patients and their family are: reduced dietary intake, conflict over food, lack of information, lack of understanding and knowledge, and perceived neglect from Healthcare Professionals (HCPs). Therefore, there is a need from the patient and family for psychosocial and educational support from the HCP. However, this review demonstrated that the HCP also requires educational support around cachexia to be able to provide support. A theme was identified, that if a conversation began around cachexia that this would then lead onto more difficult conversations relating to death and dying, and the HCP did not feel capable of this. In summary, those HCP who routinely work within specialist palliative care appear to be more able to provide this support, whereas, for others in disciplines related to palliative care there appears to be a need for development.

P-120 DEVELOPING EXCELLENT END OF LIFE DEMENTIA CARE

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Background There is a variation both in access to high quality end of life care for people with dementia (Department of Health, 2015) and how proactive hospices are in meeting their needs (Care Quality Commission, 2016). Partnership working with dementia experts is best practice (NICE, 2018; Department of Health, 2009; National Council for Palliative Care, 2009). We identified gaps in training and wrote a two-year strategy outlining how we would improve our dementia care and support.

Aim To enable staff to provide excellent individualised end of life care and support to patients with dementia, and their families. To promote equity of access to all hospice services for people with dementia.

Methods Formed internal dementia working group. Scoped, reviewed observations tools that aid assessment of pain and distress in people with dementia. Researched and wrote three e-learning packages for employed staff. Designed and delivered end of life dementia care study day/workshop for health/social care staff (external and internal). Initiated regular Dementia Friends sessions for staff and volunteers. Developed partnerships with dementia teams at local acute hospitals. Established strong links with local CCG commissioned community dementia service and dementia action alliance.

Results thus far Two observation tools implemented within hospice. Over 80 attendees at study day/workshop, well evaluated. Over 100 attendees of dementia friends' sessions including our hospice shop managers. A memory box now in use on the inpatient unit. Evaluation of staff knowledge and confidence planned. Delivered end of life care training to community dementia service and advised on their end of life care pathway which now incorporates the hospice 24hr advice line and referral process. Invitation from local hospital to deliver an End of Life Dementia Care session at their annual dementia champions study day, over 50 staff in attendance. Partnership meeting planned for acute trust dementia leads, community dementia service team manager and hospice dementia lead.

Conclusions Impact of e-learning planned, however excellent verbal feedback from staff, stating feeling more enabled. Staff report benefit of observation tools in improving assessment.

P-121 RAISING AWARENESS OF PALLIATIVE CARE NEEDS OF PATIENTS WITH HEART FAILURE: AN EDUCATIONAL APPROACH

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Funded under the St James's Place Charitable Foundation grant programme, managed by Hospice UK.

Problem identified People with heart failure, have a high burden of unmet palliative care needs. It was identified that education, support and development for team members may help (Hospice UK, 2017).

Aim To examine outcomes of a three-hour interactive heart failure workshop on perceived self-reflection of a combination of mixed health care professionals.

Methods At the start and end of the workshop the participants were asked to reflect on their understanding of heart failure, and the causes of heart failure and symptoms of heart failure. Participants were asked to identify their own personal learning objectives, these were gathered by the facilitator at the beginning and revisited at the end of the workshop.

17 workshops - 110 participants completed the questionnaire.

Results The workshops increased attendees' self-assessed understanding of heart failure and its cause and symptoms with average scores improving from 2.6 to 4.6 on a 5 point Likert scale. Before the workshop only 6% of people strongly agreed that they felt competent to care for a patient with advanced heart failure. This increased to 54% after the workshop. 97% of participants said that their personal learning needs were met.

Discussion Following the course all participants were asked to reflect on their practice and how the course may change their care. The pathology of heart failure and how this related to symptoms was identified: *'Being able to link the mechanics of the heart for what I deal with on the ward each day.'*

Participants also identified having discussions earlier and advance care planning could help also being aware of patient's prognosis.

In order to establish if application of knowledge is to be put in to practice, further research is being undertaken to explore the impact the training has had on the ability of the participants to care for patients with heart failure.

Conclusion A three-hour workshop may promote awareness, increase confidence and may enable change to practice.

P-122 REFRACTORY ANGINA IS A GROWING CHALLENGE FOR PALLIATIVE CARE: A SYSTEMATIC REVIEW OF INTERVENTIONS

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Background Refractory angina is a chronic and potentially debilitating condition that is estimated to affect 30–50,000 new patients per year in Europe. It is likely to become more prevalent as the likelihood of survival with ischaemic heart disease increases. There is a demand for palliative intervention in patients whose quality of life is significantly affected and where conventional medical treatment and revascularisation

are inadequate to control pain. Our aim was to systematically review all studies that report pharmacological and non-pharmacological interventions for refractory angina, and discuss palliative interventions appropriate for hospice and community-based care.

