Aim To understand how those who work outside of healthcare are trained to break bad news.

Method Using a snowball approach, a convenience sample of 20 participants from a range of sectors were invited to participate. Twelve completed semi-structured interviews (see table 1). Audio recordings were transcribed, anonymised and subjected to thematic analysis.

Results Though formal training was lacking in many sectors, the military, in particular, provided rigorous and consistent training courses for their Notification and Visiting Officers. Experiential learning by observing others or through own practice, or interactive learning in a safe and simulated environment (e.g. role-play) was common. Some sectors recognised the challenge of breaking bad news and have installed supportive measures. Digital learning was seen as 'the way forward', with accessibility and flexibility that matches modern working styles. There was a demand for more learning on breaking bad news, even in a digital medium, but there was little recognition of such resources being available.

Abstract 6 Table 1 Participant demographics

Variable	Participants (n=12)
Gender	
Male	4
Female	8
	Male to female ratio (1:2)
Age	
18–24	0
25–34	2
35–44	6
45–54	2
55–64	2
Sector	
Information technology	1
Law enforcement and security	4
Public services and administration	2
Recruitment and HR	5

Conclusion Other job sectors apply similar learning modalities to healthcare but place greater emphasis on training their workforce in breaking bad news. There is a need for research studying enhanced training for breaking bad news in healthcare by focusing on preparedness and support as this would likely offer comparable benefits for the healthcare sector.

Posters

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

¹Ben Bowers, ²Kristian Pollock, ¹Sam Barclay, ²Stephen Barclay. ¹University of Cambridge, UK; ²University of Nottingham, UK

10.1136/spcare-2019-mariecuriepalliativecare.7

Background General Practitioners (GPs) have a central role in decisions about prescribing anticipatory medications (AMs) to help control symptoms at the end of life. (Faull, et al. 2013)

Little is known about GPs' decision-making processes in prescribing AMs 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.

Method A qualitative interpretive descriptive enquiry with a purposive sample of thirteen GPs working across one English county. Data was collected in 2017 via 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 families. GPs preferred to prescribe drugs weeks before death was expected, while recognising this meant that many prescribed AMs were never used. 3) 'Delegating care whilst retaining accountability'. 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 warrant urgent investigation.

8 BATTERY-OPERATED FAN AND CHRONIC BREATHLESSNESS: DOES IT HELP?

¹Matilda Barnes-Harris, ¹Miriam Johnson, ²Flavia Swan, ³Victoria Allgar, ¹Sara Booth, ⁴David Currow, ²Simon Hart, ⁴Jane Phillips. ¹Wolfson Palliative Care Research Centre, Hull York Medical School, UK; ²Hull York Medical School, University of York, UK; ³Department of Oncology, University of Cambridge, UK; ⁴IMPACCT, Faculty of Health, University of Technology Sydney, Australia

10.1136/spcare-2019-mariecuriepalliativecare.8

Objectives To examine whether use of a hand-held fan ('fan') improves breathlessness and increases physical activity.

Methods A secondary exploratory analysis using pooled data from the fan arms of two feasibility randomised controlled trials in people with chronic breathlessness; i) fan and activity advice *vs* activity advice, ii) activity advice alone or with the addition or the 'calming hand', or the fan, or both. Descriptive statistics and regression analysis to explore patient characteristics associated with benefit (e.g. age, sex, diagnosis, general self-efficacy).

Results Forty-one participants were allocated the fan (73 years [IQR 65–76, range 46–88], 59% male, 20 (49%) chronic obstructive pulmonary disease (COPD), three (7%) heart failure, three (7%) cancer). Thirty-five (85%) reported that the fan helped breathing, and 22 (54%) reported increased physical activity. Breathlessness benefit was more likely in older people, those with COPD and those with a carer. However, due to the small sample size none of these findings were statistically significant. Those with COPD were more likely to use the fan than people with other diagnoses (Odds Ratio 5.94 [95% CI (95%CI) 0.63, 56.21, p=0.120]) (table 1).

