

# Poster abstracts

Saturday 9 June

## CONNECTING DIVERSITY

10th Congress of the  
European Association for Palliative Care

(3.3 times), and for the longest periods (35 days).

**Conclusions:** Patients with lung cancer are a particular important target group for reducing hospitalization at the end of life.

## 761. Intrathecal Use of Hydromorphone in Palliative Care Patients: A Case Report

Katri Elina Clemens, Ines Quednau, Helmut Hoffman-Menzel, Eberhard Klaschik

*Rhenische Friedrich-Wilhelms-University of Bonn, Department of Science and Research, Centre for Palliative Medicine, Bonn, Germany*

**Background** Hydromorphone (HM) is a semi-synthetic opioid for the treatment of malignant and non-malignant chronic pain. Its pharmacokinetics and pharmacodynamics have been well studied. In palliative care patients, it is rarely used as a solo intrathecal analgesic in clinical practice. The purpose of this case report is to describe the safety and efficacy of continuous intrathecal HM in the management of difficult cancer pain in patients with failure of continuous intrathecal morphine (M) therapy. **Methods** Case report of a patient with chronic cancer pain managed with intrathecal HM after insufficient pain relief with intrathecal M. **Results** Male patient, 76 years old, with prostate carcinoma and diffuse bone metastases in os sacrum, os ischii and os ileum, severe somatic pain with neuropathic pain components. Pre-treatment with high dose intrathecal M (50 mg/die for 88 days) was switched to intrathecal HM because of side effects and inadequate analgesic response. Nausea and vomiting, pruritus and sedation were significantly reduced by use of HM. Analgesic response clearly improved. Pain scores (NRS 0-10) at rest / on exertion at admission vs. discharge were 5/10 vs. 1/2. Intrathecal HM was continuously administered for 393 days. Mean HM dose was  $3.7 \pm 1.65$  (2.60-5.60) mg/die. **Conclusions** HM can be a safe analgesic alternative for long-term intrathecal management of chronic cancer pain in patients with pharmacological side effects or inadequate pain relief under M treatment.

## 762. The last 24 hours of life, how could it be when palliative care is undeveloped?

Ivan Justo Roll, Yobany Rodriguez Tellez, Maria Luisa Torres Pérez

*Tomás Romay, Palliative Care Team, Havana City, Western Sahara*

The last 24-48 hours of life is one of the fields that constitute a capital reason for research in the attention to the terminally ill, an ubiquitous subject of interest of palliative medicine. Based on the observations of the palliative care team members in the Old Havana, Cuba we monitored the evolution of a small group of eleven patients and their families during the last hours of life. Using semistructured interviews regarding the patient care and patients-families concerns, made able to record data for different general domains including the following: general demographic information, symptom prevalence, patient performance status, patients and family main concerns; the only criteria used to enter the study was dying from a terminal disease. Patients were dying from cancer, none of them new that they was actually dying and avoided to discussed that issue, family members were totally disoriented about the patient care, in one hand they would like to try more medical procedures to help their love one (5,45.4%) , in the other they felt there was nothing else to do (4, 36.7%). Some would like to take patients to the hospital (7, 63.6%); and others were dubious about staying at home. Some family members would like to introduce alternative ways for nourish and hydrate the patients (8, 72.7%), others think morphine could hasten patients' death.

## 760. Hospitalization of cancer patients in Germany. Who is particularly concerned?

Nils Schneider, Maren Dreier

*Hannover Medical School, Epidemiology, Social Medicine and Health System Research, Hannover, Germany*

**Aim:** To evaluate the quantity and duration of hospital stays of cancer patients in an advanced stage of disease with respect to differences between the most frequent cancer diagnoses. **Method:** Patients with the diagnoses of lung, colon, breast and prostate cancer were included, if they died from cancer in the year 2004. Using routinely compiled data of the largest health insurance company in the State of Lower Saxony, Germany, the parameters of frequency (case numbers) and duration (days) of inpatient hospital stays were examined for the five-year period of 2000-2004, with special focus on the years 2003/2004. **Results:** 355 patients were included. On average, the number of inpatient hospital stays amounted to 2.7 cases and 29 days per patient. 87.5% of the hospital stays occurred in 2003/2004. The patient groups differed significantly both in the average number of cases and in the duration of hospital stays (Kruskal-Wallis test:  $p < 0.001$ ), whereby patients with lung cancer underwent inpatient hospital treatment most frequently

## 763. A feasibility study of the use of Cognitive Behavioural Therapy (CBT) techniques for anxiety and depression in hospice patients

Tracy Anderson<sup>1</sup>, Max Watson<sup>2</sup>, Robin Davidson<sup>3</sup>

<sup>1</sup> Belfast City Hospital, Palliative Medicine, Belfast, United Kingdom

<sup>2</sup> Northern Ireland Hospice, Palliative Medicine, Belfast, United Kingdom

<sup>3</sup> Belfast City Hospital, Clinical Psychology, Belfast, United Kingdom

**Aim:**

To look at whether using CBT techniques for anxiety and depression in a palliative care population is an acceptable intervention, and whether a palliative care professional, with short training can learn to use CBT techniques which are helpful for hospice patients.

**Method:**

11 patients with scores of 8 or more in either aspect of the HADS scale were recruited from Northern Ireland Hospice and had 3-4 short sessions using CBT

# Poster abstracts

techniques. Visual analogue and HADS scales pre and post intervention were analysed statistically. Thematic analysis was carried out on themes arising during the sessions and on semistructured interviews conducted at the end of the study.

Results:

Quantitative analysis showed significant improvement in anxiety, depression, relaxation, pain and energy.

Qualitative analysis revealed that the patients found their thinking was more structured and positive, and they coped better as a result of the intervention. They benefited from creating alternative statements, using diaries, weighing up advantages and disadvantages, prioritising activities and setting goals. It was felt that the relationship with the therapist was an important factor.

Conclusion:

The content, timing and number of sessions were acceptable for most patients. Only one patient found it unacceptable, due to advanced disease. One other found sessions tiring, but still beneficial. Patients recommended it for others providing they were not too tired, unwell or too advanced in their illness.

## 764. How Far the Population in Bulgaria is Informed About Hospice and Palliative Care

Penka Kolchakova, Petroniya Karamitreva

*College of Medicine Plovdiv, Plovdiv, Bulgaria, Bulgaria*

The aim of the present study is to find out how far people are informed about hospice and palliative care and the need of it.

Methods and material: the study was conducted among 805 people /random selection/ of the population of Plovdiv during 2004 - 2005 (including data gathered on the First World Hospice and Palliative Care Day. An anonymous inquiry specially developed for the purpose was used. Alternative analysis was applied; statistical significance  $p < .05$ .

Results: 85% of the people state that they have not heard about palliative care at all; 98% point out that special care has to be provided for people with incurable diseases and for their relatives; 67% express potential readiness to be involved as volunteers; 67% of the people point out that in cases they needed such a help and support, they had turned to their family doctors, to friends - 61% and to a hospice - 3%.

Conclusions: There is a lack of information for the population in Bulgaria about hospice and palliative care and where they can receive it. There is a need to develop palliative care, supported by the fact that 98% of the people consider that suffering patients and their relatives need such a help. The potential readiness of the people (67%) to act as volunteers is a promising premise for organising and involving volunteers at palliative care in Bulgaria. It is necessary to develop a system to give people information about palliative care and where they can receive it.

## 765. Status of Palliative Care in Lithuania Today

Arvydas Seskevicius

*Kaunas University of Medicine, Kaunas, Lithuania*

**Background**The Palliative Care (PC) is only making its first steps in Lithuania. As a consequence, in the period of last 10 years is marked with significant changes in PC service in Lithuania: opioid therapy is accessible for all the terminally ill patients, the first palliative treatment department was opened, the most important documents defining the legislative status of palliative care were issued, research studies in palliative care were initiated. **Objective**To define the strengths and weaknesses, current status and future development goals of palliative care system in Lithuania. **Methods**Analysis of demographic data, legislative documents, reports from Department of Statistics at Ministry of Health, current health politics guidelines and recommendations. **Results***Epidemiological Data.* The prevalence of oncological diseases is increasing every year: it was 375/100.000 inhabitants in 1999 and 464/100.000 inhabitants in 2004. Cancer related mortality was 208/100.000 inhabitants in 1999, while it reached 238/100.000 inhabitants in 2005. *Palliative Care Service.* PC services are provided by 69 supportive treatment and nursing hospitals, 3 day care centers, 5 pain clinics. Therefore, a new PC Department (30 beds) was established in KMU Oncology Department in January 2006. *Opioid Availability.* Opioids (and some other analgesics) for all receiving outpatient and inpatient palliative care are free. *Regulation.* The Palliative Medicine Association created the special PC Group, which in 2006 produced the document Criteria and costs of palliative care services' defining the legislative status and appropriate funding of palliative care.

**Conclusion**

*Strengths:*

- Criteria and costs of palliative care services were issued by Ministry of Health;
- Narcotic analgesics are available free of additional costs for all palliative care receiving patients.

*Weaknesses:*

- A unified palliative care system is not yet available;

## 766. Survival in Hospice Patients

Stephen Connor

*National Hospice and Palliative Care Org, Research and International Development, Alexandria, VA USA, United States*

There is a widespread belief by some healthcare providers and the wider community that medications used to alleviate symptoms may hasten death in hospice patients. Conversely, there is a clinical impression among hospice providers that hospice might extend some patients' lives. We studied the difference of survival periods of terminally ill patients between those using hospices and not using hospices. We performed retrospective statistical analysis on selected cohorts from large paid claim databases of Medicare beneficiaries for 5 types of cancer and CHF patients. We analyzed the survival of 4,493 patients from a sample of 5% of the entire Medicare beneficiary population for 1998-2002 associated with 6 narrowly defined indicative markers. For the 6 patient populations combined, the mean survival was 29 days longer for hospice patients than for non-hospice patients. The mean survival period was also significantly longer for the hospice patients with CHF, lung cancer, pancreatic cancer, and marginally significant for colon cancer ( $p=0.08$ ). Mean survival was not significantly different (statistically) for hospice versus non-hospice patients with breast or prostate cancer. Across groups studied, hospice enrollment is not significantly associated with shorter survival, but for certain terminally ill patients, hospice is associated with longer survival times.

## 767. PALLIATION AND LIVER FAILURE: PALLIATIVE MEDICATIONS DOSAGE GUIDELINES

Andrew Broadbent, Charles Rhee

*Hope Health Care, Palliative Care, Sydney, Australia*

Good symptom control is one of the most important goals in palliative care. It often requires precision in the prescribing of drugs in the presence of concomitant illness and organ failure. One of the most important factors, from a pharmacokinetic point of view are the dosage requirements and/or adjustments necessary in the presence of liver failure. This poster summarises the literature and suggests guidelines for use common palliative care medications such as opioids, antiarrhythmics, antidepressants, aperients, and other medications as selected by use at a Sydney institution. Comments about the metabolism and excretion indicate how the metabolism is effected, and also the important and/or pharmacologically active metabolites. The normal dose intervals or ranges are given, along with the suggested dose or dosage interval changes depending on the degree of liver failure. Common side effects from drug or metabolite accumulation are noted. Palliation of symptoms is important in a variety of conditions, both malignant and non-malignant. These symptoms can be present in patients with chronic or acute liver failure. The further development of this information may help limit difficulties in choice of medication and reduce potential complications and improve palliation.

## 768. Cutaneous metastases of prostate cancer

Andrew Broadbent, Catherine Bailey

*Hope Health Care, Palliative Care, Sydney, Australia*

Cutaneous metastases are a rare but documented site of distant prostatic metastases and account for less than 1% of skin metastases from all cancers [1]. There have been no published case reports in the palliative care literature. The first reported cases were in the 1970s.

Almost 1 man in every 10 will develop prostate cancer in his lifetime and is the 2<sup>nd</sup> largest cause of cancer related death in men in Australia. In Australia, approximately 10,000 men are diagnosed each year and around 2,500 men will die of this disease. Half of those diagnosed will already have evidence of distant metastases. Cutaneous metastases are generally a late feature and are therefore a poor prognostic indicator.

Here we describe a patient with known carcinoma of the prostate who went on to develop cutaneous manifestations of his disease and then discuss epidemiology and palliative treatments.

## 769. RADIATION INDUCED SECOND MALIGNANCIES:

Andrew Broadbent, Abigail Walton

*Hope Health Care, Palliative Care, Sydney, Australia*

There have been significant improvements in cancer treatment in the last few decades. The use of radiation in the treatment of cancer is widespread and has increased. Up to 40% of cancer pts will receive radiotherapy as part of their management.

More successful treatment has meant improved survival rates, but conversely patients are living longer and encountering more treatment-induced complications.

The development of a second primary malignancy, often many years later, is one of the more sinister complications.

The American National Cancer Institute published data in 2006 reporting that 'Cancer survivors constitute 3.5% of the US population' but that 'second malignancies among high risk groups now accounts for 16% of all cancer incidence.

The timescale between completion of the radiotherapy and the development of a second malignancy, known as the latent period, can vary widely from as little as 5 years up to 50 years later.

In this poster we will present three cases of radiation-induced second malignancies seen in the Palliative Care setting and then give an over-view radiation induced second malignancies, looking at the aetiology, genetics and the palliative care implications for these patients.

## 770. Polypharmacy in palliative care

Andrew Broadbent, Sunitha Razu

*Hope Health Care, Palliative Care, Sydney, Australia*

Polypharmacy can be considered as "the prescription, administration, or use of more medications than are clinically indicated

It is known that elderly patients take on average four or five prescription medications, and two over-the-counter medications. In combination with advancing cancer and co-morbidities such as hypertension and insulin resistance that may fluctuate as the disease progresses, medication interactions may be very complex. Complications from the development of liver or renal failure may also alter pharmacodynamics and pharmacokinetics of drugs.

Some agents could easily be ceased in palliative patients with a short prognosis, such as lipid therapy, anti-glycaemic therapy, and antihypertensives, especially in those patients who have reduced appetites or lost weight.

Polypharmacy may be required to achieve good symptom control and improving quality of life. In patients with advanced cancer it may be difficult to find a good balance between reducing polypharmacy and achieving good symptom control

A prospective audit was designed of 75 consecutive patients admitted to a palliative care unit between September and November 2005.

This poster presents the findings of this study and considers the implications of its results.

## 771. Are palliative care issues different in patients with Primary Brain Tumours ? Data from the German Hospice and Palliative Care Evaluation (HOPE) 2002-2005

Christoph Ostgathe<sup>1</sup>, Sebastian Klein<sup>1</sup>, Lukas Radbruch<sup>2</sup>, Gabriele Lindena<sup>3</sup>, Raymond Voltz<sup>1</sup>

<sup>1</sup> University Hospital of Cologne, Department of Palliative Medicine, Cologne, Germany

<sup>2</sup> University Hospital of Aachen, Department of Palliative Medicine, Aachen, Germany

<sup>3</sup> CLARA, Berlin, Germany

**Introduction:** Little is known about symptoms and needs of patients with primary brain tumours (PBT). Therefore data from the German Hospice and Palliative Care Evaluation (HOPE) was analysed.

**Methods:** Since 1999, an annually, three months census is conducted in different palliative care settings. Pooled data from 2002-2005 was analysed to test for differences between patients with PBT and other patients (OP). Symptoms/problems (grade 0-3) were categorized, sum scores calculated (max. score physical 24, nursing: 6, psychological: 12, social: 6) and categories compared (ANOVA). Symptom/problem frequencies were tested for differences ( $\chi^2$ ).

**Results:** 5684 patients were documented, 153 (2.7%) with PBT. Physical symptoms were less intense and prevalent in PBT (average sum score physical: PBT 7.1 / OP 9.4,  $p < .001$ ; e.g. *dyspnea*: prevalence 15% / 50%,  $p < .001$  or *pain*: 53% / 76%,  $p < .001$ ). Higher intensity and prevalence of problems were found in nursing (3.1 / 2.7,  $p = .002$ ; e.g. *activities of daily life*: 95% / 87%,  $p = .003$ ), in psychological (4.7 / 4.0;  $p = .007$ ; e.g. *disorientation*: 68% /

31%,  $p < .001$ ) and in social categories (3.7 / 2.8,  $p < .001$ ; e.g. caregiver burden: 81% / 71%,  $p = .007$ ).

**Conclusion:** The presented study is the first to show that palliative care patients with primary brain tumours suffer a variety of problems that differ significantly in prevalence and intensity. These needs have to be met to achieve an adequate provision of care. Further prospective research is essential.

## 772. Are Needs Changing? A Retrospective Study Identifying Changes in a Palliative Patient Population Over the Last Decade.

Susan Pennington, Paul Paes

Marie Curie Hospice, Newcastle upon Tyne, United Kingdom

### AIM

To identify any changes in the patient population within a specialist palliative care unit over the last 10 years

### BACKGROUND

There is a perception within Palliative Care that patient characteristics have changed over the last decade. It is believed that palliative care services are seeing increasing proportions of younger patients, and patients with a different range of diagnoses.

### METHOD

A retrospective longitudinal study was undertaken looking at patient demographics within a large specialist palliative care unit. Patient demographics were extracted from the palliative care computer database for the years 1996, 2001, 2006. A number of parameters were compared including age, sex, marital status, occupation, length of stay and time between first admission and date of death.

### RESULTS

There are an increasing number of younger patients being admitted to the specialist palliative care unit. There has been a significant rise in the number of patients with tumours of unknown primary, brain tumours, and non-malignant conditions.

### CONCLUSIONS

This study supports the hypothesis that the population requiring specialist palliative care is changing. As well as increasing numbers of patients with non - malignant conditions, the nature of malignant disease is also changing. It is important to recognise the evolving nature of this patient population in the development of specialist palliative care services.

## 773. THE NEEDS AND EXPERIENCES OF PALLIATIVE CARE PATIENTS IN SOUTH AFRICA AND UGANDA

Lucy Selman<sup>1</sup>, Godfrey Agupio<sup>2</sup>, Clare Gillespie<sup>3</sup>, Thandi Mashao<sup>4</sup>, Keletso Mmoledi<sup>5</sup>, Patricia Ndlovu<sup>6</sup>, Natalya Dinat<sup>5</sup>, Liz Gwyther<sup>4</sup>, Lydia Mpanga-Sebuyira<sup>2</sup>, Barbara Panatovic<sup>3</sup>

<sup>1</sup> King's College London, Palliative Care, Policy and Rehabilitation, London, United Kingdom

<sup>2</sup> Hospice Africa Uganda, Kampala, Uganda

<sup>3</sup> South Coast Hospice, Durban, South Africa

<sup>4</sup> University of Cape Town, Cape Town, South Africa

<sup>5</sup> Witwatersrand Palliative Care, Johannesburg, South Africa

<sup>6</sup> Philanjalo Hospice, Tugela Ferry, South Africa

**Aim:** To investigate the needs and experiences of a large sample (N=128) of palliative care patients and their informal carers in South Africa and Uganda.

**Method:** Qualitative study involving single semi-structured interviews with 92 patients and 36 carers across 5 services.

**Analysis:** Interviews transcribed verbatim, translated into English where necessary and content analysed in NVivo v7. Demographic data analysed in SPSS.

**Sample statistics:** 128 interviews were conducted in 8 different languages across rural, urban and peri-urban locations. Patients had a mean age of 43.1 (range 18-84); 59 (64.1%) were female. 63 (68.5%) were HIV+; of these, 55 (87.3%) had AIDS and 40 (63.5%) were on anti-retroviral therapy. 34 (37%) had cancer. Carers had a mean age of 44.8 (range 19-77); 33 (91.7%) were female.

**Results:** Psychological symptoms (anxiety, fear of the future, sadness/ depression) were highly reported amongst patients. Carers were concerned with planning for the future care of children, and often wished to be better informed about the patient's disease. Stigma and poverty were major concerns. Culturally specific challenges around discussing death, dying and disease were identified.

**Conclusions:** This large data-set provides valuable guidance for palliative care services in South Africa and Uganda. In particular, it provides evidence for palliative care need in HIV, whether or not patients are on ART.

## 774. Patients' Satisfaction with the Quality of Life in Hospice

Zsuzsanna Kerekes<sup>1</sup>, Ferencné Pálfi<sup>2</sup>, Melinda Hidegné Müller<sup>2</sup>

<sup>1</sup> University of Pécs, Institute of Behavioral Sciences, Pécs, Hungary

<sup>2</sup> University of Pécs, Institute of Clinical Practice and Nursing Sciences, Pécs, Hungary

Hospice patients were investigated for determining the possibly influencing factors of their daily life quality. Factors like fear, anxiety, as well as physical and emotional needs received special interest in this study.

**Participants:** 122 patients at the Hospice Department Pécs, Hungary.

**Methods:** First, participants were asked on a questionnaire, including both open-ended and closed questions, about their socio-demographic details, information and knowing about resources for the terminally ill, and medical attendance. Thus, items referred, for example, to the experience with pain, the expectation on future, and the importance of religion and social life. In addition, in order to detect our participants' depressive symptoms, the Beck Depression Inventory was administered to all participants.

**Results and Conclusion:** In sum, our results were as follows. Forty-nine participants rejected the thought of death, 27 participants showed a mild level of depression, and 108 participants have clear plans for the future. These results are in line with previous results in the analgesic literature. In a broader view, our findings clearly indicate that the effectiveness of Hospice attendance requires a highly cooperative, multidisciplinary and holistic team work.

## 775. THE EFFECT OF OCTENIDYNE 775. THE EFFECT OF OCTENIDYNE DICHLORIDE ON MICROBIOLOGICAL BURDEN OF NEOPLASTIC ULCERS IN ADVANCED CANCER PATIENTS.

Maciej Sopata<sup>1</sup>, Maria Ciupinska<sup>2</sup>, Anna Glowacka<sup>1</sup>, Elzbieta Tomaszewska<sup>1</sup>, Zygmunt Muszynski<sup>2</sup>

<sup>1</sup> University of Medical Sciences, Chair and Department of Palliative Medicine, Poznan, Poland

<sup>2</sup> University of Medical Sciences, Chair and Unit of Pharmaceutical Bacteriology, Poznan, Poland

### INTRODUCTION:

Ulcers in patients with advanced malignant diseases are a very important problem in view of difficulties in treatment and questions of nursing care. They are frequently the cause of additional pain, unpleasant odour, bleeding and significantly affect patients quality of life

**THE AIM OF THE STUDY** was an assessment of octenidynedichloride - Octenisept/Schulke & Mayr/ and of its effect on the clinical condition and bacterial flora of neoplastic ulcers.

### MATERIAL AND METHODS:

This study were carried out at the PCW in february 2005 - august 2006 involved 42 pts aged 24-90 years with neoplastic ulcers. Gauze dressings with octenisept were changed twice daily. Observations were made on the clinical status of the ulcerations: presence of necrosis, amount of exudate, reddening, oedema and changes of bacterial flora documented by bacteriological sampling on the beginning and after 3 weeks of treatment.

### RESULTS:

In all 65 bacteriological strains were cultured. After 3 weeks of treatment the tests were repeated in 38 pts. Based on observations, an improvement was found of the clinical condition of the wounds - reduction of necrosis, amount of exudate, reddening and oedema and changes of bacterial flora including eradication of Gram-positive bacteria: S. aureus and S. epidermidis and Gram-negative bacteria: P. aeruginosa and P. mirabilis. In 3 pts E. faecalis and in 1 pt E. coli organisms persisted. The octenidynedichloride looks very effective in eradication of bacterial flora, help to control symptoms of neoplastic ulcers and improve quality of life in such patients.

## 776. ACTIVITY IN THE PALLIATIVE CARE SERVICES IN THE SANITARY REGION OF LLEIDA FROM 1997 TO 2005

JAUME CANAL<sup>1</sup>, MARTA GABERNET<sup>2</sup>, EVA BARALLAT<sup>3</sup>, NURIA FONTANET<sup>2</sup>

<sup>1</sup> Hospital Jaume d'Urgell, Unitat de Cures Palliatives, Balaguer, Spain

<sup>2</sup> Hospital de Santa Maria, Unitat de Cures Palliatives, Lleida, Spain

<sup>3</sup> INSTITUT CATALA DE SALUT, SOCIO SANITARI, Lleida, Spain

### INTRODUCTION

Palliative care services in the sanitary region of lleida are offered both in hospitals and domiciliary settings. Since 1997, the number of beds located in acute and long term care hospitals has increased from 23 to 26. The number

of home care teams offering palliative care services at home have also increased from 3 to 5.

### METHODS

Retrospective and descriptive study carried out from 1977 to 2005. data were obtained from database of the sanitary region of Lleida (Catalonia).Diagnosis from both oncological and non oncological diseases are based on the Internationat Disease Classification-10.The aims of our study are:

1. Relation oncological / non-oncological diagnosis ( in number and % ).
2. Five more prevalent oncological diagnosis.
3. Five more prevalent non-oncological diagnosis

### RESULTS

|       | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 |
|-------|------|------|------|------|------|------|------|------|------|
| No    | 43   | 66   | 67   | 62   | 79   | 66   | 67   | 82   | 68   |
| ONC   | 21%  | 28%  | 30%  | 26%  | 27%  | 21%  | 22%  | 24%  | 24%  |
| ONC   | 162  | 168  | 160  | 177  | 218  | 242  | 236  | 256  | 227  |
| Total | 205  | 234  | 227  | 239  | 297  | 308  | 303  | 338  | 285  |

### CONCLUSIONS

Most prevalent oncological diagnosis: Lung,colon,breast and prostate cancer. Most prevalent non oncological diagnosis: cerebrovascular accidents,dementia,coma and respiratory failure.

The total number of patients attended in the different palliative care units located in hospitals show an slow increment over the period 1997-2005 while the relation oncological/non-oncological diagnosis remain almost invariable,below the 30%.

## 777. LATE DIAGNOSIS OF CANCER - MAJOR PROBLEM IN SERBIA

Ana Jovicevic Bekic<sup>1</sup>, Natasa Milicevic<sup>2</sup>

<sup>1</sup> Institute for Oncology and Radiology of Serbia, Epidemiology and prevention, Belgrade, Serbia

<sup>2</sup> BELhospice, Belgrade, Serbia

Stage at diagnosis influences prognosis of cancer and the necessity for palliative care in cancer patients.

**AIM:** Aim of the study was to assess the epidemiological situation of cancer and the needs for palliative cancer care in Serbia .

**METHOD:** Data from national cancer registries, vital statistics and hospital registries is analyzed to asses the current epidemiological situation of cancer.

**RESULTS:** In Serbia, there are 30,000 newly registered cancer cases and 19,000 cancer deaths per year. Cancer incidence and mortality rates are constantly increasing. Lung, breast, colorectal and cervical cancer are leading cancer sites comprising for almost half of all cancer cases. Lung cancer is responsible for a third of all cancers in males and among leading cancers in females. The majority of breast cancer patients are already with a regional spread or distant metastases (50% and 10%, respectively). Incidence and mortality rates of cervical cancer in Serbia are the highest in Europe. Only 35% of patients are with early stage (Fig1 or IIa) cancers. Precise epidemiology data for these leading cancer sites will be presented in detail at the Congress.

**CONCLUSION:** The absence of cancer prevention/early detection strategies and inadequate diagnostic capacities have resulted in late stage at diagnosis for major cancers, high cancer mortality and increased necessity for palliative care in Serbia .

## 778. Symptom prevalence and factors associated with burden indices among palliative care patients: a multicentre study in 2 Sub-Saharan African countries

Liz Gwyther<sup>1</sup>, Richard Harding<sup>2</sup>, Lucy Selman<sup>2</sup>, Thandi Mashao<sup>1</sup>, Natalya Dinat<sup>1</sup>, Lydia Mpanga-sebuyira<sup>3</sup>, Keletso Mmoledi<sup>1</sup>, Godfrey Agupio<sup>3</sup>, Claire Gillespie<sup>1</sup>, Barbara Panatovic<sup>1</sup>

<sup>1</sup> Hospice Palliative Care Association of South Africa, Cape Town, South Africa

<sup>2</sup> King's College London, London, United Kingdom

<sup>3</sup> African Palliative Care Association, Kampala, Uganda

**Aim** This study aimed to measure pain, symptom prevalence and burden in 5 specialist centres in South Africa and Uganda. **Method** The Memorial Symptom Assessment Schedule with additional African-specific items was nurse-administered cross-sectionally. Additional data: age/gender, ECOG functional status, antiretroviral therapy [ART] use. Data were entered into SPSS and prevalence/burden variables were compared using non-parametric comparison of means across diagnoses. For HIV patients, 3 regression models with dependent variables of (1) Global distress, (2) Psychological distress and (3) Physical distress indices were run with age, gender, ART use and ECOG as independent variables. **Results** 315 participants (mean age 43.5, 69.8% female), 71.1% had HIV and 35.6% cancer. Of 41 symptoms, 15 had a prevalence  $\geq 50\%$ . Most significant symptom is pain reported by 83.5% of participants. Psychological symptoms were highly

# Poster abstracts

prevalent. Psychological distress burden was significantly higher for HIV patients ( $p=0.010$ ). In regressions, being on ART and age were not significant in any of the 3 models.

**Conclusion** The high psychological burden of progressive disease has not been previously reported in Africa. The differences in symptom prevalence and burden across HIV & cancer should direct assessment and management. It is noteworthy that being on ART does not affect symptom burden, therefore quality palliative care is needed alongside treatment.

## 779. The Gold Standards Framework. Improving the quality of end-of-life care in UK primary health care teams.

Karen Shaw<sup>1</sup>, Keri Thomas<sup>2</sup>, Collette Clifford<sup>1</sup>, Frances Badger<sup>1</sup>

<sup>1</sup> University of Birmingham, School of Health Sciences, Birmingham, United Kingdom

<sup>2</sup>National Clinical lead, NHS End of Life Care Programme, Department of Primary Care and General Practice, Birmingham, United Kingdom

**Aim** The Gold Standards Framework (GSF) provides primary care health teams (PCHTs) with a practice-based model to support end of life care. GSF has been implemented by a third of PCHTs in the UK. Evaluation of GSF in 200 general practices is reported.

**Method** Repeated measures design was used. Practices completed questionnaires before & 9 months after implementation of GSF. These assessed end-of-life care in relation to: communication; co-ordination; control of symptoms; continuity; continued learning; carer support and care in the dying phase. Outcome changes were calculated using appropriate statistical tests. Statistical significance was set at  $p<0.01$ .

**Results** Questionnaires were completed by 94 (36%) and 106 (32%) PCHTs in GSF Phases 7 and 8 respectively. In both Phases practices showed significant improvements in: Patient identification and review; Assignment of a nominated co-ordinator; Co-working with palliative care specialists; Advanced care planning; Symptom management, including anticipatory prescribing; Record keeping; Communication with out of hours providers; Practice based-education; Carer support; Use of agreed protocol for terminal phase; Home-death rate (Phase 7 only).

**Conclusion** The GSF is an effective framework to improve quality of end of life care in PCHTs. Future research should be directed at identifying the most effective components of the programme and ensuring that all practices can implement the GSF successfully.

## 780. NATIONAL MULTI-CENTER EPIDEMIOLOGICAL STUDY ON PREVALENCE AND TREATMENT OF CANCER-RELATED SYMPTOMS

Andrei Novik<sup>1</sup>, Tatyana Ionova<sup>2</sup>, Svetlana Kalyadina<sup>2</sup>, Anton Kishtovich<sup>2</sup>, Shelly Wang<sup>3</sup>, Charles Cleeland<sup>3</sup>

<sup>1</sup> Pirogov Medical Surgical Center, Moscow, Russian Federation

<sup>2</sup>Multinational Center for Quality of Life Research, Saint Petersburg, Russian Federation

<sup>3</sup> UT MD Anderson cancer center, Houston, TX, United States

To have a better understanding of the current status of symptom management, the national multi-center epidemiological study among patients with advanced cancer was initiated in Russia in 2005.

The analysis of data from 480 advanced cancer patients (male/female - 206/274, mean age 53.6), included in the study from 10 cancer centers across Russia, is presented. Symptom status was assessed using the M.D. Anderson Symptom Inventory at two time points.

The following distribution of patients was observed: breast (31%), hematological malignancies (30%), lung cancer (19%), gastrointestinal tumors (13%), gynecological tumors (8.4%), others (3%). The most severe symptom was fatigue (4.2) with its prevalence of 85 %. Other pronounced symptoms were pain (3.4), distress (3.0), sadness (2.9), and sleep disturbance (2.9) with their prevalence of 65.8%, 71.8%, 71.6%, and 70.0% respectively. Out of the total sample, 126 patients had only mild symptoms and 344 – at least one symptom as moderate-to-severe. Among them 131 patients had 5 or more moderate-to-severe symptoms and 13 patients experienced 10 or more such symptoms. Fatigue was treated only in 121 patients (30%); among them the decrease in fatigue level was achieved in 35% patients.

In conclusion, the results of this symptom outcome study will provide the initial data on symptom control in Russia and will establish the framework for identifying the patients who experience poor symptom assessment and management.

## 781. Audit of the Use of Antibiotics in a Specialist Palliative Care Unit

Lorraine Lester, Richella Ryan, Natasha Michael, Tony O'Brien

*Marymount Hospice, Palliative Medicine, Cork, Ireland*

The use of antibiotics in the palliative care is challenging, involving complex decision making and an individualised approach to care. The rate of bacterial infections has been described as being between 28% -55%, with 60% -72% of a hospice population at a time documented as having received antibiotics. Bacterial infections are one of the leading causes of morbidity and mortality but benefits of antibiotics with regards to outcome and quality of life is difficult to predict.

**Method.** A retrospective audit of antibiotic use over 2 months. Data was collected on demographics, number, site of infective episodes, sensitivities and antibiotic use in comparisons with local guidelines. 54 (66%) of 82 patient charts were reviewed. The average length of stay was 16 days and 34 separate infective episodes were recorded. Antibiotics were prescribed for 46% of patients. 73% of the antibiotics were prescribed empirically, with bacterial confirmation only obtained on 44% of cases. 80% of drugs were prescribed for oral administration. The dosing schedule for intravenous antibiotics was variable and reflected the lack of an in house intravenous policy. There was no clear symptom appreciable in 59% of cases. 78% of patients survived for more than 7 days post commencing antibiotics.

**Conclusion** The use of antibiotics should take into account characteristics of infections, goals of care, performance status, expected palliative benefit and local guidelines. Greater emphasis needs to be placed on defining outcome measure and to ensure optimal benefit from treatment.

## 782. The nonconvulsive status epilepticus in terminally ill patients - a medical dilemma

Stefan Lorenz<sup>1</sup>, Simon Mayer<sup>1</sup>, Gian Borasio<sup>3</sup>

<sup>1</sup> Institute of Palliative Medicine, Centre for Palliative Medicine, Munich, Germany

<sup>2</sup>Institute of Palliative Medicine, Centre for Palliative Care, Munich, Germany

<sup>3</sup>Institute of Palliative Medicine, Centre for Palliative Medicine, Department of Science and Research, Munich, Greece

Most convulsive epileptic seizures are brief because of endogenous anticonvulsant mechanisms. In contrast, nonconvulsive status epilepticus (NCSE) is characterized by progressive sequential or simultaneous failure of these endogenous anticonvulsant barriers. It does not cease without therapeutic intervention. NCSE has been reported in approximately 6% of patients with systemic cancer. NCSE may be difficult to diagnose because of the various clinical presentation ranging from altered mental status to comatose patients. Here we report the preliminary data of a prospective study evaluating the underlying disease, clinical presentation, therapeutic intervention and outcome of patients with NCSE in a palliative care setting. So far, 8 patients with NCSE have been included. Five patients were diagnosed with NCSE lasting for longer than three days before admission to the hospital. Five had never been treated with antiepileptic drugs previously. Patients who presented only with altered mental status ( $n=2$ ) responded well to treatment, whereas the other patients died during antiepileptic drug treatment. Two of these regained consciousness during treatment for at least one day. Our study intends to discuss the treatment options of NCSE in terminally ill patients and evaluate clinical and electrophysiological parameters related to the outcome of the patients to provide a useful score for treatment decisions.

## 783. Sedation in palliative care - hardly disguised euthanasia in Sweden

Anders Birr<sup>1</sup>, Gunnar Eckerdal<sup>2</sup>, Staffan Lundström<sup>3</sup>

<sup>1</sup> University hospital of Malmö, Oncology, palliative care, Malmö, Sweden

<sup>2</sup>ASIH Kungsbacka, Kungsbacka, Sweden

<sup>3</sup>Stockholms Sjukhem Foundation, Department of Palliative Medicine, Stockholm, Sweden

**Aim:** The question about sedation in end of life care has been discussed within the Swedish Palliative Research Network (PANIS). The aim of the study was to estimate the occurrence of sedation in end of life care, indications and drugs used.**Method:** A cross-sectional study was performed within the network using a patient specific questionnaire. All patients enrolled at each participating unit were registered on a specific day. The questionnaire comprised questions on diagnosis, age, gender, sedation, indications and drugs used.**Result:** 2021 patients on 51 palliative care units were registered. 22 patients (1%) had ongoing treatment with the purpose of producing

sedation to achieve symptom control. 16 patients were treated in an in-patient unit. Five patients were sedated only during part of the day. Midazolam was the most commonly used drug; Propofol and diazepam were also used. In 15 patients the indication for treatment was severe anxiety. Seven patients were treated due to confusion/delirium and six patients due to intractable pain. All patients were evaluated as having symptom control. 12 patients had a lowered consciousness, but only one patient had a continuous deep sedation. No cases were reported where treatment was given at the request of the patient for the purpose of shortening life.**Conclusion:** Sedation in end of life care is rare within specialised palliative care in Sweden. Severe anxiety is the most common indication and midazolam is the most commonly used drug.

## 784. STUDY ON DEATH ATTITUDE WITH THE LESTER ATTITUDE TOWARD DEATH SCALE

Agnes Zana, Katalin Hegedus, Gabor Szabo

*Semmelweis University, Institute of Behavioural Sciences, Budapest, Hungary*

**Aim:**

The topic of our study is a comparative investigation in death attitude among the different age groups in the Hungarian population. Our aim was to examine the concepts and the attitudes towards death, primarily relevant to the certain age groups.

**Method:**

We used the *Lester Attitude toward Death Scale* (1991) and the Multidimensional Fear of Death Scale (MFODS, Neimeyer and Moore 1994, Zana 2006). The Lester scale is different from the other fear of death scales by not only measuring fear, but even the inconsistencies in attitudes. Our sample, 178 person was divided into three subgroups: *young group* ( $N=118$ , average age: 18 ys), *adult group* ( $N=38$ , av. age: 35 ys) and *elderly group* ( $N=22$ , av. age 66 ys). Distribution by sex: 120 women, 56 men.

**Results:**

The fear of death is highest in the young age group (we have the same results with the MFODS) lower in elderly group and lowest in the adult group. Negative attitude towards death does not show high value, neither significant difference among the age groups.

Remarkable result is the specially dismissive attitude against some items of the scale characteristically of elderly group e.g.: 'I don't want to die right now, but I'm glad that I will die someday'.

**Conclusion:**

The exploration of these causes will be the subject of our further study.

## 785. Retrospective review of one hundred consecutive discharges from a specialist palliative care unit.

Kathleen Cronin, Sinead Buckley, Mary Jane O'Leary, Natasha Michael, Tony O'Brien, Fionnuala McSweeney

<sup>1-5</sup> *Marymount Hospice, Palliative care unit, Cork, Ireland*

Discharge planning is important in palliative care because the complexity of hospice patients. This is due to the severity of disease, symptomatic problems, carer support, financial constraints, and lack of community services. Very little has been written regarding the discharge of hospice patients. This review examines 100 consecutive patients discharged from a specialist palliative care unit, focusing on their in-patient clinical course, discharge process, and clinical outcome three months post discharge. PalCare, a hospice computer database, and chart review were used to collect the following data: patient demographics, type of malignant/ non-malignant disease, source of referral, discharge location, the main carer, and number of occupants in the household. As an indication of symptom control, the highest ESAS score on admission and this score on discharge was noted. Investigations conducted, medical referrals, and interdisciplinary input were recorded. Length of stay and the interval between the family meeting and discharge was obtained. Outcomes three months post discharge were defined as death or readmission. Place of death was determined. In patients readmitted, the reason and interval from original discharge was recorded. This is a work in progress which will clarify inpatient demographics, their clinical course, and the discharge process within this special palliative care unit.

## 786. Outcome of inpatient treatment in palliative care units in Germany Data from the German Hospice and Palliative Care Evaluation (HOPE) 2002-2005

Friedemann Nauck<sup>1</sup>, Norbert Krumm<sup>2</sup>, Christoph Ostgathe<sup>3</sup>, Gabriele Lindena<sup>4</sup>, Frank Elsner<sup>2</sup>, Lukas Radbruch<sup>2</sup>

<sup>1</sup> University of Göttingen, Department of Palliative Medicine, Göttingen, Germany  
<sup>2</sup> University Hospital of Aachen, Department of Palliative Medicine, Aachen, Germany  
<sup>3</sup> University Hospital of Cologne, Department of Palliative Medicine, Cologne, Germany  
<sup>4</sup> CLARA, Berlin, Germany

**Introduction:** Enabling patients to stay home in the terminal phase is considered an important goal of palliative medicine. However, for some patients inpatient treatment in specialised palliative care units is required until the time of death. We evaluated factors related to the percentage of patients discharged or treated until time of death. **Methods:** Pooled data from annual three months census from the years 2002-2005 were analysed. Demographic and disease-related factors were compared for patients discharged and patients treated until the time of death. ANOVA was used to compare continuous data and Chi2-tests for categorical data. **Results:** Inpatient treatment was documented for 4182 patients in palliative care units. Discharge or transfer to other services was possible for 55.5% (DI), 43.3% required inpatient treatment until time of death (DE). There were no significant differences for sex, age or diagnosis between the two groups. Metastases in lung (DE 30% of patients, DI 25%) or liver (DE 38%, DI 30%) were more frequent in DE (p<.001) whereas bone metastases were more frequent in DI (DE 27%, DI 34%). No difference was found for brain metastases. Performance status at time of admission was significantly worse in DE (p<.001, ECOG 4: DE 58%, DI 24%). **Conclusion:** We found a clear pattern of metastases distribution and performance status between discharged and dying patients. The prognostic value of these indicators has to be evaluated in subsequent trials.

