Poster abstracts

Thursday 7 June

CONNECTING DIVERSITY

10th Congress of the
European Association for Palliative Care

218. Sensitivity and specificity of a two-question screening tool for depression in a specialist palliative care unit.

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Objectives The primary objective in this study is to determine the sensitivity and specificity of a two-item screening interview for depression versus the formal psychiatric interview in the hospice setting, so that we may identify those individuals suffering from depressive disorder and therefore optimise their management in this often-complex population.
Methods A prospective sample of consecutive admissions (n=167) consented to partake in the study, and the screening interview was asked separately to the formal psychiatric interview.
Results The two-item questionnaire, achieved a sensitivity of 90.7% (95% CI 76.9 - 97.0) and a specificity of 67.7% (95% CI 58.7 - 75.7). The false positive rate was 32.3% (95% CI 24.3 - 41.3), but the false negative rate was a low 9.3% (95% CI 3.0 - 23.1).Chi square analysis of individuals with a past experience of depressive illness, (n=95), revealed that a significant number screened positive for depression by the screening test, 55.2% (16/29) compared to those with no background history of depression, 33.3% (22/66), (P=0.045).
Conclusion The high sensitivity and low false negative rate of the two-question screening tool will aid health professionals in identifying depression in the in-patient specialist palliative care unit. Individuals, who admit to a previous experience of depressive illness, are more likely to respond positively to the two-item questionnaire than those who report no prior history of depressive illness, (P=0.045).

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219. Illness-related hopelessness in advanced cancer: influence of anxiety, depression, and preparatory grief.

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Purpose: The growing interest in the psychological distress in cancer patients has been the major reason for the conduction of this study. The aims were to assess the relationship of hopelessness, anxiety, distress, and preparatory grief, as well as their predictive power to hopelessness.
Materials and methods: 94 advanced cancer patients were surveyed at a palliative care unit in Athens, Greece. Beck hopelessness Scale (BHS), the Greek version of the Hospital Anxiety and Depression (HAD) scale and Preparatory Grief (PGAC) were administered. Information concerning patients' treatment received was acquired from the medical records, while physicians recorded their clinical condition.
Results: The analysis, showed that hopelessness correlated significantly with preparatory grief (r=0.630, p<0.0005), HAD-A (anxiety) (r=0.539, p<0.0005), HAD-D (r=0.642, p<0.0005), HAD-T (r=0.686, p<0.0005), and years of education (r=-0.212, p=0.040). Multiple regression analyses showed that preparatory grief (p=0.0025), depression (HAD-D) (p<0.0005), gender (p=0.044), and age (p=0.056), were predictors of hopelessness, explaining 61.5% of total variance.
Conclusion: In this patient sample, depression, preparatory grief, as well as patients' age and gender were predictors of hopelessness. None of the patients' clinical characteristics either correlated or predicted levels of hopelessness.

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220. Screening for increased preparatory grief in advanced cancer patients.

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Objectives: The present study aims to determine the use of "The Preparatory Grief in Advanced Cancer Patients" (PGAC) Scale for screening increased preparatory grief according to independent criterion standards (i.e., the HAD Total scale, the HAD Depression, and the HAD Anxiety subscales) and to establish an optimal cut-off point for discriminating between subjects with and without increased preparatory grief.
Methods: 100 advanced cancer patients treated in a Pain Relief and Palliative Care Unit completed the PGAC and Hospital Anxiety and Depression (HAD) scales, while researchers recorded data on demographic characteristics, disease status and treatment regimen.
Results: Optimal balance between sensitivity and specificity for the PGAC scale as a screening instrument was achieved at a cut-off score of 40+ for all the criterion standards (i.e., HAD Total, HAD Anxiety, HAD Depression), giving a sensitivity range between 84%-92%, and specificity between 70%-86%. The area under the curve (AUC) ranged between 0.867-0.968.
Conclusions: The PGAC scale had a favorable sensitivity and specificity in identifying cases of increased preparatory grief. The ROC analyses demonstrated that the scale is a useful screening instrument in advanced cancer patients.

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221. The Distress Thermometer (DT) a tool to monitor changes in psychological distress over time in patients with supportive and palliative care needs.

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Background: The need to screen for psychological distress in cancer patients has led to the development of a single item DT. We conducted a study to assess its psychometric properties in a clinically relevant UK sample. This presentation reports the behaviour of the DT and its ability to reflect changes in distress over time.
Method: Out-patients from 6 oncology clinics completed 4 questionnaires: the DT, Hospital Anxiety & Depression Scale (HADS), General Health Questionnaire (GHQ)-12 and Brief Symptom Inventory (BSI)-18 at baseline, 4 and 8 weeks. Sensitivity to change was assessed by: 1) comparing the mean change in DT scores with scores on the criterion measures at the 3 time points in patients who improved, deteriorated, or did not change; 2) calculating standardised response means (SRM) and 95% Confidence Intervals.
Results: 111/171 patients completed questionnaires at all 3 time-points. Using a DT cut-off score of 4, against the HADS, GHQ-12 and BSI-18, the mean DT score in the "improved" group significantly reduced, in the "constant" group did not significantly change, and in the "deteriorated" group significantly increased (p<0.05). The SRM showed the DT was most responsive to deterioration in GHQ-12.
Conclusions: The DT may be useful as a simple tool to monitor change in psychological distress over time.

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222. Is Macedonia ready for palliative care?

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Aims: In December 2006 the authors conducted a rapid appraisal of the needs for palliative care in the Republic of Macedonia, as part of the Open Society Institute's International Palliative Care Initiative. The aims were to assess existing palliative services, professional education, policy, national standards and guidelines, and drug availability for pain management; then to recommend a plan to meet the identified needs.
Methods: Interviews with key personnel and collection of relevant statistical data to assess all components of the WHO Palliative Care Public Health Model.
Results: Although the term "palliative care" is not familiar to many Macedonians, the incidence of cancer is increasing in Macedonia, and with it the need for palliative care. Macedonias low per capita opioid use indicates that terminally ill patients may not receive adequate pain relief. A detailed assessment is made of the educational, policy, and medication needs for a palliative care program in Macedonia.
Conclusion: We discuss Macedonia's needs, preparedness, and next steps in developing a national palliative care program.

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223. THE FIRST EXPERIENCE OF PALLIATIVE CARE FOR CANCER PATIENTS IN GEORGIA Rema Ghvamichava, Mikhail Shavdia, Ioseb Abesadze, Giorgi Metivishvili Cancer Prevention Center Palliative Care Clinic (Georgia)

Rema Ghvamichava, Mikheil Shavdia, Ioseb Abesadze, Giorgi Metivishvili

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First palliative care clinic for advncerd cancer patients in Georgia was opened in January 2005. During first year the clinic served 216 patients, aong them 144 women (66.7%) and 72 men (33.3%). The patients stayed in the clinic for approximately 15 days. The average age of the patients was 56.6. The reason of incurability in 90% was metastasis, in 10% the locally spreaded tumors. Most frequent case observed - collorectal cancer (35.6%), breast cancer (16.2%) and cancer of the genitals (15.3%). The health condition of the patients with the scale of the ECOG. Performance status was: I gradation :6.6%, II:21.7%, III:21.7%, IV:50%. The most frequent symptoms were: asthenia (91.2%), pain (84.3%), anorexia (76.4%), the dysfunction of the gastro-intestinal tract (70.4%). Among 216 patients, strong pain was observed in 37.5%, moderate 31.5%, mild 15.3%. Visual analogy scale was used for pain assesement. Patients were provided: detoxification 100%, vitamin therapy 93.1%, pain management therapy 84.3% (by opioid in 42.9%), energy and appetite stimulation - 28.2%, small surgical manipulations (laparocentesis, pleurocentesis and others) 6.5%, radiotherapy 2.3%, chemotherapy 44.4%, the correction by bisphosphonates 5.1%, hormonal therapy 4.2%. In 117 cases 42 patients (29.8%) have been provided care for second time. Number od lethal cases - 31.5%. Therefore, the analysis of the palliative care clinic actvities during first year of its functioing can be cosidered as successfull medical organization of specific profile.

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224. Heart-Rate variability in palliative patients - a pilot study

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Aim of study: Assessing long-term prognosis is still a challenge in palliative patients. Use of scores (eg. PAP) has been proposed, but additional assessment methods are needed. Linear and non-linear measures of heart rate variability (HRV) have been used in cardiology and diabetic patients to assess risk factors for sudden cardiac death. Short-term HRV measurement is a simple bedside technique causing patients no undue stress. **Methods**: A total of 24 cancer patients receiving palliative care will be included. A short-term HRV measurement was performed several times on each patient, the number depending on survival time. Time domain and frequency domain indices were calculated (SDNN, RMS-SD, HF, LF, VLF, and LF/HF). In addition, approximate entropy (Pincus 1991) was computed as non-linear measurement. **Results**: Preliminary results will be presented on the poster. As expected, heart rate variability declined in relation to the disease. Approximate entropy also declined. Some patients however had a temporary increase in HRV, so the decline was not linear. **Conclusions**: As far as we are aware, this is the first study which has assessed HRV changes in palliative patients. The preliminary results are encouraging. HRV is potentially an interesting bedside tool for the assessment of palliative patients, but larger

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225. The Schedule for Meaning in Life Evaluation (SMiLE): Validation of a new instrument for meaning-in-life research

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The *Schedule for Meaning in Life Evaluation* (*SMiLE*) is a newly developed instrument for the assessment of individual meaning in life (MiL). In the *SMiLE*, respondents list 3 to 7 areas which they consider most important for their MiL, and rate the current level of subjective importance and satisfaction for each area. Indices of total weighting (IoW, 20-100), total satisfaction (IoS, 0-100), and total weighted satisfaction (IoWS, 0-100) are calculated.?The aim of this study was to assess the feasibility, acceptability, and psychometric properties of the *SMiLE* in its German and English version.?599 university students took part in the study. The mean IoWS was 77.7-14.2. Completing the *SMiLE* was neither distressing (1.3-1.9 on a scale from 0-10) nor time-consuming (8.2-3.0 minutes). Test-retest reliability of the IoWS was good (r=.72; p<.001), 85.6% of all areas were listed again after a test-retest period of 1 week. For criterion validity, convergent validity with the *Self*

Transcendence Scale (r=.34, p<.001), the *Purpose in Life Test* (r=.48, p<.001), a *Numeric Rating Scale on Meaning* (r=.53, p<.001), and divergent validity with the *Idler Index of Religiosity* (r=.08, n.s.) were found.?In summary, the *SMiLE* shows good psychometric properties in university students. In comparison to other MiL instruments, it is a short questionnaire which measures MiL individually and provides interesting qualitative information.

