

is harmonised. Evidence identifies a more holistic, non-drug approach to effective management. This study aimed to embed the Breathing, Thinking, Functioning clinical model in managing breathlessness into clinical practice, equipping and enabling professionals to cascade the approaches to patients and carers.

**Methods** Multi stage approach:

1. A 2 hour practical workshop to understand the Breathing, Thinking, Functioning (BTF) conceptual model of breathlessness will be offered to all staff within the palliative care teams (community, inpatient and hospital) under MCH CIC management.
2. Staff will complete pre and post questionnaires following this intervention, looking at experience, confidence and utility in managing breathlessness with questionnaires at 3 month follow-up.

**Results** 40 professionals attended the practical workshops (n=4) with participants initially rating their experience ('quite a bit' and 'very well') in managing breathlessness with 15% (6/40) compared to 77% (31/40) post-intervention, along with confidence increasing from 15% (6/40) to 72% (29/40) within the same group. Feedback was very positive with 88% (35/40) participants identifying the utility of this model in clinical practice. Follow-up at 3 months identified that confidence was still relatively high at 64% (14/22) despite lower response rate 55% (22/40).

**Conclusions** This work identified the usefulness of the BTF model in the management of refractory breathlessness in progressive respiratory disease. Professionals initially rated themselves low in confidence managing breathlessness but after the workshop, identified confidence increasing by 57%. Despite the significantly reduced numbers at 3 month follow-up (22 vs. 40), this project still identified 64% of attendees identifying themselves as confident ('quite a bit' or 'very well') in managing breathlessness, compared with an initial 15% of participants. This practical workshop approach has the potential to equip professionals in the effective management of refractory breathlessness.

## 21 DOES A ONE DAY HOSPICE PLACEMENT FOR MEDICAL STUDENTS DO MORE HARM THAN GOOD?

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**Background** In their first year as a doctor, F1s will care for 40 patients who will die and 120 patients in the last year of life. However, research shows junior doctors are often unprepared. We present data on the value of extending a hospice placement from 1 day to 4 days.

**Methods** Students were randomly allocated to 1 day or 4 days in 3 different hospices. Students completed a thanatophobia scale, self-efficacy in palliative care scale and placement evaluation questionnaire. Performance in palliative medicine and oncology questions in end of year summative exams were compared.

**Results** 153 students undertook the 4 day placement. All students (1 and 4 day) had improved self-efficacy scores. 4 day placements had a greater effect on the global score and individual questions. Thanatophobia scores were reduced for the 4 day but not the 1 day placement. Students feedback was overwhelmingly positive highlighting the high quality of teaching, alignment of classroom and placement teaching,

opportunities for work based assessments, medicines management, communication skills and interprofessional learning. 4 day students scored significantly higher in palliative medicine and oncology OSCE stations, higher for palliative medicine written questions, approaching significance in oncology written questions.

**Conclusions** Extending placements in hospices to 4 days significantly improved student's self-efficacy in palliative care and reduced thanatophobia when compared to a 1 day placement. Students valued the placements and as well as learning specific subject knowledge they developed many generic skills. 4 day students did better in both their oncology and palliative care OSCE stations and better in written palliative medicine questions. Students may have increased feelings of helplessness in caring for dying patients when they only attend a hospice for 1 day. Medical Schools should be encouraged to extend placements in palliative care and be aware for the potential increase in distress when only a short placement is provided.

## Free Papers 22 – 24 | End of Life Care

### 22 GENERAL PRACTITIONERS' DECISIONS ABOUT PRESCRIBING ANTICIPATORY MEDICINES AT THE END OF LIFE: A QUALITATIVE STUDY

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**Background** General Practitioners (GPs) have a central role in decisions about prescribing anticipatory medications (AMs) to help control symptoms at the end of life. Little is known about GPs' decision-making processes in prescribing AMs, how they discuss this with patients and families, and the subsequent use of prescribed drugs.

**Aim** To explore GPs decision-making processes in the prescribing and use of AMs for patients at the end of life.

**Methods** A qualitative interpretive descriptive enquiry with a purposive sample of thirteen GPs working across one English county. Data were collected between June and December 2017 via audio recorded semi-structured interviews and analysed inductively using Braun and Clarke's thematic analysis.

**Results** Three themes were constructed from the data: (1) 'Something we can do'. AMs were a tangible intervention GPs felt they could offer to provide symptom relief for patients approaching death. (2) 'Getting the timing right'. The prescribing of AMs was recognised as a harbinger of death for patients and their families. GPs would discuss AMs when they felt patients were ready, preferring to prescribe drugs weeks before death was expected whenever possible, while recognising this meant that many prescribed AMs were never used. (3) 'Delegating care whilst retaining accountability'. After prescribing medications, GPs relied on nurse to assess when to administer drugs and keep them updated about their use.

**Conclusion** GPs view AMs as key to symptom management for dying people. AMs are routinely prescribed even though they are often not used. In order to feel comfortable delegating care, GPs need regular access to nurses and trust in their skills to administer drugs appropriately. Patient and family experiences of AMs, and their preference for involvement in decision-making about their use have not been studied to date: we are addressing this important knowledge gap.