## 787. Organisation and quality of physician-delivered care in inpatient hospices in the state of North Rhine Westphalia, Germany

Stefan John<sup>1</sup>, Christoph Ostgathe<sup>2</sup>, Eberhard Klaschik<sup>3</sup>, Friedemann Nauck<sup>1</sup>

<sup>1</sup> University Hospital Goettingen, Department for Palliative Medicine, Göttingen, Germany  
<sup>2</sup> University Hospital of Cologne, Department of Palliative Medicine, Cologne, Germany  
<sup>3</sup> Malteser Hospital, Centre for Palliative Medicine, Bonn, Germany  
<sup>4</sup> University Hospital Goettingen, Department of Palliative Medicine, Göttingen, Germany

**Introduction:** In Germany, palliative care units (PCU) and inpatient hospices (HO) represent two different settings of care with similar philosophy, but different payment systems and organisation of services. Patients are admitted to HO when sufficient care at home is not achievable but referral to hospital/PCU in not necessary. Medical care in HO is usually ensured by the GP. The aim of this study is to assess organisation and quality of physician-delivered care in HO in the state of North Rhine Westphalia. **Methods:** A questionnaire covering 11 fields of interest was sent out to 52 heads of hospices (HH) and to 92 physicians (PH) who see the patients in these HO. Returned questionnaires were anonymised and evaluated. **Results:** Return rate was 63% for HH and PH. 58% of HO have 7-10 beds. 53% of PH and 73% of HH agreed that a cooperation of general practitioners (GP) with a consultant in palliative medicine is the best possible organisation of medical care. However, in no more than 36% HO such cooperation was provided. 59% of PH specialised in palliative medicine and 19% in pain therapy. PH stated to have deficits in their communication and psychosocial skills and their expertise in use of analgesics. **Conclusion:** The survey shows that good medical care is delivered by PH in HO in most fields covered by this study. In order to facilitate high-quality PH care in HO, the usually GP-based care needs to be complemented by specialists in palliative medicine.

## 788. PHARMACOLOGICAL MIXTURES FOR CONTINUOUS SUBCUTANEOUS INFUSION FOR PALLIATIVE CARE -Evidence in literature-

Massimo Destro, Luciana Fontana, Cecilia Dal ri, Luca Ottolini, Carlo Abati

Servizio cure palliative, Distretto sanitario, Trento, Italy

**Background:** cancer patients in the final stages of the disease suffer multiple symptoms and require numerous drug therapies. In certain cases it is not possible to administer these drugs orally due to certain conditions

(intestinal obstruction, vomiting, agonal state). In these cases it is necessary to administer drugs via a parenteral method. Administering these drugs in a subcutaneous manner has become quite important in providing palliative care due to the simplicity of handling the site and the equipment needed for infusion and the possibility to simultaneously and in a constant manner, administer more than one drug, resulting in clinical effectiveness that is equal to that of intravenous methods. **Objective:** the analysis of literature in order to analyze information regarding the use of continuous subcutaneous infusion and to study data regarding the chemical-physical compatibility and stability of drug mixtures (opiates, adjuvants and other symptomatics) that are commonly used in Italy via continuous subcutaneous infusion. Research was carried out on the Meline, Pub-Med database, and other internet sites: Palliative Care Matters, Pallmed and Palliativedrug. **Conclusion:** the pharmacological compatibility of the drugs described in the literature are limited to a certain number of drugs and the concentrations of the mixtures components, therefore if strictly applied they are restrictive for daily use. The palliative care services of Trento have begun experimentation in order to discover other possible compatible drug mixtures.

## 789. Surgical Site Infections (SSI) after surgery in advanced colon cancer patients, main complaint affecting the quality of life

Horia Traila<sup>1</sup>, Constantin Ciucurel<sup>2</sup>, Manuela Ciucurel<sup>3</sup>

<sup>1</sup> University of Pitesti, Kinesitherapy, Pitesti, Romania  
<sup>2</sup> University of Pitesti, Kinesitherapy, Pitesti, Romania  
<sup>3</sup> University of Pitesti, Psychology, Pitesti, Romania

### Aim of study

Palliative surgery in cancer patients is meant to improve the quality of life (physical and psychological aspects). But their complex medical condition puts them at high risk for SSI. The study is trying to asses at what level the SSI are reducing the quality of life we aim to improve.

### Method

A simple, non-randomized, retrospective study conducted over a 2 year period 2001-2002. Out of 116 colon resections performed in a surgery clinic, 68 were performed for advanced stages of colon cancer, 8 of them suffering a SSI in the postoperative hospitalization period, or soon post discharge. The SSI diagnostic was based on the CDC criteria, and their quality of postoperative life was evaluated based on our own mailed in follow-up questionnaire, developed upon studying the literature data and similar to those internationally in use by the de EORTC.

### Results

Of the 8 cases 3 of them were superficial SSI, 3 deep SSI and 2 were organ-space SSI. Comparatively with the control group, who had not developed a SSI, the infection group scored very high on our assessment scale, with major complaints in physical, social and psychological aspects of life.

### Conclusions

Given the high risk for infection this particular patient group has, very careful selection of the patients benefiting from palliative surgery needs to be conducted, with careful prophylactic methods in place in order to obtain the maximum reduction of the operative infection risk.

## 790. Palliative specialists advice in a consult setting: Is the reason of request matching with the real problem?

Claudia Pesenti<sup>1</sup>, Silvia Walther<sup>2</sup>, Manuela Colla Züger<sup>3</sup>, Luisella Manzambi-Maggi<sup>4</sup>, Piero Sanna<sup>5</sup>, Hans Neuenschwander<sup>6</sup>

<sup>1-6</sup> Institute of Oncology of Southern Switzerland, Palliative Care Service, Lugano, Switzerland

**Background:** The Palliative Care Service (SCP) is part of the Institute of Oncology in Southern Switzerland (IOSI) and has been operating through pluriprofessional teams in a multisite-hospital since 1996. Its core tasks are to give a consulting service and training in five different hospitals in the whole area of Southern Switzerland. **Rational:** In the first years of activity we often felt that physicians and nurses are not really aware about what SCP could offer, neither are they always able to focus on the real palliative problems. **Aim:** We would like to try to match the reasons of the requests forwarded with the real palliative issues encountered during the visit of SCP. **Method:** Our "patients list" (database) has been reviewed from 1996 to 2006 specially focusing on the mentioned points. **Results:** In a significant number of clinical situations the reason for seeking a specialist advice did not match with the real problem. Matching degrees will be quantified and situations with specially weak correlations will be highlighted. **Conclusion:** Our data suggest that physicians and nurses without specific training in palliative care are at high risk to fail in identifying complex palliative issues. This may result in an underuse of the available palliative care resources. The

result will be helpful to underline the evidence that SCP is a real need, but that general sensibility must be empowered and educational programs for physicians and nurses better promoted.

## 791. Ten years of activity - Time to look back: What kind of informations and conclusions is possible to extract from our "patients list" and should this collecting tool be modified?

Claudia Pesenti<sup>1</sup>, Silvia Walther<sup>2</sup>, Manuela Colla Züger<sup>3</sup>, Luisella Manzambi-Maggi<sup>4</sup>, Piero Sanna<sup>5</sup>, Hans Neuenschwander<sup>6</sup>

<sup>1-6</sup> Institute of Oncology of Southern Switzerland, Palliative Care Service, Lugano, Switzerland

**Background:** The Palliative Care Service is integrated in the Institute of Oncology of Southern Switzerland. Its activity started in 1996 in a multisite-hospital with a physician, a nurse and a secretary. Today there are nine of us working in little interdisciplinary consulting teams distributed in five hospitals in the whole area of Southern Switzerland. **Rational:** Data of patients are collected in a database ("patients list"), which has been only slightly modified from the beginning ten years ago. **Aim:** Describe the patients population, identify changes over the time and verify if the method of data collection is still helpful. **Method:** The "patients list" reports the following data: identification (name, sex, age...), diagnosis, including other topics as: who advanced the request and why, patient-information status... **Results:** We are going to present the results in detail and to put them in relationship with the availability of the human resources. **Comment:** The collected data are helpful to endorse our request to increase the resources of our team. On the other hand it is failing in identifying specific areas where is worthwhile to improve our competences. The development of a more sophisticated data collecting tool is therefore crucial. **Future:** That will be an opportunity to modify the way of collecting data and the content of our "patients list" for a more practical and easier extraction of informations to use in future scientific activities.

## 792. Defining the palliative care population in Extremadura

Javier Rocafor<sup>1</sup>, Félix Fernández<sup>2</sup>, Miguel ángel Cuervo<sup>3</sup>, Maria Jesús Rangel<sup>4</sup>, Fátima Díaz<sup>5</sup>, Emilio Herrera<sup>6</sup>

<sup>1</sup> Extremaduran Health Service, Regional Palliative Care Program of Extremadura, Mérida, Spain  
<sup>2</sup> Extremaduran Health Service, Regional Palliative Care Program of Extremadura, Mérida, Spain  
<sup>3</sup> Extremaduran Health Service, Palliative Care Team (RPCPEX), Badajoz, Spain  
<sup>4</sup> Extremaduran Health Service, Primary Care, Badajoz, Spain  
<sup>5</sup> Extremaduran Health Service, Palliative Care Team (RPCPEX), Badajoz, Spain  
<sup>6</sup> Extremaduran Health Service, Mérida, Spain

### Background:

Which is the Extremaduran palliative care population? Different surveys (McNamara, Franks, Rosenwax, etc) have previously looked at the question: how much palliative care do we need?. The answer is complex and probably depends on multiple visions like the literature review, the local mortality rates and the consensus of professionals and administrators.

### Method:

After reading related scientific articles, a group of professionals working in different levels of palliative care provision, identified and agreed a minimum, medium and maximum ratio of incident terminally ill patients per million inhabitants and year. These ratio were used to calculate the number of patients susceptible to receive palliative care in every health district of the region.

### Results:

The group agreed a minimum of 2400, a mid-range of 3500 and a maximum of 5200 patients pM/ year. Non-cancer diseases ratios were calculated as 600, 1500 and 3000 pM/ year, and cancer ratios as 1800, 2000 and 2200, respectively. Considering 1083879 inhabitants living in Extremadura last year, we conclude that the mid-range expected number of terminally ill patients was 3794. Distribution of these ratios per Health Districts will be shown in a map.

### Discussion:

Ratios agreed in our regions, don't differ very much with other suggested by other authors. Knowing the number of potentially users of palliative care services constitute an indispensable tool for health services administrators.

## 793. Delirium: evaluating age as a risk factor in cancer patients

Marjolein Bannink<sup>1</sup>, Hetty Van Veluw<sup>2</sup>, Lia Van Zuylen<sup>2</sup>, Carin Van der Rijt<sup>2</sup>

<sup>1</sup> Erasmus MC - Daniel den Hoed, Psychiatry, rotterdam, Netherlands

<sup>2</sup> Erasmus MC - Daniel den Hoed, Medical Oncology, rotterdam, Netherlands

### Aim

Delirium is a common complication in the palliative phase of cancer patients and is often related to opioid use. According to the literature, age > 70 yrs is one of the most consistently found risk factors for its development. At the Palliative Care Unit (PCU) of our cancer center, we monitor patients with a risk of developing a delirium for 72 hrs using the Delirium Observation Screening scale aiming to diagnose and eventually treat a delirium as early as possible. Insight in the relevance of age as a risk factor in developing a delirium at the PCU is important to determine which patients should be monitored.

### Method

Medical records of all patients admitted to the PCU between February 2004 and March 2006 were studied for a reported diagnosis of delirium. The incidence of delirium was assessed separately for patients aged < 70 and ≥ 70 yrs.

Medical records of all patients admitted to the PCU between February 2004 and March 2006 were studied for a reported diagnosis of delirium. The incidence of delirium was assessed separately for patients aged < 70 and ≥ 70 yrs.

### Results

In total 524 admissions of 400 different patients were found: male/female: 204/320, age 22-89 yrs. In the 453 admissions of patients < 70 yrs, a delirium was found in 46 (10.2%; CI: 7.5-13.3%). In the 71 admissions of patients aged ≥ 70 yrs, 6 patients (8.5%; CI: 3.2-17.5%) developed a delirium. None of the patients developed a delirium in different admissions.

In total 524 admissions of 400 different patients were found: male/female: 204/320, age 22-89 yrs. In the 453 admissions of patients < 70 yrs, a delirium was found in 46 (10.2%; CI: 7.5-13.3%). In the 71 admissions of patients aged ≥ 70 yrs, 6 patients (8.5%; CI: 3.2-17.5%) developed a delirium. None of the patients developed a delirium in different admissions.

### Conclusion

In contrast to the literature, age was not a risk factor for the development of a delirium in cancer patients at our PCU. In these patients, advanced disease and necessary symptom management e.g. by opioids, may be more important factors in developing a delirium.

## 794. Validation of the Arabic Version of the M. D. Anderson Symptom Inventory (MDASI-A)

Nejmi EL MATI<sup>1</sup>, Ibrahima GNING<sup>2</sup>, Xin Shelley WANG<sup>2</sup>, Tito MENDOZA<sup>2</sup>, Charles CLEELAND<sup>2</sup>

<sup>1</sup> INSTITUT NATIONAL D'ONCOLOGIE, ANESTHESIOLOGIE ET RAITEMENT DE LA DOULEUR, Rabat, Morocco

<sup>2</sup> UT MD Anderson cancer center, Internal Medicine, Houston, Texas, United States

This work was supported in part by Hwan Foundation. Objective:

this study was to test the validity and reliability of an Arabic version of the M.D. Anderson Symptom Inventory (MDASI-A), Methods:

The MDASI-A was developed using forward-backward translation method. We enrolled 165 Arabic speaking patients with different types of cancer, Results:

Patients (68%) had advanced cancers. , age was 49 (+/- 14) years , 56% female, 62% had an ECOG performance 3 or 4. h. In a forced 2-factor solution for the 13 items factor analysis, there was a general symptom factor and a GI factor as seen in other studies. A significant correlation between the MDASI-A summary scores for the symptom and interference subscales and ECOG 0 to 4 grades (P<0.001) provided a good concurrent validity of the MDASI-A. Significant differences in overall mean symptom severity and interference by independent sample and Mann-Whitney t-tests between patients with poor (0 - 2) and those with good (3 - 4) ECOG (P<0.01) demonstrated the known-group validity. Internal consistency was satisfied for the MDASI-A. Alpha values were 0.85 for the 19 total items, and 0.78 and 0.79 for the symptom and interference subscales.

### Conclusion:

An Arabic version of the MDASI is a valid and reliable patient reported outcome instrument

## 795. Methicillin-resistant Staphylococcus Aureus infections, a problem for palliative care patients?

Bart Van den Eynden<sup>1,2</sup>, Annick Vanderroot<sup>1</sup>, Peter Deemulenaere<sup>1</sup>, Paul Van Royen<sup>2</sup>

<sup>1</sup> University of Antwerp, Chair and Centre of Palliative Care, Antwerpen, Belgium

<sup>2</sup> University of Antwerp, Centre for General Practice, Interdisciplinary Care and Geriatrics, Antwerpen, Belgium

### Introduction

Methicillin-resistant Staphylococcus Aureus infections are a huge problem for health care, especially in hospital and caring homes. These infections are mainly transmitted by direct skin contact, doctors and nurses playing an important role. Therefore a large set of measures is worked out like rigorous hand hygiene, nurses wearing special clothes and masks while caring patient's wounds, and even isolation.

### Aim

These measures are an obstacle for good palliative care: they construct "a barrier" making a serene and intimate saying goodbye impossible for patients and relatives. As a first step we would like to know what the extent of this problem is in palliative care.

### Methodology

Fifty consecutive patients were screened for MRSA-infections at the moment of their transfer to the palliative care unit by taking a nose swab. Demographic data, referring place and data of a known MRSA-infection were registered.

### Results

First results reveal an incidence of MRSA-infections of 10 % for patients admitted at a PCU. A more detailed analyse will be presented.

### Conclusions

It seems important to study incidence and prevalence of MRSA-infections in different palliative care settings. The analyse of the significance of such infections for patients and their environment and of their feelings the prevention measures evoke is another step. All this will facilitate the development of a modified more 'dignified' prevention procedure.

## 796. Hungarian Family Physicians - Knowledge, Attitudes, and Perceived Barriers related to Hospice Care

Agnes Csikos<sup>2</sup>, John Mastrojohn<sup>1</sup>, Csilla Busa<sup>3</sup>

<sup>1</sup> National Hospice and Palliative Care Org, Quality, Alexandria, VA USA, United States

<sup>2</sup> University of Pécs, Institute of Family Medicine, Pécs, Hungary

<sup>3</sup> University of Pécs, Department of Political Science, Pécs, Hungary

**BACKGROUND:** A critical factor related to patient access to hospice of care is the physicians' understanding and acceptance of hospice as appropriate care for patients with a terminal illness.

**OBJECTIVE:** The knowledge and attitude of physicians and perceived barriers related to hospice care were studied in Baranya County, Hungary in 2005. The study gathered information and provided insight concerning hospice as an accepted philosophy of care.

**METHOD:** A cross-sectional survey using a self-administered, anonymous questionnaire.

**PARTICIPANTS:** Family Physicians working in Baranya County.

**OUTCOME MEASURES:** Data were analysed using SPSS 10.0.

**RESULTS:** The majority of Family Physicians agreed hospice care was appropriate for terminally ill patients. Of those who responded, 91% had cared for a terminally ill patient within the last year and 84% agreed that the best setting for terminally ill patients was their home. However, research results also revealed perceived barriers to care that were related to family and resource issues. Due to identified barriers, a majority of physicians disagreed or were unsure families were able to provide appropriate care in the home.

**CONCLUSION:** If addressed, the perceived barriers have substantial potential to improve access for hospice patients and their families. Future applications of this research may be the development of a national survey tool and utilization of the tool in other countries as a means to enhance access to hospice services.

## 797. Cytokine gene polymorphisms and Cancer-related symptoms in

Cielito Reyes-Gibby<sup>1</sup>, Sanjay Shete<sup>1</sup>, Xifeng Wu<sup>1</sup>, Eduardo Bruera<sup>2</sup>, Margaret Spitz<sup>1</sup>

<sup>1</sup> The University of Texas M. D. Anderson Cancer Center, Department of Epidemiology, Houston, Texas, United States

<sup>2</sup> The University of Texas M. D. Anderson Cancer Center, Department of Palliative and Supportive Services, Houston, Texas, United States

Cytokines, aberrantly produced by cancer cells, have recently been implicated in the severity of cancer-related

symptoms. We hypothesize that functional variations in cytokine genes could explain variability in self-reported pain and depressed mood in lung cancer patients. Pain, depressed mood, clinical and demographic variables were assessed at presentation, and prior to initiating any cancer treatment in 514 patients with non-small cell lung cancer (NSCLC). Using the TaqMan method, we genotyped single nucleotide polymorphisms in interleukin (IL) -6 (-174 G C), IL-8 (-251 T A), and tumor necrosis factor-alpha (TNF- ; -308 G A), and determined their associations with pain and depressed mood. Results showed that 16% of the respondents reported severe pain (score ≥ 7/10) and 7% reported depressed mood. The severity of pain and depressed mood predictably varied by disease-related variables and comorbidities. Multivariable analyses showed that carriers of variant alleles in IL8-251TA had a higher risk (OR=2;p<0.03) for severe pain. Carriers of the wildtype allele in IL6 -174GC had higher risk (OR=2.0;p<0.05) for depressed mood. We also observed a significant gene-environment interaction for severe pain: patients with variant alleles in IL8-251TA and early age of onset (≤ 50 years) had an OR=2.00 for severe pain. Classification and Regression Tree analyses showed the same distinct patterns for these symptoms. Future studies are needed to validate these findings.

## 798. Caregivers' communication with terminal cancer patients about illness and death: An explanatory model

Yaacov Bachner, Sara Carmel

Ben-Gurion University of the Negev, Sociology of Health, Beer-Sheva, Israel

**Aim:** To examine the relative contribution of three groups of variables - socio-demographic, personal and treatment characteristics - to the explanation of primary caregivers' level of communication with terminal cancer patients.

**Method:** A total of 236 primary caregivers of terminal cancer patients participated in the study. The questionnaire included measures of caregiver's communication, socio-demographic characteristics (i.e. the caregiver's age, family status, education level), personal characteristics (i.e. optimism, sense of coherence, self-efficacy) and treatment characteristics (i.e. duration and intensity of care).

**Results:** Caregivers reported of low levels of communication with patients. The study model accounted for 28% of the explained variance. Six variables emerged as significant contributors to caregivers' level of communication: family status ( =0.25, p<0.001), economic status ( =0.22, p<0.001), duration of caregiving ( =0.21, p<0.001), level of education ( =0.20, p<0.01), self-efficacy ( =0.18, p<0.02) and intensity of caregiving ( =0.01, p<0.01).

**Conclusion:** Caregivers' socio-demographic variables as well as treatment characteristics play an important role in the explanation of caregivers' communication level with patients. These variables should be considered by professionals when developing intervention programs for increasing caregivers' communication with dying patients.

## 799. Student Nurses' thoughts on communicating with Cancer Patients

Julie MacDonald

University of Hull, hEALTH AND sOCIAL CARE, hULL, United Kingdom

Those who communicate with Cancer patients should have enhanced skills or be supported by someone who has those skills (NICE 2000). Student nurses feel isolated when communicating with cancer patients, being afraid of making mistakes by saying or doing the wrong thing. Aim To investigate student nurses thoughts on communicating with cancer patients Outcomes To determine how prepared students feel when communicating with cancer patients and how supported they feel in practice. Methodology Qualitative, convenience sample. Ethical approval granted. Data from focus group taped and analysis followed Colaizzi's procedural steps. Results Grouped in theme clusters which included Verbal& non verbal communication, caring ability, personal attributes and practice issues. Implications for practice Keep communication within pre and post registration curricula Utilise role play as a teaching and learning strategy Link to competencies in practice NICE (2004) Supportive and Palliative care needs of adults with cancer NICE London

## 800. The attitude and feeling toward truth-telling of cancer: a public survey from a pharmacy in Bangkok, Thailand

Darin Jaturapatporn<sup>1</sup>, Jirapat Jaturapatporn<sup>2</sup>, Albert Kirshen<sup>3</sup>

<sup>1</sup> University of Toronto, family medicine, Toronto, Canada  
<sup>2</sup> University of Toronto, General Practice, Toronto, Canada  
<sup>3</sup> University of Toronto, Palliative Care, Toronto, Canada

**Background:** This study researched a group of Thai people coming to a pharmacy regarding their attitudes toward truth telling of cancer.

**Methods:** Self-answered survey of 80 participants coming to a pharmacy in Thailand. four questions used to collect the data included the attitude toward truth telling of cancer whether they would like to know or not, whether they will accept the result, their feeling in case they have to know the results and whether they will tell their relatives.

**Results:** In case of diagnoses with cancer, 95.00% of the participants preferred being told the truth about their diagnosis and 5.00% did not want to be told. The most emotional response is anxiety. A total of 52.50% of the participants preferred that doctors tell a beloved relative the truth about their cancer diagnosis, while 47.50% preferred that doctors not tell a relative the truth. The distributions of gender and age did not significantly differ between disclosure and nondisclosure group, however, women (100.00%) preferred being told the truth comparing to men (90.00%). Women (92.50) also had higher acceptance of their cancer status than men (82.50%).

**Conclusions:** Most of subjects in Thailand would prefer to know the truth if diagnosed by a cancer disease. Furthermore, attitudes toward truth telling of cancer differed between patients toward their relatives and the patients themselves.

## 802. Reducing team anxiety and increasing team skills: Learning from audit review of a hospice CPR policy

Corinna Midgley, Patricia Sealy, Helen Sullivan

St Francis Hospice, Palliative Medicine, Romford, United Kingdom

### Abstract

St. Francis Hospice (an independent hospice) implemented a cardiopulmonary resuscitation (CPR) policy in October 2002. A year later it was clear that "for CPR attempt in the event of" decisions were provoking much care-team anxiety, despite the guidance. Using the policy as the standard, a retrospective review of case notes of patients who had been deemed "for CPR attempt" was performed, the aim being to identify what was and wasn't being done, and to try and pinpoint problem or confusing areas.

Youth and non-malignant diagnosis were common features in patients with a "for CPR attempt" plan. Problems identified fell within two key areas. Firstly, lack of a clear review plan and secondly, lack of useful communication with professional colleagues in the primary and hospital care teams to support our own team in CPR discussions and decision making. Review guidance and the importance of shared discussion have now been highlighted in the policy, supporting documentation, and training programmes. The aim is to leave the care team much clearer and more secure in their "for CPR attempt" discussions and follow up.

## 803. An audit of the content of discharge letters from a specialist Palliative Medicine facility

Breffni Hannon, Natasha Michael, Tony O'Brien

Marymount Hospice, Department of Palliative Medicine, Cork, Ireland

### Background:

Discharge planning is an important part in the effective coordination of services in palliative medicine, but can be complex and challenging. Effective planning and communication is important to ensure a seamless continuation of treatment received in an inpatient unit and the care in the community. Discharge letters usually form the mainstay of communication between professionals, but often lack a structured, coherent framework. There is a high level of variation in terms of writing style, format and content of letters. Letters predominantly have a biomedical focus, often omitting valuable psychosocial and interdisciplinary information. There can be a significant time lag between patient discharge and receipt of discharge letter by General Practitioners, further compromising patient care. We decided to undertake a larger review of the discharge process in our palliative care unit, of which this audit forms part.

### Objectives

To assess the content of discharge letters from a specialist palliative care unit over a three month interval across a number of predefined parameters. A secondary

aim was to determine the average duration of time from discharge to dictation.

### Methods

We retrospectively audited consecutive discharge letters from the palliative care unit from July 1<sup>st</sup> to September 30<sup>th</sup> 2005 (n=29). Information contained in each letter across a number of parameters, was recorded in a standardised data sheet. This included demographic details, diagnoses, admission details, inpatient course and discharge details. We noted whether reference was made to multidisciplinary or family meetings and recorded those professionals to whom copies of discharge summaries were forwarded.

### Results

29 patients were discharged from the unit during the study period; however only 22 letters were obtainable, implying 25% of patients did not have a letter dictated post discharge. There was an average of 8.5 days between time of patient discharge and date of dictation (0-63 days). All letters contained accurate patient demographic details in addition to primary and secondary diagnoses. In 5 of the 22 letters, details concerning the place of care prior to admission were lacking. Inpatient course was referred to in all dictations; however there was a predominance of biomedical information. There was minimal mention of psychosocial information such as family meetings, multidisciplinary input, insight, bereavement and coping issues. Reference was made to family meetings in only 9 of the 22 letters. 5 of the 22 letters had significant omissions in discharge medications. In 4 letters, no reference was made to any follow up arrangements.

### Conclusions

There are significant deficits in the quality of information contained in letters currently, with a paucity of psychosocial information. We plan to pilot a new discharge letter pro forma to 20 Local General Practitioners in order to assess its usefulness in terms of content, style, and information conveyed. A chart tracking will be implemented to reduce the number of patients for whom no letter is dictated. We plan to implement this for a period of 3 months, re-audit and will present the final results at the meeting.

## 804. CANCER PATIENT-DOCTOR COMMUNICATION: PATIENT RELATED BARRIERS IN TELLING THE TRUTH PROCESS

Stefanel Vlad, Liliana Visu

CENTRAL CLINICAL EMERGENCY MILITARY HOSPITAL, RADIOLOGY, Bucharest, Romania

Telling the truth is the first step in cancer treatment according to many physicians' opinion. Patients should be told when cancer is diagnosed, but handling of these breaking bad news regarding their diagnosis and prognosis is still a problem for many doctors. On the other hand, in our country, many times cancer patients do not want to know much about their disease, and the physician is judging medical choices for their patients and is manipulating the truth about the prognosis and treatment alternatives. We consider a group of 60 new cases of cancer patients referred to our Radiotherapy Department. All of them were diagnosed with cancer (breast, rectal, prostate, lung, cervical carcinoma) 2 weeks to 6 months before the start of irradiation. Based on a specific questionnaire we analysed the effect of patient's age, sex, education and socioeconomic status on perception of:

- telling the truth about cancer diagnosis and prognosis;
- patient-doctor relationship (relationship centred on doctors vs. doctors and patients being equal partners);
- needs for information provided after cancer is diagnosed;
- family's involvement in the decision-making process. (study still in progress)

## 805. Can the use of videos of people who have had a positive experience of hospice help patients to make a decision about admission?

Paul Perkins<sup>1</sup>, Sarah Grove<sup>2</sup>, Mark Moughton<sup>3</sup>, Sally Thornton<sup>4</sup>, Sarah Fowler<sup>5</sup>

<sup>1</sup> Hinchingsbrooke Hospital, Palliative Medicine, Huntingdon, United Kingdom

<sup>2</sup> Hinchingsbrooke Hospital, Palliative Medicine, Huntingdon, United Kingdom

<sup>3</sup> Hinchingsbrooke Hospital, Information, Huntingdon, United Kingdom

<sup>4</sup> Hinchingsbrooke Hospital, Palliative Medicine, Huntingdon, United Kingdom

<sup>5</sup> University of Cambridge, Public Health and Primary Care, Cambridge, United Kingdom

**Objective:** To determine whether watching a video of hospice inpatients talking about their experiences would be acceptable to prospective hospice patients. **Design:** Prospective pilot study **Setting:** District general hospital and 3 local hospices. **Participants:** District general hospital inpatients that the hospital palliative care team thought would benefit from a hospice admission.

**Methods:** An interactive DVD was produced featuring interviews with patients who had stayed in a local hospice talking about their experiences.

**Prospective patients** who watched the DVD were asked to complete a questionnaire at 3 time points - prior to watching; after watching; and after admission to hospice.

**Main Outcome Measure:** Patient satisfaction with DVD. **Results:** All 15 patients who watched the DVD thought that videos like this were a good idea.

13/15 thought it was useful for them to have seen it. For patients who were concerned about hospices prior to watching the DVD there appeared to be a change in attitude:

6 patients' opinions regarding 'never going into a hospice' and 5 patients' opinions regarding 'what will happen to me in a hospice' changed after watching the DVD, shifting towards feeling more favourable about hospice admission.

**Conclusion:** The video was acceptable and can help patients when faced with this difficult decision.

## 806. What do palliative patients know about their diagnosis and prognosis in Belgium at the moment the hospital based palliative support team is brought in.

Nancy Cannaearts, Mieke De Pril, Inge Bossuyt, Walter Rombouts, Annick Van Laeren, Johan Menten

U.H. Gasthuisberg, Palliative Care Team, leuven, Benin

This prospective study analyses the patients' understanding of diagnosis/prognosis and the reasons for non-disclosure. Data about the patient's (non) understanding of diagnosis/prognosis and the reasons for not being informed were registered for 503 consecutive palliative patients hospitalised in 4 hospitals.

In the group of patients view of *prognosis*, 47% is informed, 33% is not informed and in 20% there is uncertainty about the degree of patients' understanding of prognosis. Still 15% does not know the *diagnosis*.

*Reasons for not informing* are the physical or mental state of the patient inhibiting informing the patient and family's and physicians' fear of talking about a life threatening illness.

Young patients and patients staying on an oncological ward are better informed. Patients receiving palliative therapy are less informed about their prognosis. Patients being discharged home with palliative home care support are better informed than patients without support. Of the patients for whom the palliative care team is asked to prepare the transfer to the palliative care unit, 30% is not aware of the prognosis.

Many palliative patients do not fully know their diagnosis/prognosis. This is due to the mental and physical condition of the patients, the fear of caregivers and family members to disclose the truth. Knowing these variables will help the PST to support the caregivers in communicating bad news.

## 807. ATTITUDES OF PAKISTANI DOCTORS TOWARDS BREAKING BAD NEWS (BBN) - A QUESTIONNAIRE SURVEY

Syed Abbas<sup>1</sup>, Syed Muhammad<sup>2</sup>, Syed Abbas<sup>3</sup>

<sup>1</sup> St Clare Hospice, Palliative Medicine, Hastingswood, United Kingdom

<sup>2</sup> Muhammad Medical College & Hospital, General Surgery, Mirpurkhas, Pakistan

<sup>3</sup> Muhammad Medical College & Hospital, Department of Medicine, Mirpurkhas, Pakistan

**Objectives:** Although there is increasing evidence that more patients want to know their diagnosis and prognosis, evidence suggests that BBN has been treated differently in different settings. We assessed the attitude of Pakistani doctors towards BBN with the help of a questionnaire.

**Methods:** A questionnaire was distributed among doctors of a teaching hospital. The questions included demographic details, their experience of BBN, their view on importance of BBN and the important components of such discussion with patients and their families.

**Analysis and Results:** 76/120 doctors returned the questionnaires. They were from varying disciplines and experience (33 <5years). All (76/76) acknowledged that it was very important for patients to know their disease status. 30/76 had broken bad news in last year less than 10 times whereas further 38/76 had dealt with patients with Bad news. 40/76 felt that BBN was done well. 61/76 felt that Bad news should be told to relatives first. 47/76 felt that it should be done by doctor in-charge personally. Main components identified as important part of discussion were whole truth-telling (48/76), empathy (44/76), family involvement (35/76), follow-up support (20/76), acceptance as will of God (17/76), prognosis time (15/76), preparation with information (12/76) and Palliative care (9/76).

**Conclusion:** Although there is understanding that BBN is important, there was lack of consistency in approach.

# Poster abstracts

Family involvement was felt very important by the doctors.

## 808. Accompanying the family in extremis : use of the genosociogram and a database in a Palliative Care Unit PCU

BURUCOA Benoit<sup>2</sup>, MILON Julie<sup>2</sup>

<sup>1</sup> Hôpital Saint-André, Palliative care unit, BORDEAUX, France

<sup>2</sup> Hôpital Saint-André, palliative unit, BORDEAUX, France

To support the entourage in our PCU, are used a genosociogram (adapted family tree) and a weekly one-hour meeting between social worker, psychologist, head nurse, physician.

To study three items: \*the concept of the "trustworthy person" \*the fragilities of the family system \*the work of the team.

An evaluation and computerised follow-up form elaborated in 2002 has been used during weekly meeting during 2004. 90 patients were concerned. The trustworthy person is: \*at the emotional level: Spouse 35 times, Child 23, Several persons 23 \*at the time/space and material availability level: Spouse 32 times, Child 20, Several 15.

Concerning family fragilities : 37 % Infants, 21% Conflicts, 18% Distance, 11 % Exclusion, 11% Difficult mourning, 21% Social assistance, 20% Merging relationship, 10% Material precariousness, 10% Legal protection.

Projects: 63% End of life within the PCU, 17% Home return, 14% Temporary leave project, 12% Other structure.

Team-family meetings: 235, 68 professional and close relation, 67 professional and several close relations.

Familial fragilities are weighty. Projects looking into leaving the PCU are frequent. Families' accompaniment is time-consuming. Intrusion must be avoided and confidentiality observed. The finality is preventing difficult bereavements. The following are considered: a study on accompanying the children close to the sick persons, a multi-centric study.

## 809. Meaning-Centered Psychotherapies in Advanced Cancer: Helping Patients Find & Maintain Meaning in Life

SHANNON POPPITO, WILLIAM BREITBART

Memorial Sloan-Kettering Cancer Center, Psychiatry & Behavioral Sciences, New York, United States

**Purpose:** This presentation will give an overview of Meaning-Centered Psychotherapies for advanced stage cancer patients. It will provide preliminary evidence for the feasibility and efficacy of both Meaning-Centered Group Therapy (MCGT), as well as Individual Meaning-Centered Psychotherapy (IMCP) for enhancing spiritual well-being and quality of life and reducing psychological distress in patients with advanced cancer. It will also explore the essential facets of these novel interventions by highlighting the basic sources of meaning that patients are taught, in order to enhance meaning and spiritual well-being.

**Overview:** Both Meaning-Centered Psychotherapy studies utilized a randomized, controlled, repeated measures design to investigate the impact of Meaning-Centered Psychotherapy on spiritual well-being, psychological distress, and quality of life in patients with stage III-IV cancer (solid tumors or Non-Hodgkin's Lymphomas). Patients were recruited from the ambulatory care facilities of Memorial Sloan-Kettering Cancer Center, under the leadership of Dr. William Breitbart. Both group and individual Meaning-Centered Psychotherapies are manualized treatments (Breitbart, Poppito, 2005), based on Viktor Frankl's existential work. This psycho-educational intervention encourages patients to explore basic sources of meaning (e.g., historical, attitudinal, creative and experiential), which are intended to help them find, maintain and enhance a sense of meaning and purpose in life.

## 810. 'Shocking talk' - Communication skills training improves rates of resuscitation discussions with patients on admission to hospice

Suzanne Ford-Dunn

St Barnabas House, Medical, Worthing, United Kingdom

Introduction

National guidelines recommend patient involvement in discussions regarding resuscitation status (RS) however, a single day survey of hospice in-patient case notes (Oct 05) revealed only 2/15 patients had been involved in discussions.

Aim

To improve communication/discussion about RS with hospice in-patients through development of a communication skills training programme.

Method

Multi-professional (hospice doctors, staff nurses, community specialist palliative care nurses) training was arranged involving role play scenarios, feedback and sharing of ideas. Participants self-rated their confidence in discussing RS prior to and immediately after the training and again 6-9 months later. A repeat random single-day case note survey was performed in Oct 06. Results

Oct 05 2/15 patients (13 %) had been involved in discussions. Oct 06, following instigation of communication skills training 11/14 patients (78% P<0.001) had been involved in discussions surrounding RS and were aware of their RS. Confidence levels for staff rose immediately following the training and this was maintained 6 months later.

Conclusion

Communication skills training regarding RS improves confidence of healthcare professionals in these discussions and improves rates of involvement of patients. Annual training in communicating RS decisions now accompanies basic life support training in our unit.

## 811. TRUTH-TELLING AND THE DIAGNOSIS OF CANCER

José Díaz-Benito, Ana Sola-Larraz, Ignacio Pérez-Litago, María Hernández-Espinosa, Clint Jean-Louis, María León-Díaz, Maite Salinas-Vidondo

Servicio Navarro de Salud, Atención Primaria, PAMPLONA, Spain

Aim

To determine the prevalence of primary care patients who would want to know their diagnosis if they were suffering from cancer, and to investigate the factors determining their decision.

Method

Design: cross-sectional descriptive study. Setting: public urban primary health care. Main measurements: questionnaire survey was administered to 247 patients selected by consecutive sampling.

Result

Mean age was 51.3 years (SD 18.7). Most patients (85.4%) would wish to know themselves if they were suffering from cancer (95% confidence interval, 81-89.8). However, persons appear more reluctant to disclose diagnostic information to family members with cancer: less than two-thirds (62.8%) thought the patient should be informed of cancer diagnosis. Forty-eight per cent thought the family doctor was the most appropriate person to tell a patient their diagnosis of cancer, 32% the hospital physician, and 20% the family members. The greatest fear of the primary care patients with regard to cancer disease is the fear of pain (43.9%). The patient's preferences regarding truth disclosure were significantly associated with younger age (p=0.024). The patients' preferences for nonhospital deaths (69.6%) were significantly associated with higher academic education (p=0.028) and younger age (p<0.001).

Conclusion

The majority of primary care patients (85.4%) would want to know the truth if they were suffering from cancer: they want to be informed of cancer diagnosis. However, when a family member has cancer, only 62.8% would prefer telling the truth.

## 812. Why we don't understand each other?

Jadranka Lakicevic

Clinic Center of Montenegro, Clinic of Oncology, Podgorica, Montenegro

Communication is one of the most important parts of professional-patient relationship, having special meaning in cancer care. Cancer brings fears, concerns and uncertainty about future. Health care professionals deal with cancer patients all the way: from diagnosis, during period of anticancer treatments, up to the terminal phase of disease and palliative care. There are many contacts with patient and family members. Good communication is a complex process and means more than delivering information. It is because of influence of different psychological, emotional and social factors as well as because of personality of both patient and professionals. Meaning of information might be transformed and lead to misunderstandings. Source of obstacles and problems for good communication might be any of these: patients, professionals and family members. Regarding patient, the issue is about what does he/she want to know about diagnosis, prognosis, outcome of disease and willing to take part in treatment decision. These questions have background in patient's psychologic profile, educational level, as social and cultural milieu. It is considered that professionals' problems in communication are due to lack of formal education and trainings, skills, and time to talk. Family members have supportive role in process, but sometimes they are too protective. It is mandatory to establish an atmosphere of confidence and empathy, with tailor-made communication for each patient.

## 813. The palliative cancer patient, his next-to-kin and his doctor: What is important? Interview study of patients and next-of-kin

Birgit Aabom<sup>1</sup>, Per Pfeiffer<sup>2</sup>

<sup>1</sup> University of Southern Denmark, Institute of Public Health, Odense, Denmark

<sup>2</sup> University Hospital of Odense, Department of Oncology, Odense, Denmark

**Background:** To achieve a "good quality death" various physical, structural, emotional and spiritual issues are important. Our hypothesis is that the relation between oncologist, general practitioner, cancer patient and his next-of-kin is of outmost importance for creating a fertile soil for successful end-of-life cancer care. **Aim:** To investigate cancer patients' on-going experience of the relation with doctors in the oncology department and their general practitioner throughout palliative chemotherapy letting the patients define the "good" doctor. **Methods:** 15 patients and their next-of-kin participated in 2 consecutive face-to-face semi-structured interviews in the patients' home. Interview transcripts were subjects to phenomenological analysis using theories from the science of philosophy and psychology. **Results:** 12 men, 3 women (age 50-80) participated in the interviews. Professionalism and competence were highly valued. Patients valued honest ness about the course of the disease in an atmosphere of hope or "not knowing". Hope was not an assurance of total cure, however, a hopeful attitude in speak and body language. A majority missed a guiding in psychosocial issues which could be fulfilled by their general practitioner. **Conclusion:** To be able to meet the patients with empathy and fostering hope for the near future, the skills of handling over issues of psycho-social character need to be developed.