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226. Longitudinal Study of Distress: The Interactions between Distress Domains and Their Impact on the Global Distress Experience of Advanced Cancer Patients from Time of Referral to Palliative Care Services to Death

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Background Distress is derived from interactions of physical, psychological, social and spiritual domains: The dynamics have not been studied over time.
Aim To explore distress over the terminal phases of cancer; determining predictors, patterns and the contribution of each distress domain to global distress.
Method Mixed methods longitudinal study: 100 newly referred patients were assessed monthly until death or for 6 months maximum through documentation of socio-demographics, medical factors and: Memorial Symptom Assessment Scale (physical), Edinburgh Depression Scale (psychological), FACIT-Sp-12 (spiritual), Global Distress Thermometer (DT) and in-depth interview (qualitative sub-sample of 20 only).
Results Significantly associated with distress: Lack of information (p=<0.001); social dysfunction (p=0.02). Trend over first 3 months: Psychological, spiritual and global distress increase. Over time all domains correlated significantly with: Global distress; psychological the most: r=0.737 (p=0.000), and with each other; psychological and spiritual most: r=-0.616 (p=0.000). Key themes: Family and communication; physical debility and associated psychological impact; control; reluctance to disclose distress.
Conclusion The 4 domains are strongly inter-related but psychological contributes most to global distress. Distress initially increases from referral except the physical element: Screening with the DT may encourage focus on non-physical distress domains, improving management.

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227. Results of a Study to Assess Quality of Life and Cost of Home-Based Palliative Care Delivery in New Delhi, India

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CanSupport is a home-based palliative care service looking after people with advanced cancer in New Delhi, India. We report on a detailed observational study undertaken jointly by CanSupport and Fondazione ANT Italia, which runs a hospital/hospice-at-home programme in Bologna, Italy, from January 2004 to December 2004, which included 74 patients who were being assisted by CanSupport under its home care programme. The objective of this study was to find out to what extent providing palliative care at home improves the quality of life of those with advanced cancer and to calculate what it costs to deliver such care. The results of our analysis shoiw that assistance from the CanSupport home care teams changed the situation significantly for patients. 54% of the patients reported complete or > 50% reduction of pain using a visual scale (from 1 to 10). Costs for drugs/nutritional supplements amounted to < $1 in 27% of the cases, while 69% calculated that they had spent between $1-$2 and 4% between $2-$3 while under CanSupport's care. Based on our study it can be said that home care delivery by a qualified team such as CanSupport costs between $4-$5 per patient/ per day. This is a miniscule amount in comparison to other investments.
Conclusions The study confirmed our hypothesis that it is possible with very little investment to guarantee dignity at the end of life to cancer patients in resource strapped countries.

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228. Quality of life in patients with prostate cancer: (A) comparison between a disease-targeted questionnaire and an individualised assessment method

Patrick Stone, Robert Murphy

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Background
Standard quality of life (QoL) instruments do not address all of the issues that patients consider to be important. The purpose of this study was to compare the performance of the Functional Assessment of Cancer Therapy – Prostate questionnaire (FACT-P) with an individualised QoL assessment method.
Patients and Methods
Patients (n = 194) completed the FACT-P, the Schedule for the Evaluation of Individualised QoL - Direct Weighting (SEIQoL-DW) and a Visual Analogue Scale (VAS).
Results
Patients scored highest on the "physical" and lowest on the "prostate specific" domains of FACT-P. The most frequently identified themes on the SEIQoL-DW were "Family, friends and relationships", "Leisure activities", "Health", "Spiritual life" and "Work". Patients with metastatic disease rated their QoL significantly (p < 0.0001) lower than other patients on the FACT-P, but not on the SEIQoL-DW (p = 0.07).
Patients whose global QoL deteriorated between assessments, showed a significant decrease in QoL on FACT-P (p = 0.038), but not on SEIQoL-DW or VAS. Of the patients whose performance status deteriorated between assessments there was a corresponding change in the SEIQoL-DW (p = 0.008) and the VAS (p = 0.05) but not the FACT-P.
Conclusions
There are limitations to both questionnaire-based and individualised assessments.

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229. Quality of life in patients with prostate cancer: (B) development and application of a hybrid assessment method

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Background: Investigator-derived quality of life (QoL) instruments such as the Functional Assessment of Cancer Therapy Prostate questionnaire (FACT-P) do not allow participants to weight the relative importance of QoL domains. We investigated the effect of allowing patients the ability to weight the relative importance of the five areas included in the FACT-P (Physical, Social, Emotional and Functional well-being and Additional Concerns).
Patients and Methods: Patients (n = 150) completed the FACT-P and gauged the relative importance of each QoL domain using a Direct-weighting approach. This was then used to provide an adjusted Hybrid QoL score. Patients also completed a Visual Analogue Scale.
Results: Patients considered Social well-being to be the most important domain and Additional concerns to be the least important. When patient weightings were taken into account overall QoL scores increased. The validity of the Hybrid score was supported by its ability to distinguish between patients with metastatic and loco-regional disease and its ability to detect expected decreases in global QoL over time.
Conclusions: Application of the Direct-weighting approach to the FACT-P allows assessments to more accurately reflect individual QoL. Unadjusted QoL scores may lead researchers to under-estimate the true QoL of respondents.

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230. DEVELOPMENT OF A PALLIATIVE MEDICINE COMPREHENSIVE COMPUTER BASED SYMPTOM ASSESSMENT QUESTIONNAIRE

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Aims
To report the paper- based framework and development process of a portable computer symptom assessment project in palliative medicine.
Methods
Expert opinion, patient face to face interviews and feedback, and expert focus groups were included in a paper-based instrument development and testing of the content and face validity.
Results
A systematic literature review on cancer assessment instruments compared symptoms and dimensions. A 54 item multi-dimensional (prevalence, severity, distress, chronicity) instrument was developed. Expert opinion (4 staff, 4 clinical and 4 research fellows) improved clarity and comprehensiveness. 30 in- and 32 outpatients were interviewed for face validity. 80% found the questionnaire appropriate and clear. Comparing in- to outpatients revealed: median (range) ECOG 2 (1-4) v 1 (0-4); mean (SD) completion time 43 (14.5) v 27 (10.8) min, p=0.001; compliance 60% v 93 %, p=0.01. More outpatients (26 v 11, p=0.006) were comfortable with one level multi-symptom, multi-dimensional assessment. More inpatients (14 v 3, p=0.006) were tired after assessment. Eight focus groups (10-12 physician and nurse experts per group) discussed symptom definitions and associated symptoms. Common opinions were systematized for symptoms and symptom groups.
Conclusions
Patient and expert opinion is important for valid practical assessments. Paper-based comprehensive multi-dimensional symptom assessment can be burdensome for inpatients, and computers may improve flexibility.

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231. 'Fear of the Unknown' A Retrospective Analysis of Management of Unknown Primary Carcinoma in a District General Hospital

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Introduction: Unknown Primary Carcinoma (UKP) is usually associated with a poor prognosis. Often the emphasis is on multiple investigations aimed at uncovering the primary site rather than timely referral to Oncology and Palliative Care. For patients, their families and their professional carers, the uncertainty of the disease process causes great angst. **Aim:** To investigate the management of patients with UKP in a hospital setting. **Method:** Retrospective case note analysis of patients with UKP diagnosed in a district general hospital between 2000 and 2001. **Results:** 58 case notes analysed. Study group consisted of 31 males and 27 females. Median age was 67 years. Over half (55%) of patients had an ECOG performance status of 3 or 4. Median survival was 2.6 months. On average, each inpatient underwent 5 investigations and 20 blood tests during admission. Of the 51 inpatients, 12 were not referred to palliative care including 2 patients who died. All palliative care referrals were seen within 48 hours of referral. The first contact with palliative care occurred on average 18 days after admission, reflecting late referral. **Conclusion:** In these patients, protracted admissions involving multiple investigations should be avoided. Management should focus on short admissions, early referral to oncology and palliative care and symptom control. ECOG performance status is an important indicator of suitability for chemotherapy. A multidisciplinary approach is imperative.

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232. Detecting symptoms of depression and anxiety in patients with severe pulmonary disease: a pilot study

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Aim: To evaluate the usefulness of the Hospital Anxiety and Depression Scale (HADS) for screening of psychological distress among hospitalized patients with pulmonary disease.**Method:** Patients (*n*=45), requiring hospitalization at Linköping University Hospital, department of pulmonology, during July 2005 were included based on informed consent. Diagnoses included primary/metastatic lung cancer (51%), COPD (13%), other pulmonary diagnoses (16%), ongoing diagnostic work-up (20%). Screening for symptoms of depression or anxiety was carried out using self-administered questionnaires containing a Swedish version of the 14-item HADS. **Results:** Depression and anxiety scores were significantly higher in cancer patients compared to non-cancer patients. Associations were also observed between depression score and poor performance status, metastatic disease, and severe pain. Associations were less apparent for anxiety. Ever use of anti-depressants/anxiolytics was associated with higher depression/anxiety scores. Among 'possible cases' of depression/anxiety, affective symptoms had been documented in either medical or nursing records in 83% (depression) and 61,5% (anxiety).**Conclusion:** In this pilot study HADS was found useful as an aid to identify patients at risk of severe psychological distress. Although small, the study suggests that certain risk patients, e.g. with metastatic cancer or ever users of antidepressants/anxiolytics, may require particular consideration.

