to remain in ongoing contact with senior team members, and supporting systematic MDT recording.

**Methods** This was a service evaluation conducted at a Specialist Palliative Care service in the North of England, part of a real-world evaluation of a complex intervention. Prior data was collected from October 2014 to September 2015, transition to the new model began in October 2015, with data collection continuing to September 2016. Outcomes were based on prior hypotheses, including absolute numbers of patient contacts, grade of professional, number and route of hospital admissions and associated economic impact. Further evaluations over a longer time period are ongoing.

**Results** In comparing the pre-intervention period with the follow-up period, the total number of patients on the case-load remained relatively stable (1521 vs 1501). There was a reduction in total visits (3725 vs 3285), number of consultant visits (105 vs 48) and number of senior nurse visits (3361 vs 2730). There was an increase in the number of band 5 nurse (0 vs 208) and registrar visits (89 vs 170). Furthermore, number of patients admitted to hospital reduced (1238 vs 1156), as did overall admissions (5571 vs 4548) and average length of stay in days (6.23 vs 5.99). The reduction in hospital bed-days translates to a cost saving of £2.7 m per year, based on costs during the study period.

**Conclusion** This service evaluation supports the successful implementation of a technological solution to improving efficiency and delivery of community palliative care, with associated reductions in visits, hospital stays and service costs.

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#### WHAT FACTORS ULTIMATELY INFLUENCE THE PLACE OF DEATH OF CARE HOME RESIDENTS? A QUALITATIVE STUDY OF THE INTERACTION BETWEEN CARE HOMES AND GENERAL PRACTITIONERS IN THE SOUTH WALES VALLEYS

Ian Jones, Dylan Harris. *Glyn Ebwy Surgery – Ebbw Vale, University of UK*

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**Background** In Wales, over 50% of care home patients at end of life die in hospital. Initiatives such as advance care planning aim to reduce hospital admissions from care homes at end of life, but improvements have been slow. This study explores why some care home patients are admitted to hospital at end of life, and why similar patients are looked after in their care homes.

**Methods** The study is a retrospective, thematic analysis of interviews with General Practitioners (GPs) and care home staff. The interviews were based on care home deaths occurring in 6 GP surgeries, 6 nursing homes and 6 residential homes in the South Wales valleys between 01/09/2016 and 31/08/2017.

**Results** Fifty-seven hospital deaths were discussed, along with a similar number of care home deaths. Overall, 78% of patients overall died an expected death in their care homes.