## 814. Searching for answers

Ruth Sladek<sup>1</sup>, Jennifer Tieman<sup>1</sup>, Amy Abernethy<sup>1,2</sup>, David Currow<sup>1</sup>

<sup>1</sup> Flinders University, Adelaide, Australia

<sup>2</sup> Duke University Medical Centre, Durham, United States

Aims of the project

To describe and quantify issues associated with searching and retrieving literature relevant to palliative care

Method

Three bibliographic studies were conducted.

1. Validating a search strategy to retrieve palliative care literature from general biomedical journals by comparing electronic search results against a dataset created by a hand search
2. Estimating indexing rates of core palliative journals within CINAHL, Embase, PsycINFO and Ovid Medline
3. Determining conversion rates of conference abstracts to publication for three palliative care conferences held in 2001 in Australia, Europe and Australia.

Results

Less than half the literature identified as relevant to palliative care was retrieved using a Master Search comprising 9 MeSH terms and three text words. Over 30% of literature within core palliative care journals was not indexed on the major bibliographic databases. Publication rates for the palliative care conference in Australia, Europe and US were 8.9%, 23.7% and 35.1% respectively.

Conclusion

Literature relevant to palliative care is not comprehensively retrieved with simple searches in a single database. Further, unless research and observation is published it can not be retrieved using electronic bibliographic searches.

## 815. Cultural Aspects in the Role of Truth in Relation to the Respect for Autonomy in Palliative Care

Thomas Jehser, Christof Müller-busch

Gemeinschaftskrankenhaus Havelhöhe, Zentrum Schmerz- und Palliativmedizin, Berlin, Germany

**Aim of Investigation:** Even in an advanced and life-threatening illness patients have a need for information and truth telling. Relatives sometimes demand for avoidance of breaking onerous news towards their beloved ones in order to protect them from "unuseful" depressive reactions. The existence of different languages sometimes amplify an asymmetrical relationship between caregivers, patients and relatives, even more if relatives pick up the role of the translator. The information transfer to the patient might be totally blocked by relatives who want to protect him by taking control over the truth telling.

**Methods:** The description of a 62 year old russian patient suffering from hepatic cancer shows these conflicts about values and communion needs.

Results: In the communication with terminally ill patients the ethic value of truth telling and the legal role of informed consent is a subject to different interpretations in dependance of the cultural and spiritual background.  
Conclusions: For the transfer of information about medical facts and prognostic estimations to terminally ill patients difficulties and even conflicts can relate to language and cultural differences.

## 816. Half dead or half alive? Factors affecting acceptance of terminal illness and dying.

Annmari Nelson

Marie Curie Centre Penarth, Research, Cardiff, United Kingdom

Psychological acceptance of a terminal diagnosis is a process affected by individual attitudes and experiences.

Two demographically similar, palliative care patients were visited at home by their Community Nurse Specialist. The visits were audio tape-recorded, transcribed and analysed using a Theme Oriented Discourse Analysis. The themes occurring were:

- Social networks and the wider community
- Past life
- Engagement with current life
- Philosophies of life and death

The two patients were diverse in their attitudes towards acceptance of their terminal status. The physical disease trajectory matters less than the psychological process. The differences in attitude were linked to patients' experiences within the themes listed above. Satisfaction with their past life, positive self perceptions of their own identity and strong engagement with their immediate social network, as well as the wider community, were key factors in promoting acceptance. Emotional withdrawal from social networks, feelings of burdening and disappointment in life, as well as negative perceptions of self were factors associated with bitterness towards prognosis.

A well aligned relationship with the CNS enabled discussion of end-of-life topics. The ability to discuss end-of-life concerns was valued highly by patients.

## 817. Communication with patients about life-threatening illness is a real problem

Hedviga Jakubikova

Faculty Hospital J.A.Reimann, Pain Clinic and Neurological Dpt., Presov, Slovakia

Staff from other departments, than palliative care units are, feel often difficulties in communication with patients about diagnosed life- threatening illness or about incurable stage of cancer.

There is tradition in our country to inform family and relatives at first and to suppress informations for patient. It's a tendency to protect patient from bad news. But law guarantees patient competence to get knowledge about the disease, prognosis and treatment facilities at first and to decide who of other persons can achieve informations about the disease.

We asked some physicians how they feel when communicating bad news. Some of them feel inadequately prepared and inexperienced, some fear the news will affect the patient, family and relationships.

In my opinion it results from insufficient education of our physicians and other health care professionals in communication skills. Physicians are not prepared how to break bad news, how to answer difficult questions and how to respond to the negative emotions. It's necessary to create guidelines for communication about life- threatening illness and to establish training in communication skills to pregradual and postgradual education in our country. Conception of Palliative Care which was accepted by Ministry of Health in June 2006 is the first condition for measure up the quality of palliative care.

## 818. Oncologists' disclosure of prognostic information at the end of life ? their reflection upon practice

Lotte Rogg<sup>1</sup>, Peter Graugaard<sup>2</sup>, Jon Loge<sup>3</sup>, Olaf Aasland<sup>4</sup>

<sup>1</sup>Ullevål University Hospital, Oncology and Palliative Care, Oslo, Norway

<sup>2</sup>University of Oslo, Oslo, Norway

<sup>3</sup>Ullevål University Hospital, Oncology and Palliative Care, Oslo, Norway

<sup>4</sup>University of Oslo, Oslo, Norway

**Background/aim:** How physicians communicate estimated prognoses may be of importance for the patient's quality of life and for the physician-patient relationship. The aim of this study was to explore Norwegian physicians' reflections on their ways of communicating prognostic information towards the end of life, and on their coping strategies in this

potentially burdensome professional activity.

**Materials/methods:** Three focus group interviews with 6-8 oncologists were undertaken. The interviews focused on challenging aspects of communication about prognosis at the end of life. The interviews were transcribed and the data analysed by the principle of constant comparison. Emerging themes and categories were identified independently by the researchers, and agreement was reached by discussion. **Results:** Oncologists underlined the importance of giving patients at least some prognostic information. They acknowledged some patients' desire not to be informed of an unfavourable prognosis, but insisted on communicating the intention for any planned treatment. The younger physicians reported to consciously search for strategies in information delivery, learning from own mistakes and from practice of senior colleges. The physicians' coping strategies related to the biomedical aspects of care, giving the physicians a sense of a shield between the patients' possible despair and their own feelings. **Conclusion:** Oncologists feel obliged to inform patients of intentions of treatment, balancing this with some patients' wish to stay uninformed of the prognosis.

## 819. From waiting for the miracle to experiencing it

Dénes Kovács

University of Szeged, Szeged, Hungary

Based on the observation that a dying person, moving towards faith, is looking for the solidarity of an authentic person, I have examined they way patients react to the presence of a person that is merely showing interest in their bodily and spiritual well-being. I was visiting about 150 dying persons.

Based on my observations I arrived to the following conclusions:

The majority of the dying likes to talk about faith, be it a confession of religiousness or the explanation of the denial of faith.

Behind the search for faith (with which patients initially are clinging to a hope in a miracle) there is a search for an authentic individual who is able to express solidarity with the dying in the rest of their life, who can offer the dying the experience that they belong to somebody.

These two observations may be taken as two pillars that support the process of helping the dying, and that define the spiritual development of both the dying and the person helping them.

In my presentation I would like to point out the fact that in case the dying experience the solidarity of an authentic person in their effort to rely on faith, a "ritualistic process" will take place between the dying and the helper, a process which offers a novel opportunity for both of them to experience the meaning of life.

## 821. Comprehensive Palliative Care Training for Family Medicine Residents

Lea Ungar<sup>1,2</sup>, Nurit Nave<sup>1</sup>, Michael Kaffman<sup>1,2</sup>

<sup>1</sup>clalit health service, family medicine, haifa, Israel

<sup>2</sup>Technion - Israel Institute of Technology, The Bruce Rappaport Faculty of Medicine, haifa, Israel

Palliative training is offered in the second-year day release residency program. It consists of two modules of thirteen 90-minute sessions each, and is taught by a senior family physician and a senior medical social worker. Teaching is conducted in small groups and includes discussions, role-play, peer consultation and self-awareness training. In the first module residents learn the principles of palliative care, the implications of disease on a patient's mental health and how to attend to patients' symptoms. In the second module, the residents practice communication skills with patients and their families, and deal with their own feelings. Ethical issues are discussed as well. The two modules are interconnected and create one continuous sequence. Residents are also required to attend to a palliative patient under close supervision and to accompany a palliative care expert to 3 home visits. All the residents (N=9) indicated that they have learnt how to deal with clinical and emotional symptoms of the palliative patient and family. In the pre and post test, a significant improvement has been found in clinical knowledge (53% pre and 76% post, p=.011). A significant improvement has been also found in self-assessment of skills (M=2.7 pre and M=3.6 post, p=.001). These results indicate that a comprehensive course of this type can improve residents' clinical skills, emotional maturity and self-awareness with regard to palliative care.

## 822. Evaluation of Educational Programme for New Nurses in and Inner City Hospice

Michael Coughlan

St Joseph's Hospice, Nursing Research, London, United Kingdom

St Joseph's is a large inner London hospice serving a socially deprived and ethnically mixed population. It recently recruited a very large number of qualified nurses to what is a relatively small organisation – 24 out of total of 69 staff nurses (i.e. 34.78%). As the majority of the nurses were Filipino with little or no experience of either cancer or palliative care nursing, and no experience of either British society or healthcare system a one week *Introduction to Palliative Care* course was organised to facilitate their assimilation, and to equip them with an understanding of the clinical specialty. The course was evaluated using a 'pre-test-posttest' design in which the nurses were invited to complete a questionnaire prior to the course and another 4 weeks afterwards. All of the new staff felt that the course had been beneficial to them and overall they felt more confident in most of the identified aspects of palliative care, with the exception of communication skills, in which a small number actually felt less confident. This is possibly to be expected in view of the nurses' cultural and linguistic backgrounds and the fact that their awareness of certain issues had been raised.

## 823. The development of an internet based course in palliative care nursing

Robert Becker

Severn Hospice, Education, Shrewsbury, United Kingdom

**Aim:** To describe the development of an internet based, free to access course on palliative care nursing.

**Method:** To write and develop text and activities that were academically rigorous, culturally neutral and learner friendly. On completion the learner gains access to a certificate that can be used within a learning portfolio. A competency assessment tool is also offered to enable the learner to assess their skills in practise. Learners can record ongoing reflection and action points in learning logs and communicate with subject experts. All authored material is blind peer reviewed prior to publication.

**Results:** Course launched on July 29<sup>th</sup> 2005 on . (a registered charity). 3148 learners have enrolled from 60 countries as of August 31<sup>st</sup> 2006. Average enrolment rate is 220 per month. Learners range from palliative and cancer nurses in hospital and community care settings (32%), patients, student nurses (7%) educators (7%), care assistants, and nurses working in medical and elderly care (23%).

**Conclusion:** Feedback has been universally positive and learners say that the course helps to fulfil a desire for continuous learning, provides access to learning otherwise unavailable, reinforces existing knowledge & builds confidence, allows for self-organised learning and deepens understanding of palliative care.

## 824. Staff Development for Incoming Nurses from Different Cultures

Carolyne Barber

St Joseph's Hospice, Education, London, United Kingdom

St Joseph's Hospice in the East End of London has recruited a large group of nurses from the Philippines and many other countries. They are qualified experienced nurses but without the opportunity to have been involved in nursing in the context of palliative and end of life care. The Department of Education developed a programme especially for this group of nurses. It covered such issues as medication and symptom control, and the use of syringe drivers. This poster presentation together with an accompanying handout describes the design and content of this educational programme and in particular the recognition of cultural differences required in its planning.

## 825. A four weeks course for home care nurses to create a network of key persons for palliative care in the primary sector of The County of Vejle, Denmark.

Tove Vejlgård, Lene Joergensen, Winnie Günther

Vejle Sygehus, Det Palliative Team, Vejle, Denmark

In May 2005 a specialist palliative care team was formed in the county of Vejle (360.000 inh). Until then no coordinated palliative care had taken place in the county. A plan for a network for palliative care in the primary sector was made. It was decided to educate a nurse as keyperson for palliative care in each home care district. A course of 4 modules of each 5 days was

# Poster abstracts

established. Main contents: Management of typical symptoms, subcutaneous administration, palliative physiotherapy, psychological aspects, bereavement, spiritual issues, socio-economic aspects, ethics, basic oncology, teaching methods, communication training (3 days, Faulkner/Maguire method). During the course there was a continuous dialogue with the nurses and their head of departments to form and create the role as key persons. The students had to perform a communication video, a pain case, a teaching session, a description of the logistics in their district, and participate in a case based group examination to pass the course. 32 nurses have participated in the course. After the course network groups have been made with 2 network meetings per year, where the nurses pass a whole day together with teaching, continuous evaluation of their role as keyperson and experience exchanging. An overall evaluation of the course, the impact on the nurses and the implementation of the role as key person was made using a questionnaire. Results from the survey will be presented at the conference.

## 826. Causes of Inadequate Cancer Pain Management in Georgia

Mikheil Shavdia<sup>1</sup>, Nia Shavdia<sup>2</sup>

<sup>1</sup> Cancer Prevention Center, Palliative Care, Tbilisi, Georgia  
<sup>2</sup> University, Department of Public Health Care and Primary Health Care, Tbilisi, Georgia

**Objective:** 50% of malignant tumor cases detected in Georgia during last period were at the IVth stage. That's why the number of incurable patients, who need palliative care, is quite high. Study of 638 cancer incurable patients showed, that the most characteristic symptoms were asthenia (85,1%) and pain (78,5%). At the same time frequency of pain syndrome was growing according to the increase of ECOG, which reaches 85,3% at the IVth gradation. So it was important to identify the level of qualification of healthcare professionals providing chronic pain control in Georgia. **Methods:** 138 practitioners of primary health care system from different regions of Georgia have been questioned. The questionnaire consisted of 6 questions, concerning the basic principles of pain control in cancer patients. The results were estimated using statistical method. **Results:** The results of questioning gave the following picture: 1.71% did not know the half-value period of concrete opioids; 2.50% were unaware of rational use of the three-stage pain control system recommended by WHO; 3.98,5% could not estimate pain intensity (by visual analogy scale); 4.83,3% prescribe opioids without identification of pain provoking causes, which often was the reason of inadequate pain control; 5.68,1% were completely unable to choose an adequate dosage of analgetics; 6.42% were unaware of a considerable part of side effects of opioids and could not control them adequately. **Conclusion:** professionals of primary health system in Georgia require an appropriate education on adequate management of chronic pain syndrome in cancer patients.

## 827. Percieved areas of concern for newly qualified doctors caring for Palliative Care patients - Implications for Undergraduate Training.

Nicola Heron<sup>1</sup>, Claire Curtis<sup>2</sup>, Lisa Boulstridge<sup>3</sup>, Richard Woof<sup>4</sup>

<sup>1</sup> West Midlands Deanery, Specialist Registrar in Palliative Medicine, Birmingham, United Kingdom  
<sup>2</sup> West Midlands Deanery, Specialist Registrar in Palliative Medicine, Birmingham, United Kingdom  
<sup>3</sup> St Giles Hospice, Consultant in Palliative Care, Lichfield, United Kingdom  
<sup>4</sup> University of Birmingham, Department of Primary Care and General Practice, Birmingham, United Kingdom

### Introduction

Teaching on Palliative Care has been recognised as a fundamental part of Undergraduate Curricula in recent years. Surveys of Medical Schools have revealed that there is much variation in content. Little is known of newly qualified doctors' views on their learning needs.

### Aims

To ascertain the perceptions of newly qualified doctors, trained at Birmingham University, as to the level of preparedness they felt for caring for dying patients. .

### Method

Semi-structured interviews of Birmingham University graduates working in their first year as a doctor at Good Hope Hospital, East Birmingham, were conducted. Qualitative methods were used to collect and analyse data.

### Results

12 doctors were interviewed. Analysis of their experiential narratives revealed five themes: Symptom control, Psychosocial issues, Support, Feelings of the Junior Doctor and Decision making.

### Conclusion

The learning needs of Junior Doctors in caring for terminally ill patients can be derived from their remembered experiences. Some of these needs have been predicted by educators before. However, there are other aspects that may require greater emphasis when planning teaching and support.

## 828. The development of a performance assessment tool for rapid evaluation of palliative care & end-of-life knowledge in fourth year medical students.

Lisa Gibson<sup>1</sup>, Jessica Maycock<sup>1</sup>, Clare Littlewood<sup>2</sup>

<sup>1</sup> Liverpool University, Medicine, Liverpool, United Kingdom  
<sup>2</sup> Whiston Hospital, Palliative Care, Liverpool, United Kingdom

### Introduction

Numerous studies have shown that patients near the end of life often receive substandard palliative care. One approach to improving this is through education of medical trainees. *Tomorrow's Doctors* identified that it is essential for doctors to obtain core skills in palliative care during their undergraduate training. Despite an increase in palliative care teaching and education, there is little knowledge of its nature within the curriculum. Moreover, evidence suggests that medical students frequently do not feel prepared to discuss end-of-life issues with patients and junior doctors report it as an area in which they feel most unprepared.

### Aim

Develop a quick and easy to use performance assessment tool to evaluate palliative care and end-of-life knowledge. It is intended to be implemented in fourth year medical undergraduates at Liverpool University following a four week palliative care attachment.

### Objectives

- Identify an appropriate palliative care curricula
- Research assessment questioning methods
- Understand the difficulties of writing assessment questions

### Method

Compile a fair assessment paper based on the research conducted and the decided curricula. Pilot and analyse the performance and feedback of students before critically reviewing the assessment and drawing conclusions.

### Results

Twenty students completed the assessment. Of a possible 57 marks the mean was 40.05, the lowest 31 and the highest 50. Based on an absolute pass mark of 60%, 16 students passed.

### Conclusion

Overall, student's felt a wide range of topics were covered in an appropriate depth. Results analysis revealed that most questions were answered well. However, several were amended to produce a successful performance assessment tool.

## 829. Evaluating an innovative educational approach

Susan Shaw

St Richards Hospice, Education, Worcester, United Kingdom

**Aim:** To evaluate an innovative approach to linking educational and professional development to the provision of evidence-based care within an in-patient hospice.

**Method:** An evaluative method was used to explore the documented planning of care to identify the degree to which evidence-based information was used to offer individualised care to patients. A set of critical questions was employed to analyse patient documentation and the professional development evidence of staff.

**Result:** The results of this study provide a useful insight into links between theory and practice. Evidence of the impact of an educational programme on the thinking and practice of nurses within a hospice is also presented.

**Conclusion:** The linking of educational and professional development is an essential component in the provision of truly individualised patient care within a hospice environment.

## 830. TRAINING IN END-OF-LIFE CARE FOR THE ELDERLY: PERSPECTIVES OF NURSES AND PHYSICIANS IN THE ELDERLY CARE AND SUPPORT SYSTEM

Michael Ewers

Munich University of Applied Sciences, Faculty of Applied Social Sciences, Dep. Health and Nursing, Munich, Germany

This presentation will document the results of an explorative study about the perspectives of nurses and physicians on end-of-life care for the elderly and the associated training needs in palliative care. The data of four focus groups with a total of 31 attending nurses, 10 interviews with nurse managers and 10 interviews with

general practitioners from several regions in Germany were analyzed using a qualitative methodology. As a result several factors are identified as barriers to perform patient centered end of life care in the traditional elderly care and support system. Furthermore expectations on training programs in palliative care were specified from the perspective of attending nurses, nurse managers and physicians. It will be shown in conclusion that the principles and options of palliative care are not yet recognized in the traditional elderly and support care system. Furthermore the possibilities of a professional palliative nursing approach are deeply undervalued. The impacts of these findings on the development of training initiatives for end-of-life care for the elderly, which will be discussed.

## 831. Swedish medical students' attitudes toward euthanasia

Marit Karlsson<sup>1</sup>, Anna Milberg<sup>1,2</sup>, Peter Strang<sup>3</sup>

<sup>1</sup> Linköping university hospital, Unit of advanced palliative home care, Lichfield, Sweden  
<sup>2</sup> Vrinnevisjukhuset, Unit of advanced palliative home care, Norrköping, Sweden  
<sup>3</sup> Karolinska Institutet, Stockholms sjukhem foundation, Stockholm, Sweden

Attitudes toward euthanasia differ between individuals and populations. Factors such as age and occupation seem to affect the attitude, and in many studies the medical profession is more reluctant than the general public. Our goal was to explore medical students' attitude toward euthanasia. A questionnaire containing open-ended questions was answered anonymously by 165 first- and fifth-year medical students. The data were analysed using qualitative content analysis with no predetermined categories. The students' arguments opposing euthanasia were based on opinions of (1) euthanasia being morally wrong, (2) fear of possible negative effects on society (the slippery-slope argument), (3) euthanasia causing strain on physicians and (4) doubts about the true meaning of requests of euthanasia from patients. Arguments supporting euthanasia were based on (1) patients' autonomy and (2) the relief of suffering, which could be caused by severe illnesses, reduced integrity, hopelessness, social factors and old age. There are several contradictions in the students' arguments, mainly concerning autonomy of the patient vs. the staff and autonomous decisions vs. euthanasia for the cognitively impaired. The results indicate a possible need for improved education for medical students, focusing on the possibility of successful symptom control in palliative care and the patients' perceived quality of life, despite severe diseases.

## 832. LOS ANGELES TO MUMBAI: PROVIDING PALLIATION USING TECHNOLOGY

Parag Bharadwaj<sup>1</sup>, Sanjay Pisharodi<sup>2</sup>, Swati Vasava<sup>2</sup>

<sup>1</sup> Cedars-Sinai Medical Center, Palliative Care, Los Angeles, United States  
<sup>2</sup> Bhaktivedanta Hospital, Palliative Care, Mumbai, India

### AIM:

The goal of this pilot project was to test the effectiveness and benefits of using the internet as a tool to narrow the knowledge gap in Palliative Care medicine between two distant locations.

### BACKGROUND:

With advances in technology, the internet has become an available medium to transfer knowledge between distant countries and to bridge the knowledge gap that helps provide better care to patients.

### METHODS:

Available computer technology was used to have interactive sessions between a physician in Los Angeles, USA and a palliative care team in Mumbai, India to build physician confidence in practicing palliative care and to ultimately provide care to patients in need of it.

### RESULTS:

Over a period of two months, patients with advanced illnesses were cared for. The focus was on helping physicians in India expand and apply their knowledge. The patients who were cared for were symptom free after initiation of their treatment. There was exchange of information and ideas from both sides. Physicians in India who participated in the project reported a significant increase in their confidence in managing advanced symptoms and care of the dying patient.

### CONCLUSION:

The internet can be an effective tool to exchange knowledge and to improve patient care in a palliative care setting. In addition, a similar exercise could be used in other disciplines of medicine and fields of education, both to teach and learn over long distances.

## 833. EDUCATION PROGRAM IN PALLIATIVE CARE: NHS and PRIVATE NO-PROFIT TOGETHER CAN MEET EDUCATIONAL NEEDS OF PRIMARY CARE PROFESSIONALS.

Simone Veronese<sup>1</sup>, Claudia Cugno<sup>1</sup>, Claudio Ritossa<sup>2</sup>, Eugenia Malinverni<sup>2</sup>, Laura Mensa<sup>3</sup>, Luisa Scuntero<sup>4</sup>, Patrizia Alberti<sup>3</sup>, Patrizio Ghio<sup>4</sup>, Filippo Valentini<sup>1</sup>, Alessandro Valle<sup>1</sup>

<sup>1</sup>F.A.R.O. foundation, Palliative Care, torino, Italy  
<sup>2</sup>Luce per la vita, Palliative Care, Rivalta (Turin), Italy  
<sup>3</sup>ASL 5 NHS, Palliative Care, Collegno (Turin), Italy  
<sup>4</sup>azienda ospedaliera s. luigi di orbassano, terapia antalgica e cure palliative, orbassano (Turin), Italy

**INTRODUCTION:** Primary care professionals involved in home care for cancer patients may have unmet educational needs impacting in the quality of their service. In our geographic area specialist palliative care teams (SPCT), organised by no profit charities, provide specialist palliative home care to advanced cancer patients in collaboration with public health system. **AIMS:** SPCS and NHS domiciliary group decided to audit these needs and to provide a palliative care course aimed at improving the professional's expertise and the quality of the network service. **METHODS:** An open questionnaire with questions about main education needs was mailed to GP's and district nurses involved in palliative home primary care. Main education needs were the following: improvement in symptom assessment and control, legal and ethical issues, communication among professionals and with relatives-patients, integration within the other specialists in the network. In order to meet these needs a 2 days course in palliative care was organized. All needs above are considered in specific sessions. 10 meetings with about 30 participants are scheduled. The first 2 went on in June and October 2006. **CONCLUSIONS:** With this program we'll educate about 300 professionals involved in primary home palliative care. SPCS professionals will educate participants enhancing teamwork skills, symptom assessment and control, legal procedures and communication with both patients/carers.

## 834. The development of a course package - Delirium in the palliative phase- for district nurses. A report of an educational project from the Comprehensive Cancer Centre South in the Netherlands

Thirza Olden, Elly Booyink, Marieke Dooremalen, Thera Pol van de

Comprehensive Cancer Centre South, Palliative Care, Eindhoven, Netherlands

A working group, consisting of eight oncology nursing specialists working in different home care organizations, collectively developed a course package to educate district nurses about delirium in palliative phase. By working together, setting goals realistic and attainable the nurse specialist managed to create a dossier filled with information and teaching material about delirium in palliative phase. The starting point is a standard PowerPoint presentation to which each nursing specialist can add extra information, cases and theses, all included in the dossier, to adapt it to the team of nurses to be educated. A questionnaire, screening instrument (Delirium Observation Scale) and a leaflet with information about delirium for informal caregivers are also included in the dossier. The course package can be used to implement the Delirium Observation Scale.

## 835. CONNECTING DIVERSITY, also in consultation?

Marjo Van bommel

Comprehensive Cancer Centre South, Palliative Care, Eindhoven, Netherlands

In the Netherlands each region has its own way in setting up consultation on palliative care at home. Is it possible to find a common approach and is the training of consultation-abilities in a team a contribution in this direction.

2004: The Dutch Ministry of Health subsidised the Comprehensive Cancer Centres (CCCs) to set up consultation facilities for GP's and home nurses, in order to improve the quality of palliative care at home. Each CCC initialised regional multidisciplinary teams who advise on palliative care by phone. As a trainer/coach I gave instructions on the "consultation method" to 12 teams in the south-west. In this method the consultant provides in a structured way tools for the care giver, who keeps his own responsibility in his care for the patient. The training provides the members with a common language to talk about the problems they meet in the consultation: being a consultant is a specific job for which you need not only knowledge and expertise, but also communication skills and the willingness to support colleagues in the field. This allows for communication

about more than symptoms like pain, and pharmacological items (opioid-rotation), like the psychosocial and spiritual items that play a role in the interaction between care givers (GP/Homenurse) and the patient and his family (WHO 2002) so training is a contribution in performing consultation concerning palliative care in all aspects in a common way

## 836. Teaching Palliative Medicine to Advanced Learners: A Four-Year Experience.

Emese Somogyi-Zalud<sup>1</sup>, Kathryn Braun<sup>2</sup>, Diane Faran<sup>3</sup>, Christina Bell<sup>3</sup>, Kamal Masaki<sup>3</sup>, Georgette Stratos<sup>4</sup>, James Hallenbeck<sup>5</sup>, Sara Katz<sup>6</sup>, Patricia Blanchette<sup>3</sup>

<sup>1</sup>University of Hawaii John A. Burns School of Medicine, Division of Palliative Medicine, Department of Geriatric Medicine, Honolulu, United States  
<sup>2</sup>University of Hawaii John A. Burns School of Medicine, Department of Public Health Sciences, Honolulu, United States  
<sup>3</sup>University of Hawaii John A. Burns School of Medicine, Department of Geriatric Medicine, Honolulu, United States  
<sup>4</sup>Stanford University, Stanford Faculty Development Center, Palo Alto, United States  
<sup>5</sup>Stanford University School of Medicine, VA Palo Alto Health Care System, Palo Alto, United States

<sup>6</sup>Kaiser Hayward Hospice, Union City, United States

**INTRODUCTION:** Palliative and geriatric medicine both have a key role in the care of people with chronic and terminal illness.

**AIM:** To evaluate the impact of a 14-hour palliative care seminars on geriatrics fellows.

**METHOD:** We introduced a curriculum developed by the Stanford Faculty Development Center. Between 2001 and 2005, data were collected on demographics, satisfaction, past training, and changes in knowledge, attitudes, and skills.

**RESULT:** Few of the 28 learners reported palliative medicine education during medical school and residency (11% and 25% respectively). The usefulness of the curriculum was rated 4.1 on a 5-point Likert scale. Sixty percent of the material was new. Educational relevance of the topics was rated between 4.2 and 4.5. Clinical relevance received ratings between 4.3 and 4.6. A 17-item knowledge test demonstrated an increase in correct scores from 57% to 65%. Skills were assessed by a 12-item 5-point Likert scale pre and post training. Average ratings increased from 2.9 to 4.0 for clinical skills and from 2.4 to 3.7 for teaching skills. On the attitude scale of 13 items average ratings increased from 3.0 to 3.4.

**CONCLUSION:** Effective ways of teaching palliative medicine remain to be researched. More than half of the palliative content was new to the geriatrics fellows. The seminars were well received with a measurable impact on knowledge, skills, and attitudes. A follow up survey will assess long-term impact.

## 837. Euthanasia - As Hungary's future medical doctors think about it

Adám Vajsz

Semmelweis Medical University, Budapest, Hungary

Euthanasia is a so-called „hot topic” not only in palliative but in every day medical care as well. But does the Hungarian, in fact, the future Hungarian doctors have a clear view on these upcoming phrases and cases? I surveyed the knowledge and attitude of 180 medical students to this topic, in other words how the Hungarian Medical System is going to cope with situations in connection with euthanasia.

**Methods:** 180 medical students were asked by a test of 20 questions. 30 randomly picked-out students from each student year, regardless their sex, age, religion, financial or familiar background. The results were analyzed in 2 groups (lower and higher grades).

**Results:** Although students get lots of information about this matter 69% of them are not totally aware of these facts and not prepared for these situations either communicationaly, medically or legally. In lots of cases not only students but even medical doctors are not well-informed about the laws and their and their patients' rights.

**Conclusion:** In the future medical universities should emphasize the importance of students' preparedness for curing and communicating with patients in terminal or serious state, and for their and their patients' interests they should pay more attention on related subjects.

## 838. Experiences in palliative care in German General Practitioners

Werner Freier<sup>1</sup>, Jens Papke<sup>2</sup>

<sup>1</sup>Praxis for oncology, Palliative Care, Hildesheim, Germany  
<sup>2</sup>Praxis Innere Medizin und Onkologie, Palliative Care, Neustadt/Sachsen, Germany

**Background:** To enable final stage oncological patients to rest at home under an adequate palliative symptom control a well educated palliative care team is necessary. The purpose of this study was to determine how education in palliative care is provided in German general practitioners. **Methods:** Using a standardized questionnaire participants of courses in palliative care have been explored. Data of their personal education in palliative care have been collected and evaluated. **Results:** During their study at university no participant learned anything about palliative care. Experience in this context has been achieved from own mistakes (31%); in courses (28%), by on-the-job training (20%) or from dying of a relative (20%). At their first own experiences they had an education status of: student (16%), assistant physician, private practitioner (26%) or consultant (5%). **Conclusion:** The curriculum of German medical students didn't include any items of palliative care. Due to these facts German physicians improved their knowledge in palliative care later as assistant physician or as practitioner. Alarming is that improvement in palliative care is in 30% associated with own mistakes. Learning by mistakes is the most common kind of palliative care education in Germany. On the initiative of the German society for palliative medicine (DGP) palliative care is now included in medical students curriculum.

## 839. 'Linking up!' Nursing Homes and End of Life Care

Catherine Baldry

West Lancs, Southport and Formby Specialist Palliative Care Team, Terence Burgess Education Centre at Queenscourt, Southport, United Kingdom

Palliative Care Education Courses are regularly provided by the Terence Burgess Education Centre at Queenscourt Hospice for Registered Nurses & Health Care Assistants. Help the Hospices subsidise the cost of the courses making them affordable. Despite this, only a few Nursing Homes regularly send staff. An audit of all Nursing Homes in the area showed that the reasons staff did not attend were:

In order to reach more Nursing Home staff (West Lancs, Southport and Formby has over 100 nursing homes) with Palliative Care Education with the aim of improving End of Life Care for their patients we provided:-

1. In house palliative care education sessions in the nursing homes
2. Development of a LINK nurse system with Nursing Homes

This poster demonstrates how the Integrated Palliative Care Services:-

1. Developed collaborative in house education programmes
2. Raised the number of Nursing Home Staff receiving palliative care education by 400%
3. Developed an active, thriving LINK Nurse system committed to improving end of life care for Nursing Home patients.

## 840. Present and Future Challenges of Postgraduate Palliative Care Education: Educating Clinicians for Changing Practice

Meg Hegarty, Kim Devery, Katrina Braden, David Currow

Flinders University, Department of Palliative and Supportive Services, Adelaide, Australia

Palliative care postgraduate education now occurs in the context of the magnitude of new work in palliative care; of emerging research areas; cross-paradigm clinical, research and educational collaborations; the proliferation of professional and lay literature; the development of the evidence base and its challenges for current practice; a diversity of practice settings; and changing clinician-patient relationships, with increasingly informed patients who wish to be involved in decision-making. These evolving trends each present challenges for clinicians and educators. Postgraduate education aims to develop clinicians' awareness and skills in the processes of clinical thinking; in retrieving, assessing and using the best available evidence; abilities in ethical clinical decision making in increasingly pluralistic societies; and a critically reflective approach, capable of challenging the mantras? when needed. In short, postgraduate education aims to foster the skills to be an effective life-long learner. New content areas (e.g. Palliative Care for Indigenous Populations; Palliative Care in Aged Care) and innovative teaching approaches (e.g. online role plays; assessment and clinical decision making frameworks; developing writing and publishing skills) will be discussed, together with evidence for effectiveness of teaching methods in changing practice.

# Poster abstracts

## 841. Development of undergraduate medical education in Palliative Care

Susanne Keilig<sup>1</sup>, Alexander Laske<sup>2</sup>, Thure Kuprella<sup>3</sup>, Bernadette Fittkau-Toennesmann<sup>4</sup>, Friedemann Nauck<sup>5</sup>

<sup>1</sup> University of Wuerzburg, Wuerzburg, Germany

<sup>2</sup> University of Greifswald, Greifswald, Germany

<sup>3</sup> HELIOS-Clinic Erfurt, Anaesthesiology, Erfurt, Germany

<sup>4</sup> University of Munich, Interdisciplinary Center for Palliative Medicine, Munich, Germany

<sup>5</sup> University of Goettingen, Department of Palliative Medicine, Goettingen, Germany

**Aim of project** Undergraduate medical education in palliative care is underdeveloped in most European countries. After graduation only 11% of French, 18% of German and 24% of Swiss young doctors feel sufficiently prepared for the task of 'caring for the dying' [1]. A working group within the German medical students' association (bvmd) commits itself to improve the education in palliative medicine. **Method** In June 2006 a survey was sent to all deans (n=36, n=25 (69%) returned). Additionally, student representatives of every medical faculty have been contacted to complete the data. **Result** A scheme was established where and to what extend palliative medicine is taught at the medical faculties. It informs about lecturers, courses, student attendance and exams. In June 2006 there are five chairs for palliative medicine (14%), providing mandatory palliative care education. At five faculties (14%), palliative care is integrated in other mandatory subjects to reach all students, ten faculties (28%) offer elective courses. Nine faculties (25%) have both integrated lectures and elective courses. At seven universities (19%), there is no palliative care education. **Conclusion** There are no standards for undergraduate medical education in palliative medicine. This survey is the first summary presenting the status quo in Germany. We believe that students may have an important role in improving palliative care education. Lit.: 1. Herzler M, Educ. 2000 Feb; 34(2):146-7

## 842. A Longitudinal Survey of Medical Student Palliative Care Education, Attitudes and Beliefs

Kori Sauser<sup>1</sup>, Clarke Anderson<sup>2</sup>

<sup>1</sup> University of Southern California, Keck School of Medicine, Los Angeles, United States

<sup>2</sup> City of Hope National Medical Center, Pediatric palliative care/Pediatric oncology, Duarte, United States

**AIMS/METHODS:** A 50 question survey of palliative care (PC) attitudes and education was administered to 660 first (M1), second (M2), third (M3), and fourth (M4) year medical students from USC. Content included demographics and questions (yes-no; Likert scale questions) about general PC, PC education, and attitudes on end of life care. **RESULTS:** 222 surveys (42% M1, 61% M2, 18% M3, 13% M4) were returned. Formal PC training (mean 1.6 lectures) was reported by 39% (M1), 67% (M2), 90% (M3), and 84% (M4) with < 22% of M1/M2 students feeling adequately prepared about PC issues, in contrast to 46% of M3 and 60% of M4's. Increasing confidence to withdraw life support and a trend to worry less that PC stress could interfere with job performance (85% M1/M2 vs. 76% M3/M4) was noted. M1/M2s were less likely than M3/M4s to agree that terminal sedation was justified (p < 0.05) and non-spiritual vs. spiritual students (M1-M4) were more likely to support physician assisted suicide (51% vs. 34%; p=0.002). All M1-M4s agreed that cultural needs should be met (4.7 +/- 0.6 on Likert scale), yet would not withhold information despite patient's cultural beliefs (3.1 +/- 1; p < 0.05). M1-M4s all agreed that complimentary medicine is useful. **CONCLUSION:** While medical students receive some PC training and become increasingly more comfortable with death/dying issues, earlier and more intensive education might decrease professional stress and improve patient care.

## 843. The virtual classroom: the challenge of distance

Katrina Breen, Kim Devery, Meg Hegarty, Meredith Legg

Flinders University, Palliative Care, Adelaide, Australia

Increasing demand for palliative care education, together with geographical diversity, have brought about significant changes in how educational institutions manage, deliver and assess programmes of study.

In response to this demand, the **Department of Palliative and Supportive Services at Flinders University, Australia** has altered its method of teaching and learning and whole postgraduate degrees/courses can now be undertaken entirely online. Real time and asynchronous teaching strategies include; focussed tutorials, debates, collaborative learning groups

and guest lecturers. Despite tremendous advances in the delivery of online courses, the move to web-based education has brought with it several challenges and pitfalls, which can be broadly grouped under the headings of; academic, technological, professional and administrative work load.

The purpose of this presentation is to explore these challenges as well as the successes of online education, thereby adding to the emerging body of literature that explores the effectiveness of online learning environment in the acquisition of knowledge, skills and attitudinal change.

## 844. Existential Issues in Pain & Palliative Care: An exploration of terminal cancer patient case studies in light of existential themes

SHANNON POPPITO<sup>1</sup>, ROMA TICKOO<sup>2</sup>, TICKOO COYLE<sup>2</sup>

<sup>1</sup> Memorial Sloan-Kettering Cancer Center, Psychiatry & Behavioral Sciences, New York, United States

<sup>2</sup> Memorial Sloan-Kettering Cancer Center, Pain and Palliative Care, New York, United States

**Purpose:** A monthly mini-course lecture series, entitled Existential Issues in Pain & Palliative Care, was developed specifically for clinical fellows in the Pain & Palliative Care Department of Memorial Sloan-Kettering Cancer Center (NYC, USA). The two main goals of this course are: 1.) to educate fellows regarding core existential themes that arise in patients struggling with pain and palliative care issues, and 2.) to support fellows in caring for their patients and families in need, as well as caring for themselves in the process. **Method:** A licensed clinical psychologist, who is well-trained in existential and developmental issues pertaining to cancer and end-of-life patient care, developed this course curriculum. It focuses on identifying core existential themes (e.g., existential pain, anxiety, guilt, isolation, ambivalence) that arise in patients struggling with pain and end-of-life issues. Dr. Tickoo, Chief Clinical Fellow, and Dr. Coyle, Head of Palliative Support Services, will examine specific patient case studies where existential issues arise. Dr. Poppito, course instructor, will then identify and explore existential themes accordingly. This presentation will give an overview of existential issues in pain palliative care as highlighted through these patient case vignettes. Case studies will include: diagnosis, pain/clinical management, personal/familial history, and ways to identify existential issues that arise in palliative care patients.

## 845. Cancer Pain and Opioids: Knowledge and Attitudes of Medical Students in their Integrated Clinical Clerkship Training

Maria Fidelis Manalo<sup>1</sup>

<sup>1</sup> Supportive, Palliative & Hospice Care, UP-PGH, Family & Community Medicine, Manila, Philippines

<sup>2</sup> Far Eastern University-NRMF Medical Center, Community & Family Medicine, Quezon City, Philippines

**Aim:** To determine the knowledge and attitudes of students prior to their ward exposure. **Method:** A random sample of 5th year medical students were asked to answer the self-administered structured questionnaire with 19 questions concerning cancer pain and opioid use. **Results:** Almost all the students mentioned that pain management was given to them during their Anesthesiology lectures while a few recalled that they had these lectures during their Family Medicine rotation in Hospice Care. More than a third (35%) of the respondents admitted to not being confident with morphine use at present. The top three reasons cited for perceived limitations in writing prescription opioids for cancer pain include addiction, side effects and cost. 50% of the respondents did not know the correct answer to the 3-item Likert scale dealing with knowledge regarding opioids. Majority of them (80%) agreed that it is appropriate to refer patients with cancer pain to hospice care and palliative medicine specialists and 60% of them would do so often. **Conclusion:** The basic knowledge of the role of opioids in cancer pain management among 5th year medical students who are already in their integrated clinical clerkship year is poor to average. It is necessary to introduce the problem of adequate cancer pain control as an important part of the curriculum in the early years of medical education with reiteration and reinforcement as they progress. It is also crucial to improve the process of teaching pain management, not limiting them to lectures only.