233. SYMPTOM VARIABILITY IN ADVANCED CANCER DURING REPEATED MEASUREMENTS

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Aim: In this prospective study we explored symptom behavior in cancer patients during repeated measurements.
Methods: Cancer patients admitted to an inpatient hospice for terminal care completed a daily questionnaire. The questionnaire was five visual analogue scales (VAS) for pain, depression, anxiety, sedation, and nausea; three verbal rating scales for pain, vomiting, and depression.
Results: 125 hospice inpatients were enrolled; 46 (38%) completed at least 3 consecutive days of the questionnaire. Using a "variability index", symptoms demonstrated daily variation. Symptoms formed changing daily correlations. Demographics influenced both symptom profile at presentation and change over time. Severity and frequency seemed stable over time. By dividing patients into those with a symptom versus those without, we demonstrated significant variation of the symptom being monitored. New symptom onset following admission was common. VAS scales revealed significant inter- and intra-patient inconsistencies.
Discussion / Conclusions: Symptoms exhibit high variability with repeated measurement. So we concluded that: (1) Timing of studies is crucial for defining study outcomes (2) Prevalence studies may be inaccurate for symptom or treatment follow-up (3) Symptom incidence following admission is an overlooked measure of risk assessment (4) VAS scales seem inappropriate for hospice cancer patients (5) Demographics may influence symptom variability.

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234. IMPACT OF ACUTE COMPLICATIONS ON QUALITY OF LIFE IN PALLIATIVE LUNG CANCER PATIENTS.

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Aim of the study: Patients with inoperable lung cancer have a poor prognosis and frequently suffer from acute complications of aggressive chemotherapy.
Methods: We conducted a descriptive study in 15 lung cancer patients (stage IIIB or IV) consecutively referred to an oncology ward either for scheduled chemotherapy (SC) (n=9) or for complications of chemotherapy (n=6) (CC). Quality of life was evaluated by the EORTC QLQ-C30 questionnaire.
Results: Median age of patients was 66 years (range 42-77) All had had chemotherapy in the past. Mean Karnovsky Index (KI) was similar in CC (KI: 53) and in SC (KI: 64) patients. CC patients were only slightly worse in physically related parameters when compared to SC patients (Physical Functioning: 75.5 vs 80.3; Role Functioning: 69.4 vs 75.9; Cognitive Functioning: 56.6 vs. 60.4) and symptoms such as pain, dyspnoe, nausea and fatigue but performed significantly worse in Emotional Functioning (38.8 vs 60.4) and Social Functioning (19.4 vs 58.3). Emotional, Cognitive and Social Functioning as well as fatigue nausea and appetite were all improved significantly at time of discharge in CC patients but generally failed to reach the level of SC patients
Conclusion: Complications of therapy lead to a severe loss of emotional and social functioning which even exceeds losses in physical functioning and increase of physical symptoms. Monitoring physical symptoms of chemotherapy associated complications only my underestimate the loss of quality of life in these patients

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235. IMPLEMENTATION OF THE MITTZ IN A PALLIATIVE CARE NETWORK IN THE NETHERLANDS

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Aim:The Maastricht Instrument on saTisfaction with Terminal care (MITTZ) measures satisfaction from the perspectives of terminally ill persons and their families.This project aimed at implementation of the MITTZ within the Palliative Care Network South-East Brabant, and at analysis of the care provided by the health organizations in this network. Method: After being informed about the MITTZ professionals in the network invited terminally ill patients and families to complete the MITTZ.During the project a helpdesk was available for professionals.Only after consent the questionnaires have been analyzed further.The results were presented to the professionals of the network. Results:The professionals discussed the MITTZ completed with patient and family, and adapted the care if needed.All questionnaires (45 patient and 56 caregiver) were available for further analysis.Opportunities for improvement particularly lay in the domains continuity/organization of care, autonomy/control, physical aspects, information/instruction, emotional support, existential/spiritual aspects.The network discussed the results and improved the quality of the care provided. Conclusions:With the MITTZ information about patient and caregiver satisfaction with care was identified.This information is used by the network to improve the quality of palliative care. Information on comparable projects in other palliative care networks will be discussed too.

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236. 'Brief Solution-Focused Practice'. A tailor-made psychological approach for palliative care

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The importance of the psychological approach in palliative care by all professionals cannot be overemphasised (NICE 2004) [1]. For those needing more formal psychological input the traditional assessment, formulation and therapeutic work is not only time consuming, but exhausting and may not be completed before the end of their short lifespan meaning that the benefits are never realised or enjoyed. Brief solution-focused therapy is ideally suited to the palliative care situation requiring an effective, brief, apparently simple, positive, approach focused on achievable goals, which can be learnt and practised by all health professionals. Furthermore, the goals may in fact be concerned not only with psychological dimensions eg anxiety, but also with physical ones eg pain management, choice of treatment etc.
Solution-focused (SF) approaches start with the "preferred future" (desired outcome) of the parties concerned (eg patient, carer, professional, institution), highlight instances where this is already happening (strengths), then identify the next steps towards that preferred future.
This poster describes the approach and its place in palliative care demonstrating through case studies the practical application of solution focused practice.

1 National Institute for Clinical Excellence. Improving Supportive & Palliative Care for Adults with Cancer. 2004

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237. Assessment of quality of life in palliative care

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Palliative care is defined by WHO as the type of care delivered to patients with an active and progressive disease and with short life expectancy. Care should be focused on symptoms relief, on prevention and mainly on quality of life. One hundred and four patients with breast and lung cancers with life expectancy less than a year and aged between 40 and 85 years old were selected in a specialized oncology hospital. A Portuguese version of the Palliative Care Outcome Scale (POS) was administered to them along with other variables including pathology, treatment and socio-demographics. Construct validity of POS evidenced five factors: emotional well-being, real fife consequences, information and support, anxiety and burden of disease. A moderate to strong correlation was shown when POS scores were compared to EORTC QLQ-C3o. Test–retest reliability and internal consistency were very good. Sensitivity after 1 month was also tested with good results. Comparing pathologies we observed that the burden on the patient is sensitive to his/her pathology. In conclusion, this study evidenced the good performance of the Portuguese version of the Palliative Care Outcome Scale.

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238. Is continuity of care for the terminally ill possible when offered by Palliative Support Teams (PST) in general hospitals (GH)?

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Little is known about the views regarding to palliative care (PC), palliative medicine (PM) and terminal care (TC) held by PST-professionals in GHs.
Objectives : To provide representative conclusions about the number of employees and their profession and their views on PC, PM and TC.

A postal survey was conducted among the coordinators of all PSTs in GHs in Flanders, with questions on the number of professionals working both officially and non-officially and on the work organization. Answers with the legal obligation of ? FTE MD, nurse and psychologist per 500 beds were compared.

57 coordinators (79.2%) provided us with a representative response. Only 13% of the PSTs have a sufficient official number of appointed professionals. About 35 to 60% of the professionals (MDs, RNs, psychologists, social workers and others) working in a PST is officially appointed.

Some of the legal obligations are reported to be met by all PSTs: a.o. to spread the culture of PC and to advise on PC. 94% report to organize training for professionals, 82% is coordinating admission.

Other reported tasks are not legally prescribed such as taking care of family (95%), coaching professionals (92%), providing bedside care (84%), scientific research (22%).

Continuity of care is possible in a minority of the GHs. Most PST's show a considerable amount of professional voluntary work and fulfill legally prescribed tasks and take on more than that.

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239. Evaluating the effectiveness of hospital-based palliative care team: the first 3-year audit using a numeric rating scale in Japan.

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Background: Over 90% of terminally ill cancer patients die in acute care hospitals in Japan and since 2002,hospital-based palliative care team (HPCT) services have been covered by Public Health Insurance for achieving symptom control.With this date as a turning point,the number of HPCTs has been increasing. Despite this increase, there has been limited research evaluating their effectiveness**.** In particular,research using a patient rating scale is very rare.
Aim: This study investigated the effectiveness of HPCT using a patient rating scale.
Subjects and Method: All cancer cases referred to our HPCT in the first 3-year period were enrolled in this study. We prospectively recorded patient symptoms (e.g. pain and dyspnea) on a structured data-collection sheet at the first assessment and 1 week later. Numeric rating scale (NRS; symptom scale of 0-10, 0=no symptom, 10=worst imaginable) was selected as the assessment tool because both the validity and convenience of NRS have been established in an acute care setting.
Result: There were 393 cases (528 episodes) referred to our HPCT. Statistical comparison of the scores between the first assessment and 1 week after were performed.The symptom scores after 1 week were significantly lower than at the first assessment (pain: 2.4±3.0 vs 7.3±2.9, $p<0.0001$;dyspnea: 2.0±2.0 vs 5.8±3.0, $p<0.001$).
Conclusion: HPCT may be sufficiently effective in achieving symptom control in an acute hospital setting in Japan.