Conclusions These exploratory data support that the fan helps chronic breathlessness in most people and adds new data to indicate that the fan is perceived to increase people's

Abstract 8 Table 1 Univariable regression of patient characteristics and help with breathlessness

The fan helps breathlessness							
		Yes (35) Mean (SD), median (IQR) or n(%)		No (6) Mean (SD), median (IQR) or n(%)		Odds ratio (95% CI)	p-value
Age		70.7 (9.5) 73 (66-76)		66.5 (9.8) 66 (59-77)		1.05 (0.96, 1.14)	0.324
Sex	Male	20	83%	4	17%	Reference	0.663
	Female	15	88%	2	12%	1.50 (0.24, 9.30)	
Diagnosis	COPD	19	95%	1	5%	5.94 (0.63, 56.21)	0.120
	Other	16	76%	5	24%	Reference	
Carer	Yes	12	86%	2	15%	1.04 (0.17, 6.54)	0.964
	No	23	85%	4	15%	Reference	
GSES		31.2 (4.7) 31 (28-35)		34.5 (6.6.) 36 (27-40)		0.87 (0.72, 1.05)	0.151

SD – Standard Deviation; CI – confidence intervals; IQR – interquartile range; COPD – chronic obstructive pulmonary disease; GSES – general self-efficacy score.

physical activity. There is also a signal of possible particular benefits in people with COPD which is worthy of further study.

No funding was required for this study.

9 MEETING THE DEMANDS FOR THE FUTURE: HOW DO SPECIALIST IN-PATIENT PALLIATIVE CARE SERVICES NEED TO CHANGE TO MEET THE NEEDS OF THE POPULATION IN 2040?

Isobel Morton. North Middlesex University Hospital, UK

10.1136/spcare-2019-mariecuriepalliativecare.9

With advances in anti-cancer treatments, for some, cancer is becoming a chronic disease. As life expectancy increases many are living longer with a higher burden of morbidity. Consequently, there is a higher demand for specialist in-patient Palliative Care services. In order to meet the requirements for the future, how does in-patient Hospice Care need to evolve?

Data regarding Hospice in-patient services was collected from Hospice Care in the UK (Hospice UK, 2017). Data regarding population forecasts was collected from the Office for National Statistics (Office for National Statistics, 2018). From this, the data was extrapolated to make forecasts about how in-patient Palliative Care will need to grow in order to satisfy the growing population.

In 2017 there were 2760 in-patient hospice beds in the UK with 71% of service users over the age of 65. This served a population of 66.4 million of whom 18.2% (12,084,800) were over 65 (Office for National Statistics, 2018). By 2040 the UK population is forecasted to increase by 9.1% to 72.7 million, with the over 65 population increasing to 25% (18,172,063) (Office for National Statistics, 2018).

This suggests the number of in-patient Palliative beds will need to increase by 36% to 3749 by 2040 in order to meet the requirements of both a growing and aging population.

The demand for specialist in-patient Palliative Care services is set to increase exponentially, therefore the number of in-patient hospice beds will need to increase dramatically. However, this will not be sufficient in isolation, with the need for the development of other Palliative services as part of a longer-term strategy to support this increased demand.

10 COMPLETION RATES OF DISCHARGE SUMMARIES FOR PATIENTS THAT DIE DURING THEIR ADMISSION TO HOSPITAL

Heather Holyoak, Ningyu Chai, Farid Bazari. Kingston Hospital, UK

10.1136/spcare-2019-mariecuriepalliativecare.10

All patients admitted to hospital should have a discharge summary completed, including those that have died during their admission. This ensures good continuity of care between secondary and primary care.¹ We looked at the current level and practice of doctors completing discharge summaries for these patients, and the quality of information provided.

We initially looked at patients who died between November and December 2018. 114 patients died. Only 35 (31%) patients had a discharge summary completed. A survey of junior doctors highlighted confusion about what documentation was required, they felt they are often too busy to do discharge summaries and see patients who have died as a lesser priority.

A project was conducted to highlight the importance of these summaries and to improve the quantity and quality of them being done. This included presenting our initial data at Grand Round, the Junior Doctor Forum and piloting a 'Bereavement Box' on one of the medical wards. This was used in morning board rounds to highlight summaries that needed to be done, but to also use it as an opportunity to debrief and learn from deaths.