## 846. Eastern-European Training Resource Centre in Budapest

Katalin Muszbek<sup>1</sup>, Barbara Kalló<sup>1</sup>, Eszter Biró<sup>1</sup>, Mary Callaway<sup>2</sup>

<sup>1</sup> Hungarian Hospice Foundation, Budapest, Hungary

<sup>2</sup> Open Society Institute, New York City, United States

**Objective:** Palliative care began to develop only in the last several years in Eastern and Central Europe. The goal was to establish a regional educational and resource centre that may serve as the source of the development of palliative care.

**Method:** The Hungarian Hospice Foundation organizes trainings with the support of the OSI in Eastern and Central Europe for health care professionals in the subject of palliative treatment. The 40-hour-training focuses on theoretical and practical issues of palliative care, pain control, psychological, social and spiritual problems. A special problem in this region is adequate communication with patients and ways of breaking bad news, since these issues are not discussed in medical education. That is why developing communicational skills is an integral part of the training. We shall also present the Foundation's strategy for fundraising and PR.

**Results:** In the last few years we had 28 participants from Georgia, Rumania, Lithuania, Ukraine, Turkey and Moldavia. These were all countries where palliative care was in an early phase or it has not even started yet. Georgia is one of the countries where palliative care started as a result of such a cooperation. Currently, we are launching a new training with ten Turkish health care professionals in Ankara and Cyprus.

**Conclusion:** Due to the support by the OSI, the Budapest Training and Research Centre contributed greatly to the development of palliative care in Eastern and Central Europe. The Budapest Hospice House may serve as a model for the development of other systems.

## 847. Paintings and sculptures as tools to sensitize health carer's empathy

Raffaella Dobrina, Chiara Mastroianni, Chiara Taboga, Giuseppe Casale

Antea palliative care unit, Palliative Care, rome, Italy

Literature supports empathetic approach to terminal patients when fear of death, emotional distress and suffering require adequate attention and answers. At the same time, working with empathy enhances job satisfaction in health carers. Students need to be sensitized to empathy in order to be opened to patients' provocation. This paper is to suggest use of art works to develop student's empathy through analysis of paintings and sculptures representing suffering and dynamics raised by death and illness. Previous studies focused only on few art models (Munch's "Sick child" in Wikstrom BM, 2003). In contrast, we propose a wider variety of choices suitable for specific educational targets (e.g. Arca's "Deposition" and Sacchi's "St. Anna's death" for dynamics in front of death; Munch's "Scream" for mute, expressive request of help; Chiesa's "Maddalena's penitence" for asthenia)

## 849. 'Knowing me, knowing you' Reflections on a specialist palliative care peer observation of teaching programme

Paula Powell, Catherine Baldry, Karen Groves

West Lancs, Southport & Formby Palliative Care Services, Terence Burgess Education Centre at Queenscourt, Southport, United Kingdom

Those involved in specialist palliative care services have an important function in providing education and training on the principles and practice of palliative care. Individual practitioners should ensure that they have the knowledge and skills required for the roles they undertake? (NICE 2004) However many professionals within palliative care teams find themselves teaching in isolation and without ever having undergone training in the skills of teaching and learning. The West Lancs, Southport & Formby Palliative Care Services are actively involved in teaching and our commitment to this has increased since the opening of The Terence Burgess Education Centre at Queenscourt in March 2003. Three members of the team have gained postgraduate certificates in teaching and learning in clinical practice and this has proved very valuable. Reflection and evaluation are important in maintaining all skills and teaching is no exception. This poster describes a programme of peer observation developed to respond to the needs of individuals within the palliative care team for evaluation of their teaching skills and as a mechanism to ensure quality and equity of provision within the education centre. <sup>1</sup> National Institute for Clinical Excellence. Improving Supportive and Palliative Care for Adults with Cancer. 2004

## 850. Junior doctors' self-assessment of skills in paediatric palliative care: undergraduate training and clinical experience is not enough.

Lynda Brook

*Alder Hey Children's Hospital, Paediatric Palliative Care, Liverpool, United Kingdom*

**Aims:** To correlate junior doctors self perceived skills and confidence in paediatric palliative care with clinical experience and previous education and training.

**Methods:** Junior doctors attending paediatric palliative care training were invited to fill in an anonymous self-assessment questionnaire. **Results:** 52 junior doctors completed questionnaires over the 3-year period. Fifty percent had looked after a dying child in the last 6 months but 12 doctors had never looked after a dying child. Respondents with the MRCPCH exam part 1 or 2 (n= 34) reported looking after a dying child a median of 2.5 times a year (range 0 – 7). Of these 14 reported previous palliative care training but only 5 at postgraduate level. Respondents reported their palliative care training moderately useful (median 6.5cm on a linear rating scale) but reported low levels of confidence undertaking key tasks in end of life care including pain and symptom management, discussing resuscitation and breaking bad news (mean 3.4cm, standard deviation 2.8cm). There was no correlation between reported palliative care training, recent care of a dying child or more frequent care of a dying child with perceived skills. **Conclusion:** On average trainee paediatricians are likely to care for a dying child at least twice a year. Undergraduate training and clinical experience alone appear insufficient to ensure that paediatricians have the necessary skills for end of life care and formal training is needed.

## 851. Effect of end-of-life education on medical students' death attitude

Katalin Hegedus, Ágnes Zana, Gábor Szabó

*Semmelweis University, Behavioural Sciences, Budapest, Hungary*

*The aim of our research* was to evaluate the effect of 30 hours' end-of-life course on medical students' death attitude. **Method:** 68 medical students completed the Multidimensional Fear of Death Scale (MFODS) (Neimeyer and Moore, 1994; Zana, 2006) on the first and last day of the courses.

**Results:** The most significant factors of fear of death by the MFODS are: Fear for Significant Others, Fear of the Dying Process and Fear of Premature Death. Overall fear of death scores are reduced as an effect of the courses, the alteration of the components of fear of death depends on the participants' gender and age. The fear of death of women and younger participants (18-21 years) is higher than men's and older participants'. Among 22-30 years old medical students the decrease of factors of Fear for Significant Others (p=.009) and Fear of Conscious Death (p=.055) is important. Decrease of Fear of Conscious Death is significant in women (p<.050). Improvement was observed in attitudes that can be related to the increase of knowledge on the quality care of dying patients like fear from the process of dying and fear from conscious experience of death.

**Conclusion:** In the undergraduate medical education is important to make communication on death more open by exploring critical issues related to fear of death to reduce anxiety and to improve attitude to dying patients.

## 852. Dutch Guidelines for Palliative Care Online Available in English

Jaap Gootjes, Margriet Nolet, Joke Van den Bogert, Alexander De Graeff

*Association of Comprehensive Cancer Centres, Utrecht, Netherlands*

**Introduction** In The Netherlands attention for palliative care is growing. This induced the need to develop national guidelines, which could serve as 'golden standard'. **Method** Several authors (at least 1 physician and 1 nurse) developed 32 guidelines and 38 short versions for a pocketbook. Comments of national expert groups were added and the guidelines were finalized by two editors. The guidelines are based on the available evidence and can be used by physicians, nurses and other professionals. **Results** In 2006, the ACCC published the guidelines in a guideline book, a pocketbook an online via . In 10 months 9,600 guideline books and 25,000 pocket books were sold. Online the guidelines are visited 9000x a month. Because the guidelines are widely used in The Netherlands, the text of the Pocket book has been made available for an international audience via translation in English. Every guideline in the Pocket book has the same set-up: 1. Significance for the patient 2. Causes and risk factors 3. General measures 4. Medication 5. Special circumstances. **Conclusion** The Guidelines and the Pocket book fill a large need in The Netherlands, which

increases the care for terminal ill patients. As of May 2007 the English version of the Pocket book will be available online via and can be used internationally by all professionals in the palliative care.

## 853. A training programme for new specialist nurses in palliative care

Michele Golden<sup>1</sup>, Lallita Carballo<sup>1</sup>, Maggie Bisset<sup>2</sup>, Katherine Hopkins<sup>3</sup>

<sup>1</sup>North London Cancer Network, Nursing, London, United Kingdom

<sup>2</sup>North London Cancer Network, nurse, London, United Kingdom

<sup>3</sup>University College Hospital, Palliative Care Team, London, United Kingdom

<sup>4</sup>Royal Free Hospital, Palliative Care Team, London, United Kingdom

The paper introduces the innovative Training Programme for Specialist Nurses in Palliative Care brings new Clinical Nurse Specialists (CNS) into Palliative Care and develops their advanced skills by means of a work-based curriculum delivered by experienced Specialist Palliative Care Nurses. This pilot examines the feasibility of a rotational training programme to build knowledge and skills of specialist palliative care in differing services, with a view to establish the model across London in the future. The pilot tests out a palliative care work based curriculum for CNSs and commenced in May 2006. Over the two year programme, CNSs will have the opportunity to work in different clinical environments and to have 10 weeks directly supervised clinical experience in a specialist area of choice. Once a month for the duration of the training, the CNSs meet for a day of Problem Based Learning (PBL). These days are facilitated by PBL Leaders who come from palliative care services within the sector. The PBL days emphasise aspects of the work based curriculum covering three main areas: developing expert practice, palliative nursing management of long-term conditions and palliative nursing practice. In each placement the CNS has a Clinical Facilitator who acts as a Critical Companion (Titchen 2000), and although s/he will not manage the CNS, s/he will be responsible for signing off the learning outcomes from the curriculum.

## 854. Education and Communication in Palliative Care in Albania

Albert Leka, Arti Tarja, Marinela Leka, Age Deti

*PCEE-Palliative Care and Education Center, Education Center, Lezha, Albania*

**Aim of the study:**

There is clear evidence that education and training is deficient among doctors, nurses, and social workers working in palliative care in Albania. This study aims to focus on the importance and the crucial role that Education and Communication has in Palliative Care Practice. **Method:** Published reports from the Cochrane Library, books, manuals and magazines related to palliative care have been consulted during the study. We have consulted also the Albanian literature related to palliative care and the literature from the most developed countries where palliative care now is a medical specialty. **Result:** From 160 health professionals we contacted for a 6 months' period in Lezha district, we found out that only doctors, 37.5 % of the individuals contacted, had some information related to palliative care. More than 90 % (146) of the professionals we contacted did not have any information about palliative care provision at home or multi-professional working in palliative care.

**Conclusion of the study:** The study arrived in the conclusion that Palliative Care Education must be part of Continuing Medical Education curricula for health professionals. Lack of good communication between team members, team and family, family and patient and team with the patient will guide to the lack in providing good palliative care.

## 855. Learning in Clinical Practice – An Innovative Palliative Care Open Learning Resource.

Stevens Stevens<sup>1</sup>, Carol Young<sup>2</sup>

<sup>1</sup>Royal College of Nursing, Palliative Nursing forum, London, United Kingdom

<sup>2</sup>Erskine Hospital, Palliative Team, Erskine, United Kingdom

This poster depicts the production and implementation of an innovative open learning resource which is intended to increase participants' knowledge and understanding and skills in palliative care whilst they continue to work in their own clinical area. The resource is aimed at nurses, who work in a non-specialist

palliative care setting e.g. care homes, community and psychiatric units. Learning is undertaken in learning sets i.e. groups of nurses who work in the same clinical area. Learning set members work through the resource in some parts individually and in others as a team. The learning of the set is supervised by a facilitator who meets with them at regular intervals. This allows for the discussion of learning and the implementation of new ideas. Not only does the resource allow participants to examine the essential components of palliative care it provides an in depth discussion of best practice in the management of four symptoms of advanced disease. It also provides information on quality assurance related to palliative care. The poster shows how one pilot site utilised the learning resource to develop a comprehensive palliative care system within their own clinical environment. This ex-servicemen's care home has recently been commended on the standard of palliative care provision following completion of learning and the implementation of new palliative care standards.

## 856. Does systematic evaluation of the care given last week in life improve performance of the caregiver?

Greger Fransson, Bertil Axelsson, Staffan Lundström, Maria Olsson

*Swedish National Registry of Palliative Care, Board of the Registry, Kalmar, Sweden*

**Aim:** To evaluate the use of The Swedish National Registry for Palliative Care as a tool for improvement of end of life care.

**Method:** A subgroup of units which had been members of the registry for 12 months or more and had answered the yearly unit-specific questionnaire concerning routines was studied. Individual questionnaires filled in after the death of a patient at these units were analysed. **Result:** In a question on overall symptom control during last week in life there was an improvement over time. Initially over 50% of the answers were registered as symptoms only being partially controlled. This was reduced over time to 14% in favour of complete or almost complete symptom control. Staff satisfaction of the care given also improved. Looking at units claiming they had written routines on offering follow up talks during bereavement, talks were offered in 95% of the deaths. The corresponding figure in units not having written routines was 40%. Prescription of injectable drugs on demand for nausea was also studied. Seventy percent of the patients in units where written routines were present had this prescription in their charts, compared to 10% of patients in units not having written routines.

**Conclusion:** Participation in the registry and awareness of important questions contributed to improvement of end of life care. Written routines on different topics of care improved the conditions of care delivery. There is a need for validation of the method used by the registry.

## 857. HUNGARIAN-GEORGIAN PARTNERSHIP FOR DEVELOPMENT OF PALLIATIVE CARE IN GEORGIA

Inga Sharikadze<sup>1</sup>, Rema Ghvamichava<sup>2</sup>, Ioseb Abesadze<sup>3</sup>

<sup>1</sup>Cancer Prevention Center, Palliative Care, Tbilisi, Georgia

<sup>2</sup>Cancer Prevention Center, Palliative Care, Tbilisi, Georgia

<sup>3</sup>Cancer Prevention Center, Palliative care and Rehabilitation Medicine, Tbilisi, Georgia

**Objective:** Palliative Care is comparatively new, but rapidly developing sphere in Georgia. Partnership with Hungarian Hospice Foundation and Cancer Prevention Center (CPC) have greatly contributed to realization of theoretical and practical activities in this direction. Recent goal of the collaboration was development of Educational- Training Center for South Caucasian region. **Method:** International workshop "Development of Palliative Care in Caucasian region" has been held in June 7-12, 2005 with participation of Georgian, Armenian, Azerbaijan, Hungarian oncologists and experts of Palliative Care. 2 days theoretical part of the workshop covered the issues: pain management, symptom control, communication and breaking of bad news; PR and fundraising. 3 days were dedicated to site-visits at patients' houses, practical case discussions and round table meetings with policy makers on drug availability issues. **Results:** Cancer Prevention Center Educational – Training Center will serve as the base for collaboration and professional development between Hungarian Hospice Foundation and neighboring countries of South Caucasian region; **Conclusion:** Due to the support by the OSI, partnership of Cancer Prevention Center and Hungarian Hospice Foundation contributed to the development of palliative care in Georgia and starting of new initiatives in South Caucasian Region.

# Poster abstracts

## 858. The conception of the 'Nankya model of palliative care development' in Africa

Julia Downing

*African Palliative Care Association, Kampala, Uganda*

**Aim of Study** An evaluation was undertaken of a HIV/AIDS palliative care education strategy in rural Uganda which aimed to evaluate the impact of the programme and the health models used in developing palliative care. **Method** The evaluation of the training was undertaken from 2004-2006. Based on a case-study design, multiple sources of qualitative data were identified and a grounded theory approach used. **Results** Having identified that change in practice had occurred through the training, it was important to determine what had happened to enable this to take place. Throughout the programme key milestones were identified, along with changes that had occurred. In order to achieve these milestones and make the changes, advocacy was needed for palliative care at different levels, along with working with other stakeholders. Out of this a model for the development of palliative care in the rural African context emerged: the 'Nankya model of palliative care development'. This outlines what needs to happen in order for a service to move from no palliative care provision, to the provision of palliative care. **Conclusion** Palliative care currently receives much attention in Africa and APCA is trying to promote the development of palliative care in different countries. The Nankya model will help guide this work. The model may be generalisable and useful in the development of palliative care services in Africa. Further work needs to be done on validating this model.

## 855. Learning in Clinical Practice - An Innovative Palliative Care Open Learning Resource.

Stevens Stevens<sup>1</sup>, Carol Young<sup>2</sup>

<sup>1</sup>Royal College of Nursing, Palliative Nursing forum, London, United Kingdom

<sup>2</sup>Erskine Hospital, Palliative Team, Erskine, United Kingdom

This poster depicts the production and implementation of an innovative open learning resource which is intended to increase participants' knowledge and understanding and skills in palliative care whilst they continue to work in their own clinical area. The resource is aimed at nurses, who work in a non-specialist palliative care setting e.g. care homes, community and psychiatric units. Learning is undertaken in learning sets i.e. groups of nurses who work in the same clinical area. Learning set members work through the resource in some parts individually and in others as a team. The learning of the set is supervised by a facilitator who meets with them at regular intervals. This allows for the discussion of learning and the implementation of new ideas. Not only does the resource allow participants to examine the essential components of palliative care it provides an in depth discussion of best practice in the management of four symptoms of advanced disease. It also provides information on quality assurance related to palliative care. The poster shows how one pilot site utilised the learning resource to develop a comprehensive palliative care system within their own clinical environment. This ex-servicemen's care home has recently been commended on the standard of palliative care provision following completion of learning and the implementation of new palliative care standards.

## 859. A Guideline for Nurse education in palliative care in the Netherlands

Paul Vogelaar, Arianne Brinkman, Marianne Kamphuis, Wendy Pree de, Els Prikker, Herlin Woldberg

*NVVPZ, Nijmegen, Netherlands*

In October 2005 the Dutch translation of the European Guideline appeared. Subsequently in 2004 the Professional Profile for Nurses working in Palliative Care was developed and the Professional Nursing Educational Act was established. The NVVPZ has attempted to integrate and transform these three pieces into the Dutch situation. The committee has developed a quality criterion for nursing education by describing the competences necessary for the diverse levels of expertise. By using this approach, the NVVPZ wants to give recognition for Palliative Care education for nurses in the Netherlands. In following the European Guideline, there are three course levels differentiated: basic, advanced and specialized. The basic level is for nurses in training and registered nurses. On the secondary level, there is a distinction made between the nurses who regularly come in contact with palliative care and nurses who have specific team and organisational tasks in palliative care. The tertiary level is specifically for nurses who are engaged in policy making and involved in research in palliative care. On the poster, the NVVPZ will present its viewpoint and what it understands of the three described levels. The

application of the European Guideline in the Dutch situation has led to a concrete plan of competences for every professional level and description of the quality criterion for education. The poster will also cover the problems and queries the committee came across during their developments.

## 860. Interagency collaboration. A model of shared learning between Palliative Care and Mental Health Nurses

Philip Larkin<sup>1</sup>, Siobhan Smyth<sup>1</sup>, Clodagh Cooley<sup>1</sup>, Kate Kelly<sup>1</sup>

<sup>1</sup>University College Galway, Nursing & Midwifery Studies, Galway, Ireland

This presentation reports on an education programme using a problem-based learning (PBL) approach designed to explore interagency collaboration with a group of qualified experienced nurses undertaking postgraduate education in palliative care and mental health. Participants (N = 17) undertook a 12 week programme exploring team, collaboration and shared working based on a series of clinical cases studies. The programme was facilitated by PL and SS as Programme Directors for their respective specialist programmes - PL (Palliative Care) and SS (Mental Health). Students were given the opportunity to develop skills in assessment, joint planning and partnership, team roles, giving and receiving feedback presentation and peer and self-assessment.

The programme was evaluated through both written evaluation and focus groups. Students identified shared learning as a very positive experience and could equally identify ways of adapting their learning into clinical practice. Students gained confidence in challenging complex situations.

A problem-based approach to shared learning is particularly suited to adult learners with considerable clinical experience, seeking ways to adapt knowledge to practice. We conclude that shared learning is of particular benefit to palliative care as it enables practitioners to seek new ways of integrating their discipline into established main-stream health care.

## 861. Physicians view on competences and training in palliative care

Birgitt Van Oorschot<sup>1</sup>, Christine Schleussner<sup>2</sup>, Ulrich Wedding<sup>2</sup>, Winfried Meissner<sup>3</sup>

<sup>1</sup>Julius-Maximilians-University, Klinik und Poliklinik für Strahlentherapie, Würzburg, Germany

<sup>2</sup>Friedrich-Schiller-University, Klinik für Hämatologie und Onkologie, Jena, Germany

<sup>3</sup>Friedrich-Schiller-University, Klinik für Anaesthesie und Intensivmedizin, Jena, Germany

Training physicians in fundamental principles of palliative care is essential to improving care of patients with life-threatening illnesses in hospitals. We wanted to know more about hospital physicians' interests in improving their competences in palliative care and about their views on deficiencies in palliative medicine. **Methods:** In November 2005, a self-leading questionnaire (16 items) was sent to all clinical physicians working in the hospital of Friedrich-Schiller University, Jena (n=500). **Results:** 141 questionnaires were sent back (28%), mostly from younger physicians (78% younger than 40 years) and working in non-surgical areas. 48% expressed uncertainty in palliative care. As difficult / very difficult were labelled: psychosocial aspects (57%), lack of time (57%), ethics (49%), organisation and communication (48%), financial aspects (52%) and medical aspects. They desired training in pain-therapy (87%), communication skills (57%), interdisciplinary cooperation (52%) advanced directives (50%), teamwork (48%) and general symptom control (30%). The vast majority of the respondents anticipated the most benefit through bedside-teaching and consulting (91%) or hospitalisation (51%). **Conclusion:** Although the low-yield prevents general statements, great interest in palliative-care training became apparent. The conception of training programmes should take the high interests in bedside teaching and consulting into consideration. The results from a comparative survey in Würzburg (planned for 2/07) will be presented and discussed too.

## 862. Changes in education of palliative care in the Hungarian Oncology

Agnes Ruzsa

*Zala County Hospital, Oncological Dept., Zalaegerszeg, India*

The palliative therapy is necessary for the terminally ill cancer patients. The Hungarian educational books of the clinical oncologists did not have chapter about palliative care before 1990. It was not allowed telling truth to the patients suffering from any kind of cancer, receiving a false final report. Medical oncologists

abandoned breaking bad news not only the dying patients but also they did not tell the diagnosis of cancer for any cancer patients. The drug availability was very poor, only the morphine injection. After the law 1994 the palliative care education and practice changed. The author reviews the development of education of clinical oncologist, the changes in drug availability the telling truth, breaking bad news.

## 863. Changes in Skills, Knowledge and Attitudes of Family Medicine Registrars: Measuring the Impact of a Palliative Care Course

Jose Pereira<sup>1</sup>, Terry Collin<sup>2</sup>, Mone Palacios<sup>2</sup>, Rob Wedel<sup>2</sup>

<sup>1</sup>University of Lausanne, Service de Soins Palliatifs, Lausanne, Switzerland

<sup>2</sup>University of Calgary, Centre for Distance Education in Palliative Care, Calgary, Canada

**Aim:** The goal of this study was to assess whether the knowledge, attitudes and skills of rural family medicine residents (2005) changed as a result of a 4-month long palliative care course that used a combination of classroom (3 days)- and web-based learning (4 mths), but no clinical rotation. **Methods:** Knowledge, attitudes and self-perceived comfort were evaluated by a 16-item MCQ quiz, 12-item survey and 22-item scale respectively, all developed specifically for this study. Three objective standardized clinical examination stations (OSCEs). All the instruments underwent testing and psychometric assessment. Identical quizzes, surveys and OSCEs were conducted pre- and post-course.

**Results:** 16/20 residents participated in both the pre- and post-course evaluations. The internal reliability values of the OSCE score sheets ranged from 0.65 to 0.82. A significant improvement was noted in OSCE 2 (t= 2.9, p=0.01, d effect sizes 1.94 respectively). Although the change in OSCEs 3 was not significant, the effect size was large (d=1.34). (OSCE 1 d=0.21) There were significant improvements in knowledge levels (t= 8.99; p<0.01; effect size d=2.24) as well as in comfort levels (t=4; p<0.01; d=1.64). Attitudes improved but did not reach significant levels; the effect size was acceptable (t=1.82; p=0.09; d=0.65). The internal reliability (Cronbach) of the knowledge, attitudes and comfort scales were 0.29, 0.68 and 0.92 respectively.

**Conclusions:** Significant improvements were demonstrated in knowledge, self-perceived comfort levels and some skills.

## 864. Schooling of children with severe life-limiting illness

Helene Porchet

*University, Education, Lausanne, Switzerland*

**Aim:** Investigate the school follow-up for severely ill children and identify their educational needs + identify the hospital teacher's work, their role and competences **Method** Semi-structured interviews with 11 ill children-their parents-3 teachers who integrated a severely ill child in class-3 hospital teachers'1 regional director of education

**Results** Serious illness affects the child's schooling at different levels: physical (frequent hospitalizations, side-effects therapy) psychological (motivated ++ by school, need to feel accepted by others through keeping contact with them, need for information within the class) practical (adaptations to the school environment) Parents feel unsupported and complain about a lack of communication from the teachers and school management systems. The hospital teacher's job is not well recognized, overlapping the 2 worlds of instruction and care. The hospital teacher should be competent to integrate and balance the needs of children, parents, school programs, usual teacher and current hospital life. **Propositions** Create an individualized integration plan through networking (family - teachers - health and school professionals - hospital teacher). Hospital teachers working with children who face life-limiting disease also need to develop communication networks at a national and European level.

**Conclusion** Enabling a severe ill child to keep up with his schooling, according to Children's rights, is a key element for his quality of life by giving him hope and meaning to his life.

## 865. EMERGING E-LEARNING TECHNOLOGIES IN PALLIATIVE CARE

Jose Pereira<sup>1</sup>, Michael Aherne<sup>2</sup>, Mone Palacios<sup>3</sup>, Ron Spice<sup>3</sup>

<sup>1</sup>University of Lausanne, Service de Soins Palliatifs, Lausanne, Switzerland

<sup>2</sup>Pallium Project Canada, Palliative Care, Edmonton, Canada

<sup>3</sup>University of Calgary, Centre for Distance Education in Palliative Care, Calgary, Canada

**AIM:** Generational transition in the health workforce, convergence of Information and Communications

Technologies (ICTs), increased demands of busy professionals for flexible learning opportunities and demand for palliative care among geographically dispersed, drives e-learning innovation. This report links several e-learning technologies for palliative care capacity-building. **METHOD:** Effective e-learning is practical and sensible about how people learn and work, while considering available institutional and consumer ICTs which are accessible and used. Several models field-tested in palliative care will be highlighted, including a "POTS to PodCast" model for translating large participant-volume telephony-based professional development sessions into MP3/.wav on-demand resources; use of digital video across multiple platforms including classroom-based DVD, web-based streaming media and MP4 for video iPod based on-demand learning/reinforcement. A learning object repository, the Palliative Learning Commons, will be featured as well as an Independent Learning System (ILS) to support individualized, self-directed learning. **RESULT:** E-learning responses are being employed to provide flexible learning and decision support for busy professionals so they may provide better access and quality in palliative care services. **CONCLUSION:** Practical e-learning technologies are important tools transforming when, where and how practitioners learn to develop and maintain palliative care competence.

## 866. The Psychometric Properties of Palliative Care (PC) OSCE Instrument to Measure Changes in Knowledge and Skills

Jose Pereira <sup>1,2</sup>, Terry Collin <sup>1</sup>, Mone Palacios <sup>1</sup>

<sup>1</sup> University of Calgary, Centre for Distance Education in Palliative Care, Calgary, Canada

<sup>2</sup> University of Lausanne, Service de Soins Palliatifs, Lausanne, Switzerland

**Aim:** The goals were to develop 3 long (each 20 min.) objective structured clinical examination stations (OSCEs) and score sheets to assess a variety of PC competencies and establish their psychometric properties. **Methods:** Guidelines for developing OSCEs were followed. Actors/actresses followed scripts and underwent training, as did raters (6 PC consultants). Each OSCE score sheet consists of an itemized checklists and a global scale - "fail", "borderline" or "pass". 20 rural family medicine registrars completed pre and post-course OSCEs as part of a PC course. Surveys and focus groups were conducted post-course. Earlier testing of the OSCEs on a similar group of learners had revealed good inter-rater reliability scores (0.87 to 0.92). **Results:** Face and content validity was acceptable. Internal-reliability values of the score sheets ranged from 0.65 to 0.82 across the 3 stations. The correlations between the total checklist scores and the global scores were significant ( $r=0.47$  to  $r=.77$ ;  $p=0.001$  to  $p=0.07$ ). Inter-item coefficient correlations identified several items that appeared redundant and others that provided evidence for divergent and convergent validity of the scales. **Conclusions:** The 3 palliative care OSCEs possess acceptable psychometric properties and are useful for evaluating skill-related competencies in formative and summative evaluations. They also support experiential learning. Potential limitations are recognized. A generic standardized score sheet for palliative care OSCEs (Pal-OSCE) is proposed.

## 867. Reflective Video Vignettes to Change Attitudes of Primary Health Professionals in Managing Difficult Family Situations in Vaud, Switzerland.

Jose Pereira <sup>1</sup>, Thierry Currat <sup>2</sup>, Marie-Jose Paquier <sup>3</sup>, Francoise Porchet <sup>4</sup>, Anne Vacanti-Robert <sup>2</sup>, Martine Kübler <sup>5</sup>, Yves Kühne <sup>3</sup>, Olivier Frei <sup>6</sup>

<sup>1</sup> University of Lausanne, Service de Soins Palliatifs, Lausanne, Switzerland

<sup>2</sup> CHUV, Service de Soins Palliatifs, Lausanne, Switzerland

<sup>3</sup> Réseau Nord Broye, EMSP, Orbe, Switzerland

<sup>4</sup> CHUV, Centre de Diffusion Soins Palliatifs, Lausanne, Switzerland

<sup>5</sup> Réseau ARCOS, Soins Palliatifs, Lausanne, Switzerland

<sup>6</sup> CHUV, CEMCAF, Lausanne, Switzerland

**Aim:** Evaluating and changing attitudes is elusive. The goals was to develop short video vignettes and evaluate them alongside small group learning in a 3-hour interdisciplinary course aimed at changing attitudes of primary health professionals towards managing difficult family situations. **Method:** Seven video vignettes based on real life experiences involving difficult family situation were developed. Based on reflective learning principles, they weave inept skills amongst exemplary behaviour and integrate communication, ethical and psychosocial issues, and medical problems. A 6-item attitude survey was developed, distributed pre- & post-course and compared using paired sample t-tests. Learners also evaluated the videos. **Results:** 45/55 learners completed the pre- & post-course evaluations (38 nurses & nurse aides, 4 physicians, 3 others). Attitudes changed significantly on 4/6 items ( $p: 0.04$ ,

0.03, 0.01, and 0.03; SD: 0.3, 0.7, 0.1 and 0.8 respectively). Support for the inclusion of patients in family conferences increased, as did the inclusion of families in decision-making and responses to the question "How long does he have to live?" All respondents felt that the videos were realistic and stimulated discussion. Psychometric testing of the instrument was limited by the number of items. **Conclusions:** The course resulted in significant attitude changes amongst participants. The videos appeared to enhance the learning experience. Future research should assess the psychometric properties of the survey and compare the course with and without videos.

## 868. Interprofessional learning and the effect on the collaboration among different professions in palliative care

Urška Lunder <sup>2</sup>, Gasper Podobnik <sup>2</sup>

<sup>1</sup> Palliative Care Development Institute, Oncological Dept., Ljubljana, Slovenia

<sup>2</sup> Palliative Care Development Institute, Oncological Dept., Ljubljana, Slovenia

<sup>3</sup> kh hietzing, 33000, Ljubljana, Slovenia

<sup>4</sup> kh hietzing, 33000, Ljubljana, Slovenia

<sup>5</sup> kh hietzing, 33000, Ljubljana, Slovenia

<sup>6</sup> kh hietzing, 33000, Ljubljana, Slovenia

**Background:** In Slovenia, communication skills in palliative care are traditionally organized as an interprofessional learning. Effects of the workshop on the teamwork were examined.

**Methods:** The questionnaire was developed to evaluate the subjective opinion on team collaboration change after the workshop. Knowing other team members, team conflict management, learning from mistakes, quality of meetings and process of accepting new ideas in team work were explored. 30 participants of two-day workshops answered the questionnaire 2 to 8 months later.

**Results:** The majority of team members became more aware of their colleagues' skills, and became more respectful and appreciative of each other. Knowing other team members better and building a common vision were crucial effects to develop some better collaboration. More open atmosphere in the team meetings and conflict management was possible after the workshop. They found important to know each other in different professions also on the personal level. Those participants who were from the same working department together on the same workshop reported better results on interprofessional relationships.

**Conclusions:** Results are suggesting that interprofessional learning is effective in supporting better team work. It is especially effective when sensitively organized in one working setting. More effort should be given to the interprofessional learning in the undergraduate education.

## 869. The impact of a multi-disciplinary education initiative on the attitudes and behaviours of non-specialist health care professionals delivering palliative care.

Stuart Milligan

Ardgowan Hospice, Education, Greenock, United Kingdom

The aim of this study was to assess the impact of attendance at a two-day, locality-based, multi-disciplinary palliative care course on confidence, team-working and innovative practice amongst primary care professionals. The course was specifically designed, not only to equip participants with palliative care skills, but also to challenge practice by encouraging teamworking and addressing local issues.

The attitudes and behaviours of course participants were assessed by a questionnaire sent to all attenders ( $n=293$ ). Respondents were asked to rate their confidence in five different areas of palliative care practice, and to give examples of how their practice had changed as a result of their attendance. Scale data were analysed using SPSS and free text responses subjected to simple content analysis.

Return rate was 45%. Scale data confirmed that respondents experienced improved levels of confidence in each of the five areas of practice. Respondents also reported improved ability to work with colleagues, and greater preparedness to deliver palliative care locally. Thematic analysis of free text confirmed these findings and provided fascinating examples of real improvements in practice.

The data generated by this study confirm that a carefully targeted education initiative can deliver tangible benefits for non-specialists delivering palliative care in primary care settings. Perhaps more importantly, there is also evidence that these health and social care practitioners changed the way they worked as a result of attending the course.

## 870. "Palliative Care: The Essentials" Evaluation of a multidisciplinary education program.

Karen Quinn, Peter Hudson, Michael Ashby

St Vincent's Health and The University of Melbourne, Centre for Palliative Care, Melbourne, Australia

The WHO promotes a team approach to address needs of palliative care pts & their families. Australian Commonwealth funding was secured to educate clinicians from a range of settings. Aim: To develop, deliver & evaluate a multidisciplinary education program focusing on core elements of palliative care. A 2-day program was developed based on a literature review and input from an expert panel. Evaluation consisted of a pre-post test q/aire for each session and overall program assessment. Participants evaluated changes to perceived levels of knowledge, skill & confidence in eight key areas: 1) recognising the need for palliative care 2) team work, 3) patient & caregiver support 4) communication skills, 5) symptom management, 6) legal & ethical issues, 7) spiritual & cultural concerns and 8) grief & bereavement. The program was delivered 4 times in metropolitan & regional areas to a total of 537 participants incorporating a range of disciplines & care settings. Participants reported statistically significant improvement in each of the eight key areas, with some variability between disciplines. The program was successful in meeting the learning needs as identified by the majority of participants. The findings demonstrate multidisciplinary educational approaches can be effective in the context of palliative care. The high demand to attend the program suggests the need for ongoing education in this area.

## 871. The development of a competency based model for nurses working in specialist palliative care

Penny Hansford, Vicky Robinson

St Christopher's Hospice, Nursing, London, United Kingdom

The challenge of developing a defined rôle and career pathway for specialist palliative care nurses has been met at St Christopher's Hospice through the development of a competency model. Initially for Community Clinical Nurse Specialists, it looked in detail at the components of the rôle, analysing the task, skills and knowledge needed and the evidence required to demonstrate that the skills had developed to complete the task. It also outlined the training needed to fulfil the competency. A measuring tool was developed which involved self and managerial assessment. Despite initial reservations amongst staff, it proved an effective and efficient management tool. The framework has 6 domains 1) Clinical practice and leadership, 2) education and training, 3) grief, loss and bereavement, 4) quality, 5) communication 6) management. The essence of assessing competency is to gather evidence through observing the individual at work, listening to others who have observed, considering products of the work e.g. documentation, listening to claims from the nurse and by questioning the nurse about their effectiveness. The framework has now extended into the inpatient unit. It is linked to the NHS Knowledge Skills Framework, meaning that it is transferable to other health care settings. The framework defines Agenda for Change bands 2-8A - each nurse now knows what is expected of them at their grade and is aware of what to expect of their colleagues

## 872. A distance learning course in palliative medicine for General Practitioners

Jason Ward

Mid Yorkshire NHS Trust, Department of Palliative Medicine, Dewsbury, United Kingdom

Studies have shown that General Practitioners (GPs) have limited access to palliative care education and often lack the necessary knowledge and skills to care for palliative care patients (Barclay S 1997, Macleod 1991, Oliver 1998).

**Aim/Method**

To describe the development of a six-month education programme for GPs.

**Results**

The CRISIS criteria for effective continuing education were used to develop the course; convenience, relevance, individualisation, self-assessment, interest, speculation/systemic (Harden & Laidlaw 1992). Course comprises of;

1. Independent study modules with clear aims, objectives and competencies, including journal articles and case studies to be completed each month. 7 different topics addressed; principles of palliative care, pain, GI symptoms, end-of-life care, respiratory symptoms, palliative care emergencies, and communication.
2. Monthly attendance at a half day 'consultant teaching clinic' based on SNAPPS model of learner-centred

## Poster abstracts

outpatient education (Wolpaw et al 2003). GPs assess patients with different palliative care problems, and develop initial treatment plans. Financial assistant towards locum cover is provided.

Evaluation using a combination of qualitative and quantitative methods is being undertaken.

### Conclusions

The course development and early evaluation including course materials will be presented.

### 873. LEARNING TO CARE; RESULTS OF A LONGITUDINAL STUDY EXAMINING THE EFFECTS OF AN EDUCATION PROGRAMME FOR MEDICAL UNDERGRADUATES

Stephen Mason, John Ellershaw

Marie Curie Palliative Care Institute Liverpool, Liverpool, United Kingdom

**Background.** Although the context of palliative care presents challenges for educators, research examining a new PBL curriculum at the University of Liverpool has demonstrated positive changes in attitudes and perceived efficacy in practice. Whether this is maintained over time is unknown.

**Method.** Between 2000-02, a pre(t1) – post(t2) survey of medical undergraduates (N=313) participating in a palliative care education programme was completed using: i) Self-Efficacy in Palliative Care scale (SEPC) ii) Thanatophobia Scale. In 2005, a convenience sample of this cohort was surveyed at the end of their first year of independent clinical practice as a qualified House Officer(t3). Additionally, control data from House Officers that had not studied under the new curricula (n=89) were recorded.

**Results.** Although a small decrease in mean scores were recorded between t2-t3, data indicates statistically and educationally significant long lasting improvement in the SEPC subscales (e.g. Communication  $t_{1-3} = -7.762$ ,  $p < 0.001$ ) and Thanatophobia ( $z_{1-3} = -2.11$ ,  $p < 0.001$ ). Further, comparison between the control and experimental group identified significant discrepancies between the preparedness of each group to meet the needs of palliative care patients.

**Discussion.** Although caring for the dying patient presents many challenges, results indicate that the new curriculum engenders deep, long lived learning that will translate into improved patient care.

### 874. Palliative Care education for nurses in Romania

Cristina Ghiran

Hospice, BRASOV, Romania

The standardization induced by the communist regime was readily seen in nursing education, with one single level of education available for all nurses. After the revolution in 1989, the whole system was re-developed and new further educational institutions appeared. Not long after this, in an effort to improve nurses' education, the College of nursing was opened, followed by nursing at a university level. During this time different projects aimed to offer nurses the possibility to specialize in a particular area. Hospice "Casa Sperantei" worked to design the curricula and to implement the program for competency in Palliative Care. Unfortunately, due to political instability, this process was ended prematurely. A very good asset in terms of a higher quality of nursing care was the continuing nursing education which involves accumulating a mandatory number of credits of continuing education. In this context the nurse lecturers from Hospice "Casa Sperantei" run accredited courses all over Romania for nurses. These bring not only specific knowledge and attitudes to the nurses but using techniques such as role play, demonstration, small groups, fish-bowl, we manage to facilitate critical thinking and initiatives in their role which is often seen primarily as delegate. The way forward is to develop curricula for university level courses, competency in Palliative Care and continuing education for nurses.

### 875. Learner Centred Communication Skills Training for Undergraduate Medical Students; Cross Cultural Comparisons.

Stephen Mason<sup>1</sup>, Chitra Venkateswaran<sup>2</sup>, Manoj Kumar<sup>3</sup>, John Ellershaw<sup>1</sup>

<sup>1</sup> Marie Curie Palliative Care Institute Liverpool, Liverpool, United Kingdom

<sup>2</sup> St. Gemma's Hospice, Leeds, United Kingdom

<sup>3</sup> St. James University Hospital, Liaison Psychiatry, Leeds, United Kingdom

<sup>4</sup> Marie Curie Palliative Care Institute Liverpool, Liverpool, United Kingdom

**Aim:** To examine and contrast the effects of learner centred communication skills training in palliative care for undergraduate medical students in England and India.

**Method:** A experiential learner centred communications skills training programme, based on existing validated models, was developed and delivered to 4<sup>th</sup> year medical students at the University of Liverpool, England (n=317). A similar programme was delivered at the Medical College, University of Calicut (n=105). Students were surveyed pre and post intervention with the Communication sub-scale of the Self-Efficacy in Palliative Care scale (SEPC-c). Qualitative data from course evaluations were recorded.