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240. Screening for psychological distress in palliative care using Touch screen questionnaires

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Psychological distress at end of life is less well described, as the focus has been mainly on problems arising in the context of diagnosis and treatment of cancer. Screening for distress is now considered an essential first step in improving care of these patients.
Aim:The study aims to examine the feasibility and validity of a set of screening instruments in detecting psychological distress in a palliative care population attending two hospices in Leeds, U.K
Method:Patients are recruited by convenient sampling from St-Gemma's and Wheatfield's hospice, Leeds. Recruited patients, after an initial cognitive screening, complete a set of three questionnaires (Brief Symptom Inventory-18, General Health Questionnaire-12 and Distress Thermometer) on touch screen laptops developed by Psychosocial Oncology Research Group, Leeds. After completion of questionnaires a structured psychiatric interview (SCAN) is carried out by trained psychiatrists, who are blind to the results of screening. The two investigators are trained in SCAN and have established inter-rater reliability.
Initial results: Out of a total number of 62 patients

considered eligible so far, 17 opted out, 7 dropped out and 38 patients completed the assessments. Of the completed patients approximately 25% has a diagnosable psychiatric illness, Adjustment disorder being the most common. Sensitivity, specificity and cut-off's for the questionnaires (ROC analysis) will be presented

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242. The effect of the Liverpool care pathway for the dying: a multi centre study

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We studied the effect of the Liverpool care pathway for the dying (LCP) on documentation of care, symptom burden, and communication during the last three days of life. We applied an intervention study. Two hospitals, two nursing homes, and two home care organisations in the Netherlands participated. Between November 2003 and February 2005 (baseline period), care was provided as usual. Between February 2005 and February 2006 (intervention period), the LCP was introduced and used for all patients for whom the multidisciplinary team agreed that the dying phase had started. After the death of a patient, a nurse and a relative filled in a questionnaire. In the baseline period, 220 patients were included in the study. Nurses and relatives filled in a questionnaire for 219 and 130 patients, respectively. During the intervention period, 255 patients were included in the study. The LCP was used for 197 of them. Nurses and relatives filled in a questionnaire for 253 and 139 patients, respectively. Patient characteristics were comparable in both periods. In the intervention period, the documentation of care was significantly more comprehensive as compared to the baseline period. According to both nurses and relatives, the average total symptom burden was significantly lower in the intervention period. Relatives appreciated communication about the patient's impending death equally in both periods. We conclude that LCP use contributes to the quality of documentation and symptom control.

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243. Prevention of Pathological Fractures: Do Healthcare Professionals Recognise the Warning Signs?

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Introduction?Patients prognosis with metastatic bone disease (MBD) has improved. UK guidelines on investigation and management of MBD exist. Prediction of pathological fracture before the event is a relevant clinical problem?Aims?Do healthcare professionals (HCP's) recognise features of MBD and impending pathological fracture. Are they aware of UK guidelines??Methods?A questionnaire on management of MBD, awareness of risk factors and guidelines was given to HCP's in Specialist Palliative Care (SPC) and Orthopaedics in our local cancer network?Results?84 responses (67 SPC;17 Orthopaedic). 12/84 knew of existing UK guidelines. 9/84 were aware of a tool used to assess risk of pathological fracture.16/84 felt they had access to a lead orthopaedic surgeon for MBD in their locality. 41/84 couldn't name any features of pain that would make them suspicious of MBD. 10/84 thought the prognosis of all patients with MBD was less than 12 months. 10/84 were unaware of clinical features and 21/84 could not describe radiological features of impending pathological fracture. 81/84 felt there was value including an orthopaedic surgeon in the management of patients with MBD. 57/84 were aware surgery should be performed prior to radiotherapy at the site of impending fracture?Conclusion?Greater awareness of existing UK guidelines for investigation and management of patients with MBD is needed. After this study local guidelines on the Prevention of Pathological Fractures were implemented

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244. Subjective well-being, meaning in life and personal values in health care professionals working in palliative care vs. maternity wards

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According to current theories of social psychology, subjects who are confronted with mortality exhibit a distinct way of coping with their fear of death which is reflected in their personal values and may enhance their subjective well-being.We have investigated individual meaning-in-life (MiL), subjective well-being and personal values in health care professionals (HCP) who are confronted daily with death (palliative care) or with new life (maternity ward). A cross-sectional questionnaire study was performed in four Munich hospitals.140 HCP took part in the study (response rate, 74%). Self-transcendence values were higher in palliative care HCP, while self-enhancement values predominated in the maternity wards. Regression analysis showed that these differences were not dependent on the working environment but on religiosity. Palliative care HCP were older and more religious compared to maternity ward HCP, and listed significantly more MiL areas which were related to spirituality or nature experience. No group differences were found for subjective well-being. A regression analysis showed that HCP working part-time scored higher in well-being as compared to full-time workers.

In summary, there are significant differences in personal values in both groups, but these seem to depend on religiosity. The question remains whether higher religiosity derives from the confrontation with death or whether more religious individuals are more likely to work in palliative care.

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245. The enigma of documenting nursing care according to the hospice philosophy

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Background: Although palliative care has improved markedly in the last decade, there is evidence that nurses may have insufficient knowledge about the psychosocial needs of patients. In nursing records, medical and physical needs are well documented, but aspects related to a holistic understanding of the patients' situation are not. Thus, neither the hospice philosophy nor the knowledge which is a prerequisite for individualized patient care is appearing in the documentation.
Aim: The aim of this developmental project is to improve nursing care in a hospice by implementing a new approach to nursing documentation.
Methods: A structure to document nursing care inspired by Weisman and co-workers
Conclusion: All nurses at the hospice are now required to document according to the new structure. Evidence however, show difficulties to leave behind the traditional biomedical way of thinking and documenting. Examples and positive and negative experiences of the implementation process will be presented and discussed at the conference.

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246. EFFECTIVENESS OF SYMPTOM CONTROL IN ADVANCED CANCER PATIENTS FOR PALLIATIVE CARE TEAMS IN CATALONIA SPAIN

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AIM To assess the effectiveness in symptom control, mainly in pain control, of palliative care teams (PCT) To promote cooperation between PCT and to identify areas of improvement **METHOD** Descriptive, longitudinal multicentre study.
Subject
Included 159 patients cared for by 111 PCT. (Date: 24-28/01/05)**Variables**Severity of 4 symptoms by a verbal numeric scale (VNS), 0-10. Registered at the 1st visit, and one week later.
Demographic data.
Statistics Symptom control was analysed using Wilcoxon sing rang test.
Result
Place of admission was outpatient 19%, Hospital Support Team 19%, Unit 24%, Home ST 60%.
KPS 50 61,35%

Analysed using Wilcoxon sing rang test

Table 1	Day 1 % patients%	Day 7 patients	*p* day 1-7
VNS	≤ 3 > 4	≤ 3 > 4	
Basal Pain	38.9 *61.1*	67.5 32.5	**0.0001**
Crisis Pain	8.0 *92.0*	21.1 78.9	**0.0001**
Weakness	15.3 *84.7*	19.2 80.8	**0.001**
Anxiety	25.8 *74.2*	50.5 49.5	**0.0001**
Insomnia	22.6 *77.45*	4.5 45.5	**0.0001**
	Number crisis / Day		
	≤ 2 > 3	≤ 2 > 3	
Nº Crisis	39.8 *60.2*	73.1 26.9	**0.0001**

CONCLUSION
- The intervention of the PCT through pharmacological and interprofessional measures show a significant decrease in the intensity of the symptoms seven days after the first consultation.
- It will be important to study their repercussion in the patients and family perception of quality of the end-of-life.

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247. Measurement of meaning in life: a systematic review of meaning-in-life scales (1956-2006)

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

For patients with terminal illnesses, the question of meaning in life (MiL) is essential. Loss of MiL is associated with higher levels of psychological distress and requests for hastened death. Different scales have been developed to assess MiL in various samples. However, the extent of psychometric validation of many scales is unclear.

We conducted a systematic review of published MiL scales in accordance with the Cochrane Handbook for Systematic Reviews of Interventions, version 4.2.4. The scales were evaluated according to the recommendations of the Scientific Advisory Committee of the Medical Outcome Trust.

Using EMBASE 1989-2006, OLDMEDLINE 1950-1965, MEDLINE 1966-2006, PsycINFO 1806-2006 and PSYNDEXplus 1977-2006, we found 439 papers on MiL assessment. Nomothetic instruments (e.g. Purpose in Life Test, Life Regard Index, Sense of Coherence Scale) as well as idiographic measures (e.g. Meaning in Life Depth, Schedule of Meaning in Life Evaluation) were included. The psychometric properties of the scales were investigated regarding their conceptual and measurement model, reliability, validity, responsiveness, interpretability, burden, alternative models of administration, and cultural and language adaptations as well as translations. Detailed results will be presented at the congress.

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248. Symptom Control In An Acute Palliative Care Unit: Preliminary Results

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Aim
To study prospectively the efficacy in the control of a set of core symptoms after 7 days of admission in our acute palliative care unit.
Material & methods
Patients admitted from 8/06 till 10/06 which fulfil 3 consecutive evaluation for a core set of symptoms (pain, anorexia, constipation, insomnia, dyspnoea, vomiting, anxiety and depression) for the days 1, 3 & 7 of stay. Evaluation was done under the daily clinical practice without a close protocol. Symptom control was analysed using Wilcoxon sing rang test, level of significance 0.05.
Results
We admitted 137 patients, being evaluable 41(30%). The 3 main reasons for not being evaluable, multiple causes, were symptom missing data 78 (57%) cases, admission less than 7 days 52 (38%) [14 for death], and severe cognitive failure at admission 13 (10%). Regarding evaluable patients; 72% were men & mean age 66.2 ys. Mean stay was 18.5 days & mortality during admission was 47%. Fifty percent of patients were classified 2 or 3 in the ESS. All symptoms evaluated obtained a sig. improvement after 7 days, but insomnia and depression.
Conclusions
- Taking into account that 40% of the evaluable patients were admitted under a crisis situation, at the end of the first week of admission a significant symptom improvement is obtained for all core symptoms but insomnia and depression.
- Results should be taking as a trend, since the small size of the sample and the possible bias introduced mainly for the selection of the more fit patients.

249. Predictors of patient ratings of depression on admission to a tertiary-level inpatient palliative care unit: What is the role of pain and symptom burden?

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Aims: To describe symptom burden and identify independent predictors of patient-rated depression in advanced cancer patients on a tertiary palliative care unit (TPCU). **Method:** We retrospectively examined TPCU database records to obtain patient demographics and Edmonton Symptom Assessment Scale (ESAS) scores [0-100(worst)]. Consecutive first admission data for patients surviving more than 3 days were eligible for analysis. Independent variables (age, gender, cancer, substance abuse history, 8 ESAS scores) were entered into multiple regression models to determine independent associations with the first 36-hour patient-rated depression intensity average (dependent variable). **Results:** Of the target sample (n=1351), the analyzed sample consisted of 879 patients (65%) with complete patient-rated ESAS scores. Median age was 63 and 50% were men. The four highest median symptom scores were 60 (appetite), 58 (tiredness), 50 (wellbeing) and 48 (pain, drowsiness). The median for depression was 30. In simultaneous and stepwise regression models, R^2 was 0.60. In the stepwise model, ESAS scores for anxiety, wellbeing, nausea and drowsiness were significant positive predictors for depression ($p<0.05$). Appetite and hematological cancers were significant negative predictors ($p<0.05$). **Conclusions:** Depression intensity in advanced cancer patients is strongly linked with multidimensional symptoms. Surprisingly, pain and tiredness were not identified as independent predictors in this sample.