Methods We performed a literature search of six databases and a search of available grey literature. Studies relating to first- and second- line pharmacological treatments were excluded, as were interventions that had undergone systematic review within the last three years.

Results 4475 studies were screened, 37 studies were included in our analysis. Interventions were cardiac shockwave therapy (twenty two), transcutaneous electrical nerve stimulation (TENS) (four), perhexiline (two), optimal medical therapy (two), multi-disciplinary care programmes (two), psychotherapy (two), cardiac rehabilitation (one), morphine (one) and intranasal alfentanil (one). The majority of studies reported positive results, with improvements in pain, angina class, exercise tolerance and quality of life. Very few adverse effects were reported across all studies but quality assessment was varied and risk of bias was generally high.

Discussion There is a significant body of literature regarding interventions for refractory angina that is over-looked in current clinical practice. While the quality of these studies varies, improvements have been reported in symptom control and quality of life with few adverse effects. There is a need for further research into these interventions which could be useful within the contexts of cardiology and palliative care.

P-123 CALCIPHYLAXIS AND THE CHALLENGES OF ADVANCE CARE PLANNING IN END STAGE RENAL DISEASE

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Background Calciphylaxis is a rare and poorly understood complication of end stage renal disease (ESRD) that causes a complex pain difficult to manage in the acute hospital and hospice environment. Its management is further confounded by the symptom burden of ESRD and the challenges of facing the extremely poor prognosis associated with this condition.

Aim We aim to share our experiences in treating this condition using a holistic, cross-specialty approach. We would also like to suggest our guidance in managing the physical and psychosocial symptoms of calciphylaxis whilst exploring advance care planning (ACP) in ESRD in a short time frame.

Method We present a case of a patient newly diagnosed with calciphylaxis on a background of ESRD. The patient was managed by the hospice palliative care team with input from the renal physicians in both the acute hospital and hospice environment, spanning a period of two months from acute presentation to death. The case illustrates the impacts of various methods used in treating the patient's symptoms. There is also a review of the evidence and guidelines for the use of opioids in ESRD as well as the guidance on ACP in ESRD.

Results We found that a cross-specialty approach is key to managing the symptoms of calciphylaxis and ESRD even when dialysis is discontinued. A variety of analgesics and

formulations were required in treating the associated ischaemic pain. In utilising the multidisciplinary team, a comfortable death was achieved whilst placing the patient's choices at the centre of their care.

Conclusions In treating the complex symptom burden and unusual presentations of ESRD, a close working relationship between the palliative medicine and renal team is essential. ACP conversations are desired by these patients but can be infrequent in reality and should be instigated earlier and repeatedly throughout their patient journey.

P-124 EVOLUTION AND REVOLUTION IN MANAGING HOSPICE PATIENTS' BLOOD GLUCOSE LEVELS

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Background On outpatient review, a recent in-patient initiated on steroids was newly diabetic. Given the minimal hospice guidance on blood glucose management, a quality improvement programme was initiated.

Aim Evolution and revolution in care to provide high standards of blood glucose management in patients taking steroids, with diabetes or nearing end of life.

Method Process over four years, informed by three audit cycles.

Firstly, development of hospice standards for blood glucose management in patients with diabetes or on steroids, based on Diabetes UK End of Life Diabetes Care Recommendations (3rd ed., 2018), which was adopted as hospice policy. Overall, standards were to ensure:

- Recording of blood glucose levels and documentation of clear, appropriate management plans for diabetic patients or on steroids;
- Reviewing of blood glucose management in last days of life;
- Accurate recording and prescribing of blood glucose lowering drugs.

Secondly, recurring multifaceted and multidisciplinary education of staff on diabetes and the importance of blood sugar management, supported by publicity about the new policy and hospice standards in all clinical areas.

Thirdly, change of existing blood glucose monitoring proforma to include more detail and increased guidance regarding target blood glucose levels.

Results Initial audit demonstrated inadequate management plans, no blood glucose target range setting, poor blood glucose monitoring, no last days of life review of management or monitoring of blood glucose levels for patients on steroids.

Second audit demonstrated significant improvement in management of patients with diabetes, including at end of life but continued poor monitoring and management of blood glucose in patients with steroids.

Final audit demonstrated high compliance in all areas.

Conclusion Evolution of clinical management culture may be challenging and prolonged. Combination of techniques is necessary, including repeated, multidisciplinary education of the underlying issues, publicity regarding change, practical guidance for staff and revolution in aspects of multidisciplinary working and care.