**Results:** Statistically and educationally significant improvements in the SEPC-c score were recorded within both groups ( $t_{1-2} = -35.35$ ,  $p = 0.001$ ;  $t_{2-3} = -12.06$ ,  $p = 0.001$ ). Although a statistically significant different pre-test SEPC-c score was recorded between groups ( $t = -2.42$ ,  $p = 0.017$ ), no difference was recorded post-test ( $t = 0.42$ ,  $p = 0.67$ ).

**Discussion:** Despite distinct cultural settings, concerns regarding difficulties in communicating with patients are shared by both groups. However, results indicate that learner centred experiential training elevates confidences to a comparable level across both groups. Considered in line with results from parallel research and the theoretical driver underpinning the SEPC-c, such improvements are likely to translate into improved clinical practice and be maintained over time.

### 876. A one-day education in soft tissue massage; the experiences and attitudes of palliative care nurses.

Berit Cronfalk<sup>1,2,3</sup>, Peter Strang<sup>1,2</sup>, Anna Milberg<sup>4,5</sup>, Maria Friedrichsen<sup>2,4,6</sup>

<sup>1</sup> Karolinska Institutet, Department of Oncology-Pathology, Stockholm, Sweden

<sup>2</sup> Stockholm's Sjukhem Foundation, Research and Development Unit, Stockholm, Sweden

<sup>3</sup> Vardal Institute, Swedish Institution for Health Sciences, Lund, Sweden

<sup>4</sup> Linköping University, Dept of Social and Welfare Studies, Linköping, Sweden

<sup>5</sup> Linköping university hospital, Advanced Palliative Home care, Linköping, Sweden

<sup>6</sup> Vrinnevisjukhuset, LAH, Linnea-enhet, Norrköping, Sweden

**Background.** According to Cochrane Library soft tissue massage is gaining interest among patients with cancer and dementia. **The aim** of this study was to evaluate a pedagogical one-day teaching concept (theory and practice), as regards to perceived knowledge and usefulness in palliative cancer care. **Methods.** 135 nurses took part in groups of 15-20 participants, with individual training opportunities. One month later focus group interviews were performed with a total of 30 participants. The interviews were tape-recorded, transcribed verbatim and analysed using qualitative content analysis. **Results.** The analysis revealed five themes; positive aspect, negative aspects, attitudes, hindrances and opportunities. Theory was essential for understanding, but training and hands-on manual as well as the teacher as a role model were emphasised even more. Own experiences and attitudes influenced the outcome. In general touch was regarded as a natural part of nursing care, however the interviews did reveal bodily taboos. Too few training opportunities, lack of time, worries about technical issues and certain conditions were important hindrances for practising the gained knowledge. **Discussion.** The pedagogical concept seems sufficient as an introduction for most nurses, however, for some more training would be necessary before practising in the every day care.

### 877. Evaluation of knowledge and attitudes of medical students with regard to palliative medicine, symptom control and euthanasia in a German university

Katri Elina Clemens, Eva Klein, Birgit Jaspers, Ines Quednau, Eberhard Klaschik

Rhenische Friedrich-Wilhelms-University of Bonn, Department of Science and Research, Centre for Palliative Medicine, Bonn, Germany

**Aim:** Palliative medicine (PM) education for medical students in Germany has been an increasing focus of attention in recent years. However, little is known about effectiveness and acceptance of palliative care education in German medical schools. The aims of this study were to assess knowledge in basic principles of PM, symptom control and attitudes towards euthanasia in students with and without PM education. **Methods:** 441 3<sup>rd</sup>, 5<sup>th</sup> and 6<sup>th</sup> year medical students were surveyed in 08-11/2006 using an anonymised e-mail questionnaire. Of 33 questions, 23 covered knowledge in PM and symptom control, 10 attitudes towards euthanasia. Statistic: mean±SD (range), ANOVA, significance  $p < 0.05$ . **Results:** Of the 123 (28.0%) responding students 33 (26.8%) were male. Mean age was 25.6±2.5 (22-34) y. On average 47.4±15.1 (7-73) of a maximum of 90 points were given. Significant increase of results from 28.5±14.1 (7-63) points in 3<sup>rd</sup> year students (without

PM education) to 48.3±11.1 (18-73) ( $p = 0.001$ ) in 5<sup>th</sup> and to 53.6±13.0 (17-73) ( $p = 0.006$ ) / ( $p < 0.001$ ) points in 6<sup>th</sup> year students. 74.0% of all think that legalisation of euthanasia would promote misuse but 21.0% approved the legalisation of euthanasia. 49.6 % think PM tuition is still underrepresented. 44.7% are in favour of an obligatory practical training in PM.

**Conclusions:** Tuition in PM resulted in a significantly high increase in students' knowledge. Research in reasons for alarmingly high rate of approval of euthanasia is urgently needed.

### 878. Teaching and learning about death and dying

Karen Forbes

University of Bristol, Palliative Medicine, Bristol, United Kingdom

The literature on teaching and learning about death and dying has tended to focus on descriptions of teaching programmes available in various institutions, with evaluation of these programmes focusing largely on the more 'mechanistic' aspects of care (which are most easily measured) and on student satisfaction. More recent studies have explored medical students' lived experiences of learning about death and dying. Many of these studies originate in the USA.

In this study I have explored fifth year UK medical students' experiences of being on hospital wards and learning about death and dying using narrative methodology. Twelve final year students at the University of Bristol medical school were selected randomly and invited to participate. Eleven students were interviewed using a narrative approach. Ten evaluable interviews were transcribed and analysed and student narratives encompassing major themes preoccupying students were extracted/constructed.

Students' narratives emphasised the importance of the hidden curriculum in enabling or hindering them in maintaining involvement with dying patients, the importance of sensitising students to palliative care situations and of the need for a meaningful role for the developing professional, in order to enable students to access learning about death and dying. Possible solutions to the issues raised will be discussed.

### 879. A new model for psychological assessment and support at level 1.

Michael Connolly<sup>1</sup>, Maria Noblet<sup>2</sup>, Lesley Thomson<sup>2</sup>, Julie Orford<sup>2</sup>, Yvonne McKenna<sup>1</sup>, John Perryman<sup>3</sup>, Claire Haskins<sup>1</sup>

<sup>1</sup> University Hospitals of South manchester NHS Foundation trust, Supportive and Palliative Care, Manchester, United Kingdom

<sup>2</sup> University Hospitals of South manchester NHS Foundation trust, Breast Care Unit, Manchester, United Kingdom

<sup>3</sup> University Hospitals of South manchester NHS Foundation trust, Chaplaincy, Manchester, United Kingdom

The National Institute for Clinical Excellence in England and Wales (2004) challenged cancer services to improve the psychological assessment and support. A four-level model was proposed with level 1 being relevant to all health and social care professionals. A working group of cancer and palliative care specialists, a chaplain and a cancer patient within this hospital have developed a simple, patient focussed structure as a guide for all staff.

The working group was established to identify the training needs of staff at level 2 (Health and social care professionals with additional expertise). However, it became clear that there was scarce provision for cancer patients at levels 3 and 4 (trained accredited professionals such as clinical psychologists and mental health specialists) and no training at level 1. The group consequently focussed on the training of staff at level 1.

Through role play, examination of the research evidence and involvement with a patient, a three-hour training package around a structure we have called SAGE & THYME was developed. The training package has been piloted twice with a mixture of 60 health and social care staff. Comparison of pre and post course skills and confidence rating are highly encouraging. The team has applied for a research grant to evaluate its effectiveness. The process of model development and the model itself will be described.

### 880. PALLIATIVE CARE IN NURSING EDUCATION: THE EDUCATIONAL NEEDS OF THE NURSING FACULTIES STUDENTS OF THE REGIONE LAZIO

Chiara Mastroianni, Michela Iucci, Laura Carbonara, Ilona Hendrichova, Raffaella Dobrina

Antea palliative care unit, Palliative care unit, Rome, Italy

Palliative Medicine is involving an increasing number health professionals, giving the nurses a prominent role on the basis of their expertise in care needs management. The observation of the existing education

opportunities in the Italian universities and the daily clinical practice rise the necessity to define guidelines for the design of specific education modules. The study aims to analyze the education offered by the universities of Rome compared with the educational needs perceived by the students. The analysis has been conducted through:

1. definition of which and how many nursing faculties insert the palliative care teaching in the undergraduate education programs;
2. analysis of the of the student's educational needs.

## TOOLS AND METHODS

Provision of two questionnaires: one for the Nursing Faculties Branches Coordinators (40) and one for the students (850). Data emerged can be considered as a basis on which undergraduate palliative care teachings can be designed; the palliative care teaching based on theory must be integrated with practical training based on specific objectives and skilled clinical tutoring. An undergraduate teaching providing the students with the basis of palliative care philosophy and with an understanding of the patient's needs will allow the students to become "careful carers", able to recognize and answer the needs of a patient that is living the last days of his life.

## 881. Use of non-medical tutors in palliative care teaching for medical students: Results of a prospective evaluation

Maria Wasner, Traugott Roser, Bernadette Fittkau-Tönnemann, Gian Borasio

*Interdisciplinary Center for Palliative Medicine, Munich University Hospital, Munich, Germany*

Background Palliative medicine was introduced as a mandatory subject for all medical students at the University of Munich in 2004. The course consists of 3 modules: patient-physician communication (3rd semester), psychosocial aspects, spirituality and bereavement (6th semester), and symptom control (9th semester). The tutors of module 2 (consisting of 3 units of 90 min each, group size 15 students) are non-medical members of the palliative care team (psychologists, social workers, chaplains, nurse). Participants and methods Student evaluation forms were filled out before and after the 2nd module, and again after 3 semesters. They included a self-assessment of the students' general competency in palliative medicine, and of their knowledge, skills and attitude regarding psychosocial aspects, spirituality and bereavement. Results 804 pre/post-course questionnaires were evaluated, and 314 after 3 semesters. The pre/post-course data show a significant improvement in self-perceived knowledge, skills and attitude for all 3 topics ( $p < .001$ ). 3 semesters later, skills and attitudes were still significantly increased while knowledge was not. 92% of the students consider palliative medicine as important, 86% judge the course positively, and 97% experience the tutors as competent. Conclusion The course and the non-medical tutors are well accepted by the students. A significant increase in self-perceived competency was detected and persisted in skills and attitude over a period of 18 months.

## 882. Strategic Planning for Palliative Care Education in Ireland

Virginia Dunn<sup>1</sup>, Pat Quinlan<sup>2</sup>, Eugene Murray<sup>3</sup>, David Clark<sup>4</sup>

<sup>1</sup> Irish Hospice Foundation, Dublin, Ireland

<sup>2</sup> Irish Association for Palliative Care, Dublin, Ireland

<sup>3</sup> Irish Hospice Foundation, Dublin, Ireland

<sup>4</sup> Lancaster University, Institute for Health Research, Lancaster, Ireland

## Background

In Ireland, palliative care was recognised as a medical specialty in 1995, and the report of the National Advisory Committee for Palliative Care (NACPC) was endorsed as government policy in 2001. The NACPC report identified the requirements for the comprehensive provision of palliative care and the human resources needed to meet those requirements. Consequently, development of education programmes in palliative care has become a priority.

## Strategic Aims

A consortium of Irish palliative care organisations planned and convened an invitational "round table" of 43 stakeholders invested in palliative care education. These stakeholders included policy makers, education providers (both specialist and generalist), service providers representing various settings and users of services. The aims were to: 1) explore current provision; and 2) begin to identify strategic directions.

## Actions

focused on 3 areas:

1. Strategic Planning for ongoing development
2. Education Deficits in 5 levels of palliative care delivery
3. Education Delivery Outcomes to Date

1. A report of the findings & recommendations from

the Round Table has been submitted to the Department of Health and Children.

2. An interim Strategic group was convened to explore the implications of the recommendations.
3. The development of an Irish Institute of Palliative Care was endorsed and emerging discussions supported.

## 883. Online Discussion Forum during a Blended Learning Course on Palliative Care in Portugal

Isabel Galriça Neto, Vivelinda Guerreiro, António Barbosa

*Faculty of Medicine of Lisbon, Palliative Care/Bioethics Centre, Lisbon, Portugal*

We report findings of a very innovative educational programme developed by the Palliative Care Unit of Faculty of Medicine of Lisbon, based on the use of new online technologies. The programme was a blended multidisciplinary e-learning course, with 120 hours of online training and 21 hours of face-to-face training. In each of the twelve weekly available modules, built according to the Recommendations provided by the EAPC for this area, we discussed a clinical scenario and there was a discussion forum with clinical supervision by a PC Specialist doctor (one of the authors). We analyse quantitative and qualitative issues of the discussions online and the nature of interactions between students and the facilitator, with special attention on the self reflection topics, on the connection between the cognitive content of the course, the references of the literature and the contents of the reflections. We also emphasise the role of the facilitator, when setting the learning objectives, promoting the discussion, praising the students for their reflections and contributions, clarifying some misconceptions and summarizing the main teaching points. This is a very innovative and flexible teaching tool, student centred and adapted which permits a practical approach, suitable to the students' needs and experiences.

## 884. Medical students' needs for training in communication with patients at the end of life

Van Romotzky<sup>1</sup>, Bernd Sonntag<sup>2</sup>, Christian Albus<sup>2</sup>, Christoph Ostgathe<sup>1</sup>, Raymond Voltz<sup>1</sup>

<sup>1</sup> University Hospital of Cologne, Palliative Care, Cologne, Germany

<sup>2</sup> University Hospital of Cologne, Psychosomatic Medicine, Cologne, Germany

**Aim of project:** The aim of this project is to improve communication education for medical students in the context of palliative care (PC). In view of this students' wishes and needs were assessed and analysed before start of a training course with standardised simulated patients. **Method:** A semi-standardised questionnaire explored students' views on their communication skills (CS) and how well-prepared they feel to communicate end-of-life issues. Data was analysed on a descriptive basis. **Result:** 16 medical students in 3 to 4<sup>th</sup> year of education (4 male, 12 female, age: 22-31) participate in the course and answered the pre-course questionnaire. Of these 75% don't feel well-prepared through their studies, 81% think that courses for communication in PC should be part of the curriculum as required course. Only 19% feel able to disclose a terminal illness to the patient, 13 % feel able disclosing it to a family member. 38% feel overloaded by anticipating a conversation with a critically or terminally ill patient. **Conclusion:** The presented data confirms that students feel unsure communicating with critically and terminal ill patients. This shows the urgent need for better communication training of medical students in end of life issues. As bedside teaching in PC is not achievable for all students, training with standardised simulated patients can be a way to have an authentic situation. In the next step the implemented course will be evaluated with mixed methods approach.

## 885. The Impact of Formal Palliative Care Education on African Practitioners

Gillian Chowns

*University of Southampton, Social Work Department, Southampton UK, United Kingdom*

## Aims

The need for palliative care is arguably at its greatest in Africa, where late patient presentation, limited resources, and the AIDS pandemic combine to produce huge populations of seriously ill individuals requiring palliative care - and few trained staff to deliver it. Education is therefore a key issue, and this study investigates the provision of formal palliative care education and its impact on day to day practice, in six African countries.

## Method

Field visits were conducted in ten locations in six

countries of East and Southern Africa -Tanzania, Malawi, Botswana, Zimbabwe, Uganda and Kenya. These embraced hospices, hospital and community palliative care teams and included three examples of countries approaching integration and three with localized provision ( IOELC four-part typology). In-depth qualitative interviews were conducted with policy makers, practitioners, patients and families; clinics, home visits, staff meetings and teaching sessions were observed.

## Results

This study will conclude in March 2007; results will be available for the conference.

## Summary

Recognition of the importance of, and need for, formal palliative care education is welcome. However, the appropriateness of Western models for diverse African contexts is debatable. In resource-poor settings, where sustainability is a critical issue, education must take account of the politics, policies and poverty that provide the context for palliative care.

## 886. Integration of Palliative Care into medical oncology A three years experience of realizing the ESMO concept

Kloke Kloke

*Kliniken Essen-Mitte, Zentrum für Palliativmedizin, essen, Germany*

The portion of patients with severe physical, psychosocial and spirituell problems requiring integrated palliative care increased dramatically within an oncological department. Therefore, the European Society for Medical Oncology (ESMO) endorsed the Designated Centers of Integrated Oncology and Palliative Care Accreditation program in 2003, by designing a set of 13 criteria. The Departement for Medical Oncology of the Kliniken- Essen-Mitte has been certified three years ago. **Aims and methods:** 1<sup>st</sup>: Analysing how these 13 criteria has been realized within our departement with regard to the chronological course and to the difficulties during the process. 2<sup>nd</sup>: Developing a method how to evaluate the efficacy of this program. **Thesis:** the programmatic integration of palliative medicine into medical oncology improves overall treatment quality (especially pain and symptom control) for the cancer patients who cannot be cured. does not supersede the necessity of a specialized palliative care unit for a substantial number of patients has socioeconomic advantages. **Conclusions:** Preliminary results accentuate the need of integrating palliative medicine into medical oncology. This should be realized on a programmatic level. Nevertheless, the 13 criteria of the Designated Center Program should be more specified.

## 887. The importance of a professional and experienced volunteer and coordinator.

Paula Matla, Hans Bart

*Volunteers Palliative Terminal Care (VPTZ), National Centre, Bunnik, Netherlands*

## Aim of project

Since the '80 the Dutch association VPTZ has its specific position next to healthcare professionals. In 2005 6200 patients and their relatives are supported by VPTZ volunteers. Well trained volunteers and coordinators have the expertise to help patients and their relatives to feel that their life is meaning full. VPTZ consists of 210 local organizations with 6700 volunteers and 400 coordinators. 140 organizations offer care at home, 70 organizations offer hospice care. The surplus value of well-trained volunteers is their interest in the lives of the patients and in helping them to live their lives till the moment they die. Coordinators monitor the continuity and quality of the voluntary care; they support and train volunteers and keep in touch with the professional health care.

## Method

The quality of the work of VPTZ stands or falls with a high-quality training programme. The NC offers an extensive training program on a yearly base for more than 1200 volunteers, coordinators and members of the board of the VPTZ organizations. Training offers them the possibility to bring their expertise on a higher level and to keep it up.

## Conclusion

Well trained, professional and volunteers and coordinators have the expertise to help patients and their relatives to feel that their life is meaningful. The relatives and informal caregivers are satisfied (30%) to very satisfied (68%) about the support of the volunteers. They give volunteers an average score of 8,7 on a 10 pointscale.

# Poster abstracts

## 888. Experience of Blending Learning Course on Palliative Care In Portugal

Vivélinda Guerreiro, Isabel Galriça Neto, António Barbosa

*Faculty of Medicine of Lisbon, Palliative Care/Bioethics Centre, Lisbon, Portugal*

We describe and discuss the aim, contents, learning organization and assessment of first blended learning course on palliative care developed in Portugal. The general aim is to fulfil one of the priorities of the National Palliative Care Programme(2004), mainly developing basic level training to health care professionals. The programme was constructed based on a concept of team work building running from the discussion of a case to conceptual and clinical approach. The participants were selected by the regional health authorities with the goal of creating multidisciplinary teams in the community centres and support teams in hospitals. The structure of the blended learning programme provide 120 h of online training and 21 h of face-to-face training. The contents were constructed in 12 modules, according to the EAPC Recommendations for this area. Each module became weekly available. There was stimulated a discussion forum with clinical supervision. We covered 3 main regions of the country and next year we aim to cover all the country. The outcomes were particularly positive. There was no drop out and all participants had been approved with normal distribution marks. The evaluation by the students was particularly satisfactory, mainly in what concerns accessibility, flexibility, quality and usefulness of the contents. We stress the pertinence and relevance of this learning method and show some of the results on the impact of this kind of actions on the creation of local resources to support terminal patients and their families.

## 889. Effectiveness of two different training methodologies in post-graduated learning on palliative care

António Barbosa, Isabel Galriça Neto, Vivélinda Guerreiro

*Faculty of Medicine of Lisbon, Palliative Care/Bioethics Centre, Lisbon, Portugal*

We compare the effectiveness of two courses on palliative care in the Faculty of Medicine of Lisbon: a master course (12 months) and a post-graduate course using the blended learning methodology (3 months). Both courses have a set of similar contents organized with the same structure but with different teaching methodologies. A sample of 62 participants from two palliative of care course: a master course (n=29, 27,6% male, mean age 35,5 y, 37,9% doctors and 51,2% nurses) and 33 from a blended learning post-graduate course (n=33, 18,2% male, mean age 42,4 y, 36,4% doctors and 48,5% nurses). We assess both groups by: expectancy questionnaire, pre and pos multiple choice test and students evaluation of the course questionnaire. We found significant statistical differences between the total scores of pre and pos multiple choice test: master course (t=9,07; p<0.0001), blended learning course (t=11,81; p<0.0001). There was no significant statistical differences between initial scores of multiple choice test of the two groups as well as final scores. Blended learning group found their course very flexible, easy to follow and very useful for their clinical practice. Blended learning methodology showed the same effectiveness of the master course in the comparable cognitive domains and it is suitable and easy methodology to train large number of teams.

## 890. "Bringing students forward to palliative care" - implementation of an integrated palliative care curriculum

Christian Schulz, Anika Mitzkat, Martin Schnell

*Witten/Herdecke University, Integrated Curricula, Witten, Germany*

Modern health care increasingly calls on physicians to provide for high-quality palliative medical care along with the traditional curative medical approach. However, undergraduate palliative care education programs are still underrepresented and widely scientifically unexplored in Germany. A young team of researchers at Witten/Herdecke University, Germany, has started a model project implementing an undergraduate palliative care curriculum into the existing medical program. The curriculum is intended to lead students to a professional attitude towards the care of terminally-ill patients and their relatives by teaching knowledge, skills and attitudes in the categories "Patient", "Communication", "Interdisciplinarity" and "System". The development of the program was facilitated by an extensive international literature review and is mainly based on feedback-oriented and interactive didactic methods. Along with the

implementation of the curriculum we evaluated the effect of our curriculum towards the preparedness of students to care for terminally-ill patients by self-assessment questionnaires in a pre-, post- pre-post-design. The assessment-instrument was validated by pre-testing and a multi-professional Delphi-process. The longitudinal quasi-experimental study also assessed acceptance and practicability of each part of the curriculum. This poster describes the components of this integrated Palliative Care curriculum and presents first results of the evaluation study.

## 891. Developing and piloting a comprehensive training curricula on Palliative Care in HIV/AIDS for multidisciplinary teams - a way to improve provision of services to PWHA

Elena Vovc<sup>1</sup>, Inna Jurkevich<sup>2</sup>, Arsen Kubataev<sup>3</sup>, Vasily Shakhgildyan<sup>4</sup>

<sup>1</sup> American International Health Alliance (AIHA), Regional office, Russian Federation, Moscow, Russian Federation

<sup>2</sup> American International Health Alliance (AIHA), Head Office, Washington, D.C., United States

<sup>3</sup> American International Health Alliance (AIHA), Regional office, Russian Federation, Moscow, Russian Federation

<sup>4</sup> Federal AIDS Center of Russian Federation, Clinical and epidemiology department, Moscow, Russian Federation

Recent efforts of AIHA in developing effective interventions to strengthen the care and treatment in PLWHA in Russia focused on piloting comprehensive training curricula on palliative care for multidisciplinary teams. AIHA have actively collaborated with the Federal AIDS Center of Russian Federation, the US partners, OSI and GFATM and faith based NGO in Russia. Several trainings were piloted in 2006 (a clinical training for MDs, nurses, social workers and mental health specialists, training for stakeholders, a workshop for faith based organizations). Reliable evaluation tools were used to assess the level of knowledge and level of confidence in applying palliative care concepts into practice. There was found a ~25% increase in knowledge level of professionals and significant increase of levels of confidence in applying basic approaches of palliative care into practice. AIHA also implements mentoring activities for health providers involving the international expertise in the partnership project sites. Experts shadow multidisciplinary teams to monitor clinical skills and counseling methods applied. A continuous professional development together with monitoring of quality of services is one of effective strategies to improve provision of services to PLWHA in the era of HAART. AIHA works with federal level stakeholders in Russia and international organizations on replicating successful experience.

## 892. The development and implementation of a comprehensive assessment strategy for specialist training in Palliative Medicine in the United Kingdom

Fiona Hicks<sup>1</sup>, Meyer Meyer<sup>2</sup>, Michael Minton<sup>3</sup>

<sup>1</sup> St James University Hospital, Palliative Medicine, Leeds, United Kingdom

<sup>2</sup> St Helier Hospital, Palliative Medicine, Carshalton, United Kingdom

<sup>3</sup> Sir Michael Sobell House, Palliative Medicine, Oxford, United Kingdom

Medical training in the UK is undergoing substantial change. A competency-based curriculum was introduced in 2002 by the Royal College of Physicians for all the sub-specialties of medicine. This covers the 4 years of higher specialist training. In 2006, it was expanded and is now explicit about the competencies to be acquired before higher specialist training, the model of learning, learning experiences to be provided, supervision and feedback, curriculum implementation, and curriculum review. Underpinning the new curriculum is a comprehensive assessment strategy using a variety of methods to sample across the curriculum areas. These assessment methods have been devised to test trainees' knowledge, skills and behaviours in clinical practice and include the following: Clinical Evaluation Exercise (Mini CEX), assessing clinical skills; Directly Observed Procedural Skills (DOPS); Multi-Source Feedback, assessing team-working and communication skills; Record of Reflective Practice, encouraging personal reflection on clinical experiences and other scenarios; Case-Based Discussion, presentation of clinical findings and development of a management plan. The assessment strategy aims to triangulate the use of different methods to assess broadly across the whole curriculum in a way that is practical and consistent with the parallel delivery of a clinical service. Details and examples from the new training programme, curriculum and assessments will be presented.

## 893. The Implementation of a Supervisory Alliance for Healthcare Assistants Working in Community Palliative Care

Isabella Quinn

*Sir GB Hunter Memorial Hospital, Chest Clinic/North Tyneside Palliative Care Team, Wallsend, United Kingdom*

**Aim of research:** To explore whether reflective practice is a relevant means of enhancing the knowledge of healthcare assistants working in palliative care settings. Whilst there is evidence to demonstrate that activities such as reflective practice and clinical supervision are beneficial in enhancing the education and practice of qualified nurses, there is a deficit of literature about the benefits to healthcare assistants. This action research project entailed setting up a supervisory alliance for these individuals as a pilot study and the ongoing evaluation of the project over a period of 6 months.. Following the implementation of this initiative, data was collected using reflective journals and focus groups.

### Key findings:

- Participants felt that reflective practice was a valuable learning experience
- The healthcare assistants demonstrated awareness of how previous experience contributed to the learning process.
- The levels of reflection demonstrated by participants were measured using Mezirow's 7 levels of reflection and were comparable to other studies with qualified nursing staff.

**Conclusion:** Within the context of palliative care, reflective practice has been demonstrated as a valuable mechanism to allow healthcare assistants generate a broader understanding of many complex situations and the associated education needs.

## 894. Children facing parental death: using case study methods for service evaluation

Catriona Kennedy<sup>1</sup>, Rosemary McIntyre<sup>1</sup>

<sup>1</sup> Napier University, School of nursing, Midwifery and Social Care, Edinburgh, United Kingdom

<sup>2</sup> Napier University, School of nursing, Midwifery and Social Care, Edinburgh, United Kingdom

This presentation is based on two linked papers both reporting aspects of an evaluation of a new Children and Family Support Service in Palliative Care. Macmillan Cancer Support funded the new support service, and its evaluation. The other paper (McIntyre and Kennedy), will report findings from the evaluation using a thematic framework. This paper will consider aspects of qualitative evaluation design using case study methods in palliative care service evaluation. A précis of the study will be followed by discussion of the challenges inherent in conducting research with vulnerable children and families. The balance between philosophical purity and pragmatism and the need for utility of findings in applied research will then be considered. The conceptual framework used to analyse, interpret and report case study data will be described. The efficacy of the framework to capture the voices of the children, families and key stakeholders will be evaluated. Conclusions will be offered about the appropriateness of the methods, challenges encountered and how issues of quality and rigour were managed. The robustness of the findings to support recommendations for the continuation, development and transferability of this service will be considered.

Reference: McIntyre R Kennedy C 'Supporting children and families facing parental death: case study presentation' Abstract submitted to EAPC 2007

## 895. Older peoples' experiences of living with cancer: systematic review and meta-synthesis of qualitative studies

Nic Hughes

*Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom*

**Background** 'Systematic review' is increasingly used as a tool for synthesising results of research studies. 'Meta-synthesis' is an approach to qualitative literature which uses a process of systematic review to create new knowledge. Three stages are involved: systematic search for studies; systematic review of reports; meta-synthesis of findings. This paper reports on stage one, focusing on differences between electronic and hand searches. **Aim** To produce a meta-synthesis, as part of a doctoral study, which will yield insights about older peoples' experiences of living with cancer. **Method** Subject and key word searches of 6 electronic databases were conducted using qualitative filters. Hand searches of 15 relevant journals were also carried out. Reference lists were followed up and the final sample sent to expert informants with a request for suggested inclusions. **Results** Electronic database searches yielded 214 citations of which 4 reported studies were relevant to the topic. Hand searching yielded 65 citations of which 10

studies were suitable for inclusion. **Conclusion** Hand searching yielded more relevant citations than searches of electronic databases. This is time consuming and against expectations of available technology. Better indexing of qualitative studies would improve the precision of electronic searches. Authors can help by including appropriate key words in study titles and abstracts.

## 896. The role of the Cancer Experiences Collaborative (CECo) UK in the development of research capacity in supportive and palliative care: narratives of cancer and life threatening illness: informing practice and policy

Amanda Bingley<sup>1</sup>, Carol Thomas<sup>2</sup>, Janice Brown<sup>3</sup>

<sup>1</sup> Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom

<sup>2</sup> Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom

<sup>3</sup> University of Southampton, School of Nursing and Midwifery, Southampton UK, United Kingdom

### Background

In 2006, CECo, a partnership between five UK universities, was funded over five years to develop research capacity in supportive and palliative care. The narrative research theme responds to a phenomenal increase in narratives about personal experiences of illness.

### Aims

Promote study of narratives to better understand patient and carer experience in the context of life-limiting illness.

Assess how narrative analysis can be used as a tool for service improvement and practice development.

### Methods

Tri-annual protocol development events bring together collaborative researchers, clinicians, and service users to build methodological skills, develop research proposals and seek new funding. Annual 'State of the Science' meetings focus on developing new initiatives and knowledge in narrative research methods. Web-based resources support research development, a communication network and forum.

### Outcomes

A collaborative interdisciplinary research programme uses a range of narrative research methods to build and sustain research excellence in palliative and supportive care. Projects include the development of narrative methods to conduct textual and discourse analysis of published writings, internet and research focused diaries and qualitative interviews as narratives; secondary analysis of interview data using narrative methods, and therapeutic uses of narrative within creative therapies.

## 897. Is it possible to enhance response rates in a postal survey used in a study of the organisation of the care of Palliative Support Teams (PSTs) in all general hospitals (GHs), their activities and their perception of palliative care (PC), palliative medic

Ruddy Verbinnen, Fred Loucky

Vrije Universiteit Brussel, Department of Health Sciences, Brussels, Belgium

A postal survey was conducted among all 72 PSTs in GHs in Flanders. Little is known about the views held by PST-professionals on the policies of care for palliative patients.

Objective : To provide representative conclusions about the number of staff and their profession, the organisation of the care and the views on PC, PM and TC.

Questionnaires were sent to all coordinators of PSTs and a selection of 216 professionals working in PSTs. The average time to fill out the questionnaire was over one hour. Different strategies were used to reduce the potential non response. Among them the Total Design Method (Dillman, 1978) which is a tested cost effective method to increase response rates. We ensured anonymity, contacted most of our respondents beforehand, set a strict deadline and organised follow-ups. Our connections with the Flemish League against Cancer and the Federation of Palliative Care Flanders had significant impact.

The overall response rate was 71%. The response was high for the coordinators (79.1%) and fair for the PST professionals (67.6%). Of 97.2% of the PSTs, at least one completed questionnaire reached us. The characteristics of the respondents are representative and non respondents showed the same characteristics as the survey population.

It is possible to increase the response rate using low-cost (additional) strategies, even when using an elaborate questionnaire, leading to representative data.

## 898. Analyze the activity developed by the Home Care Support Team (ESAD) in the island of Mallorca after seven years of service .

Marta Verdaguer<sup>1</sup>, Juli Fuster<sup>2</sup>, Yolanda Mu oz<sup>1</sup>

<sup>1</sup> primary health, Palliative Support Team, Mallorca, Spain

<sup>2</sup> primary health, primary health care, Mallorca, Spain

### OBJECTIVE:

The objective of this research is to analyze the activity developed by the Home care Support Team (ESAD) in the island of Mallorca after seven years of service to detect points of improvement.

### METHODOLOGY

The following variables are analyzed: number of patients, average time of stay in the program, total of exits at home and derivation to another level of attention.

Teaching activity is exposed in relation to the integral approach of the terminal patient.

### RESULTS:

The total number of cases is 2706. The average patient stay in the program was of 65 days. The exits at home is 1143 patients of the total. The evaluation and provenance of patients from socio-sanitary levels has been of 1697 admissions to Palliative Care Unit (UCP) 40 internal resident doctors have been formed by the ESAD in the specialty of family and community medicine in their last two years of formation, and 16 students from the last year of Nursing School.

218 teaching sessions have taken place in the health and sanitary clinics.

### CONCLUSION:

Once the team has been consolidated, at the present time we are capable to elaborate and to work with indicators of assistance quality in the home area, as well as in different aspects of our labor.

Moreover, the ESAD has revealed itself as an effective resource to start and give continuity to new programs that relate primary care to different levels of assistance.

## 899. Criteria validity of the HRCA-QL: a quality of life questionnaire for palliative patients follow up.

JOAN LLOBERA<sup>1</sup>, MERCE LLAGOSTERA<sup>2</sup>, JOANA RIPOLL<sup>1</sup>, MAGDALENA ESTEVA<sup>1</sup>, ENRIQUE FERRER<sup>2</sup>, YOLANDA MU OZ<sup>2</sup>, MARTA VERDAGUER<sup>2</sup>, LLORENÇ ROIG<sup>2</sup>, ENRIC BENITO<sup>3</sup>

<sup>1</sup> Majorca Primary Care Department-Ibsalut, Unit of Research, Udine, Spain

<sup>2</sup> Majorca Primary Care Department-Ibsalut, Unit of Domiciliary Palliative Care, Palma, Spain

<sup>3</sup> Majorca Primary Care Department-Ibsalut, Unit of Palliative Care, Palma, Spain

### Criteria validity of the HRCA-QL: a quality of life questionnaire for palliative patients follow up.

**Objectives:** Assessment of criteria validity of Spanish version of HRCA-QL<sup>1</sup> in terminal patients.

### Methods:

Setting: Home Palliative Care Team, family doctors, public hospitals. Majorca Health Service, Spain.

Design: Validity study. Criteria validity was obtained comparing the dimensions of the Hebrew Rehabilitation Centre for Age-Quality Life (HRCA-QL) with other quality of life scales.

Subjects: terminal cancer patients, prognosis 1 month, who spend more than 15 days at home, Karnofsky Performance Status (KPS) 30.

Measurements: HRCA-QL: 5 dimensions (1 item each) scoring bad, fair, good. Rotterdam Symptom Checklist (RSCL) as gold standard; KPS. Analysis: Spearman correlation, ANOVA.

### Results:

N=91, 63,7% men; mean age 70,1 years old ; 63,3% KPS 60; 10% HRCA-QL 4, 48.4% HRCA-QL 5-7, 41.6% HRCA-QL >7. Correlation HRCA-QL global score and KPS= 0,70. Correlation HRCA-QL global score with the global item RSCL= -0,52.

Daily activities independence and mobility of HRCA-QL is correlated (0.76 and 0.66 respectively) with physical activity RSCL; correlation between HRCA-QL health dimension and fatigue RSCL= 0.45, correlation between HRCA-QL mental status and psychological dimension RSCL= 0.57.

Mean scores of RSCL physical activity are differently distributed in all categories of the HRCA-QL daily activities and mobility dimensions (P<0.001). Fatigue scores RSCL and health scores HRCA-QL differ for the categories good and bad, and fair and good (p<0.001). Similar results between psychological dimensions RSCL and mental status HRCA-QL (p<0.001).

### Conclusions:

HRCA-QL showed good criteria validity in front of RSCL, especially in dimensions of physical status. It can be recommended for terminal patients follow up.

## 900. End of life psychological distress - making sense

CHITRA VENKATESWARAN<sup>1</sup>, PARVEZ THEKKUMPURATH<sup>2</sup>, MANOJ KUMAR<sup>3</sup>, MIKE BENNETT<sup>1</sup>

<sup>1</sup> St-Gemma's Hospice, Leeds, United Kingdom

<sup>2</sup> University of Leeds, Leeds, United Kingdom

<sup>3</sup> Leeds Mental Health Trust, Leeds, United Kingdom

**Introduction:** Suffering is compounded by psychological distress in advanced cancer. Under-recognition of treatable causes of distress can happen, when, in the context of terminal care, distress is interpreted as a normal consequence.

**Aim:** To discuss the issues surrounding diagnosis of psychological distress in palliative care.

**Method:** Evidence in the area of screening and diagnosis of psychological distress in cancer were examined. Analysis of the methodology and quality of studies, and the efficacy of screening instruments, their validation process and relevance to palliative care and treatment carried out.

**Results:** Understanding of the concept of distress varies in various studies with recent focus being on psychiatric categories such as adjustment disorders, depression and anxiety disorders. Validation of screening instruments has mainly been against other validated questionnaires. Psychiatric diagnoses by trained psychiatrists with good inter-rater reliability have been used in very few studies only. Structured psychiatric assessments as the gold standard will add to the clarity in this field.

**Conclusions:** Despite the recognition that there is a high prevalence of distress in palliative care populations, the clinical correlates remain unclear. Unless distress can be mapped to established clinical constructs, interventions are not likely to be tried. Use of screening methods, validated locally against clinically relevant gold standards would be a good starting step.

## 901. Sedation for Refractory Symptoms of Terminal cancer patients that are Attended at Home

Alberto Alonso-Babarro, María Varela-Cerdeira, Eva Sanz-Peces, Ana Tordable-Ramírez

Servicio Madre o de Salud, ESAD (Equipo de Soporte de Atención Domiciliaria), madrid, Spain

**Aim of study:** Investigate the frequency of terminal sedation in patients that are followed in their homes, the reasons of its indication, the decision taking process and the administered drugs to achieve this.

**Method:** Retrospective study carried out by a Support Team for Domiciliary Care checking all patients on the unit during 2 years (370).

**Results:** Sedation was given to 12% of patients. The average age of the patients was 57.6 years and 55% were women. Sedated patients were younger (57 vs 68 years), although there were no other significant differences between the groups. Refractory symptoms that determined the use of sedation were delirium (62%), dyspnoea (10%), anxiety (10%), pain (4%) and other causes (14%). In 45% of the cases the decision to sedate was taken jointly between the patient, family members and the team (the patient expressed this wish directly in 21% of the cases and in 24% it was by means of a living will), other 45% only family members and the team intervened, while in 10% of the cases there was no registry of the decision taking process in the clinical history. In 93% of the cases the administered drug was midazolam (average dose of 74mg/day) while the remaining 7% was given levopromazine (average dose of 125mg/day). The average period of administration from the start of the sedation until death was 2.55 days

**Conclusion:** Sedation at the end of life is used with similar frequency and indications as in previously published studies.

## 902. Building a helpful national register for those who care for the dying patients

Greger Fransson, Bertil Axelsson, Staffan Lundström, Per-Anders Heedman, Maria Olsson, Monika Eriksson, Ulrica Melcher, Marina Jones, Ulla Larsson, Carl Johan Furst

Swedish National Registry of Palliative Care, Board of the Registry, Kalmar, Sweden

**Aim:** Palliative care in Sweden is an issue for hospices and specialised palliative care services but also for hospitals, district nurses and community services. At present time the aim of the Swedish national registry for palliative care is to gradually improve the care for the dying among all caregivers. **Method:** A yearly questionnaire covers the area of staff, beds, documentation etc. A second individual questionnaire covers the last week in life. It is completed by the staff each time a patient dies. Answers are based on documentation, team discussion and personal knowledge of the responsible nurse/doctor. The registry

# Poster abstracts

is now fully computerized and there is a routine for immediate validation of data. Different kinds of reports are automatically generated online. Several reports are open for the public, some are open for caregivers only. A pilot study was conducted during summer 2005 and the registry is now fully working. Result: At present (Nov 2006) the registry covers 7 % of all deaths in Sweden. It is spread all over the country and to all kinds of caregivers even though palliative care services dominate. Conclusion: The board of the registry has managed to develop a real-time concept based on a set of patient oriented objectives. Filling in the questionnaires has started a debate in the local clinics concerning care given. A systematic work to improve routines locally has started. Several examples of improvement over time can now be shown in the registry.

## 903. Barriers to the development of palliative care in Central and Eastern Europe and Commonwealth of Independent States

Thomas Lynch<sup>1</sup>, David Clark<sup>1</sup>, Carlos Centeno<sup>2</sup>, Javier Rocafort<sup>2</sup>, Luis Alberto Flores<sup>2</sup>, Anthony Greenwood<sup>1</sup>, Simon Brasch<sup>3</sup>, David Prail<sup>3</sup>, Amelia Giordano<sup>4</sup>, Liliana De Lima<sup>5</sup>

<sup>1</sup> Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom  
<sup>2</sup> Universidad de Navarra, PAMPLONA, Spain  
<sup>3</sup> Help the Hospices, London, United Kingdom  
<sup>4</sup> European Association for Palliative Care, Milan, Italy  
<sup>5</sup> International Association of Hospice and Palliative Care, Houston, TX, United States

**Background:** The EAPC Task Force for the Development of Palliative Care in Europe Eurobarometer Survey has produced comprehensive information on the provision of palliative care across Europe. This paper focuses on one part of the survey relating specifically to 22 countries in Central and Eastern Europe (CEE) and Commonwealth of Independent States (CIS) **Aims:** To identify barriers to the development of palliative care in CEE and CIS **Method:** A qualitative survey was undertaken amongst boards of national associations, eliciting opinions on opportunities for, and barriers to, palliative care development. By July 2006, 44/52 (85%) European countries had responded to the survey. We report here on the results from 22/27 (81%) countries in CEE and CIS **Analysis:** Data from the Eurobarometer survey were analysed thematically by geographical region and by the degree of palliative care development **Results:** From the varied data contained within the Eurobarometer, we identified four significant barriers to the development of palliative care in CEE and CIS: (i) lack of funding (ii) lack of opioid availability and choice (iii) lack of public awareness and government recognition of palliative care as a field of specialisation (iv) lack of palliative care education and training programmes **Conclusion:** Despite huge variations in the levels of provision across many countries, data collected in the Eurobarometer survey reveal many common barriers to development of palliative care in CEE and CIS.