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250. COST EFFECTIVENESS OF ORAL OPIOIDS IN PAIN MANAGEMENT

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13 kg (92,9%) from total 14 kg of opioids used in Georgia in 2005 was injectable, whereas oral opioids are mostly administered for adequate pain relief in world developed countries. Implementing international standards, only 46,1% of injectable opioids was used during two months in our clinic and corresponding study have been conducted.
Objective: Study of cost- effectiveness of oral opioids for adequate pain management in cancer patients.
Method: While part of the patients was administered injectable opioids, the other part was prescribed prolonged oral opioids (12 hours) after defining the daily dosage. During the period November 4,2005 ; January1,2006, only 829 ampoules of Sol. Morphini hydrocloridum 1% - 1 ml have been used in combination with 323 tablets of Doltard 30 mg. (total cost 54,91GEL). To achieve the same effect of pain management during the same period it was estimated that 1798 ampoules of Sol. Morphini hydrocloridum 1% - 1 ml (1 amp/4hours) with total cost of 1348,50 GEL should be used for 20 patients of the clinic. (Cost of 1 ampoule 0,60 GEL, syringe, alcohol, cotton 0,15 GEL ; total 0,75GEL). Actually, instead of planned 1348,5 GEL only 676,6 GEL was spent during two months. So, economical effect was estimated as 48,8%.
Conclusion: 1. Administration of prolonged oral opioids appeared to be effective both in respect of improvement of patients' quality of life and cost-effectiveness 2. Recommendations for Health Care policy makers have been worked out for improvement of oral opioid's availability.

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251. CROSS CULTURAL ADAPTATION OF THE SPANISH VERSION OF THE EDMONTON SYMPTOM ASSESSMENT (ESAS)

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It is necessary to be accessible instruments cross cultural adapted in different languages. The?Edmonton Symptom Assessment System (ESAS) is an instrument of symptom assessment widely used in Palliative Care. A process of adaptation was designed to do a cross cultural adaptation of the ESAS to Spanish. Five Spanish translations of the questionnaire were made by Spanish bilingual translators working in Palliative Care with experience with ESAS. Four reviewers measured cultural adaptation, clarity and common language. A committee of three health's professional designed the first version. This version was used in a study with twenty patients with cancer. With the comments of the participants, the committee choose a second Spanish version of the questionnaire that was translated back into English by two bilingual translators of English origin. Four reviewers evaluated semantic equivalence, cultural adaptation and psychometric aspects of each item. With these ratings, the committee developed a third version of the questionnaire. A second study was performed with twenty patients. With several remarks from the evaluators the committee proposed a final Spanish version of the ESAS. Three items need clarifications in semantic studies. The final version was approved by the committee and also the author of the original English version of the questionnaire. The process of Spanish adaptation of the questionnaire was satisfactory. Our group follow working in the validation of the ESAS in Spanish.

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252. Production of a computer-based database for use in clinical palliative care.

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Shimane University Hospital, Palliative Care Centre, Izumo, Japan

Introduction: It is important to assess and analyze a patient's clinical status. Data analysis is indispensable in providing better care for patients. This requires a good database of patient information. Often, a database on paper is not very practical for data analysis. A computer-based database however, appears to be useful for detailed assessment and analysis. Working in palliative care is hard in any hospital, and the collection and integration of patient data into a useful database is equally problematic.?Aim: We intended to produce a computer-based database for palliative care. We also wanted staff to be able to input data at bedside.?Method: We prepared software and hardware as follows. System software: Microsoft Windows XP Professional Version 2002©, Microsoft Windows Mobile 5.0®. Application software: FileMaker Pro 8.0®, FileMaker Mobile 8®. Handheld computer: Hewlett-Packard iPAQ® The main items in the database were as follows. Clinical data (ID, diagnosis, purpose of consult, etc.), physical and psychological status, medications, projected prognosis, STAS (Support Team Assessment Schedule), pain score, etc. The database must be interactively linked between desktop and handheld computer.?Result: We have produced a database for which it is possible to input patient data using a handheld computer at bedside.

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253. Evaluation of the palliative care activity with using palliative care database.

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Introduction: The needs for the intervention by palliative care team (PCT) have been increased in Japan. The appropriate timing and actions of the PCT is important to improve the quality of the cancer patients and their family. Therefore, we utilize a computer-based palliative care database on the basis of the periodical assessments to plan a strategy of PCT.
Aim: This study was designed to evaluate the PCT activity retrospectively with using a palliative care database to improve the team action.
Methods: We studied characteristics the symptoms requested to palliative care, the symptoms, which were needed to be cared by the PCT, and the outcome in the 152 patients, consulted to the PCT from a computer-based database from Apr. 2005 to Mar. 2006.
Results: The main symptoms consulted by the ward staffs were physical pain (89%) and psychological care (12%). The patients suffered from physical pain (93%), anorexia (56%), nausea and vomiting (36%), general fatigue (35%) at that time. Fifty-two patients died during the hospital stay. Fifty-six % of them died patients mainly received the palliative care and 39% received disease modifying therapy. Their mean hospital stay were 66 and 79 days, respectively.
Conclusion: The results showed the differences between the consultation from ward staff and the care needed for patients, suggesting the importance of timely repeated assessments and care.

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254. Measuring quality indicators in all Extremaduran palliative care teams

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Background: Indicators are widely used as a strategy to improve quality provision. In palliative care, standard indicators are not been described and usually programs or institutions made their own ones. The Spanish Palliative care Association (SECPAL), made a group of quality criteria and quality indicators.A group of professionals from the Extremaduran palliative care program, revised the SECPAL indicators, adopted 22 of them and created 6 new ones. The aim of this study is to identify the percentage of indicators achieved.
Method: 28 indicators were evaluated by two researchers in the eight Extremaduran palliative care teams, including data from the year 2005. A minimum recommended score was defined for every indicator.
Results: All Extremaduran teams participated in the study. The mean minimum score recommended was 88,39% and the mean achieved was 85,05%. Four indicators (Weekly meetings; Protocols to wellcome patients; Other protocols; and Specialized Care education activities) were more than 20% under the recommended values.
Discussion: Six indicators (23-28) are self-produced, so there is no possibility to compare them with other programs. Other twenty two indicators (1-22) have been measured in 8 specialized palliative care teams, which provide care both in hospital and in the community. Probably the results obtained are not comparable with other teams working only in hospitals or in the community. There are not previous studies measuring these indicators.Some indicators are frequently under minimum recommended standard and identificate improvement areas.

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255. Attitudes of Nurses a key to outcome measures in palliative cancer care?

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Aim: To explore the experience among nurses in palliative cancer care toward systematic assessments of quality of life (QoL) by using a questionnaire.
Method: A study-specific semi-structured questionnaire was constructed. The questionnaire consisted of 6 topic areas covering experience of routine use of the EORTC QLQ C-30 in palliative cancer care. The present pilot study is qualitative and explorative.
Results: Two concepts were constituted in the analysis. The first was *facilitators;* including aspects related to daily work. The feasibility of systematic assessments and quality assurance was perceived in a positive way. The nurses also perceived indirect benefits for the patients, as the patients "being see" by the nurses. *Barriers* were the second concept constituted; concerning questionnaire design issues, readability and intrusive questions. Time was seen as a barrier, as well as impact of illness. Other barriers in using this type of assessment tool was e.g. the nurses judgement of the patients inability to participate due to subjective and objective signs of illness or distress.
Conclusion: It is important to use systematic assessment of QoL to increase patient wellbeing, and it is also important that this is informed and shaped by the needs and experiences of individuals and organizations delivering palliative care. Further research is also needed to map out the bigger picture of using quality of life outcome measures in palliative care.

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256. Occurrence and nurse documentation of oral problems in palliative care.

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Background: Oral problems are often underdiagnosed and undertreated in palliative care patients. The primary aim of this study was to survey the occurrence of oral problems in palliative inpatients. A secondary aim was to audit nurse documentation in patient records concerning oral problems.
Methods: All patients (n=19) on one hospice ward on the two days of study in May 2005 was asked to participate. 18 patients participated. The oral cavity was assessed with the Revised Oral Assessment Guide (ROAG).
Results: The majority of the patients had problems from the oral cavity such as dryness and fured togue. Hoarse voice and redness of the oral mucous was also frequent. The documentation in the records was defective.
Discussion: The result of the study indicates that there is a need for an assessment tool and for interventions to improve care associated with problems from the mouth. An assessment tool is a valuable aid for nurses in their work with mouth related problems. It is a guide on how to examine the oral cavity, assess problems found, give instructions for treatment and provide a structure for documentation.

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257. Effectiveness of parenteral antibiotics in terminally ill hospice patients: a retrospective study

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Rationale: The role of parenteral antibiotics in terminally ill patients is uncertain. There is a need to establish practice guidelines based on the collective experience of their effectiveness in hospice care.
Method: Retrospective longitudinal study
Results: Of 209 consecutive admissions to Marie Curie Hospice Liverpool from June-October 2006, 18 patients (42-86 years) received 20 courses of parenteral antibiotics. Consent for treatment was recorded in 13 episodes (65%). In 17 episodes (85%), antibiotic treatment was based on clinically diagnosed infection, confirmed on microbiological testing in 5 cases. Treatment indication in 3 episodes (15%) was acute deterioration of uncertain cause. The parenteral route was used for inability to swallow (35%), infection severity (40%), lack of response to oral antibiotics (20%) and antibiotic sensitivity precluding oral use (5%). Mean duration of treatment was 66.3 hours (range 6-144 hours). Antibiotics were discontinued due to non-response in 8 episodes (42%), changed to oral antibiotics following clinical improvement in 9 episodes (47%) and stopped due to unavailable venous access in 2 episodes (10.5%). 16 patients died (89%) at a median time following initial treatment of 15 days (range 40 hours to 9 weeks).
Conclusions: Parenteral antibiotic efficacy in terminally ill patients could not be readily determined, although short-term improvements may result. Justification for use remains arbitrary, in view of high early mortality.

