

improvement and 7% showed worsening. However, in the patient group of starting lower pain scores 1–2 we found that only 12% showed an improvement, while 28% did not show any change and an astonishing 60% showed worsening in their pain scores. Going into this study we were not expecting to find the above result. Reassuring that we are impacting positively for those patients with higher pain scores. However patients with lower pain scores did not appear to have their pain as well controlled. We need to consider possible hypothesis why is this the case. Is it that their AKPS is deteriorating and this is reflected in their pain score? (Total pain theory). Have they fewer distractions at the hospice and is this making their pain worse? Are they witnessing other patients in pain and this is impacting on their impression of their own pain? Are those with higher pain scores getting more attention/time with trained staff and is this having a placebo effect on their pain? At this time we do not have conclusive hypothesis but we will be undertaking a prospective study following new inpatients that have been identified with low pain scores initially, which has increased on 2nd IPOS. We will be creating a short questionnaire to identify and test our hypothesis.

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161 PALLIATIVE CARE FOR YOUNG PEOPLE WITH LIFE-LIMITING ILLNESS: WHAT SHOULD WE BE TEACHING SPECIALIST PALLIATIVE CARE TRAINEES?

Amelia Stockley, Karen Forbes. *University of Bristol, NIHR*

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Background Advances in medicine mean children with life-limiting illness are living into, and therefore dying in, adulthood when they would once have died in childhood. Studies suggest a lack of training for physicians is a major obstacle to achieving adequate care for these young people (YP). The adult palliative care specialist training curriculum requires attainment of broad-brushstroke objectives only. The curriculum needs to provide a workforce competent to deliver palliative care for YP with life-limiting illness.

Aims To identify what issues experienced doctors working with YP with life-limiting illness perceive are key to delivering good palliative care to this group of patients.

Methods 15 semi-structured, face-to-face interviews with experts were undertaken exploring the key issues faced by YP with life-limiting illness. Participants were also invited to comment on the current palliative care specialist training curriculum. Data were analysed using the principles of grounded theory analysis.

Results Six main themes were identified: context, challenges, clinical care, communication, decision-making and planning ahead.

Conclusions The learning-objectives pertaining to YP and transition in the current curriculum are unlikely to generate a workforce competent to provide palliative care to this group.

An understanding of the unique contexts of these YP and their families as they transition from children's services is required to provide excellent holistic palliative care. Challenges and clinical skills were identified that should be considered within the curriculum for delivery of services and good clinical care to this relatively unfamiliar group of YP. Adolescents, YP with cognitive- and communication-problems and families with long-established patterns of interacting require a distinct set of communication skills. Prior experiences of decision-making should be taken into account. A common framework for prognosticating, identifying palliative care need and supporting advance care planning in this group of YP is yet to evolve.

162 ROLE OF SPECIALIST PALLIATIVE CARE IN CARE CONFERENCES IN A TERTIARY REFERRAL HOSPITAL IN INDIA: A RETROSPECTIVE CASE NOTE ANALYSIS

Sunitha M Daniel, Chitra Venkateswaran. *Amrita Institute of Medical Sciences, Amrita University, Kochi, India*

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Background Care conferences are team meetings held for every patient receiving health care in hospital or other care facility. It involves the patient, carers and family and it facilitates sharing information and working together to meet the person's needs. Successful communication is an important component of the process which results in appropriate decisions being made in relation to available care resources. Integrating early palliative care with cancer treatment improves quality of life and survival. Effective communication among physicians, patients and their loved ones is crucial to end-of-life, hospice and palliative care discussions. The palliative care team in our hospital has been actively involved in the care conferences organised by various specialities. The aim of this study was to evaluate the role of the specialist palliative care team in care conferences held in a tertiary referral hospital.

Method A retrospective case note analysis was completed on patients who had care conferences conducted while they were inpatients in the hospital over a period of 6 months.

Results The team were involved in advanced care planning of fourteen patients during this period. The median age was 44; the youngest patient was of 6 months of age. Our team was involved in discussion around goals of care and discharge planning. The median duration from admission to care conference was 17 days while the duration to discharge was 3.5 days. The outcome of meeting varied from agreeing for best supportive care, decisions about not attempting resuscitation, early shift out from intensive care unit and facilitating discharge home with involvement of home care team.

Conclusion Specialist Palliative care team has an important role in initiating and leading care conferences to enable better communication between specialities, provide quality care to patients and families and prevent futile medical treatment at end of life.