## 904. A cross-national and regional analysis of palliative care provision in Central and Eastern Europe and Commonwealth of Independent States - progress 2002-2005

Thomas Lynch<sup>1</sup>, David Clark<sup>1</sup>, Michael Wright<sup>1</sup>, Carlos Centeno<sup>2</sup>

<sup>1</sup> Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom  
<sup>2</sup> Universidad de Navarra, PAMPLONA, Spain

**Background:** The International Observatory on End of Life Care (IOELC) website contains 27 country reports for Central and Eastern Europe (CEE) and Commonwealth of Independent States (CIS). Originally prepared in 2002, the reports are being updated in a project funded by the *Open Society Institute*. The work is being undertaken in close collaboration with the *EAPC Task Force for the Development of Palliative Care in Europe* **Aim:** To map changes in palliative care provision in CEE and CIS between 2002-2005 **Method:** A common template is used to facilitate a multi-method approach. Each country report draws on several research traditions in the social and health sciences, both quantitative and qualitative **Analysis:** A cross-national and regional analysis is undertaken to highlight changes in palliative care provision in the region. Variation in the definition of palliative care services is fully considered **Results:** Between 2002 and 2005 total services across the whole of CEE and CIS increased from 467 to 823 (+76%); in CEE from 378 to 601 (+59%); in the CIS from 89 to 222 (+150%). A notable increase in services occurred in Bulgaria, Hungary, Poland and Romania (CEE); and in Armenia, Kazakhstan, Republic of Moldova, Russian Federation and Ukraine (CIS) **Conclusion:** Several barriers to the development of palliative care still exist in CEE and CIS, but the significant increase in services between 2002 and 2005 is a source of much encouragement.

## 905. Enabling Patients in Cancer clinics: a cross-sectional survey using the Patient Enablement Instrument (PEI)

Anne-marie Carey<sup>1</sup>, Laura McTague<sup>1</sup>, Jenny Freeman<sup>2</sup>, Karen Wilman<sup>3</sup>, Ikumi Okamoto<sup>4</sup>, Sam Ahmedzai<sup>1</sup>, Bill Noble<sup>1</sup>

<sup>1</sup> University of Sheffield, Academic Unit of Supportive Care, Sheffield, United Kingdom  
<sup>2</sup> University of Sheffield, Institute of General Practice and Primary Care, Sheffield, United Kingdom  
<sup>3</sup> University of Sheffield, Consumer Research Panel, Sheffield, United Kingdom  
<sup>4</sup> University of Southampton, School of Nursing and Midwifery, Southampton, United Kingdom

### Aims

- To explore the use of the PEI in cancer care outpatient clinics
- To determine principle factors associated with enablement as an outcome measure in cancer care consultations

### Method

Cross sectional postal questionnaire based survey in cancer outpatient clinics, in a UK Cancer Network Outcome measures: Patient Enablement Instrument (PEI), EORTC QLQ-C30, HADS

### Results

Response rate 78%(936/1205) (49% male, mean age 63, 46% cancer diagnosis). Mean PEI score 3.17. Enablement scores were higher if patients felt clinic staff knew them well ( $p \leq 0.001$ ), or intended to discuss their illness/treatment with their GP following clinic ( $p = 0.001$ ). PEI scores were lower ( $p = 0.003$ ) and anxiety scores higher ( $p \leq 0.001$ ) in females; however, there was no significant correlation between PEI and HADS or EORTC QLQ-C30. Significant clinic variables associated with higher PEI were a review by consultant surgeon/oncologist, junior doctors with communication training, clinic slot length >30mins.

### Conclusions

The PEI may be a useful tool for assessing cancer care consultations as it appears to be independent of psychological distress and quality of life. There is an association between high PEI score, patients feeling that staff knew them well or intend discussing issues with their GP, pointing to a possible link between enablement and continuity of care. PEI is associated with clinic factors which could be expected to improve consultations.

## 906. Validation of a system to prioritize first visits to the Palliative Care Outpatients Clinic

Angela Durán, Jesus González-Barboteo, Jose Espinosa, Josep Porta-sales, Silvia Paz, Xavier Gomez-batiste

Institut Catala d'Oncologia, Palliative Care Service, Barcelona, Spain

A series of factors have been related to a higher risk for palliative care (PC) patients to fail outpatients follow up. These factors are: a Palliative Performance Status <50, Age <60 years, Anxiety >5 on a Numeral Analogue Scale as well as invalidating dyspnoea, social constraints and uncontrolled symptoms

### Aim

to validate an appointment system to prioritize first visits to the PC outpatients clinic based on risk factors

### Objectives

to optimise the appointment process in the PC outpatients clinic

### Method

Patients referred to the PC outpatients clinic were assessed on the phone for the above mentioned risk factors by the specialist nurse. Based on this assessment, a score system was designed to arrange patients into three groups: high risk, to be visited within 48 hours; intermediate risk, to attend during the first week and low risk, to be seen within 15 days.

At the first consultation, a patient record was taken as whether any other type of hospital resource was used.

### Preliminary results

Between August 1<sup>st</sup> and October 30<sup>th</sup> 2006, 105 patients were referred to the PC outpatients clinic. Fifteen patients were excluded from the study as they were referred to the home care team. Ninety patients were included. A total number of 80 patients (89%) attended the first visit.

**Conclusion** This system allows to effectively assess patients according to risk factors as well as to optimize patients first visit allocation.

## 908. AN EVALUATION FRAMEWORK FOR A COMPLEX PALLIATIVE CARE PROJECT

Dorian Frere<sup>1</sup>, Jose Pereira<sup>2</sup>, Michael Aherne<sup>2</sup>

<sup>1</sup> D. Frere & Associates, Red Deer, Canada  
<sup>2</sup> Pallium Project Canada, Calgary, Canada

**AIM:** Governments investing public funds mandate accountability through evaluation. The goal is accountability for results and to demonstrate citizens receive value for money. The Government of Canada 's, Primary Health Care Transition Fund (PHCTF) invested 2.8 million in a palliative care capacity-building project (Pallium Project) as part of its investment in primary health care renewal. The PHCTF required accountability for five common objectives. The study's aim was to design and implement a robust evaluation framework applicable to demonstrating goal attainment across diverse subprojects. **METH:** An evaluation team designed a multi-faceted program evaluation framework. Quantitative and qualitative methods included document and product content analyses, descriptive variance analysis, process evaluation and continuous improvement, impact/outcome mapping and Participatory Evaluation from Health Canada's, Participatory Evaluation Framework. The Government of Canada's, Results Based Management and Accountability Framework and The World Bank's LOGFRAME (Logical Framework) also informed design. **RESULT:** A comprehensive evaluation was produced with the necessary information to meet PHCTF requirements. A meaningful synthesis was produced for summative evaluation which provided a comprehensive project overview emerging from 70 subprojects and initiatives. **CONCL:** Large scale, complex palliative care projects require a sufficiently robust program evaluation framework and supporting protocols to achieve accountability for large public investments

## 909. Methodological issues in the evaluation of educational initiatives

Jorge Eisenclas<sup>1</sup>, Marisa Pérez<sup>1</sup>, Celina Berenguer<sup>1</sup>, Gustavo De Simone<sup>1</sup>

<sup>1</sup> Hospital B. Udaondo & Pallium Latinoamerica, Palliative Care Service, Buenos Aires, Argentina

**Background:** In evaluating educational initiatives (EI) pre-post designs are often used, which are prone to bias given the changes in the students internal standards (response shift). Hence, then-test evaluations have been advocated.

**Objective:** To evaluate an EI by using two different ways of time-series analysis (pre-post test vs. pre-then test).

**Method:** In agreement with the objectives of a multidisciplinary palliative care course in Buenos Aires, knowledge, skills and attitudes (KSA) about end of life issues were evaluated through a structured questionnaire. Every student filled the questionnaire a) at the beginning (pre) and b) the end of the course (post), both questioning about current KSA and; c) at the end of the course, although questioning about KSA at the course starting (then-test). Changes in the mean differences of pre-post versus then-post questionnaires were compared by non-parametric tests.

**Results:** All the students finishing the course filled the 3 questionnaires (n61). There were improvements ( $p < 0.05$ ) in 15/24 and 19/24 items in the pre-post and then-post comparisons respectively. Mean difference for questions related to knowledge and skills was also significant ( $p < 0.05$ ).

**Discussion:** This study suggests that response shift might account for differences in the evaluation of EI. Those changes could impact on the results of the evaluation itself, making necessary to adequately evaluate the methodology to use when planning this type of studies.

## 910. Development of a computer based questionnaire for assessment of physical function (PF) in palliative cancer patients

Line Oldervoll<sup>1</sup>, Jorunn Helbostad<sup>2</sup>, Marit Jordhoy<sup>3</sup>, Gerd Ringdal<sup>4</sup>, Jon Loge<sup>5</sup>, Stein Kaasa<sup>6</sup>

<sup>1</sup> Norwegian University of Science and Technology Trondheim, institute for cancer research and molecular medicine, Trondheim, Norway

<sup>2</sup> Norwegian University of Science and Technology Trondheim, institute for cancer research and molecular medicine, Trondheim, Norway

<sup>3</sup> Norwegian University of Science and Technology Trondheim, institute for cancer research and molecular medicine, Trondheim, Norway

<sup>4</sup> Norwegian University of Science and Technology Trondheim, Department of Psychology, Trondheim, Norway

<sup>5</sup> Norwegian University of Science and Technology Trondheim, institute for cancer research and molecular medicine, Trondheim, Norway

<sup>6</sup> Norwegian University of Science and Technology Trondheim, institute for cancer research and molecular medicine, Trondheim, Norway

**Background:** Despite being highly important for palliative patients' quality of life and the planning and provision of their care, assessment of PF seems to be of minor impact in palliative QoL measures. Further development of valid instruments for clinics and research is needed. **Aim:** The purpose of this paper is to present PF in palliative patients by use of items from a computerised questionnaire (PAT-C) under development. **Methods:** Data were collected for 380 patients from 8 different in- and out patient palliative units. A tablet PC was used to answer 22 questions on PF, with activities ranging from low to high levels. Response categories were divided into 4; not at all, a little, some and very much. **Results:** 188 men and 192 women participated with mean age 64 and the mean Karnofsky status was 70 (20-100). Preliminary results demonstrated the following percentages with some to very much difficulties with performing activities; turning around in bed 45%, getting out of bed independently 29%, difficulties getting out of a chair 38%, climbing one flight of stairs 69%, performing moderate household 63%, walking 1000 meters 80% and walking uphill 90%. **Conclusion:** the more difficult the task is the fewer success in managing it. Further analysis will be performed to see whether it is possible to rank PF hierarchically in this group of patients. The data collection is still ongoing and more thoroughly conducted analyses will be presented at the conference

## 911. Applying two methods for a prognostic evaluation in Hospice

Carlo Abati, Massimo Destro, Cecilia Dal ri, Carlo Tenni

*servizio cure palliative, distretto sanitario, Trento, Italy*

**Introduction:** One of the most frequently asked questions by terminally ill patients (Pt) and their relatives is how much time they still have left, which is also an important parameter for the correct allocation of healthcare resources (example access to a hospice). It must also be considered an important factor when important decisions must be made by the healthcare staff. A reliable prognostic evaluation can be of help in order to avoid making clinical decisions that may be useless or worse yet, to insist upon continuing therapy. In the district of Trento (160.000 inhabitants) a palliative homecare service is currently in place (250 Pt/y) and in March 2006 a hospice (6 beds) was opened. They are jointly managed. **Methods:** Many studies (S) show that the expected survival time foreseen by the healthcare staff and based on their clinical experience can modestly be associated to the actual survival time. In literature, several methods are described that increase the accuracy of the assessment of the prognosis. This S takes into consideration two of these S: the PPS and the PPI. The S indicates that the two tests must be carried out by the same doctor on the day that the patient enters the Hospice. The S began in September 2006 and it will conclude in December 2006 (30 Pt). **Objectives:** to compare the reliability of the PPS and PPI, in order to use one of these methods in a systematic manner in the reality in which we effectively deal with, in particular it will be used to select Pt that are best suited for the hospice.

## 912. An evaluation framework for examining palliative care networks (PCNs)

Daryl Bainbridge

*McMaster University, Health Sciences, Hamilton, Canada*

**Introduction:** Globally there has been a move to form regional palliative care networks (PCN) to integrate care, creating systems that are more cost-effective and responsive. Networks are particularly relevant where different professional skill sets are required to serve the broad spectrum of patients' needs. The objective of this research is to propose and test a comprehensive framework for evaluating PCNs, focusing on the nature and extent of inter-professional collaboration. **Methods:** In the absence of an overarching structure for examining PCNs, a framework was developed based on previous models of health system evaluation, explicit theory, and research literature on indicators of inter-professional collaboration. The utility of this framework will be tested through the examination of a PCN network in Canada, using an embedded case study methodology with system, process, and outcomes levels of consideration. **Results:** A comprehensive conceptual framework for evaluating PCNs has been developed. An evaluation using the proposed framework is planned. **Conclusions:** Realizing palliative patients' needs for complex packages of treatment and social support, in a seamless, cost-effective manner, are major drivers of the impetus for network-integrated care. There is a global need for whole system research in palliative care; however, no evaluative framework exists for examining PCNs. A program of research is proposed to test and refine a multilevel conceptual framework.

## 913. Building Psychosocial and Spiritual Palliative Care Capacities in Residential Aged Care: A Dynamic Model of Care

Stewart Clarke

*Sacred Heart, St Vincent's Hospital, Community Palliative Care Team, Sydney, Australia*

### Introduction

The Australian Government Department of Health and Ageing National Palliative Care Program have funded a series of initiatives aimed at enhancing the delivery of a palliative approach within the context of Australian Residential Aged Care Facilities (RACFS). This paper examines the methodology of one of these.

### Aims and Methodology

The South Eastern Sydney Palliative Interface with Aged Care (SES PIAC) Project is being coordinated by a Palliative Care Social Worker/Adult Psychotherapist. It operates from the Sacred Heart Palliative Care Service in Sydney. The focus of this two year project is to build local RACF capacities to identify and respond to the psychosocial and spiritual needs of residents and their families. A range of qualitative and quantitative baseline data collection strategies are being utilized. A formative evaluation methodology enables innovative responses to data uncovered.

Pilot interventions draw on Interpersonal theory, giving attention to the experiences of workers and RACF residents. Interventions include the development and delivery of evidence based training; A facilitated case discussion group; Collaborative work with projects focusing on different dimensions of a palliative approach; Social Work consultations with a sample of RACF Residents/ Interdisciplinary Aged Care Teams.

### Conclusion

Important insights into a dynamic methodology aimed at enhancing care provision will be discussed.

## 914. The Back to Back Approach: Family Support Social Work and Complementary Therapy Working Together

Felicity Hearn, Louise Smail

*Sue Ryder Care, Palliative Care, Cheltenham Gloucestershire, United Kingdom*

The B2B service is a collaborative approach between social work and complementary therapy within the voluntary sector in response to needs and views of specialist palliative care users. The service was initiated by a young daughter caring for her mother who had a recurrence of breast cancer. It demonstrates the integration of the hospices pre-existing, stand alone family support and complementary therapy services and also how we continually strive to recognise need, and find innovative ways to meet it. People with life-shortening illness or their carers may present with complex psychosocial needs regarding the illness, its progression or inevitable outcome. People are referred when their distress begins to affect their ability to function and manage their everyday lives. Following joint assessment with the social worker and therapist to identify the physical and emotional symptoms of stress, the social worker facilitates time to talk for up to 1 hour. The essential 15 minute handover between these sessions enables the client to summarise key issues and target areas of complementary therapy. Our aim is for the person to leave with their defence mechanisms intact, and enhanced ability to manage their lives

## 915. Balance Group

ROY Radcliffe

*Sue Ryder Care, Palliative Care, Cheltenham Gloucestershire, United Kingdom*

Many patients implode psychologically after they have successfully negotiated the diagnosis and treatment of cancer. The Balance group aims to reconnect the patient with the person they were and to give them resources and skills to enable them to bring back some realistic psychological control and hope, just when their world has become crazy, unpredictable and fearful. The Balance group is specifically aimed at a mixed gender group for all types of cancer. It focuses on younger people (under 55). This group grew out of the realization that many post treatment cancer patients had in some way lost the individual that they were prior to their illness. They were lacking confidence, disempowered and were finding difficulty comprehending and relating to the post illness world that they found themselves in. They were in fact struggling to come to terms with what was for them a new world order where many of the old assumptions, certainties, rules and expectations about what their life and world confirmed to have been blown away. The Balance group is an eight week professionally facilitated program constructed to enable participants to examine and hopefully resolve some of the psychological issues that the post treatment phase of cancer can bring about.

Each week, the course takes as its theme an element which can assist in bringing about a sense of psychological wellbeing. The resultant reduction in anxiety and tension enables considerable psychological healing and personal growth to take place thus enabling movement towards reintegration with their new lives. Involving users as decision partners in their own care is paramount to the success of this group. A suggested framework is used to plan the first session which is then adapted according to the individuals needs. To maximise the choices available to users a variable and flexible timetable exists allowing for the "here and now" issues which may arise.

## 916. Is Demand a Measure of Success?

Sandra Flanagan

*Sue Ryder Care, Palliative Care, Cheltenham Gloucestershire, United Kingdom*

The complementary therapy service at Leckhampton Court Hospice aims to meet the needs of, inpatients, day care patients, carers and staff. The realisation that enhancing the sense of wellbeing and relaxation is fundamental to a positive outlook inspires us to extend the service to meet increasing and new demands. Whilst acknowledging the benefits of conventional treatment we seek to treat holistically through assessment, review, frequent evaluation and reflection. Our clients are empowered to make informed choices and are helped to maintain or regain a sense of control. We constantly research new techniques in an effort to offer appropriate therapies from diagnosis to death, for example, the m technique a very gentle, slow reassuring structured system of touch suitable for the critically ill, the very fragile or the dying. The development of the Hospice @ Home Service would enable us to deploy those therapists who have many years palliative care experience to reach those dying at home. Our existing service could be continued in the expert hands of our dedicated volunteer therapists. We strive always to enhance our practice through continual professional development.

## 917. Patients' conceptions of physiotherapy in palliative care.

Ylva Dahlin<sup>1</sup>, Susanne Heiwe<sup>2</sup>

<sup>1</sup> Karolinska Universitetssjukhuset, Palliative Support Team, Stockholm, Sweden

<sup>2</sup> Karolinska Universitetssjukhuset, Dept. of physiotherapy, Stockholm, Sweden

**Introduction:** Physiotherapy have been part of palliative care in recent years. Few studies elucidate the patient's conceptions of palliative physiotherapy. **Aim:** The aim was to describe how patients with incurable cancer perceive physiotherapy. **Method:** Seventeen patients from two palliative care units (twelve women and five men) were interviewed. They were recruited strategically to represent a wide range of perceptions. The interviews were analysed according to the phenomenological method. **Result:** Two major categories were identified; physiotherapy as being clear and satisfactory and physiotherapy as being unclear and insufficient. In the first category, six different perceptions were identified: participation, motivation and encouragement, independence, relief and well-being, security and hope. The second category contained two different perceptions: physiotherapy as an unclear part of the care, and insufficient interventions. **Conclusion:** The patients valued physiotherapy highly. Participation seemed to be a prerequisite for satisfaction with the other categories. The results highlight the importance of physiotherapists clarifying the benefits of physiotherapy in palliative care. Some patients had a vague idea of palliative physiotherapy, perceiving it as an unclear part of their care. **Key words:** participation, palliative care, patient perspective, physiotherapy, qualitative research

## 918. Facilitating the development of palliative care through the Worldwide Palliative Care Alliance

Nick Pahl, David Prail

*Help the Hospices, Center for Palliative Studies, London, United Kingdom*

The Alliance has grown to have an important role in advancing palliative care - in particular in global advocacy and providing a basis for national palliative care associations to develop. Its mission is to promote universal access to affordable quality palliative care through the support of regional and national hospice and palliative care organisations. It aims to support skill sharing, joined up working and support the development of national associations in their work to advance hospice and palliative care.

# Poster abstracts

The Alliance has been instrumental in the development of World Hospice and Palliative Care Day, with Voices for Hospices, which in 2005 year led to more than 1100 events in 75 countries. An global report "Suffering at the end of life: the state of the world" was produced. The Korea Global Summit produced a charter for funders, an advocacy tool kit and the Korea declaration. This declaration was successfully used by a number of national associations in lobbying for improved care for the dying with governments around the world. The Alliance has also been involved in advising national association development in various countries.

This presentation will update the audience on projects include 1) a worldwide tool kit on national association development 2) a publication on setting up an information service 3) the 2007 Global Summit in Africa

There will also be an opportunity to discuss formalising the network and agree how to make the greatest impact for patients and their families.

## 919. Flying Home - Palliative Care during International Air Travel

Katri Elina Clemens, Helga Kaiser, Eberhard Klaschik

*Rhenische Friedrich-Wilhelms-University of Bonn, Department of Science and Research, Centre for Palliative Medicine, Bonn, Germany*

**Background** From time to time health professionals are involved in helping terminally ill patients to travel to their home countries. Arrangements can be difficult. With careful planning, it is possible to facilitate a comfortable and safe journey for these patients. The purpose of this case report is to provide essential information for caregivers. **Methods** Case report of a patient with terminal multiple sclerosis (MS) with tetraparesis, increasing dyspnoea due to hypersecretion. **Report** Male patient, 47 years old, with severe dyspnoea, cough and dysphagia due to MS, was escorted to the airport by ambulance and via aircraft from Germany to Windhoek/Namibia. The following problems had to be solved:

- *medical*: provision of emergency equipment for oxygen delivery, controlled drugs and patient-based documents
- *nursing*: bedding and washing of the patient, suction of mucus, administration of drugs
- *social*: caring for the patient and his wife, calculation of expenditure for the flight (minimum 6 seats for 1 patient who needs to travel lying down), knowledge of legal regulations
- *psychological*: empathic communication with the patient and his wife about the patient's fear to die before arriving at home; strengthening and reassuring measures
- *spiritual*: acknowledgement of the patient's wish to die at home in the face of his limited life expectancy. **Conclusions** A short prognosis should not be an obstacle to travel home provided careful travel arrangements are made in advance.

## 920. Palliative care for people with intellectual disabilities (ID) : a two-phase study identifying issues affecting the delivery of services by palliative care professionals to people with ID in London

Irene Tuffrey-wijne<sup>1</sup>, Linda McEnhill<sup>2</sup>

<sup>1</sup> *St George's, University of London, Division of Mental Health, London, United Kingdom*

<sup>2</sup> *National Network for the Palliative Care of People with Learning Disabilities, Cambridge, United Kingdom*

**Aim:** To identify issues affecting the delivery of services by palliative care professionals to people with ID in London. The outcome of the study will be the identification of strategies that will enable palliative care professionals to offer improved support to people with ID.

**Methods:** This is a two-phase mixed-method study.

**Phase 1:** Semi-structured, tape recorded interviews with 33 palliative care professionals from across London. Objectives included exploring their knowledge, understanding and experience in caring for people with ID, and identifying both examples of exemplary practice and examples where palliative care for people with ID could have been improved. Data analysis was supported by a computer package for qualitative analysis (Nvivo). Recurring themes were identified and related to the existing body of knowledge.

**Phase 2:** Postal questionnaire (based on the results from Phase 1) sent to a comprehensive cohort of around 1300 palliative care professionals in London.

**Results:** Many issues affect the delivery of palliative care services to people with ID, including building trust, communication, challenges in symptom assessment, family issues, and lack of information. Phase 2 will be completed in spring 2007, and full results will be presented.

**Conclusion:** People with ID benefit from the support of palliative care services, but a range of issues needs to be

addressed before they can enjoy equal access and benefit fully.

## 921. Using Nominal Group Technique (NGT) to investigate the views of people with intellectual disabilities on end-of-life care provision

Irene Tuffrey-Wijne, Jane Bernal, Gary Butler, Sheila Hollins

*St George's, University of London, Division of Mental Health, London, United Kingdom*

**Aims:** To establish the views of people with intellectual disabilities (ID) about what is important in end-of-life care provision. **Methods:** Students with mild and moderate ID at a London theatre company were asked to volunteer to take part. Three groups of people with ID were convened (total: 14 participants). Each group was show a drawing of an ill woman, and told that the woman was going to die. Participants were asked what they thought would help the woman. Answers were elicited using Nominal Group Technique. This involves listing all participants' answers, grouping them together, and inviting participants to rank them in order of importance. **Results:** Participants generated a wide range of ideas. Issues around empowerment, involving families and keeping normal activities going were paramount. Saturation has not been reached.

**Conclusion:** People with mild and moderate ID are capable of giving their views on end-of-life care, and should be asked to do so. NGT is a useful method for eliciting their ideas.

## 922. The South African Mentorship Programme - A Cascade of Quality

Kathleen Defilippi<sup>1</sup>, Susan Cameron<sup>2</sup>

<sup>1</sup> *Hospice Palliative Care Association of South Africa, Patient Care, Cape Town, South Africa*

<sup>2</sup> *Hospice Palliative Care Association of South Africa, Patient Care, Cape Town, South Africa*

The enormity of the need for palliative care in a country ravaged by HIV/AIDS, resulted in the Hospice Palliative Care Association of South Africa (HPCA) introducing a mentorship programme in 2001. The initial thrust was to expand the reach of member hospices by using those hospices with a well established Integrated Community-based Home Care (ICHC) programme to mentor others, in the promotion of this collaborative model of care. Since then, the mentor concept has been successfully applied to accelerate progress in community organizations wishing to meet the criteria for HPCA membership, the development of Centres for Palliative Learning and in assisting hospices to comply with comprehensive palliative care standards. The process of linking mentorship to accreditation and the impressive results that this has achieved will be described. HPCA's ultimate aim is to equip each of its member hospices to function as an effective palliative care resource, able to mentor government, community and faith-based programmes and to graft a quality palliative care component onto the supportive care that these programmes currently provide. It is unrealistic to think that hospices alone will ever be able to meet the needs of the vast numbers of South Africans in need of palliative care. It is hoped that sharing the South African mentor experience may be beneficial to other situations where the need for palliative care outstrips available and foreseeable resources.

## 923. FINDING HIDE FEELINGS

Lina Andrade, Marília Pereira, Vera Fialho

*Centro de saude de ponta delgada, primary health care, ponta delgada, Portugal*

**ABSTRACT** As it appears to us that the relative accompanying the end of life of a loved one in the hospital is, in a certain respect, outside of the focus of nursing care, we became motivated to study this specific situation. With this in mind, let us begin with the question:- What nursing care was experienced by the relative of the cancer patient ending life in the hospital? As the study is qualitative, exploratory, and descriptive, let us define the objectives:- Identify the nursing care administered to the relative of the oncology patient in the process of dying:- Identify the needs felt by said relative while accompanying the oncology patient in the process of dying:- Analyze the feelings experienced by the relative of the oncology patient ending life in the hospital.

In the attempt to attain these objectives, we used the semi-structured interview as our method of gathering data from nine relatives who accompanied an oncology patient ending life in the hospital whose death occurred in a period of one month to one year.

Taking into account the type of study and not knowing what information we would obtain, we opted

for a categorical analysis, after the fact, and, within this, a thematic analysis.

After exhaustive analysis of the interviews, we developed two aspects - needs felt by relatives and feelings/emotions of the relatives, with respective categories, subcategories, and sub-subcategories.

Within this study we propose to describe experiences of relatives with the nursing care directed toward them, as they were related to us.

We felt the participants grateful for the opportunity to speak of their experiences for the purpose of contributing to this study.

We conclude that the relative who accompanies the end of the life of a dear one in the hospital is a person who presents a need for greater support and, as such, is a subject who requires nursing care.

## 924. The existential impact of corticosteroid treatment in advanced cancer.

Staffan Lundström, Carl Johan Fürst, Peter Strang

*Stockholms Sjukhem Foundation, Palliative Medicine, Stockholm, Sweden*

**Aim:** Treatment with corticosteroids have many important symptom-relieving effects in patients with advanced cancer. The aim of this study was however to explore the deeper meaning and implication of corticosteroid treatment in patients with advanced cancer.

**Method:** Six women and four men with advanced cancer were interviewed individually using a semi structured interview guide both before starting corticosteroid treatment and after one week of treatment. The interviews were tape-recorded for subsequent verbatim transcription. Data were analysed by the three authors using qualitative content analysis with no predetermined categories. Both a manifest and a latent focus were used.

**Results:** The analysis yielded three manifest(descriptive) main categories: Problems at baseline, expectations, and effects of the treatment. As expected, the treatment produced to a very high degree improvements of appetite, mental and physical strength and autonomy. The latent(interpretative) focus were on profound existential changes. Corticosteroid treatment contributed to a change towards normalized life, symbolising health and hope, while the disease itself and symptom progress had an underlying meaning of threat and death.

**Conclusions:** Successful as well as poor symptom control has existential implications in end of life care. This has probably been underestimated so far in palliative care and has consequences when communicating goals of treatment and care with the patient and the family.

## 925. Opening the spiritual gate Part II

Marijtte Drijfhout, Karen Groves, Cath Baldry, Ruth Killin

*Queenscourt Hospice, TEBC, Southport, United Kingdom*

Spiritual care is an integral part of the holistic care provided by Specialist Palliative Care teams. UK national guidelines emphasise the need for accountability and structure in this area of care.

Queenscourt Hospice in Southport has taken a lead by developing a Spiritual Care training course for their staff.

To gauge the effect of the training on the team's awareness of patient's spiritual needs we counted the number of relevant entries in the patients' notes. The percentage of entries regarding spiritual need was < 10% before any training was given.

It rose to 40% following the first round of training.

Now, after the second course we have a 70-75% (final number will be known in Dec) of case notes detailing patients' spiritual needs.

This second time we have also used a standardised pre-and post course questionnaire based on the work of Tom Gordon and David Mitchell: "The Marie Curie Spiritual & Religious Care Competencies for Specialist Palliative Care teams."

Team members report an increase in competence and confidence in providing spiritual care following the training course, as measured by the questionnaire response.

We were delighted to be able to use this recognised measuring tool to help us build an evidence base for the value of the course.

The Poster will describe the training course in more detail and explain the above-mentioned use of the Marie Curie Competencies.

There are plans for the development of a course manual, to be made available for use by Specialist Palliative Care teams who want to offer Spiritual Care training to their staff.

Gordon T. Mitchell D. A competency model for the assessment and delivery of spiritual care. Palliative Medicine 2004 18(7):646-51

National Institute for Clinical Excellence: Supportive + Palliative Care for Adults with Cancer. 2004.

## 926. Euthanasia: evaluation of a protocol

Dirk Schrijvers, Edel Maex

*ziekenhuisnetwerk Antwerpen-Middelheim, Medical Oncology, antwerp, Belgium*

### Introduction

Euthanasia is allowed within the framework of the Belgian Law. A procedure of euthanasia was tested in the "ZiekenhuisNetwerk Middelheim (ZNA-Middelheim)", a 650-bed community hospital in the region of Antwerp, Belgium.

### Methods

The procedure included all legal requirements for euthanasia. Euthanasia was by first administering midazolam 60 mg in 5-10 minutes to induce sleep followed by natriumpentothol 4000 mg and atracuriumbesilate 50 mg intravenously. Symptoms were recorded prospectively and more than 1 symptom was possible.

### Results

From 25/02/2003 until 8/11/2006, 64 cancer patients (35 men and 29 women with a median age of 70 years (range 39-90 years)) died according to the procedure. In all situations, the family of the patient was present during the administration of the drugs. All patients were death at the end of the procedure: 32 fell into a coma and died without any symptoms; 8 developed rales; 16 coughed, 5 breathed heavily, 1 rerurgitated stomach fluid, 1 defecated, 1 developed contractions in his legs and 2 patients snored. One patient already on high dose of benzodiazepines did not go into a coma after midazolam. After administration of natriumpentothol he died peacefully.

### Conclusion

This procedure for euthanasia is effective and can be performed in a serene atmosphere and without distress.

## 927. DISTINGUISHING THE SPIRITUAL AND PSYCHOLOGICAL DIMENSION OF PALLIATIVE CARE

Carlo Leget, Anke Oerlemans

*Radboud University Medical Centre, Ethics, Philosophy and History of Medicine, Nijmegen, Netherlands*

**Aim**Both in theory and practice there seems to be a widespread conceptual and practical confusion about the distinction between the spiritual and psychological dimensions of palliative care. Our study focuses on clarifying this double confusion. **Method**We performed a systematic review of medical and psychological literature on spirituality and psychology in palliative care. Additionally, 16 semi-structured interviews were conducted with pastoral caregivers, psychologists, physicians and nurses working in palliative care practice in hospital, hospice or nursing home, asking them about distinguishing between both domains. **Result**Both in the literature and in palliative care practice there is a tendency to focus on pathological reactions and a solution-oriented approach when discussing the psychological dimension, while spiritual issues are considered to be a 'normal' part of the process of dying. The theoretical confusion present in the literature is recognized in practice, but is generally not deemed problematic by the caregivers. **Conclusion**We think that the conceptual confusion and the inability to distinguish between the psychological and the spiritual domain has a negative influence on daily practice. Patients are withheld spiritual care, because it is either reduced to psychological intervention or confused with normal attention to the patient's needs. More research, especially participating observation, is needed to evaluate the actual influence of the theoretical confusion on palliative care practice.

## 928. Using telehealth technology to support physicians and nurses working with palliative, medical home care in the Southwest part of Stockholm

Susanne Bergenbrant, Christina Jigström

*ASIH, Långbro Park, Stockholm, Sweden*

"ASIH, Långbro Park", is situated within the Stockholm County Council. The unit is serving a population of 280.000 people. We have a palliative-program where qualified medical home care is provided for patients with advanced medical problems. Our team with physicians, nurses and paramedical personal provides medical care to 120 patients, admitted from hospital and treated in their own homes. By using a standard, computerised patient record system (TakeCare), and making it able to access out of office, physicians and nurses can use mobile laptops and Internet access via 3 G. The care providers will have a comprehensive view of patients' healthcare and medical history when visiting

the patients in their own homes. **3 G** is short for **third-generation**. The services associated with 3G provide the ability to transfer non-voice data (such as ). Numerous pilot studies have demonstrated that telehomecare technology may improve client outcomes and reduce return visits to hospitals and physician offices. In Previous investigations in the telemedicine field, patients' have been given the telemedical solutions. In this study we will give the healthcare staff the telemedical access to information. We plan to investigate both how the medical quality may improve and how the technical assessment and security will function.

## 929. Quality of life in palliative care: patients'tales and representations

Maria Fernandez-Petite

*Fondation Rive-Neuve, Villeneuve (VD)-Suisse, Switzerland*

Palliative CH consider that palliative care includes «« all medical treatments, nursing, psychological, social and spiritual support for patients affected by incurable and advanced disease.

Their aims are pain relief, symptoms control, comfort and quality of life for the patient.

In most of the accessible definitions, we find the concept of providing improvement of quality of life, rather than duration. This definition is accepted and used by all the different partners in palliative care and medicine. Yet, is quality of life easy to define ?

With help from the patients'tales and representations, we are going to attempt an approach to one or several definitions.

This study is based on a methodology inspired by «« grounded theory »» (Strauss, A, Corbin , J.,2004) whose basic postulate is putting in parenthesis the preexisting notions related to a phenomenom in order to let it speak for itself. Thus, the research theorisation refuses itself any «« a priori »» construction of concepts or research hypothesis on the social phenomenom in study (Lapierre, A., 1997). This is why we won't build any hypothesis in this research.

The research protocol can be described as follows : the first encounter with the patient occurred on admittance day. Within three days from admittance, the first interview of the study took place. Then about a week later (between 5 and 8 days), the second interview was scheduled. The semi-structured interviews were not recorded ; the researcher taking notes on key-words and sentences given by the patient, so that the interview may unfold in a sharing and conversational mode, in the most possible authentic fashion. Each interview ended with y the patient's self assessment of his/her quality of life. Eleven patients – five women and six men – composed the research group, all of which were admitted for palliative care at the Fondation Rive-Neuve. One of the male patients died before the end of the protocol, so the final results concerned only 10 patients.

## 930. Guideline (risk of) fatal bleeding in patients with malignant head-neck tumours in the palliative phase.

Monique Booms, Erwin Kompanje, Lia Van zuylen, Mirjam Dudok-Smit, Yvette Sollewijn-Gelpke, Wilma Neeleman, Martin Zwaard, Lilly-Ann Van der Velden

*Academic Medical Center, Department of Oncology, rotterdam, Netherlands*

**Introduction** Every year 600 new patients are treated with a malignant head-neck tumour in the Erasmus MC and approximately 170 of them cannot be cured.A small number of these palliative patients bear a risk of a fatal bleeding.Among qualified nurses is uncertainty with regard to competence and treatment during this fatal event.

**Question Can we develop a guideline for fatal bleeding in patients with a malignant head-neck tumour during the palliative phase?**

**Methods**A Pub Med literature search of existing guidelines was conducted by our group. The current practice in the Erasmus was analysed. An guideline was developed and implimentated.

**Results**Literature concerning fatal bleeding in patients with malignant head-neck tumour is limited and guidelines offer unsatisfactory practical assistance. In the Netherlands and at the Erasmus MC few different guidelines exist. The premise for this guideline is sedation in the case of a fatal event. Considering the daily practice however a guideline was needed. Two flow charts were developed:

-acute care for patients with a malignant head-neck tumour in the palliative phase in case of a fatal bleeding  
- and-anticipating care for patients with a malignant head-neck tumour in the palliative phase who have a risk of a fatal bleeding.

**Conclusion**The implementation of the guideline makes the palliative care for patients with a malignant head-neck tumour in the palliative phase with a risk of a fatal bleeding unambiguous.

## 931. CANCER RELATED FATIGUE (CRF): PHYSIOLOGICAL (EGG AND EMG) RESPONSE TO ETHYLPHENIDATE

Dilara Khoshknabi<sup>1</sup>, Tugba Yavuzsen<sup>1</sup>, Jordanka Kirkova<sup>1</sup>, Mellar Davis<sup>1</sup>, Declan Walsh<sup>1</sup>, Ruth Lagman<sup>1</sup>, Susan LeGrand<sup>1</sup>, Vlodek Siemionow<sup>2</sup>, Vinoth Ranganathan<sup>3</sup>, Guang Yue<sup>2</sup>

<sup>1</sup> *Cleveland Clinic, Palliative Medicine, Cleveland, United States*

<sup>2</sup>*Cleveland Clinic, Neural Control Laboratory, Department of Biomedical Engineering, The Lerner Research Institute, Cleveland, United States*

<sup>3</sup>*Cleveland Clinic, Physical Medicine and Rehabilitation, Cleveland, United States*

To demonstrate a corresponding objective to subjective response in CRF treated with methylphenidate. A 58 year old female with multiple lung cancers, severe CRF (7 on the Brief Fatigue Inventory) received 5 mg methylphenidate twice daily (bid), titrated to 10 mg bid after 2 weeks and remained on 10 mg bid for 8 months. She performed a sustained elbow flexion contraction at 30% maximal until exhaustion, electrical stimulation-evoked muscle responses and continuous 128-channel scalp-EEG data recorded before, during and after task. This was repeated 8 months after methylphenidate. Spectrum analysis of EEG signals was performed. Comparisons were made before methylphenidate and after 8 months.Data analyzed by Brain Electrical Signal Analysis (BESA) Program and Spike 2 (CED). Fatigue, hand grip strength, maximum voluntary contraction improved and M-wave amplitude increased with methylphenidate (indicating improved neuromuscular junction efficiency). Twitch force decreased at the end of task on methylphenidate (indicating improved muscle recruitment). Gamma waves decreased during sustained motor task and Theta waves increased in the left (dominant) hemisphere during task on methylphenidate. During recovery from fatigue, the power of Theta waves was reduced with methylphenidate. These changes indicate normalization of brain signals towards those of normal individuals. Improvement in severe CRF (BFI score) and normalization of neurophysiological testing occur with methylphenidate.

## 932. Consultation for palliative sedation

Alexander De Graeff<sup>1,2</sup>, Adri Jobse<sup>1</sup>, Anja Moonen<sup>1</sup>

<sup>1</sup> *comprehensive cancer centre middle netherlands, utrecht, Netherlands*

<sup>2</sup>*University Medical Center Utrecht, Department of Medical Oncology, utrecht, Netherlands*

**Background:** Palliative care services in The Netherlands are increasingly consulted with regard to palliative sedation (PS). Last year a national guideline was published establishing criteria for PS.**Aim of the study:** To gain insight in consultations regarding PS.**Methods:** All consultations of a regional telephone helpdesk during a one-year period were screened for questions regarding PS. An in-depth analysis was performed of all consultations in which PS was discussed.**Results:** PS was discussed in 208 of 659 consultations (31%), involving 159 patients (57% male; median age 66 years; 88% at home; 85% with cancer diagnosis; 70% estimated life expectancy <7 days). At the first consultation, advice was sought (predominantly by general practitioners) for initiation of PS (72%), during an ongoing sedation (13%), anticipating for the near future (11%) or for general information (4%). The helpdesk gave a positive advice (following the guideline) for PS in 60% of consultations for initiation of PS. The main refractory symptoms necessitating PS were restlessness (53%), pain (28%), physical and/or spiritual exhaustion (18%), dyspnoea (13%) and nausea/vomiting (11%). Reasons for a negative advice in these consultations were the absence of refractory symptoms (90%) and/or a life expectancy >1-2 weeks (27%).**Conclusion:** PS is an important reason for consultation in our region of The Netherlands. Requests for PS frequently do not meet the criteria defined by the national guideline.