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258. Body composition changes in advanced cancer associated with Angiotensin-Converting Enzyme gene polymorphism (ACEGP): preliminary results.

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Introduction: ACEGP greatly influences functional status and is currently the gene most involved in human fitness. Healthy individuals homozygous for the insertion-insertion polymorphism (II allele) had a greater anabolic response to intensive exercise than did those with either insertion-deletion or deletion-deletion alleles. II allele was associated with lower ACE levels and insulin resistance, along with higher glycogen stores, fat stores, and glucose uptake in skeletal muscle of animal tissues.
Aim: To gather preliminary data on the potential association between body composition with ACEGP in human tissue of advanced cancer patients (ACP).
Methods: DNA samples were obtained from 40 patients 18 years or older, newly diagnosed with Stage III (inoperable)-IV non-small cell lung cancer and unresectable/metastatic gastrointestinal cancers seen within the McGill University Health Centre. Muscle tissue surface area was measured by computerized tomography. Lean body mass (LBM) and muscularity (M) of the whole body was calculated by extrapolation of image analysis used to quantify muscle tissue in abdominal slices.
Results: II allele was associated with both higher LBM and M independent of age, gender, diagnosis, and treatment received.
Conclusion: Our data suggest ACEGP may influence muscle loss in ACP. The role of ACEGP in the pathogenesis of cancer cachexia is currently being investigated in a larger sample of ACP.

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259. What does the experience of people with intellectual disabilities tell us about the concept of "total pain"?

Linda McEnhill

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The concept of "total pain" developed by Cicely Saunders is vital within palliative care.The application of this concept is a defining aspect of hospice care and engenders the need for a multi professional team to meet each of the needs identified within the model (e.g. spiritual, emotional,existential, psychological pain). Methods for the assessment of total pain are implicit within the literature from which it would appear there may be inherent assumptions about a "baseline" quality of life; the deviation from which would signify the presence of aspects of total pain. For the "ordinary" person this baseline might include notions of 'relatedness', "self determination" and "self actualisation"; but what might a baseline quality of life look like for the intellectually disabled person and against what measures might the presence or absence of 'total pain' be measured? This presentation will initiate an exploration into the quality of life literature within the respective fields of intellectual disability and palliative care. The "total pain" literature will be considered alongside personal accounts of death and dying by people with intellectual disabilities. From this exploration a tentative hypothesis will be developed as to what constitutes "total pain" in someone with an intellectual disability and how this pain should be assessed and treated.

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260. Assessing sleep disorders in hospitalized patients: attention to details

Jorge Eisenchlas, Joanna McEwan, Maximiliano Zuleta, Cecilia Jacobsen, Marisa Pérez, Lorena Alvarenga, Gustavo De Simone

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Hospitalized patients frequently suffer sleep disturbances. Furthermore, perceptions of sleep quality could differ between patients and professionals.
Objectives:Evaluate the prevalence of sleep disturbances, its components and the ability of a single question to assess sleep quality in patients admitted at a Digestive Disease Hospital in Buenos Aires.
Methods:Every patient admitted to the wards for >6 d. was assessed using the Pittsburgh Sleep Quality Index (PSQI) and a screen single item extracted from the Zung Self-R. Depression Scale:"I have trouble sleeping at night".Sleep disorders was defined as a PSQI>4 and/or VAS>3 (0-10) for the single question. **Results**:120 consecutive patients were recruited (male 53%). PSQI was>4 and VAS>3 in 100 and 56 patients respectively (83.3%and 46.6%). Correlation between the single question and the PSQI was significant (r0.59;p<0.01). Sensibility and specificity of the single question were 54% and 90% respectively. Sleep components most highly rated were latency and duration (m1.68 and 1.56). Subgroup analysis did not show statistical difference between cancer (n37)and non-cancer patients (n83) **Discussion**:This population showed high prevalence of sleep disorders. A single question did not show to be useful for screening purposes. The problem of bad sleep in Hospitals and its assessment, and the common pattern of sleep disorders in cancer and non-cancer patients warrants further investigation.

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261. FEASIBILITY STUDY OF THE PALLIATIVE OUTCOME SCALE (POS) IN HOSPITALIZED PATIENTS

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Patient-reported outcomes are essential to measure the effectiveness of health-related interventions, although their use in the palliative care setting remains difficult
AimsEvaluate the possibility of completing the POS by cancer inpatients assisted by hospital-based palliative care teams (HPCT) in Buenos Aires
Methods During 4 months, every inpatient submitted to the HPCT were approached to complete the POS every 3-4 days for 1 week(T1;2;3). Performance status, educational level, pain, fatigue, MMSE and depression, were also assessed
ResultsThe POS was offered to 128, 73 and 59 patients at T1,T2 and T3 respectively (response rate= 65%,63% and 66%). As a whole, the POS was completed 168 times (rate response 65%;CI95 59-70%). Overt cognitive impairment accounted for 62% of the failures to fill in the POS. Of the measured variables, MMSE score was the only associated with completing the POS. Furthermore, 75/81 patients with MMSE >19 at T1(93%) filled the tool. 28/35 patients who did not finished the primary school (80%;CI95 66-94%) were able to use the tool atT1. In 24(9%) of the cases patients did not want to fill the POS
DiscussionCompletion of the POS was possible for the majority of the inpatients assisted by two HPCT .No barriers were found to its completion apart from cognitive impairment. The possibility to complete the POS by patients with low educational levels makes this tool useful to explore the effectiveness of palliative care in developing countries

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262. Collecting research data by computers in palliative care: results from a pilot study

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Background: Use of modern computer technology can give more precise symptom registration. As part of the PAT-C project, software has been developed for collecting research data on pain and physical function.
Aim: To explore palliative patients' reactions towards the use of computerised assessment of symptoms and functioning.
Methods: Touch-screen laptops with the PAT-C software were administered to 20 patients in the in- and outpatient clinic of The Palliative Medicine Unit (PMU) at St. Olavs Hospital, Trondheim. To enhance usability, text was set to 30 pixels and the size of radiobuttons was twice the standard. Data on the patients' reactions were collected by systematic interviews and observations.
Results: Six women and 14 men (mean age 61) participated. Karnofsky scores ranged from 40 to 100 (median 70). Nine had no previous experience with computers. Relatives assisted the patients with the computer assessment in three cases. No one reported problems with reading the text, but three had difficulties using the radiobuttons. One person found the computerized pain body map difficult to understand. Eleven preferred computer assessment, five had no preference and three preferred the pen-and-paper format (one missing).
Conclusion: Even if nine of the patients had no prior experience in using computers, computerised assessment was preferred.

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263. WATCH OUT FOR THE MOUTH -taking care of the oral cavity in palliative care-

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INTRODUCTION: From Sept.2000 to Sept.2006, the palliative care services(PCS)of Trento provided care for 1200 oncological patients(Pt) up until the moment of death.Our experiences revealed a high incidence of pathologies(Pa) by the oral cavity.The correlated symptoms are very disturbing to the Pt and contribute in causing a state of malnutrition.To elaborate an effective protocol (Pr),that will be able to standardize preventive intervention and the treatment of Pa that are caused by the oral cavity in cancer Pt that are under the care of palliative care services. Bibliographical research was carried out in *Medline* and *Cochrane*.Pr: includes 1) the preventive phase: identifying the Pt that are at risk, will allow preventive measures to be taken therefore minimizing the incidence and morbidity of Pa linked to oral toxicity; 2) the treatment phase: specific intervention for each single Pa regarding the oral cavity is described.
CONCLUSION:Pr is in the phase of being put into use.Several indicators have been identified to quantify its results: Number(N)of Pa regarding the oral cavity that were prevented or diagnosed and treated early on.N Pa cured,N symptoms correlated to Pa that were diagnosed and treated N of healthcare professionals that know and correctly implement the interventions that are described in the Pr(>75 %). N of Pt that correctly follow the instructions that they have received as part of the educational intervention of the Pr(>75 %).

264. Web based After Death Analysis (ADA) tool for supporting End of Life care in primary care

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Background The Gold Standards Framework (GSF) provides primary care teams with a practice-based model to support end of life care(Thomas 2003). Monitoring progress with GSF using an After Death Analysis tool (ADA) can help practices review and improve end of life care. Anonymised data entered on-line into the ADA are downloaded to a data-base to enable intra- and inter-practice review.
Aims 1.To pilot and develop the web based ADA. 2.To obtain longitudinal data to track progress in delivering end of life care by adopting the GSF programme, using a Locally Enhanced Service.
Methods One primary care trust in England introduced GSF to 37 practices, monitoring progress using the pilot ADA. 20 questions record care during 5 recent non-accidental deaths, completed quarterly.
Analysis 1. Quantitative analysis of item responses. 2. Qualitative interviews with practitioners to identify the value of the ADA to practice and suggested developments.
Results Data analysis is in progress and will be complete by spring 2007. Initial indications are that practices are finding ADA valuable for auditing care. Suggestions for improving ADA are made and adopted for national use.
Conclusion Evidence of the value of the ADA is presented in tracking progress towards improved patient-centred outcomes in end of life care using GSF. This tool is of interest for national evaluation of GSF and end of life care improvements.