## 933. Interprofessional collaboration to improve patient safety in palliative home care

Barbro Norrström, Ing-britt Cannerfelt, Helen Frid, Kim Roos, Helena Ramström

*ASIH, Långbro Park, Palliative Care at Home, Stockholm, Sweden*

**Background and aim:** One of the most important areas for improving patient safety is the medication use and management process. An organisational change in the palliative home care, ASIH Långbro Park, switching from drugs on prescription to dispensing the drugs in dosett boxes by nurses, resulted in an increased risk of incidents. Thus, addressing an improved patient safety, the overall aim of the present study was to decrease the medication errors by 50%. **Method:** A quasi-

# Poster abstracts

experimental strategy was used with a baseline period followed by an intervention period. Since the success in reporting of medication errors relies on several factors, other parameters were also followed, *e.g.*, the safety climate and drug utilisation. Improvement in the staff perception of the safety climate has been linked to decreases in actual errors. **Results:** The most common medication errors were related to the drug charts, dispensing and administration of drugs. An important issue of allowing the staff to anonymously report on medication errors was to identify errors related to failure in the system. The response rate of the safety climate survey was 83%, and 62% of the staff reported a positive safety climate. The introduction of prescriptionists dispensing the drugs, resulted in comments from the nurses, *e.g.*, more time can now be spent in the care of the patients, and the prescriptionists are an asset to answer questions related to medication. To further improve the drug handling process, pharmacists have also performed drug reviews. **Conclusion:** The interprofessional collaboration, including prescriptionists and pharmacists, in the palliative home care has increased the awareness of different professional competences for their optimal use that may favourably affect the total outcome.

## 934. A User Involvement Survey of UK Hospices

David Hart, Ann Macfarlane, Mandy Paine, Di Cowdrey, Munir Lalani, Pat Garratt, Nick Pahl, Nikita Ranchhod

*Help the Hospices, London, United Kingdom*

### Objective

To help gain a better understanding of user involvement in hospices, share experiences and give hospices the opportunity to feed into the development of new support in this area

### Background

The UK Department of Health (21 August 2006) states that 'Patient and service user involvement is key to developing and delivering responsive services'.

User involvement is an active process, involving the people who receive and experience services. Involving users gives them a voice and allows them to speak out and act for themselves. It often means being consulted on particular issues or being asked to be members of formal groups and bodies with a focus on user involvement.

### Methods

Help the Hospices, the national charity for the hospice movement in the UK conducted a survey of UK hospices of their activity related to user involvement. The survey was devised by the Help the Hospices User Involvement Group - which comprises of palliative care patients with an interest in this area. The survey was sent to 220 hospices across the UK and 54 completed responses were received.

### Results

Results were compiled into a report to show the findings; this was publicised to all UK hospices and the report has been made available by email.

### Conclusions

The results show that User Involvement is an integral part of the development of hospice services, but varies in depth of involvement. Some users have instigated significant change to their hospices, in areas such as buildings, layout, food, staffing, visiting hours and activities. However, user involvement activities were not in place in a significant number of hospices. The survey found that hospices have acknowledged that it is important to make developments in this area. Lack of knowledge and resources are key factors of why user involvement did not take place - reinforcing the fact that education and promoting awareness of user involvement is necessary. As a result of the survey half of the respondents agreed to a member of the Help the Hospices User Involvement Group visiting their hospice to start activity in this area, and Help the Hospices held a seminar about user involvement with more scheduled to take place in 2007.

## 935. Analysis of Reasons of Severely Ill Patients Hospitalization

Arvydas Seskevicius, Jovita Demskyte, Ingrida Kaulinyte

*Kaunas University of Medicine, Nursing, Kaunas, Lithuania*

### Background

Nursing needs are apace growing because of morbidity's of chronic diseases and malignant tumors increase and community's aging. Palliative care nowadays is given at oncology, nursing, general care hospitals. Incurable ill patients or severely ill patients on last stages are hospitalized in nursing hospitals; nursing and supportive care services are given. It is defined that 52% of patients die in hospitals.

### Objective

To identify the physical, social/economical, psychological, spiritual reasons of severely ill patients' hospitalization.

### Method

Questioning (nursing hospital's patients, their relatives

and nurses were investigated); also analysis of legal documents of nursing hospital and Ministry of Health.

### Results

Patients and their relatives indicated mobility disorders as main reason of hospitalization, but nurses think that pain is main problem. Patients more accented fear and anxiety as psychological reasons. Relatives and nurses think that hope's lost is main spiritual problem. Majority of patients cured in nursing hospitals are widows/widowers, also singles. All 3 respondent groups selected same social/economical reasons - loneliness and self care inability.

### Conclusion

Complex of physical, social/economical, psychological and spiritual reasons influences patients' hospitalization to nursing hospital.

## 936. BIOELECTRICAL IMPEDANCE ANALYSIS (BIA) AND SURVIVAL IN ADVANCED CANCER

Dilara Khoshknabi<sup>1</sup>, Jordanka Kirkova<sup>1</sup>, Wael Lasheen<sup>1</sup>, Mellar Davis<sup>1</sup>, Declan Walsh<sup>1</sup>, Ruth Lagman<sup>1</sup>, Matthew Karafa<sup>2</sup>, Susan LeGrand<sup>1</sup>

<sup>1</sup> *Cleveland Clinic, Palliative Medicine, Cleveland, United States*

<sup>2</sup> *Cleveland Clinic, Quantitative Health Sciences Department, Cleveland, United States*

**Aim:** Bioelectrical impedance analysis (BIA), a noninvasive method measures resistance (mainly fat mass), capacitance (stored charge within membranes) and phase angle (PA) (vector relationship between capacitance and resistance). Extracellular (ECW), intracellular (ICW) and total body water (TBW) are directly measured and body composition determined through conversion equations. We correlated BIA parameters with survival.

**Methods:** Patients hydrated parenterally were eligible. BIA was performed with hydration at baseline and for 2 consecutive days. Six parameters of BIA (capacitance, resistance, phase angle, TBW, ICW, and ECW) were recorded daily x 3 days. Comparisons of BIA parameters on day 3 as well as the changes from day 1 to day 3 were made using hazard ratios (HR) and 95% confidence intervals from univariable Cox proportional hazards models. **Results:** Forty eight cancer inpatients have participated, 29 were females. 21 have died. Mean age was 63 years. 39 received NaCl 0.9, 2 D5W, 45 NaCl, and 8 D5W. Resistance ( $P=0.86$ ) and TBW ( $P=0.63$ ) did not correlate with survival. Increased PA (HR: 1.2 (CI =1.01-1.34;  $P=0.003$ ) and capacitance (HR: 1.03 (CI = 1.01-1.06;  $P=0.005$ ) correlated with shorter survival. Increased ECW/ICW (HR: 0.08 (CI = 0.01-0.62;  $P=0.016$ ) correlated with longer survival. **Conclusion:** BIA changes in advanced cancer may predict survival.

## 937. 'Colours of life'. Bringing colour into quality of life

Catherine Baldry<sup>1,2</sup>, Linda Dutton<sup>1</sup>, Karen Groves<sup>1,2</sup>, Cliff Bashforth<sup>3</sup>

<sup>1</sup> *Queenscourt Hospice, Palliative care unit, Southport, United Kingdom*

<sup>2</sup> *West Lancs, Southport & Formby Palliative Care Services, Uldine, United Kingdom*

<sup>3</sup> *Colour Me Beautiful, Penwortham, United Kingdom*

A young female patient with advanced ovarian cancer presented with abdominal ascites and cachexia wearing a short sleeved black teshirt and illfitting trousers. Her loss of identity and body image problems were highlighted by the stark clothes she wore. She was keen to learn how she could dress to make the most of her assets but died before this could be arranged for her. As a result of this episode, contact was made with a colour analysis and image organisation who gave staff basic colour awareness and trained one staff member as a colour analyst and style consultant. Staff were able to use their new skills to advise patients about colour and style of clothes to enhance what remained of their natural colouring and, often changed, shape. Palliative Care embraces the whole person including their dignity, self esteem and sexuality. This poster describes the stories of several such patients and the effects of their new image on their perceived body image in the last few weeks and months of life.

## 938. 'Deaths off the Vigil'. Audit of non-use of care of the dying pathway in a specialist palliative care unit

Jane Hough, Karen Groves

*West Lancs, Southport & Formby Palliative Care Services, Queenscourt Hospice, Southport, United Kingdom*

The "Vigil" pathway (based on the Liverpool Care of the Dying Pathway Ellershaw et al) is in use across all health care settings within West Lancs, Southport & Formby and should be used for 100% of all predicted deaths.

However it was clear that even in the specialist inpatient unit there were occasions on which the pathway had not been used. A retrospective audit of all deaths occurring in the unit between July 2004 and June 2005 was undertaken to look at the reasons why the Vigil Pathway had not been used. The poster describes the results of that audit and looks at the reasons why 9.6% were not on the pathway and the actions taken as a result of the audit.

## 939. 'Quest for Meaning'. Audit of the Confidence and Perceived Need for Education of Palliative Care Professionals in Assessment of Spiritual Needs and Provision of Spiritual Care

Marijtje Drijfhout, Phil Saltmarsh, Catherine Baldry, Bernice Sanders, Karen Groves

*Merseyside & Cheshire Cancer Network, Supportive Care Group, Spirituality Subgroup, Liverpool, United Kingdom*

The Merseyside & Cheshire Cancer Network (MCCN) appointed a Supportive and Palliative Care Group (SPCG) to oversee the implementation of the NICE (National Institute for Clinical Excellence) Supportive and Palliative Care Guidelines within the MCCN. The Spiritual Care Subgroup of the SPCG undertook an audit of the confidence of, and the perceived need for education by, palliative care professionals in recording of spiritual and religious needs and the provision of spiritual and religious care across both adult and children's services in MCCN area.

The results of this audit were presented to the Merseyside and Cheshire Palliative Care Network Audit group at Easter 2006 and the Children's Palliative Care Clinical network group in December 2006..

This poster/presentation outlines the findings of that audit and outlines the planned educational programme that resulted from it.

## 940. 'Because it's natural it must be safe!' Alternative Medicines in Palliative Care

Steven Simpson

*West Lancs, Southport & Formby Palliative Care Services, Integrated Palliative Care Services, Southport, United Kingdom*

The use of alternative medicines amongst cancer patients appears to be significant. Because these medicines are readily available and often naturally occurring substances purchased from non orthodox health outlets and the internet, they are considered by patients to be safe. However manufacturing processes are subject to less stringent quality control and require no evidence based licensing procedure. This presentation highlights experiences at a palliative care unit where the use of specialist pharmacist with access to drug information resources and natural medicines information databases, helps clinicians inform patients of the possible harm, lack of efficacy and potential interactions with conventional therapies and other alternative agents. Patients are then in a better position to make informed decisions about their choices of all treatment options and clinicians are more aware of potential problems.

## 941. Clinical relevance of CYP2D6 deficiency in prescribing in palliative care

Steven Simpson, Andrea Whitfield

*West Lancs, Southport & Formby Palliative Care Services, Integrated Palliative Care Services, Southport, United Kingdom*

Individuals who are deficient in the isoenzyme CYP2D6 have the potential to develop toxicity with certain drugs commonly prescribed in palliative care. This presentation is based around a patient with metastatic penile carcinoma who presented with severe extrapyramidal movements whilst on oxycodone, amitriptyline and domperidone. He was subsequently found to be one of the 2- 10 % of the Caucasian population to be deficient in the isoenzyme CYP2D6. We will explore the implications of this deficiency on drug metabolism and for prescribing in palliative care.

## 942. Timeliness of 'End of Life' drug prescribing

Katie Marley, Karen Groves

*West Lancs, Southport & Formby Palliative Care Services, Queenscourt Hospice, Southport, United Kingdom*

As patients near the end of their lives, they may need parenteral drugs for symptoms which arise during this period. The Liverpool Care Pathway for the Dying (Ellershaw et al) suggests that a strong opioid, anxiolytic, antsecretory and antiemetic be prescribed, as the pathway commences, to be used as required by the

nurses caring for the patient, according to guidelines. A retrospective audit of 29 consecutive recent inpatient deaths was undertaken and information retrieved about the date of commencing the pathway in relation to the date of prescribing of these drugs. Although most were prescribed all of these drugs, the antiemetic was the least well prescribed and in terms of timing - 86% were prescribed an opioid, 86% an anxiolytic, 80% an antsecretory agent and 73% an antiemetic either before or at the time of commencing the pathway. This poster describes the results of the audit, the actions taken to improve timely prescribing within the inpatient unit and the plans to reaudit across the whole integrated service.

## 943. Terminally ill patients and their caregivers' quality of life in Taiwan

Woung Ru Tang

Chang Gung University, School of Nursing, Tao-Yuan, Taiwan

Even though hospice care promoted in Taiwan over the last decade is becoming popular, only few scientific evidences discuss its benefits. Therefore, the aim of this study is to compare quality of life (QOL) on terminally ill patients and their caregivers who received in-patient hospice care or active treatment. This is a quantitative cross-sectional study. MQOL, CQOLC, SWBS, and MOS-SS were used to measure patients' QOL, caregivers' QOL, their spirituality, and social support. Total of 598 subjects (including 317 patients and 281 family caregivers) participated from five hospitals across Taiwan. Results indicate that no matter what treatment they choose, patients still maintain an intermediate QOL (hospice care group: M = 5.3, SD = 1.5; active treatment group: M = 5.2, SD = 2.0). No difference was found between groups ( $t = .39$ ,  $p = .70$ ). In terms of caregivers, the data analysis presents the same finding as the patient groups. Caregivers still maintain an intermediate QOL (hospice care group: M = 66.1, SD = 21.2; active treatment group: M = 66.2, SD = 22.0). No difference was found between groups ( $t = -0.04$ ,  $p = .97$ ). It is possible that short length of stay in hospice care, the promotion of mobile hospice care at non-hospice unit, and the continuity of care may contribute to the above findings. More research is needed to test the effectiveness of the hospice care around the world. Keywords: hospice care, quality of life

## 944. Implementation of guidelines: decision-making in palliative care

Marieke Schreuder-cats<sup>1</sup>, Henk Vrehan<sup>1</sup>, Ginette Hesselmann<sup>1</sup>, Anja Moonen<sup>2</sup>, Saskia Teunissen<sup>1</sup>, Alexander De Graeff<sup>1</sup>

<sup>1</sup> University Medical Center Utrecht, Department of Medical Oncology, utrecht, Netherlands

<sup>2</sup> comprehensive cancer centre middle netherlands, utrecht, Netherlands

Background: In January 2006 national guidelines for palliative care were published in the Netherlands. In these guidelines, a structured approach of symptom management in 4 phases was developed: phase 1: gather information; phase 2: formulate working hypothesis, aim of the treatment & treatment plan; phase 3: evaluation; phase 4: readjust if necessary. Implementation of these guidelines is considered of the utmost importance to optimize palliative care. Aim of the study: To implement a structured step by step approach of palliative care using guidelines for symptom management. Method: A regional pilot project at 5 sites: 1 academic, 1 non-academic medical oncology ward, 1 palliative care unit in a nursing home and 2 hospices (high-care and low-care). A decision aid was developed (based on the approach mentioned above) of symptom management, supplemented by 11 summary cards concerning frequently occurring symptoms. After an initial education session clinical nurse specialists visited the site once a week during 6 weeks for coaching and for observation during the multidisciplinary patient meeting or daily ward rounds. Questionnaires were completed by doctors and nurses before the start and after 6 weeks. Results: Results of the evaluation are not yet available and will be presented at the meeting. Preliminary impression: This decision aid helps to ensure a structured approach of palliative care and to implement the use of symptom management guidelines in daily practice.

## 945. What is seen as good practice in palliative care (PC), palliative medicine (PM) and terminal care (TC) according to medical doctors (MDs), nurses and psychologists working in a Palliative Support Team (PST)?

Ruddy Verbinen, Fred Louckx

Vrije Universiteit Brussel, Department of Health Sciences, Brussels, Belgium

Little is known about the views held by PST-professionals on what they consider to be good practice of PC, PM and TC. Objectives : To provide representative conclusions about the perception on good care for palliative patients of MDs, nurses and psychologists working in PSTs, and comparison of three models PC, PM and TC within and between groups of professions. A postal questionnaire was designed, tested and sent to 216 professionals (including MDs, nurses and psychologists) working in one of the PST's. The questionnaire was designed following a profound study of the literature and in-depth interviews with 30 PC pioneers and experts and was put to a pilot study in 30 other PC experts. A battery of questions on perceptions of good practice were asked for the three models. 146 professionals (67.6%) provided us with a representative response. PC is considered to be different from curative care by 40% and complementary by 52%. We compared the three models. Most of the respondents perceive them as different from each other although a vast majority consider PC to be the umbrella of PM and TC. What is seen as good practice is different between the three models. The highest proportion of consensus for what is good practice exists in PC. Significant differences between MDs, nurses and psychologists will be discussed. There is no consensus on good practice in PC, PM and TC. The clearest dimension of care is the physical one.

## 946. A Set of National, Core Audit Tools to Help Hospices Meet the Requirements for Audit

Pauline Flanagan<sup>1</sup>, Andrew Thomson<sup>1</sup>, Marie Ballard<sup>1</sup>, Simon Fisher<sup>1</sup>, Maggie Griffiths<sup>1</sup>, Karen Maryon<sup>1</sup>, Usha Sodha<sup>1</sup>, Jenny Redman<sup>1</sup>, Jane Elliott<sup>1</sup>, Nick Pahl<sup>2</sup>

<sup>1</sup> Help the Hospices, National Audit Tools Group, London, United Kingdom

<sup>2</sup> Help the Hospices, International Development, London, United Kingdom

### Objective

To produce a set of generic audit tools that are supported by a set of excel spreadsheets which can be used by all hospices

### Methods

Help the Hospices National Audit Tools Group (NATG) was set up with a remit to produce a set of core audit tools, which could be used by all hospices irrespective of their processes or documentation systems.

The three topics that were chosen to be developed initially:

- In-Patient Admission and Initial Assessment
- Day Care Services
- Pain Management

Help the Hospices released the In-Patient Admission and Initial Assessment in February 2006 and Day Cares Services in September 2006. Pain Management is scheduled to be released in January 2007.

Two further audit tools, Medicines Management and Infection Control are currently being developed by the group.

The National Minimum Standards (Hospice and Core), the Standards for Better Health and the NICE Guidelines on Improving Supportive and Palliative Care for Adults with Cancer, 2004, together with other relevant national guidelines have been used to produce each of the audit tools.

Prior to release, the audit tools were tested in at least five hospices, quality reviewed by an independent external audit organisation and approved by the IHRC Quality and Standards Group. Following release, the tools will continue to be reviewed and updated.

### The type of audit

The audit tools have been designed to help hospices to undertake retrospective audits of patients' notes.

### Analysis of the data

Each audit tool is accompanied by a user friendly Excel spreadsheet pack. Once the data has been inputted, summary sheets and charts are produced automatically. These summary sheets and charts can be dropped directly into an audit report and/or Powerpoint presentation.

### Conclusions

The audit tools help hospices provide evidence that they have a systematic approach to audit, which is an integral part of the Healthcare Commission's inspection process. The importance of this work is recognised by the IHRC Quality and Standards group, therefore is included in the work plan for the period 2006-2011.

## 947. An audit of documentation and monitoring of steroid use in community palliative care patients

Sumana Pal, Yolanda Augustin, Harriet Roebuck, Joy Ross

St Joseph's Hospice, Palliative Medicine, London, United Kingdom

Background: Steroids are used for many indications in palliative medicine. Good practice requires monitoring of efficacy and side-effects. Details must be communicated when patients are transferred between clinical settings.

Aim: To evaluate prevalence of steroid use in community palliative care (CPCT) patients and assess documentation and monitoring of steroid use according to good practice guidelines.

Method: Notes of 175 CPCT patients were reviewed to identify patients taking steroids. A standardised proforma was used to document indications for use, dose, duration, co-prescribing of gastrointestinal protection, use of steroid cards and monitoring of efficacy and side-effects. Telephone interviews with 25% of patients assessed patient awareness of steroid prescribing.

Result: 48 patients (52% male) were on steroids. Indications for steroid use was documented in 73%: appetite/energy 43%, brain metastases 26%, chemotherapy 8%, pain 6%, cord compression 3%, other 14%. Start date was recorded in 81% but intended duration not documented in 56%. Treatment had been initiated by CPCT (35%), hospital (54%); unknown in 11%. Gastrointestinal protection was co-prescribed for 77%; no patient had a steroid card. Date of review by CPCT was recorded in 46%. 11/12 patients knew they were on steroids and intended use.

Conclusion: Documentation around steroid use needs to be improved. Guidelines for CPCT practice have been introduced with educational support prior to re-audit in 3 months.

## 948. The development of palliative nursing in the Netherlands 2002-2007

Thirza Olden, Koningswoud Koningswoud

Comprehensive Cancer Centre South, Palliative Care, Eindhoven, Netherlands

The Dutch Association of Palliative Nursing was founded in 2002. Starting with 62 members, the association has grown to 200 members, all nurses working in palliative care, in 2006. In the past five years, a lot of projects have been developed. The association would like to present these to our European colleagues in a posterpresentation by using a timeline. The projects the association will be working on in 2007/2008 will also be included in the poster.

## 949. PalCall - 3 years of a palliative care out-of-hours telephone support service

Iain Lawrie, Mary Elliker, Colin Campbell

St Catherine's Hospice, Scarborough, United Kingdom

It is increasingly recognised that patients with advanced, incurable disease and those involved in their care in the community require support and professional advice out-of-hours. For many, such support may enable them to remain living at home. In response to a perceived need for such support in the area served by St Catherine's Hospice, Scarborough, the PalCall out-of-hours telephone service was created. In the 3 years of its operation, the service has registered over 1200 patients, and has taken in excess of 1500 calls, each lasting on average 10 minutes. The majority of calls are received from those caring for someone with an advanced incurable illness, and almost one fifth of calls for advice or support have been from other health professionals. Calls were evenly split between those for advice regarding symptom control and those for other advice or support. A quarter of calls received required a visit to the patient in their own home by an NHS doctor, and one in ten by a general community nurse. Satisfaction with the PalCall service has been high among all users. The experiences from this project have been that patients and carers value and actively rely on support out-of-hours and, in many instances, this support has allowed patients to continue to be cared for in their own homes. Extension of the service to provide 24-hour cover is a possible future development.

# Poster abstracts

## 950. Spirituality in medical care

Etienne Rivier, Stéphanie Colombey

*Hôpital de Mottex, Gériatrie et soins palliatifs, Blonay, Switzerland*

What does the term spirituality mean for the nursing staff and doctors?

**Method :** at the beginning of a training session on spirituality for nurses and doctors working in palliative care ward, we have asked the participants to answer to four questions :

- 1) can you write three words which identify spirituality for you
- 2) is spirituality a part of the care you give in your daily activity?
- 3) is spirituality mentioned in the interdisciplinary team you are working in?
- 4) is your job a resource for you own spirituality?

**Preliminary results :** The first three words on a list of more than 100 words have been : beliefs, listening, meaning. For the majority of the participants, the answers have been yes to the questions 2 and 4.

**Discussion :** there is no universal definition of spirituality in the medical literature. However the importance of this concept and its approach for a good practice in palliative care is essential. Through this questionnaire we have determined three concepts for a pragmatic definition of spirituality and been able to verify its importance in the daily practice.

## 951. Family Meetings & Discharge Planning

Irene Murphy, Amanda Stavrou, Mary Buwalda, Yvonne Finnerty

*Marymount Hospice, Social work, Cork, Ireland*

Discharge planning is a complex part of palliative care services. Literature on discharge refers mostly to elderly patients in acute hospital settings, highlighting factors integral to discharge -eg needs assessment; early planning for discharge; adequate notice; multidisciplinary work; involvement of patient & family; liaison with community services. In Marymount the family conference facilitates communication with patients & families. The purpose of this research is to establish whether all identified patients had a pre-discharge family conference & whether the meeting covered the issues identified as important in discharge. A multi-disciplinary, retrospective review of 100 patient discharges from 2005 is being conducted. The social work team is reviewing family conferences as part of the review. A pro forma of factors facilitating discharge has been compiled. This includes time gap between meeting & discharge; presence of patient & carers at meeting; awareness of diagnosis & prognosis; identification of care needs & community resources. Retrospective audit has been criticized as time consuming & dependent on quality of records. But it makes an important contribution in evaluating practice, focusing on structure, process & outcome. It is hoped that the study will yield baseline information & a template for review of discharge planning.

## 952. Palliative physiotherapy: what is done and with what evidence?

Ulla Frymark, Lilian Hallgren, Ann-Charlotte Reisberg

*Stockholms Sjukhem Foundation, Oncology and Palliative Care, Stockholm, Sweden*

Palliative physiotherapy: what is done and with what evidence? Background The broad goal for physiotherapy in palliative care is to support the healthy—both physical and psychosocial – to help the patient attain the best possible quality of life during the remainder of his/her life. Specific short-term goals vary in response to patients' assessed needs. In general, palliative patients live longer today than previously and sometimes with great loss of function. This increases the need for rehabilitative efforts. Aim This poster will describe methods for the clinical practice of palliative physiotherapy in a specialized oncological palliative care centre, and the existing evidence for their use. Method All physiotherapeutic treatments (e.g. physical training, combined decongestive therapy, massage, TENS, etc) performed in a 6 month period have been documented in terms of frequency and time use. A literature search has been conducted to explore the evidence-base for the methods in use. Results A major function of the physiotherapists at this centre is to train and activate patients, in order to maintain their independence as long as possible. An evidence base exists for most treatment methods used, although not always developed from studies of palliative care patients. Since physiotherapeutic methods generally focus on specific symptoms, knowledge is often relevant for many patient situations, but should be used with good sense. Studies of the strengths and limitations of these methods in palliative care are needed.

## 953. Medical and nurse staff perceptions about symptom control, emotional support and family care in a University Hospital onco-hematological ward.

Joaquim Julia, Jordi Trelis, Montserrat Bleda, Emma Costas, Susana García, Merce Riquelme

*Institut Català d'Oncologia, Palliative Care Service, Badalona, Spain*

**Introduction:** Perceptions in symptom control (SC), emotional support (ES) and family (Fm) care among professionals working in an Onco-hematological ward are important in order to promote palliative in a University Hospital. Objective: Knowing about perceptions in medical and nurse staff on how SC, ES & Fm care are delivered. **Methods:** A semi-structured, self-administered, anonymous questionnaire was offered to all medical (Oncologists (O) and Hematologists (H)), nurse (N) and auxiliary nurse (A) staff from the onco-hematological ward in October 2006. Answers were blindly collected. Items about SC, ES and Fm care were rated by VAS (0: worst; 10: best). **Results:** Answer rate: O: 40%, H: 53%, N & A: 39%. Pain control (O/H/N/A): 6, 4/7, 3/3, 5/4, 7; Delirium control: 6, 1/7, 1/3, 9/4, 7; Constipation control 5, 8/5, 3/4, 7/4, 2; Xerostomy control: 6, 2/4, 8/5, 7/5, 6. Patient (Pt) ES: 7, 9/6, 9/4, 3/4, 8; Fm ES: 7, 9/6, 9/3/4, 9/4, 6; Professional ES: 1, 6/3, 0/1, 5/1, 6; Professional opinion: 7/3, 5/9, 3/0, 2/2. Pt information: 7, 2/6, 7/4, 0/3, 6; Fm information: 7, 6/7, 6/4, 2/3, 7; Fm attention: 8, 1/6, 9/5, 6/5, 8; Fm comfort: 2, 4/3, 0/3, 6/3, 7. **Conclusions:** N & A notice worse pain, delirium, constipation control and ES to Pt & Fm than O and H do. N & A feel their opinion to have the lesser impact on decisions about patients. H express to get better ES than O, N & A. H also notice worse xerostomy control than the rest of staff H and O feel Pt & Fm to be better informed than N and A do. O feel Fm to be better cared than other staff do. All medical and nurse staff notice a low level of Fm comfort

## 954. Poetry Reading as Creator of Meaning - Poetry Reading Groups in Nursing Homes and Hospices

Inger Eriksson

*Lund University, Theology, Lund, Sweden*

There is a need for patients in palliative care to express existential issues and find opportunities for that. Poetry and a poetry reading group can be such places. Through the ambiguity of a poem and its use of metaphors and rhythm participants in a poetry reading group are given the opportunity to express their own experiences indirectly. This study about poetry reading groups in nursing homes and hospice run by the hospital chaplaincy focuses on how poetry and poetry reading in a group that offers opportunities for conversation can help patients in palliative care to cope with their life situation. It is a qualitative study that combines intervention, participant observation, interviews and the use of theoretical perspectives. The study shows that poems arising memories and poems where participants recognise themselves touch deeply. Urgent themes include love, death and despair. Poems with an atmosphere in tune with the mood of the reader, as well as those in a different mood, can mentally help. Poems that help the participants to express and share feelings and thoughts about their own life situation are helpful for their coping.

Poetry reading and conversation in a poetry reading group can give the participants fellowship, meaning, a sense of well-being, relief, comfort, joy, inner peace and an opportunity to express their hope, longing, grief for losses and concern about important issues in life.

## 955. Growth Trends in Palliative Care Consultation Requests

Steven Radwany, Hallie Mason, Steve Clarke, Teresa Albanese, Lynn Clough

*Summa Health System, Internal Medicine, Akron, United States*

**Aim:** The aim of this research is to describe and analyze trends in palliative care consult services in a 645 bed tertiary care teaching hospital over the first four years. **Methods:** This retrospective study uses descriptive trend analysis of the Palliative Care Consult Services administrative data. **Results:** The palliative care consult service is projected to serve more than 2300 patients and their families in the first four years. The number of referrals has increased steadily with 289 in 2003 and 805 projected for 2006. The most prevalent primary diagnoses of patients continue to be respiratory failure, lung cancer, end stage heart disease, and stroke. The primary reason

for consult requests continues to be for end-of-life issues. Initially, most referrals came from intensive care units. Over the years, there has been a steady growth of patient referrals from general medical floors. Trends in days of admission until referral have shown a consistent annual decline, thus indicating reduced delay for referrals. It is estimated that the Palliative Care Consult Service saved over 2900 unnecessary patient days for intensive care units and the general medical floors.

**Conclusions:** Growth in palliative care consult requests reflects physicians' recognition of the benefit of the service to patients and their families in addressing end-of-life issues.

## 956. A Cost Comparison of Patients Dying on an Acute Palliative Care Unit versus other Inpatient Units

Mamta Bhatnagar, Steven Radwany, Charina Gayomali, Teresa Albanese, Lauren Currie

*Summa Health System, Internal Medicine, Akron, United States*

**Aim:** This project aims to measure the impact of an acute palliative care unit (APCU) on the cost of care in an acute tertiary care hospital.

**Methods:** We are conducting a retrospective case control study of patients who died in a 12 bed palliative care unit and patients who died in other medical and surgical units. The patients will be divided into 2 cohorts based on their premorbid diagnoses of cancer and non-cancer conditions. Noncancer diagnoses include congestive heart failure, respiratory failure, debility and chronic kidney disease.

**Results:** The results represent care provided to approximately 200 patients during the first 6 months of operation of an acute palliative care unit. Analysis of variance of mean total costs will identify differences between the cost of care of cancer and non-cancer patients on the acute palliative care unit and other inpatient medical units. Descriptive data analysis will include patients' mean length of stay, personnel time and costs, patient/family satisfaction, and the average monthly census on the APCU.

**Conclusions:** The results of this study will document the financial impact of an acute palliative care unit in a tertiary care hospital and inform the design of prospective studies that include clinical outcomes to assess the value of acute palliative care units.

## 957. A REVIEW ON THE CARE OF THE DYING PATIENTS IN A HOSPICE IN SINGAPORE AFTER IMPLEMENTATION OF A MODIFIED INTEGRATED CARE PATHWAY FOR 4 YEARS

Joshua KOK

*Dover Park Hospice, Singapore, Singapore, Singapore*

Introduction: Our hospice implemented an Integrated Care Pathway (ICP) for the dying patients in Nov 2002. The ICP was modified from the model developed by Royal Liverpool University Hospital. We conducted a review on the care of our dying patients from the period May to Oct 2006, and compared with a similar review done when ICP was first started.

Method: We compared the proportion of deaths that were started on ICP, anticipatory prescribing for the common symptoms in the last hours and the control of these symptoms in the last 4 hours of life.

Results: Proportion of deaths started on ICP was 85.1% (previously 70.7%). The anticipatory prescribing for common symptoms were all 100% (previously 78.5 to 98.5%). Symptoms were well controlled in the last 4 hours in 96.9% (pain), 99.2% (agitation), 87.8% (respiratory tract secretion), 99.2% (nausea & vomiting) and 77.7% (breathless). These were similar to before but proportion of uncontrolled breathlessness had increased.

Conclusion: The ICP is a useful outcome indicator of the care of our dying patients in our hospice over different periods of time. The increased in proportion of deaths on ICP showed that the staff were more confident in recognising death was near. Certain change in policy could help to improve the care. We are currently analyzing our data for the probable reasons for the increased in uncontrolled breathlessness.

## 958. PALLIATIVE CARE IN A DEVELOPING COUNTRY: PROBLEMS TO BE SOLVED

Natasa Milicevic, Leonida Mirilo, Bojana Kostovic

*Centre for palliative care and palliative medicine BELhospice, Belgrade, Serbia*

In Serbia, the country with 7,5 million inhabitants, palliative care is not recognized as a holistic approach for patients with limited life expectancy. In 2004., BELhospice was established as the very first specialized palliative care service in our country.

**Aim:** To indicate main problems that BELhospice faces.

**METHOD:** Personal and professional observation about the obstacles after two years of experience.  
**RESULTS:** The main problems are: actual legal framework, professional bias and poor opioid availability. The cultural inheritance and limited funds additionally complicate our professional work.  
**CONCLUSION:** In near future, the education for professionals, general public and policy makers is highly warranted.

## 959. Meaning-in-life in the Federal Republic of Germany: Results of a representative survey

Martin Fegg<sup>1</sup>, Mechtild Kramer<sup>1</sup>, Frederic Stiefel<sup>2</sup>, Gian Domenico Borasio<sup>1</sup>

<sup>1</sup> Interdisciplinary Center for Palliative Medicine, Munich University Hospital, Munich, Germany  
<sup>2</sup> Psychiatry Service, University hospital, Lausanne, Switzerland

The construct of meaning-in-life (MiL) has important implications for palliative care. Difficulties regarding the measurement of MiL are related to the various conceptual approaches and its interindividual variability. Therefore the "Schedule for Meaning in Life Evaluation" (SMiLE), a respondent-generated instrument for the assessment of individual MiL, was developed. The aim of this study was to evaluate the individual MiL in a representative German sample. In July 2005, 1,004 individuals were randomly selected and interviewed by telephone. 3,521 areas of MiL were listed and assigned to 13 a-posteriori categories. Subjects were most satisfied with partnership and religion/spirituality, and least satisfied with work and finances. Health, partnership, and family were most important for MiL, home/garden and leisure time were least important. 16-19 y/o subjects were most likely to list friends, 20-29 y/o listed partner, 30-39 y/o work, 60-69 y/o health and altruism, and >70 y/o animals/nature and spirituality. Females scored higher on all outcome scores. Individuals with higher education, higher net income, and subjects living in rural areas were most satisfied with their MiL. This study is a first nationwide survey on MiL in a randomly selected representative sample. The MiL areas of the age stages seem to correspond with Erikson's theory of psychosocial development. The results provide comparative data for further MiL studies in palliative care patients.

## 960. A history of the Project on Death in America: programs, outputs, impacts

David Clark

Lancaster University, Institute for Health Research, Lancaster, United Kingdom

**Background:** From 1994-2003 the Project on Death in America (PDIA) was a prominent part in end of life care innovations in the United States. PDIA programs involved numerous individuals and organisations, working across the USA and also in Eastern Europe  
**Aims:** To develop a fully documented analysis of the history of PDIA, including its management, programs, outputs and impacts.  
**Method:** 59 individual and group interviews; case studies of specific initiatives and programs; documentary analysis of key PDIA sources (correspondence; minutes of meetings, reports, web pages, financial statements); literature reviews.  
**Findings:** PDIA produced a wide range of innovative activities that explored the meanings of death in American culture and highlighted experiences of care at the end of life. It led to extensive service development and practice innovation. It contributed to the evidence base for palliative care and the emergence of a new field of specialisation. It addressed the needs of underserved communities at the end of life and barriers to improved care, as well as legal and ethical challenges.  
**Conclusion:** PDIA generated innovative strategies for transforming the culture of end of life care, by: empowering individuals and communities; promoting organisational change; encouraging research and development and educational activities; supporting public debate and the consideration of ethical issues.

## 961. Freedom in Movement

Unni Nygaard

Hospice Lovisenberg, Oslo, Norway

At Hospice Lovisenberg in Oslo, Norway, the patients are offered the choice of various physical activities and exercises, adapted to the individual patients functional ability. These activities take place either indoors, or outdoors. There is a choice of individual training, group activities (in the form of exercises, or simple games), walks, ball games, swimming, or other aquatic exercises. In past winters, there was even a trip out on snow-shoes! Movement and function are some of the key concepts in physiotherapy, and one of the purpose

of the activities at Hospice Lovisenberg, is to give patients the experience of a few moments of freedom from their serious illness. Obviously the day-care patients are the most mobile – in varying degrees – but the ward patients are also offered activities to suit their abilities. Patients can, for example, experience the following:-awareness of their bodies by everything from light massage to slightly more strenuous activities - a feeling of having some control over some part of their bodies-doing some activities that people who not are ill also are doing. Small things can mean a lot for the chronically ill patients, and there are no limits to what can be offered – just possibilities!

## 962. Malignant Spinal Cord Compression: A Retrospective Study of Current Management and Adherence to Prospective National Guidelines

Jyotsna Magapu<sup>1</sup>, Helen Emms<sup>2</sup>, David Husband<sup>3</sup>

<sup>1</sup> University of Liverpool, Faculty of Medicine, Liverpool, United Kingdom  
<sup>2</sup> St Johns Hospice, Wirral, United Kingdom  
<sup>3</sup> Clatterbridge Centre for Oncology, Wirral, United Kingdom

### Introduction

Malignant spinal cord compression (MSCC) is an important complication of cancer associated with high morbidity and mortality. Research based evidence for its management exists but no UK national guidelines have been implemented.

### Aims

1. Identify delays in management
2. Assess whether current service provision in Wirral adheres to existing regional and prospective national guidelines
3. Assess functional mobility and survival after MSCC

### Method

A retrospective study on alternate patients with MSCC over a 12 month period in a regional oncology centre. Data was collected on presentation, management, mobility and mortality.

### Results

57 patients were included. 86% (49/57) were referred within 24 hrs of presentation. Leg weakness (70%; 40/57) and back pain (65%; 37/57) were the commonest presenting symptoms. 34/40 (85%) referred to oncology without imaging had an MRI scan within 24 hrs. The commonest compression site was thoracic (79%; 45/57); 21% (12/57) had 2 or more compression sites. 81% (46/57) received palliative radiotherapy within 24 hours. Mobility 2 months post-treatment was universally worse. 53% (30/57) died within 90 days; 81% (46/57) within the year.

### Conclusions

Poor casenote documentation made evaluation difficult. Education and review of use of resources out of hours are required to overcome identified delays in management. Local management of MSCC generally adheres to local guidelines; aspects of prospective national guidelines were seen to be in practice already.

## 963. The development and implementation strategy of multidisciplinary palliative care in a large teaching hospital in the Netherlands

Luc Strobbe<sup>2</sup>, Marjo Glibling-Gommans<sup>1</sup>, Cilia Galesloot<sup>1</sup>, Nelleke Engels-Keegstra<sup>1</sup>

<sup>1</sup> Comprehensive Cancer Centre East, Palliative Care, Nijmegen, Netherlands  
<sup>2</sup> Canisius-Wilhelminaziekenhuis, Department of Surgery, Nijmegen, Netherlands

The Canisius Wilhelmina Hospital (CWZ) is a large teaching hospital (583 beds) in the east of the Netherlands. More than 600 patients die every year in this hospital. Some 240 of them have a chronic disease and do not die abruptly. Despite this large group of patients in need of palliative care no general strategy was developed in the hospital until 2001. Especially guidelines, teaching policy or multidisciplinary palliative care team were lacking. The hospital board started a multidisciplinary working group to evaluate the care for the dying. In the first survey major problems encountered by nurses and medical specialists proved to be differences in individual knowledge or expertise, and differences in culture between the departments in the way palliative care was handled. These results were the starting point for an improvement strategy. The main aim is a step by step implementation of the national guidelines in palliative care in the hospital. The implementation will follow a structured path tailored to the needs of each department. Each department will start to develop a pathway for the main issue that has been recognized in the first survey. Each solution will be generalized for introduction in a hospital broad format. This means improvement of knowledge, expertise and practise. With each next cycle the hospital as a whole should improve on selected palliative care items. Repeating this cycle should lead to progressive implementation of the guidelines throughout the hospital.