265. OUR PLAN FOR THE PATIENT - applying the N.A.N.D.A. recommendations in Trento-

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INTRODUCTION: in order to guarantee that the patient's (P) problems are adequately cared for and managed, international literature considers that it is essential that nursing professionals adopt an individualized healthcare plan.
OBJECTIVE: to produce an effective instrument that is able to guarantee that the uniformity of the interventions, continuity of care and the monitoring of the P current problems.
METHODS:a workgroup that was made up of Nurses from the Palliative Care Services of Trento,identified some of the diagnoses/problems that are the most frequent to manifest themselves in P during the terminal phase of their lives,as defined by the NANDA.The handbook for the healthcare professional consists of a description of 24 problems with the diagnoses made by nurses and/or collaborative problems.Each diagnosis also indicates the expected results,the interventions that are needed and the healthcare professionals involved.The operating synthesis of this instrument is a form which is part of the healthcare clinical records, it therefore remains at the home.The form that is used summarizes the diagnoses and/or collaborative problems that the patient currently has or that have been cured,which causes the healthcare professional to re-evaluate them each time.The instrument has been produced and it is currently being used.At the present time, after having evaluated this instrument several times with all the staff that is involved, it seems to be coherent to the objective that was proposed and it meets the needs of the P and the healthcare professionals

266. Heart rate variability for prediction of life sapn in hospice cancer pateints

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The exact prediction on the length of survival is crucial for hospice patients. Therefore, we studied the usefulness of heart rate variability (HRV) for predicting the length of survival. From March 1, 2004 to May 31, 2006, of 71 patients in total, 62 (87%) died. As performance status scale was lower, as Lymphocyte percentage was lower, or when combined with dyspnea, the length of survival was much shorter. In the case of HRV parameters, the group of which the mean heart rate was more than 100 per minute or the group of which SDNN is 21.3ms (75% percentile) or less showed a statistically significantly short length of survival. The final multivariate analysis reflecting the correction of the factors such as age, sex, FBS and total cholesterol also showed that the hazard ratio was 3.217 and 3.08 respectively. Performance status, dyspnea, lymphocyte percentage were identified as independent prognostic factors. Among HRV parameters, mean heart rate and SDNN were meaningful for predicting the length of survival.

267. Diagnostic Value of Kidney, Ureter, and Bladder (KUB) Radiographs in Palliative Management of Gastrointestinal (GI) Symptoms. Preliminary Findings

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Background:
GI symptoms are common and KUB is often used in assessment. Its utility in guiding decisions and management is unknown.
Objective:
To assess the value of a KUB in diagnosis and guiding medical management in an inpatient palliative unit.
Methods:
All patients admitted over 6 months will be included. Demographics, symptoms, medications, preliminary diagnosis, radiologic interpretation, management decisions and outcomes were recorded.
Results:
Initial results involve 32 KUBs .Median age was 62 years (range 44-89), 14 males, 31 has cancer. Constipation (24) was the most common complaint, followed by abdominal pain (17), nausea (15), vomiting (12), distention (6) and early satiety (5). All patients were on opioids, 27 on a bowel regimen, and 9 on steroids. The 2 most common reasons for the KUB were constipation (27) and suspected obstruction (7). Constipation (20) was the most common interpretation, median constipation score was 6 (range 0-11). 7 KUBs were unremarkable and 4 interpreted as obstruction. Official reading was unremarkable in 25 films, constipation in 4, ileus in 2, and obstruction in 1. 24 patients had management aided by the KUB. 22 had enemas/extra laxatives, 2 opioids, 8 no change in management. Symptom resolution seen in 26 patients.
Conclusion:
KUB influenced medical management in 69% (22/32).

268. Prospective study of workload in palliative care unit

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CENTRE HOSPITALIER LYON SUD, Centre for Palliative Medicine, Lyon, France, France

Introduction
In France many tools are used for measuring the workload but they are not adapted for the palliative care unit's type of care
Methodology
All caregivers coming in the patient room are requested to fill a chart recording the time and the task they do in the room, and if they come by them self or requested by patient or family.
This record was perform for all the patients admitted in the unit and during day and night
Results
Global results
The time spend in each patient room by day are:
- 1h 63 for nurses
- 1 h for help nurse
- 0 h 67 Students
- 0h38 physician
- 0h15 for cleaning people
- 0h14 for the chief nurse
- 0h13 re-education and psychomotricity
- 0h10 psychologist
- 0h06 for the social worker

Discussion
The data collection was not so easy and many caregivers forgot to fill the chart; the results are under-assessed
For each patients the time spend in the room are highly variable and unpredictable, during day and night; the adaptation of the workload and the number of caregivers are very difficult to foreseen.
The time spend in the patient room is only one of the aspect for the workload in the PCU some time are spend in communication, preparation, exchanges, organisation, cleaning...
Conclusions
We need to have and easy and reliable tool to measure the workload in a palliative care unit
For the staff management

269. Improving the Holistic Assessment of Palliative Care Patients Needs -A Help the Hospices Initiative

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The UK's NICE guidance on Improving Supportive & Palliative Care for Adults with Cancer, highlights key areas for the improvement of patient assessment (NICE 2004). It has also been recognised that a standardised approach to the assessment of patient's physical, psychological social and spiritual needs, together with a 'specification', for patient needs assessment tools should be developed (NAO, 2005, *Richardson, Sitzia, Brown et al, 2005)*.

A *Help the Hospices* 'Patient Needs Assessment' working group was initiated to develop an integrated care pathway (ICP) for the assessment of palliative care patients needs on admission to hospice.

Issues to be assessed within the first day/24 hours of admission included generic/demographic details, orientation to hospice, functional and physiological assessments. Days 2-3 focus on assessment of psychological, social and spiritual domains, ending with a summary of the patient's current needs, goals and proposed actions. All issues within the ICP are recorded, with unmet items documented through variance recording. Audit of completion (including assessment of relevance) was conducted in one hospice setting.

The initiative has resulted in a 'best practice example' of holistic assessment for UK hospice. Audit indicates good levels of completion and relevance of content, with areas of weakness highlighted. The ICP effectively addresses the NICE recommendations for the assessment of specialist palliative care patients.

270. Suffering and Relational Centred Medicine in Palliative Care

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We describe a theoretical model of intervention on suffering in patients with untreatable and life-threatening illness as contribute for a more relational centred health care intervention in palliative care, allowing caregivers, by means of a meaningful relationship, to explore all dimensions of suffering and prioritize and direct their interventions to the patient, the family and the environment.?We consider that normal existential anxiety vulnerabilized by threat/loss of the integrity and/or continuity, as it occurs in untreatable and life-threatening illness and be transformed in existential despair with two main directions related to the meaning attributed to the vulnerability agents: the loss meaning develop demoralization syndromes with depressive or detached modulations, the threat meaning can assume two main issues: a disbelief/denegation or a anxiety/turbulence modulation. All this ways of suffering expression are determined by physical, psychological, mental, socio-cultural, family and spiritual components of suffering that must be recognised in order to help patients, using a hope construct, to attain a state of existential proud before dying.We stress the importance of an existential vigilance in the caregiver/health team in order to be able to help patients and their families in this important period of their life.

271. Palliative care needs assesment in rRoma community.

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Aim: to explore the needs and particularities of rRoma community in Brasov districts (588366 inhabitants out of them 44600 rRoma) Method: Survey , face to face administered questionnaire through the rRoma health care mediators. The questionnaire was piloted on rRoma health mediators. Results: 1200 questionnaires were distributed to health mediators, 845 returned and 830 included for final analyzing. rRoma communities in our study were characterised by: poverty(entertained by lack of occupation),low education(men doing slightly better),inappropriate living conditions (space, sanitary),existing access to health care but no prophylactic use of it, religion is a private and sensible topic. There was low awareness in rRoma community what hospice is and even a lower acknowledgement and use of services offered by hospice Casa Sperantei. The main source of information is from person to person contact (neighbouring, medical staff). When it comes to palliative care needs and ways to fulfil them: drugs for pain, food, nursing support are rated as most important and specialized centres to admit patients in need for palliative care and trained persons from the rRoma community to make home visits are seen as the solutions. Main cause of dependence and death reported were non-malignant diseases rather than cancer. Conclusion: the low use of palliative care services by rRoma members are both the results of low awareness and inappropriate design of the services

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272. SICP Suggestions of Recommendations on Palliative Sedation/ Sedation at the end of life

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The decision of working process of sedation is still debated in Italian Palliative Care Units.

The purpose is to consider the practice of sedation and to help the operators in the difficult decision-making process.

In June 2005 a working group was formed under the auspices of SICP.

The group is multidisciplinary and make up of nurses, physicians, psychologists, an expert in ethical problems and a spiritual father, working in different Italian Palliative Care Units.

The working method consisted of a review of the international literature before the drafting of recommendations. After several meetings of discussion with elaboration of drafts that treated the different aspects of the sedation processing, was writed a conclusive paper.

The paper presents several articles: Definition, Indications, Pharmacological Therapy, Communication with the patient and the family, Spiritual Aspects, Ethical Aspects, Management of sedation processing.

The document is directed not only to the attention of palliative care teams, but also to medical practitioners, to specialists in hospital wards and to anyone who works in geriatric clinics to help the interdisciplinary decision –making process of sedation.

Therefore, we hope to spread in different setting of care guidelines for valutation and treatment of sedation and to omogenize the behaviours

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273. The Borg CR 10 Scale - an alternative to NRS in symptom assessment?

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Background. Numeric rating scales (NRS) are commonly used for symptom assessment in PC, for a single or several symptoms (eg ESAS). **Aim.** Do patients assess symptoms different depending on scale **Method.** Ten pts with advanced cancer were included in this pilot study. **Results.** Patients mean scores for the three symptoms at four occasions were generally higher on the NRS as compared to the Borg CR-10. However, the differences were not statistically different. All mean and median scores were <3 on both scales. Generally patients found it easier to use the Borg CR-10. Patients with symptom changes during the 15 min interval were excluded. **Discussion.** The consistently lower scores on the Borg CR10 for different symptoms emphasize the importance of the scale design. The number of patients was small as was symptom intensity. There is a need for further development of scales. One clinical aim related to quality of care is to define a non acceptable degree of symptom intensity. On the Borg scale the intuitive non acceptable score is 3 (=moderate), on the NRS a non acceptable level is not given a priori.