## 964. The challenge of effective communication in the dying phase: benchmarking evidence from the Liverpool Care of the Dying Pathway (LCP) in two cancer networks in England

Maureen Gambles<sup>1</sup>, Tamsin McGlinchey<sup>1</sup>, Deborah Murphy<sup>1</sup>, Stephanie Gomm<sup>2</sup>, John Ellershaw<sup>1</sup>

<sup>1</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom  
<sup>2</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom  
<sup>3</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom  
<sup>4</sup> Salford Royal Hospitals NHS Trust and Trafford Healthcare NHS Trust, Medical, Manchester, United Kingdom  
<sup>5</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom

**Aim** Communication between health care professionals and patients and carers remains a challenge (NICE, 2004). The aim of the present study was to survey the care documented on completed LCPs against communication goals with patients and carers in the hospital environment. Goals included: assessing awareness of prognosis; spiritual and/or religious need and discussion regarding the revised plan of care on commencement of the LCP. **Method** In a retrospective case note survey of data from 20 consecutive completed LCPs from 5 hospitals (Phase 1a – 96 patients) and 12 hospitals (Phase 1b – 207 patients) were scrutinised. Descriptive statistics were used to summarise the % of goals 'achieved' after patients who were coded 'comatose' were removed from the sample.

### Results

| Goal                                       | Phase 1a<br>(n = 96) | Phase 1b<br>(n=207)                  |                |     |
|--------------------------------------------|----------------------|--------------------------------------|----------------|-----|
| Patient                                    | Carer                | Patient                              | Carer          |     |
| Awareness of Prognosis                     | 48%<br>(n=77)        | 85%                                  | 42%<br>(n=142) | 82% |
| Assessment of Spiritual/<br>Religious need | 65%                  | 55%<br>(n=163)                       | 68%            |     |
| Explanation of the plan of care            | 83%                  | (assessment of patient and/or carer) | 33%<br>(n=147) | 82% |

**Conclusion** Communication with carers is documented 'achieved' in a relatively high proportion of these goals. The need for specific training is highlighted for: face to face communication with/assessment of patients and for the assessment of spiritual/religious needs. Future research should explore the barriers to optimum achievement of these goals. (assessment of patient and/or carer)

## 965. Benchmarking Care of the Dying with the Liverpool Care of the Dying Pathway (LCP)

Maureen Gambles<sup>1</sup>, Tamsin McGlinchey<sup>1</sup>, Deborah Murphy<sup>1</sup>, Stephanie Gomm<sup>2</sup>, John Ellershaw<sup>1</sup>

<sup>1</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom  
<sup>2</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom  
<sup>3</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom  
<sup>4</sup> Salford Royal Hospitals NHS Trust and Trafford Healthcare NHS Trust, Medical, Manchester, United Kingdom  
<sup>5</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom

**Aim** A benchmarking exercise using the LCP was undertaken in one cancer network (phase 1a) to explore care delivery in the dying phase in 16 organisations. Areas of good practice as well as areas for improvement were highlighted and the exercise was positively evaluated. The aim of the present study was to replicate this work in a second cancer network specifically to map the use of the LCP and to use the LCP to survey the care delivered to provide a comparison between organisations in hospice, hospital and community sectors. **Method** In a retrospective case note survey organisations using the LCP were invited to contribute data from 20 consecutive pathways of patients who had died under the care of their teams. **Results** 24 organisations: 12 hospitals; 6 hospices; 6 community teams submitted data from 394 patients. Results broadly replicated those of phase 1a. Good practice exists in all sectors, particularly for anticipatory prescribing and discontinuing inappropriate interventions (mean - 83% hospital, 89% hospice, 89% community). For insight, communication and religious support, the means were lower in the hospital environment (68%) compared to the hospice (83%) and community (86%). Goals concerning communication with the patient were lower across the board. **Conclusion** The survey provided meaningful comparative data across salient areas of care, and has formed the foundation for a national audit of the care of dying patients in acute hospitals in England.

# Poster abstracts

## 966. Attachment Security and Depressive Symptoms in Patients with Metastatic Cancer: A Longitudinal Study

Gary Rodin <sup>1,2</sup>, Andrew Walsh <sup>2</sup>, Christopher Lo <sup>2</sup>, Camilla Zimmermann <sup>1,2</sup>, Lucia Gagliese <sup>2,3</sup>, Jennifer Jones <sup>1,2</sup>, Frances Shepherd <sup>4</sup>, Malcolm Moore <sup>4</sup>, Michal Braun <sup>5</sup>, Mario Mikulincer <sup>6</sup>

<sup>1</sup> Princess Margaret Hospital, University Health Network, Psychosocial Oncology and Palliative Care, Toronto, Canada

<sup>2</sup> University Health Network, Toronto General Hospital Research Institution, Behavioral Sciences and Health Research, Toronto, Canada

<sup>3</sup> York University, Kinesiology and Health Science, Toronto, Canada

<sup>4</sup> Princess Margaret Hospital, University Health Network, Medical Oncology, Toronto, Canada

<sup>5</sup> Hadassah University Hospital, Sharet Institute of Oncology, Jerusalem, Israel

<sup>6</sup> Bar-Ilan University, Psychology, Ramat-Gan, Israel

**Aim:** This prospective study tested a model for the emergence of depressive symptoms in patients with metastatic GI or lung cancer. **Method:** Outpatients attending oncology clinics at a comprehensive cancer center in Toronto, Canada, completed bimonthly assessments until the end of life. Measures included BDI-II, MOS-SSS, FACIT-sp, MSAS and Experiences in Close Relationships. **Results:** At baseline (n=326), patients reported a mean of 6.9 (sd=4.8) physical symptoms, and 23% of the sample reported significant levels of depression (BDI≥15). Depressive symptoms were associated positively with physical symptoms (p<.001) and negatively with spirituality (p<.001) and social support (p<.001). Attachment security buffered the negative effect of physical symptoms on depression (p<.001), which was partially mediated through social support (p<.05). Longitudinal analyses on a subset of patients who subsequently died (n=231) indicated that depression and physical symptoms increased over time (p<.004) but that attachment security protected against the effect of progressive physical symptoms on increasing the severity of depression (p=.007). **Conclusion:** These results suggest that attachment security may protect from depression as physical burden increases and the end of life approaches. These findings have implications for the evolution of emotional distress in patients with advanced and terminal disease and for the early provision of support tailored to specific relational needs.

## 967. 'Meaning of Life' Audit of Spiritual Assessment and Care in Specialist Palliative Care

Karen Groves, Marijtte Drijfhout, Phil Saltmarsh, Catherine Baldry, Bernice Sanders

Merseyside & Cheshire Cancer Network, Supportive Care Group, Spirituality Subgroup, Liverpool, United Kingdom

The Merseyside & Cheshire Cancer Network (MCCN) appointed a Supportive and Palliative Care Group (SPCG) to oversee the implementation of the NICE (National Institute for Clinical Excellence) Supportive and Palliative Care Guidance within MCCN. The Spiritual Care Subgroup of the SPCG undertook an audit of the recording of spiritual and religious needs and the provision of spiritual and religious care across both adult and children's services by palliative care staff in MCCN area.

The results of this audit were presented to the Merseyside and Cheshire Palliative Care Network Audit group at Easter 2006. This poster/presentation demonstrates the findings of that audit and the Network Spiritual Care Standards and Guidelines which resulted from it.

## 968. Reviewing Life Review in the Palliative Care of People with Learning Disabilities

Tricia Allen <sup>1</sup>, Linda McEnhill <sup>2</sup>

<sup>1</sup> St. Christopher's Hospice, Social work, London, United Kingdom

<sup>2</sup> St. Christopher's Hospice, Education, London, United Kingdom

Life Review (LR) has been described as "Story of the Self in the world" (Levinson 1980). This tool, which provides an organising framework for the interpretation and resolution of the individual's life story, was developed initially for use with elderly people and later modified to take account of Erikson's "Ages of Man" concept (Erikson 1963). It has since been adapted for use with dying people of all ages and seen by many practitioners as an integral element of palliative care (Butler 1963, Lester 1995, Sheldon 1997, Truman & Parker 2004). Despite this it has been suggested that it is unsuitable for use with people who have intellectual disabilities (PWID) on the basis that those such as Edinberg suggest that LR can only be offered to "clients who have sufficient verbal skills and cognitive ability both to recall previous events and achieve some insight into them" (Edinberg

1985, Lester 1995). This paper will review that thinking in the light of PWID's ability to utilise other types of therapeutic enterprise, will utilise case material demonstrating LR with PWID and make suggestions of ways in which both the tool and practitioner need to adapt to effectively hear the stories of patients with intellectual disabilities at the end of life. By the end of the session delegates will have gained an overall understanding of this technique in therapeutic end of life care and its specific application for PWID.

## 969. Identification of potential risks in how prescribing and dispensing of medication is handled in palliative care in Sweden: A telephone based interview study with physicians by PANIS, the Swedish Palliative Care Research Network. Barbro Norrström, ASIH

Barbro Norrström

ASIH Langbro Park, ASIH, Stockholm, Sweden

**Background&Aim** Most challenging goal to achieve is symptom control which to a great extent is accomplished by medication. Adverse drug events (ADE) are common and cause serious harm. Do a potential risk of ADE relate to the prescriptions and drugs delivered from the chemist or from a ward stock in Dosett boxes according to the drug chart? Do changes enhance the risk? Is the supply of "as per required" (p.r.n) medication a risk if delivered from ward stock separately? **Method** PANIS covers more than 80 % of specialised Swedish palliative care units. The network is internet based. Descriptive research can be performed easily. Physicians in charge had an introductory letter-questionnaire. **Results** 63 palliative care physicians were contacted 46 interviews took place covering 6076 patients 23 units had Dosetts from stock for some or the majority of patients. Dispensing and delivering Dosetts did not appear to be regarded as a potential risk of ADE: Guidelines in units with a longer history of dispensing in Dosett were very strict. Generic drugs can cause serious ADEs. "P.r.n medication" can create a problem if delivered from the PHC dispensary unless strict assessment guidelines. **Conclusion** To some degree an awareness of patient safety exists. "P.r.n" and the reducing or withdrawing of medication in Dosetts as potential ADEs still seem to be underestimated. Emphasising existing guidelines and acknowledging the need of new guidelines is crucial.

## 970. Australian Palliative Care Clinical Studies Collaborative (PaCCSC)

Tania Shelby-James <sup>1,2</sup>, David Currow <sup>1</sup>, Debra Rowett <sup>3</sup>, Susan Whicker <sup>1</sup>, John Plummer <sup>4</sup>, Geoff Gourlay <sup>4</sup>, Simon Eckerman <sup>5</sup>, Amy Abernethy <sup>1,6</sup>

<sup>1</sup> Flinders University, Department of Palliative and Supportive Services, Adelaide, Australia

<sup>2</sup> Repatriation General Hospital, Department of Palliative and Supportive Services, Adelaide, Australia

<sup>3</sup> Repatriation General Hospital, Drug and Therapeutic Information Service, Adelaide, Australia

<sup>4</sup> Flinders Medical Centre, Pain Management Unit, Adelaide, Australia

<sup>5</sup> Flinders University, Flinders Centre for Clinical Change and Health Care Research, Adelaide, Australia

<sup>6</sup> Duke University Medical Centre, Durham, United States

**Background:** The Australian Government has provided funds for a national multi-site palliative care clinical studies research collaborative. The collaborative (PaCCSC) will build the evidence base to improve the affordable access to key medications for symptom control in the community. PaCCSC includes key people experienced in palliative care clinical research, complemented by experts in clinical pharmacology, pharmacoeconomics, biostatistics and clinical study methodology. PaCCSC will work with all stakeholders to deliver the best outcomes.

**Methods:** A national Board oversees the activities of PaCCSC. A Scientific Committee made up of a wide range of experts outside palliative care will be the peer review process for trial development. A Trial Management Committee will oversee the execution of individual studies. Six sites have been identified.

**Results:** Medications for the first studies have been identified and trial committees formed to begin protocol development. It is anticipated recruitment for these studies will commence in early 2007.

**Conclusion:** PaCCSC will allow palliative care to more formally explore efficacy, effectiveness and safety of key medications. At the same time, it is going to allow palliative care clinical researchers from across the country to work closely together on rigorous, adequately powered randomised studies. The infrastructure developed by PaCCSC will facilitate capacity building for future work.

## 971. A study of nutritional problems and support in cancer patients- enrolled in palliative advanced home care teams in the Stockholm region of Sweden

Ylva Orrevall <sup>1,3</sup>, Carol Tishelman <sup>2,3</sup>, Johan Permert <sup>1</sup>

<sup>1</sup> Karolinska Institutet, Department for Clinical Science, Intervention and Technology, Stockholm, Sweden

<sup>2</sup> Karolinska Institutet, Department of Neurobiology, Care Sciences and Society, Division of Nursing, Stockholm, Sweden

<sup>3</sup> Stockholms Sjukhem Foundation, Research and Development Unit, Stockholm, Sweden

**Aim:** To study nutritional problems and support in cancer patients in palliative stages in relation to time to death. **Method:** Data was collected at two time points through telephone interviews with cancer patients enrolled in 21 advanced home care teams in the Stockholm area. The structured interview investigated nutritional problems, food-preference, nutritional support and similar issues, focusing on the week prior to the interview. Clinical and demographic data was collected from patients' medical records. **Results:** Data from 623 interviews is under analysis. Patients' mean age was 67 years and 55% were women. 35 % of the sample lived <3 months and 25% lived >1 year. Eating problems at some point during illness were reported by 87% of the patients, with 58% reporting eating problems during the past week. During the week prior to interview 39% had used oral nutritional supplements (ONS) and 14% received artificial nutrition (parenteral or tube feeding). Artificial nutrition was received by 9% and oral nutritional supplements by 39% of patients living > 3 months post interview, while 40% of patients had lost >10% of their body weight but reported no nutritional support. Of patients living < 3 months post interview 22% received artificial nutrition and 38% ONS. The completed analysis will be presented in relation to time to death post interview, and discussed in terms of relationships between patients' needs and nutritional support.

## 972. Use of and payment for health and social care in the year before death: How does it vary with financial circumstances and age?

Barbara Hanratty, Ann Jacoby, Margaret Whitehead

Liverpool University, Division of Public Health, Liverpool, United Kingdom

**Background** Terminal illness presents a financial challenge for many households, but in Britain the situation should be eased by state benefits, such as attendance allowance, which is available to everyone in the last six months of life irrespective of income. **Objectives** To investigate use of and payment for health and social services by people in the year before death, and receipt of illness-related benefits, by individuals in differing financial circumstances.

**Design** Analysis of individual data on the 1652 community dwelling decedents from 12 waves of the British Household Panel Study (1991-2003)

**Results.** In the year before death over 90% of decedents had seen their family doctor, and around one third had spent some time in hospital. More than 80% paid no fees for any services. Over a third of decedents aged over 65 reported financial strain, but fewer than one in six of these were receiving attendance allowance. People who felt that they were having financial difficulties were more likely to be frequent attenders in primary care, taking age, health status and other factors into account (adjusted OR 1.9, 95% CIs 1.3 to 2.6 p<0.001). Older age was associated with lesser use of primary, but not secondary care.

**Conclusions.** Financial strain was common, but benefit uptake low. Primary care professionals saw nearly all decedents in their last year, and could play an important role in ensuring that the elderly and the less well-off are aware of services and benefits available.

## 973. CONFLICTS IN END OF LIFE CARE IN FRENCH SPEAKING WALLIS - SWITZERLAND: A PUBLIC HEALTH ISSUE?

EMMANUEL KABENGLE MPINGA <sup>1</sup>, HENK VERLOO <sup>1</sup>, PHILIPPE CHASTONAY <sup>2</sup>, CHARLES-HENRI RAPIN <sup>1,2</sup>

<sup>1</sup> Institut Universitaire Kurt Bosch / Sion - Switzerland, Ethics and Palliative Care, Sion - Switzerland, Switzerland

<sup>2</sup> Geneva University, Social & Preventive Medicine Institute, Geneva, Switzerland

### Background

In palliative care, conflicts in end of life are often present. Their prevalence, intensity, causes, effects and resolution strategies remains little known.

**Objectives** To identify health professional's conflicts perceptions in the end of life and to analyze their nature, prevalence, intensity, causes effects and resolution strategies.

**Methods** A cross-sectional study was done among 460

health professionals working in acute hospitals, chronic health institutions, nursing homes and ambulatory palliative care units.

**Results:** 233 persons replied (50.6%)- 82.4% reported to be confronted to end of life conflicts- Conflicts were quite rare (66%) and of medium or high intensity (86%)- Conflicts were of medical nature (74%) or related to ethic issues (64%)- Conflicts occurred among family members (68%), medical doctors and nurses (49%) or patients and medical staff (16%) Poor communication, ambivalence among parties, differences in value systems were the main causes. Waste of resources, physical and the psychological burn-out were noted as the effects of these conflicts. Interdisciplinary seminars, internal supervision procedure and the sharing of experiences appeared as resolutions strategies. Neither age, nor gender, professional experience, working place, training were predictive of exposure to conflicts.

**Conclusion:** End of life conflicts are common. They may compromise the quality of care and contribute to high economic and social costs. They should be put on the public health agenda as a high priority.

## 974. Symptom control, caregivers satisfaction and terminal cancer patients care at home.

JOAN LLOBERA<sup>1</sup>, MERCE LLAGOSTERA<sup>2</sup>, MAGDALENA ESTEVA<sup>1</sup>, JOANA RIPOLL<sup>1</sup>, ENRIC BENITO<sup>3</sup>, ADORACION SANCHE<sup>1</sup>, EVA MARSO<sup>1</sup>

<sup>1-3</sup> Majorca Primary Care Department-Ibsalut, Unit of Research, Palma de Mallorca, Spain

**Objectives:** To evaluate the satisfaction of the caregivers terminal cancer patients at home in relation with symptom control.

**Methods:** Design: Follow-up study. Main caregiver interview after 1-3 month of patient death. Setting: Majorca; 40 primary centres, 5 home care (HC) teams. Subjects: cancer patients that spend almost 15 days at home in the last month of life and their caregivers. Measurements: Caregivers interview contained symptoms evolution and satisfaction on health care (SERQUAD), a questionnaire validated for home care based on likert responses (degree agreement 1 to 5).

**Results:** 107 patients, 88,8% caregivers women, aged 52,5 years (SD 10.6). They declared that most of the symptoms worsened in the last days: 67.7% in those with pain, vomiting in 36.1%, dyspnea in 78.8%. In spite of symptoms worsening, caregivers agree (score 4-5/5) that health professionals relieved symptoms; 88.2% in those with pain, 90.9% with nausea's, 87.1% with dyspnea. Caregivers stated that also 74.5% of patients worsened their emotional status. They considered that doctors and nurses has been concerned about this fact (95,6%). Caregivers were very satisfied (82.6%) with health HC. Only 7.8% considered that the patient would be better cared at hospital.

**Conclusions:** In spite of the very poor health status of terminal patients in the last days, caregivers declare that health care professionals relieved their symptoms and were concerned with patients mental distress. Caregivers were very satisfied with the care received at home.

## 975. Deficits in hospital-based palliative medicine limit discharge of patients with home care technology

Renske Boogaard,, Erica Witkamp,, Angelique Wit, de, Karin Rijt, van der

Erasmus MC - Daniel den Hoed, Medical Oncology, rotterdam, Netherlands

### Introduction

Patients with complex problems in palliative care are often admitted to hospital for symptom management. In some of these patients parenteral medication is needed. Many patients prefer spending as much time as possible at home. However, transfer of patients who need home care technology (HCT) for parenteral medication is complex. In the Erasmus MC nurse specialists with specific knowledge and expertise in palliative care and HCT coordinate the discharge of these patients to home. Other hospitals in Rotterdam seldom discharge patients with HCT. We analysed the reasons for this paucity.

### Method

In 3 hospitals semi-structured interviews were held with 27 professionals, i.e. medical oncologists, anesthesiologists, pharmacists, (oncology) nurses, to evaluate their opinion on the management of symptoms in palliative care, the discharge process and its pitfalls.

### Results

Results were similar in the 3 hospitals. In none of the hospitals a vision on palliative care was developed, neither were treatment protocols for pain and symptom management. Communication between different disciplines was poor. Deficits in knowledge on pain management and HCT were mentioned. Furthermore, in case of HCT the discharge process was not protocolized.

### Conclusion

Hospitals need to develop a vision on their role in palliative care. Communication between professionals

need to be improved. Courses on palliative care and HCT are needed and the development of protocols may facilitate discharge processes.

## 976. How much subcutaneous route do we use?

Javier Rocafort<sup>1</sup>, Silvia Librada<sup>2</sup>, Laura Blanco<sup>3</sup>, Teresa Galea<sup>4</sup>, Yolanda Ruiz<sup>5</sup>, Beatrice Pop<sup>6</sup>

<sup>1</sup> Extremaduran Health Service, Regional Palliative Care Program of Extremadura, Mérida, Spain

<sup>2</sup> Extremaduran Health Service, Regional Palliative Care Program of Extremadura, Mérida, Spain

<sup>3</sup> Extremaduran Health Service, Regional Palliative Care Program of Extremadura, Mérida, Spain

<sup>4</sup> Extremaduran Health Service, Palliative Care Team (RPCPEX), Cáceres, Spain

<sup>5</sup> Extremaduran Health Service, Palliative Care Team (RPCPEX), Badajoz, Spain

<sup>6</sup> Extremaduran Health Service, Palliative Care Team (RPCPEX), Navalmonal de la Mata, Spain

### Background:

Subcutaneous route (SCR) is frequently used in palliative care (PC) settings. It is recommended by the literature as an alternative to the oral route when patients lost it. The aim of this study is to know the prevalence of use of SCR between the whole universe of terminally ill patients in Extremadura, an Spanish region.

### Method:

Patients followed by all PC teams in Extremadura in three given days (separated 45 days) were included in the survey. Investigators asked to physicians for number of patients treated by SCR, number of patients under continuous infusion of drugs, and type of drugs used.

### Results:

All PC teams participate in the survey, and 407 patients were included. 40 patients (9.83%) used SCR. 26 of them (65%) by continuous infusion. Prevalence of drugs used was: 32(80%) morphine; 19(47.5%) haloperidol; 10(25%) hyoscine; 9(22.5%) midazolam or methoclopramide; and 3(7.5%) dexamethasone or ondansetron. Only 1(2.5%) used SCR for hydration.

### Discussion:

This is a preliminary survey oriented to show the prevalence of SCR use in a whole region where >80% of terminally ill cancer patients are followed by PC teams. We don't know other similar studies to compare the 9,83% prevalence observed in Extremadura. Our results confirm that morphine is the most common drug used by SCR, as other authors showed previously.

## 977. Is hospice care a real choice for gipsies? The experiences of a Hungarian survey among people living in enduring poverty

György Gyukits, Cecília Keresztes, Katalin Muszbek

Hungarian Hospice Foundation, Budapest, Hungary

The aim of our qualitative survey was to help organizing different forms of hospice care among gipsy people living in enduring poverty. We have contacted severely and incurably ill people (most of them suffering from cancer), and the relatives of those, who have died of such illnesses. We have made 50 structured interviews with the support of Open Society Institute in Budapest, Miskolc, Taktaszada and Sajószentpéter, at those districts, where many gipsy people live in segregation. Our results show that the most important problems in hospice care in these marginalized groups are social-economical ones, like problems in accessing medication, and they often suffer from the symptoms of pathological bereavement due to these social problems. The cultural problems are less important than these social ones, because the cultural problems can be handled and cured by the empathy and thoughtfulness of the team members caring for the patient and the family. However it is especially hard to solve the social-economical problems, because these are outside of the competencies of the hospice care. So we may have to reconsider the tasks of hospice care, too.

## 978. Single Dose Fluconazole in the Treatment of Oral Thrush in Hospice Patients

Ruth Lagman, Mellar Davis, Susan LeGrand, Declan Walsh, Bushra Cheema

Cleveland Clinic, Harry R. Horvitz Center, Cleveland, United States

**Background:** Oral thrush is common in patients with advanced illness. There are multiple contributing factors.

**Objective:** To test single dose fluconazole in the treatment of thrush in hospice patients by objective and subjective outcomes.

**Methods:** 26 patients were initially enrolled. All had metastatic cancer. Demographics, previous anti-tumor treatment, history of diabetes and previous episode of thrush were recorded. Symptoms of thrush and the extent of involvement were recorded before and after

administration of the drug. Single dose fluconazole 150 mg tablet was administered. Patients were reevaluated on either Day 3, 4 or 5.

**Results:** Median age was 62 (range 34-87), 17 males, 3 had diabetes, 6 had dentures, and 17 were on steroids. There were 21 first episodes of thrush. On initial evaluation, the median number of symptoms was 4 (range 1-11) and the median severity score was 13 (range 2-30). After treatment, the median number of symptoms was 2 (range 0-9) and the median severity score was 2 (range 0-17). 20 had complete objective resolution. 5 patients had more than 50% reduction in their lesions with 1 patient less than 50% improvement. Side effects were nausea, abdominal pain and diarrhea on 3 patients.

**Conclusion:** Based on preliminary data, single dose fluconazole is effective in treating oral thrush in hospice patients.

## 979. Using evidence from the Liverpool Care of the Dying Pathway (LCP) in a Cancer Network in England to compare patient comfort in the last days of life in hospice and hospital environments

Maureen Gambles<sup>1</sup>, Tamsin McGlinchey<sup>1</sup>, Deborah Murphy<sup>1</sup>, Stephanie Gomm<sup>2</sup>, John Ellershaw<sup>1</sup>

<sup>1</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom

<sup>2</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom

<sup>3</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom

<sup>4</sup> Salford Royal Hospitals NHS Trust and Trafford Healthcare NHS Trust, Medical, Manchester, United Kingdom

<sup>5</sup> Marie Curie Palliative Care Institute Liverpool, Research, Liverpool, United Kingdom

**Aim:** The LCP was developed to transfer the principles of hospice care into the hospital setting. It contains goals of care pertaining to anticipatory prescribing for common symptoms in the dying phase and allows assessment of the condition of the patient in terms of these symptoms in the last days of life. The aim of this study was to use the data collected from 12 hospitals and 5 hospices to assess patient comfort in these settings. **Method:** Retrospective case note survey - 17 organisations invited to contribute data from 20 consecutive LCPs of patients who had died in their care. **Results:** Hospital n= 207 patients (61% Cancer); Hospice n=100 patients (98% Cancer).

| Goal                         | Anticipatory Prescribing% goal met |               | Patient comfortable% observations documented yes |               | Patient Comfortable% observations not documented |               |
|------------------------------|------------------------------------|---------------|--------------------------------------------------|---------------|--------------------------------------------------|---------------|
|                              | Hospital n=207                     | Hospice n=100 | Hospital n=962                                   | Hospice n=453 | Hospital n=962                                   | Hospice n=453 |
| Pain                         | 90                                 | 98            | 71                                               | 77            | 25                                               | 11            |
| Agitation                    | 83                                 | 97            | 71                                               | 69            | 25                                               | 11            |
| Respiratory Tract Secretions | 78                                 | 94            | 69                                               | 70            | 25                                               | 12            |
| Nausea & Vomiting            | 89                                 | 88            | 74                                               | 87            | 25                                               | 12            |

**Conclusion:** In the hospice setting, appropriate medications were documented as prescribed for all the symptoms in nearly all patients. In the hospital setting this was lower, particularly for agitation and Respiratory Tract Secretions. Although patient comfort appears to be similar in both sectors (except for nausea and vomiting more education is required in the hospital sector to promote better compliance with the document before firm conclusions can be made.

## 980. What are the key journals in palliative and supportive care, and are they freely available to the clinical and research community?

Richard Stevens<sup>1</sup>, Denise Brady<sup>2</sup>, Melanie Hodson<sup>3</sup>, Sam Ahmedzai<sup>4</sup>

<sup>1</sup> University of Sheffield, Academic Unit of Supportive Care, Sheffield, United Kingdom

<sup>2</sup> St Christopher's Hospice, Library, London, United Kingdom

<sup>3</sup> Help the Hospices, Information, London, United Kingdom

<sup>4</sup> University of Sheffield, Academic Unit of Supportive Care, Sheffield, United Kingdom

**AIMS:** The evidence base in the field of supportive and palliative care is at a developmental stage. One area of uncertainty is how research results reach the public domain. Although health services, universities and other public agencies pay for much of this research, its results are often published in journals for which they must pay again to access. Medline is freely available on the internet, and there are calls for all scientific research similarly to be freely available online - e.g. via open-access journals. **METHODS:** We asked professionals in the UK for their 'wish list' of journals and compared this with the journals subscriptions bought for them by the NHS. A range of methods was used. **RESULTS:** 73 responses were returned: 53 by hand, fax or email; 20

# Poster abstracts

via a website survey. Respondents included doctors, nurses, therapists, researchers, administrators, educators, and several hospice or NHS librarians reporting journal usage in their institutions. The top 4 journals emerged very clearly. The NHS currently provides free online access for its professionals to just 3 of the top 15 titles. Of 73 journals voted for by respondents, only a small fraction is freely available to them online. No votes were received for any open-access journals. **CONCLUSIONS:** In the NHS, few of the top journals in the field are freely available online to many professionals. This means they are reliant on their institutions meeting increased journals subscriptions if they are to stay abreast of the best evidence. There is low awareness of open-access journals.

## 981. Developing Clinical Guidelines in Palliative Medicine

Iain Lawrie<sup>1</sup>, Annette Edwards<sup>2</sup>, Jason Ward<sup>3</sup>

<sup>1</sup>Leeds Teaching Hospitals Trust, Palliative Care, Leeds, United Kingdom

<sup>2</sup>Wheatfields Hospice, Palliative Care, Leeds, United Kingdom

<sup>3</sup>Mid Yorkshire NHS Trust, Palliative Care, Dewsbury, United Kingdom

Although evidence-based medicine continues to develop, such an approach can present difficulties in specialities such as palliative medicine where research in many areas of practice is lacking. Evidence commonly has to be 'generalised' from other disciplines or from the general population. The Yorkshire Palliative Medicine Clinical Guidelines Group has been systematically developing regional clinical guidelines for almost ten years. Examples of the predominantly drug based guidelines include the management of breathlessness, nausea and vomiting, depression, sweating, itch, and the use of alternative opioids. Essential components to the development of the guidelines include: (1) a specific area for investigation with pre-defined questions to be answered; (2) a comprehensive literature search strategy with consistent limits; (3) fixed terms of reference for reporting within a set time frame; (4) a recognised method for assessment of the quality of the evidence; (5) a practically useful summary of the evidence; (6) implementation of guidelines in local palliative care practice; (7) wide dissemination to professional groups; and (8) regular updates. The guidelines are presented in a standard format for ease of use. Future developments include audit of their use and wider dissemination. This poster describes the development of guidelines in palliative care in more detail.

## 982. Differences in palliative care staff's concerns and management of patients relating to safety to drive issues in Northern Ireland and the Republic of Ireland

Michele Lovell<sup>1</sup>, Regina McQuillan<sup>2</sup>

<sup>1</sup>St Francis Hospice, Home Care Team, Dublin, Ireland

<sup>2</sup>St Francis Hospice, Medical Director, Dublin, Ireland

**Background:** Medications including opioids, benzodiazepines and antidepressants impair ability to drive and are implicated in increased motor vehicle accident risk. These agents are commonly used in palliative care. Research at St Francis Hospice has shown that 19% of home care patients drive, and 83% of clinical staff have had concerns within the last 12 months about one or more patient. Differences exist between legislation and guidelines in Northern Ireland and the Republic of Ireland.

**Aims:**

1. To establish if any evidence or guidelines for palliative care staff prescribing these agents exists.
2. To determine palliative care staff's concerns and management when safety to drive issues arise
3. To identify if there are any differences between the concerns and management in Northern Ireland and the Republic of Ireland.

**Methodology:**

A literature review about medications, palliative care and driving risk was performed.

A survey has been sent to staff in Northern Ireland and the Republic of Ireland to prioritise concerns and identify what interventions are undertaken.

**Conclusions:**

There is a large body of published material about these medications and their effect on driving. Articles specific to palliative care patients were only identified for stable doses of opioids.

Survey results are still being analysed at this time.

## 983. Palliative care and assisted suicide: bridging the borders.

Claudia Gamondi<sup>1</sup>, Nikolaos Ikonou<sup>1</sup>, Bea Marx<sup>2</sup>, Lorenza Ferrari<sup>2</sup>, Hans Neuenschwander<sup>1</sup>

<sup>1</sup>Institute of Oncology of Southern Switzerland, Palliative care unit, Lugano, Switzerland

<sup>2</sup>Palliative Care Program, HOSPICE, Lugano, Switzerland

**Background:** In Switzerland euthanasia is punished by law, but if certain conditions are given, Assisted Suicide (AS) is not prosecuted. Some organizations are providing support to patients asking assistance for suicide.

**Aims and methods:** To review the charts of the patients referred to three different palliative care facilities networking in Ticino (southern Switzerland), who formally asked for AS from 2000 to 2006. To check the appropriateness of the pathway we developed to deal with assisted suicide requests. **Results:** We retrospectively analyzed 3057 patient's files. In 16 patients the request for AS had been reiterative and consistent. For these 16 patients, symptom burden data were collected from the time of referral until death. Seven patients died by assisted suicide. Eight patients died for natural causes, requesting and receiving palliative sedation in the last days of life. One patient is still alive. The results indicate that the caring team favoured the holistic approach of our pathway. **Conclusions:** AS is a restricted phenomenon, but its echo in a palliative team is very loud. Requests for AS in our patients seem to come from types of distress other than physic, according to literature. Our pathway is useful in dealing with these patients because it highlights the emotional and existential suffering and supports the team in taking care of these very complex patients.

## 984. Facilitated Assistance, Research, & Outreach for Seniors (FAROS): A process evaluation of patient navigators in a comprehensive cancer control program for older Latinos.

Isabel Torres Vigil, Angelica Herrera, Richard Hajek, Janice Chilton, Lovell Jones

The University of Texas MD Anderson Cancer Center, Department of Health Disparities Research - Center for Research on Minority Health, Houston, Texas, United States

**Aim:** Ethnic health disparities in the U.S. exist across the entire cancer spectrum, from primary prevention to palliative care. FAROS is a 4-year demonstration project funded by the Centers for Medicare and Medicaid Services designed to assess if patient navigators (PN) can improve the utilization of cancer prevention services, early detection and treatment of cancer, and various outcomes for older Latino Medicare beneficiaries in Houston, Texas. For those diagnosed with breast, cervical, colorectal, prostate, and lung cancers, the intervention will be evaluated on: clinical and health outcomes; symptom management; quality of life; and cost-effectiveness. **Methods:** A total of 3600 community-based participants (360 with cancer) will be enrolled and randomized into an intervention or comparison group. PN will be trained for 2-weeks on cancer disparities, mapping resources, assessment of patient barriers, principles of PN, communication skills, cultural competence, patient advocacy and ethics. **Results:** Process indicators will be used to evaluate PN success in coordinating care and facilitating problem-solving. PN will complete pre-and posttests. Computerized tracking of enrollees, coupled with PN formal support networks, provide additional markers for evaluation. **Conclusion:** FAROS is an innovative attempt to implement the PN model on a large scale with older Latinos. Formative and outcome evaluation measures will be closely documented to facilitate replication elsewhere.

## 985. Palliative Care Development in Europe: A bibliometric approach.

Javier Rocafor<sup>1</sup>, Carlos Centeno<sup>2</sup>, David Clark<sup>3</sup>, Luis Alberto Flores<sup>4</sup>, Anthony Greenwood<sup>3</sup>, Liliana De Lima<sup>5</sup>, Thomas Lynch<sup>3</sup>, Amelia Giordano<sup>6</sup>, Simon Brasch<sup>7</sup>, David Prall<sup>08</sup>

<sup>1</sup>Extremaduran Health Service, Regional Palliative Care Program of Extremadura, Mérida, Spain

<sup>2</sup>Clinica Universitaria de Navarra, Regional Palliative Care Program of Extremadura, PAMPLONA, Spain

<sup>3</sup>University of Lancaster, International Observatory on End of Life Care, Lancaster, United Kingdom

<sup>4</sup>Sanidad Castilla y León, Centro de Salud de Medina del Campo Urbano, Medina del Campo (Valladolid), Spain

<sup>5</sup>International Association of Hospice and Palliative Care, Houston, TX, United States

<sup>6</sup>European Association for Palliative Care, Head Office, Milan, Italy

**Background:**

Palliative care (PC) provision is growing in Europe. Following the UK model, many initiatives set-up, and some regions developed their programs. Scientific literature shows both scientific and organizational

improvements. The aim of this study is to check scientific articles describing these developments.

**Method:**

51 countries (WHO European countries, excluding the UK) were included. A systematic review of the literature was made using two databases (Medline, Cinahl). Search criteria were: "country" & "PC, hospice or terminal care", limits: years 2000 to 2005; language: Eng, Fre or Spa. All titles obtained were reviewed and a first selection of interesting articles was made. After abstracts revision a second selection was made in order to read full articles. A list of articles recommended by experts were added. Information about some topics previously considered was classified in a template. Criteria to determine which countries had enough information were defined.

**Results:**

309 articles were considered for full lecture. 1259 interesting sentences from 37 countries were obtained and they were classified in a template with 5 main topics. The number of sentences for each topic was: PC levels:561; Policy:389; Associations:79; Teaching:208; Research:22. Enough information (>9 sentences & 3 topics analyzed), was found in 28 countries.

**Discussion:**

The number of sentences published about is a new approach for knowing temporal evolution of PC development. Information obtained can be compared with other sources like books, interviews or surveys.

## 986. Patients Perceptions of Spiritual Care

Caroline McAfee, Barbara Cochrane, George Kernohan

Northern Ireland Hospice Care, Belfast, United Kingdom

**Aim**

To evaluate the chaplaincy service in Northern Ireland Hospice Care with the Association of Hospice and Palliative Care Chaplains, Standards for Hospice and Palliative Care Chaplaincy, London, (2003).

**Method**

Standards 1, 2 and 3 were evaluated.: 1) All patients and carers have access to the chaplaincy service; (2): Patients and their carers of all faiths or no faith have their spiritual and religious needs assessed and addressed; and (6); The unit ensures the chaplain is provided with the resources to fulfil his or her job description, supervision and training needs.

Patients' perceptions and experiences of the chaplaincy service were explored using semi-structured questionnaires. Their records were reviewed and chaplains' experiences were investigated through in-depth qualitative interviews.

**Results**

Sixty two patients and 6 chaplains participated. 92% of patients had a faith in God or Higher Being. Spiritual and religious needs were identified with over 80% of patients stating these needs were met. Their perception of the quality of the chaplaincy service was explored under various headings for example: understanding the role of the chaplains; visits being helpful or unhelpful; preference to gender and religion of the chaplain. - these were positively answered.

**Conclusion**

There is evidence of spiritual and religious contemplation by patients. Their perceptions of chaplaincy interactions highlight the importance and relevancy of the service. National Standards were met.

## 987. A Randomised Controlled trial of Cognitive Behaviour Therapy (CBT) for Common Mental Disorders in Patients with Advanced Disease under the Care of a Specialist Palliative Care Team

Barbara Monroe<sup>1</sup>, Stirling Moorey<sup>2</sup>, Elizabeth Cort<sup>1</sup>, Matthew Hotopf<sup>3</sup>, Marcia Kapari<sup>3</sup>, Penny Hansford<sup>1</sup>

<sup>1</sup>St Christopher's Hospice, London, United Kingdom

<sup>2</sup>The Maudsley Hospital, London, United Kingdom

<sup>3</sup>Institute of Psychiatry, London, United Kingdom

**Aim**

To discover if basic CBT techniques used by palliative care nurses in the homes of severely ill and dying patients could reduce symptoms of anxiety and depression. No previous randomised controlled trial of CBT has been performed in this setting.

**Method**

Patients were randomised to home care from palliative care nurses either with or without additional CBT training. Patients in both groups were administered the hospital anxiety and depression scale (HADS). Patients who scored greater than 8 were visited by a researcher who repeated the HADS and administered the mental adjustment to cancer scale and the cancer coping questionnaire. Those continuing to show a high HADS score were eligible for the trial. Both groups received usual care, but if randomised to the care of a CBT trained nurse this included CBT focused on their emotional problems. Patients were re-assessed by the researcher at 6, 10 and 16 weeks after entering the trial.

**Results**

The St Christopher's Home Care Team improves

symptoms of anxiety in terminally ill patients. Nurses trained to use basic CBT skills in their home visits have a greater impact on anxiety symptoms than nurses not trained in these methods. This effect is most marked for patients surviving 4 months from the start of the intervention.

**988. Pain and symptom burden among HIV patients newly referred to a palliative care service in Kampala, Uganda**

Ita Harnett, Rob Cornford, Patrick Kazooba

*Hospice Africa Uganda, Kampala, Uganda*

Background: Up to 40% of HIV patients cared for by Hospice Africa Uganda, Kampala are now accessing ARV (anti-retroviral) medications. We wished to assess symptom burden among HIV patients newly referred and the extent to which they were receiving adequate analgesia prior to referral. Method: Retrospective chart review of HIV patients enrolled Jan-March 2006. Results: Of 76 patients referred, 45 were enrolled. Mean age was 41 yrs. 38% were receiving ARVs. 41 of 45 (91%) patients reported pain, of whom 31 reported moderate-severe intensity. Of those receiving ARVs, 88% reported pain. Commonest pains: joint pain (n=21), neuropathic pain (n=16), Other (n=13), headache (n=13), abdominal pain (n=11), mouth pain, chest pain, throat pain and back pain. Of those with pain, 49% were receiving no analgesia, and of 26 reporting severe pain, 11 (42%) were receiving no analgesia. 66% subsequently required morphine. Mean number of symptoms was 6.2 (range = 0-17). Commonest: Anorexia (n=27), Cough (n=19), Nausea (n=17), Dry mouth (n=13), Itchy skin (n=13), Dysphagia (n=12), Skin rash (n=10), Vomiting (n=9) and diarrhoea (n=7) Discussion: A majority of HIV patients referred, including those on ARVs and being reviewed at other clinics, had uncontrolled pain and multiple symptoms. Almost half were receiving no analgesia. Two-thirds subsequently required opioid analgesia for adequate control of pain. Despite increasing availability of ARVs, symptom burden remains high, highlighting the need for awareness of palliative care among ARV providers to improve comfort.