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274. Liverpool Care Pathway - integration into the electronic patient record

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Background. Liverpool Care Pathway (LCP) is an integrated care pathway aiming to improve the care of the dying patient. LCP was developed at the Marie Curie Hospice in Liverpool and is increasingly used in the UK and other countries. Until now a paper based version is used for LCP. An computerized version of LCP is needed as part of the development of electronic patient records. ?**Aim**. To make an integrated electronic version of LCP for use in the patient record system at a palliative care unit.?**Procedures**. The electronic patient record system is Profdoc Take Care©. The initial and after death assessments and the continuing follow up parts of LCP were integrated at different levels of the system. Reports were designed and a print out version similar to the paper version of LCP was made available. A positive test study of accuracy and user friendliness was performed. It was possible for the IT specialists at the unit to do all adaptations of software. ?**Conclusion**. LCP was successfully adapted to a computerized patient record system. Since the number of different IT systems for patient records is different within hospitals, regions and countries a "one for all solution" is not possible. The present study should be seen as an inspirational example and a sharing of experience.

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275. Complementary Therapies at St Joseph's Hospice

Maura Cochrane

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Complementary therapies are encompassed within the concept of supportive care, and are now well established as part of the multi-disciplinary approach to care at St Joseph's Hospice which opened a dedicated complementary therapy unit (The Wellspring) in 1999.The hospice is located in the richly diverse area of East London, and one of the main challenges the developing service has encountered has been influencing the perception of complementary therapies among potential service users and adapting the delivery of the therapies to the cultural mores of the various groups. For example, many 'traditional East-Enders' regard complementary therapy as something for younger "hippie" new age types, and not for them. Muslim females, on the other hand, would not undress for certain therapies, and would only accept a female therapist. In addition, certain forms of touch therapies would not be appropriate for a range of cultural and religious groups.Over the past 7 years the Wellspring team has worked hard to make the service acceptable to the many different cultures that are represented in the hospice. The complementary therapies offered include aromatherapy, reflexology, acupuncture, massage and relaxation. Research has been conducted to establish the benefit of these therapies to our diverse client group.

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276. Psychosocial Intervention in C.P.: Art and Meditation as a road to the Spiritual Dimension of the Being

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Introduction: We consider spirituality a constituent dimension of the human existence, present in every manifestation of its being. Art, in its different expressions, and meditation are roads that facilitate access to the spiritual dimension.The psychotherapist can use these approaches as a tool to allow expression of the processes of acceptance, communication, coping and sense of transcendence.Objective: To present various experiences with patients, who through these approaches were able to reach acceptance of the process of disease, the expression of thoughts, feelings, emotions, and the feeling of integration of the person in a broader dimension.Methods and Materials: Artistic work: drawing, mandalas, collage, haiku poetry, short stories and free writing. Meditation techniques: conscious breathing, meditation, deep relaxation and visualization guided by symbols and images.Conclusion: These expressions, given their depth and intensity, were facilitated by the above mentioned techniques. To be able to work with the expressive capacity within a therapeutic frame, facilitated verbal and non-verbal communication, and helped towards the integration of the different aspects of the being.The experiences conducted allowed us to observe the richness in the expression of the images, feelings and emotions, with regard to disease, life and death; allowing adaptive coping strategies and enhancing resiliency.

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277. A PNIE POINT OF VIEW (Psychoneuroimmunoendocrinological).COMPLEMENTARY THERAPEUTICS FOR SYMPTOM CONTROL.

Gustavo Rodio[1,2,3], Dorita Gonzalez[1,20,4], Gabriela Bosso[1,20,5], Ana Laura Ottonello[10,6], Varya Kuis[1,2], Stella Salgueiro[1,2]

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The mind-body dichotomy in health sciences has divided man, explaining illness with divided models, applying these criteria on treatment strategies.The person has been treated as a mind by the psychologist and a body by the physician, different types of knowledge and language not integrated at the time of understanding and treatment. Since the beginnings of the XX century the transdisciplinary constructions have allowed us to go beyond psyche soma reductionism, understanding man as a unity within a multiplicity, a complex system Bio-Psycho-Social-Spiritual, who as such is not possible to assist with models that sustain such dichotomy.The PNIE model applied to P.C. could sustain the efficacy of non-pharmacological interventions of the psychosocial area of symptom control in chronic, progressive and disabling diseases. Such interventions are non-invasive; they promote a better quality of life, reducing distress, anxiety, depression, pain, nausea, etc, preserving the autonomy of the person and respecting their individuality. These complementary techniques are: relaxation, meditation, visualization, biofeedback, hypnosis, etc.The PNIE intervention model reveals the complex psychological and physiological processes which interact dynamically in the onset and control of symptoms. They show the mind-gene interconnections involved (Rossi 1977), which maximize drug action, producing larger effects with smaller doses, which would result in less side effects.

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279. EVIDENCE OF ART-THERAPY EFFICACY IN PATIENTS WITH TERMINAL CANCER.

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Emotional and spiritual issues require innovative interventions of the interdisciplinar palliative team. Art-therapy can be there a strong allied health profession. The **aim** of this study was to determine the benefits of individual art-therapy process for adult terminal cancer inpatients, using a quasi-experimental pre-post data design (n=51). **Method:** Prior to and after a minimum of three 30-60 min creative sessions, we used open-ended questions to inpatients, families and team to evaluate their percepcions of the experience. The Palliative Care Outcome Scale *(POS)* and the Mac Gill Quality-of-life Questionnaire *(MQOL)* were used to assess the quality of life. Intensity of symtoms was measured by Edmonton Symptom Assessment System (ESAS) and Support Team Assesment Schedule *(STAS)*. **Results:** Patients, families and team expressed a high level of satisfaction with the process and 78.4% of patients comunicated the feeling to get better. The greatest benefits observed were distraction, emotional relief, well-being, relaxation and renewal experiences such as memories, creativity or higher acceptance of the reality. Statistically significant increase was proved in all the quality of life parameters, as well as a significant reduction of the majority of symptoms. **Conclusion:** This study provides some evidence of the benefits of art-therapy within the palliative approach. We plan a randomized controlled study to confirm the specific contribution of this creative treatment.

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280. The role of a physiotherapist at the Hungarian Hospice Foundation

Nóra Ferdinandy

Hospice Foundation, Palliative Care Team, Budapest, Hungary

The presentation will introduce the work that I have been doing at the Hungarian Hospice Foundation in the past five years.

The Foundation was established fifteen years ago and works in two main sectors; home care and in-patient care at the Budapest Hospice House.

The Foundation works also as a method center where Hungarian as well as foreign applicants – including college students studying physiotherapy – can take advantage of further education in specific fields several times a year.As a physiotherapist I am a member of a multidisciplinary team. 95% of the patients suffer from metastatic cancer. Their final two months are dominated with pain, fatigue and in most cases lymphatic edema. Making a concerted effort to better the quality of life and to ease the pain of our patients is our primary concern.I will give an overview of my job, tasks and responsibilities and introduce the methods and tools, as well as, the aims and results which have given us so much strength to carry out this noble task.

281. Alternative Therapy in Cancer In seeking of the Miracle Cure or the Power and the Ethics of the advertisement

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No matter how successful is the treatment of cancer there is long standing tradition in Bulgaria – The cancer patients and their relatives use, are willing to use or even insist to use other kinds of treatments concomitant or instead of the well established anticancer treatment modalities as surgical treatment, radiotherapy and chemotherapy. These treatment options are often called alternative medicine or non traditional or unofficial methods of treatment. Often there are little or even no evidences for their effectiveness. Usually these kinds of treatment in Bulgaria are not prescribed by the physician responsible for the anticancer treatment. Many of these alternative treatment modalities are usually performed by the patient and his/her relatives without asking for opinion or informing the responsible for patient's treatment oncologist. In this investigation the authors asked patients and their relatives about their use of alternative treatment modalities, how they learned about these treatment possibilities, did the patients informed about these kinds of treatment the responsible for their treatment oncologist. The patients were asked about the efficacy of the applied alternative treatment, its effectiveness and their satisfaction of the preformed treatment.

282. The Combined use of Complementary Therapies and Bio-medically Oriented Health Care in Palliative Stages of Cancer: A Narrative Analysis

Johanna Hök[1], Caroline Wachtler[2], Torkel Falkenberg[1], Carol Tishelman[1, 3]

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People with advanced cancer commonly use complementary and alternative therapies (CATs). Rather than using CATs and biomedically-oriented health care (BHC) in isolation, these different therapies are often used in a complementary fashion. Little research to date has given attention to individuals' experiences of the combined use of BHC and CATs. This paper therefore examines one individual's negotiation between complementary self-care methods and BHC. Using narrative analysis, we explore how a personal narrative is told, in addition to what is told, in order to see how meaning of the negotiation between different therapies is created. Our analysis suggests that the BHC may maintain a vital role as a frame of reference even for the use of certain CATs. It also became apparent how one CAT can be used for different purposes simultaneously by one individual. A positive example is shown of how a spouse's experience of positive communication about CATs with a BHC provider was interpreted by the spouse as indicative of a shift from a hierarchical to a more collaborative relationship. Such increased collaboration between stakeholders is an important aspect of models of 'integrative medicine'. Our findings highlight the need for an open and respectful dialogue about CATs between patients, their significant others and BHC providers.

283. The use of Phallus Impudicus as a complementary remedy in palliative care in cancer

Sergejs Kuznecovs, Klara Jegina, Ivans Kuznecovs

Preventive medicine Society, Cancer Research Laboratory, Riga, Latvia

Background: Phallus Impudicus extract (PhI) is regarded as a complementary cancer therapy and the most commonly used palliative care remedy in Latvia. This study aimes to determine whether the use of PhI prolongs survival time of patients with advanced cancer.
Methods: During the period from 1991 to 2006, 25415 cancer patients with bronchogenic carcinoma, breast, ovarian colon, rectum, stomach carcinoma and melanoma were involved in a prospective long-term epidemiological cohort study, including 11548 patients used PhI and 13867 control patients, who had used or had not used other complementary therapies. Main outcome measures were survival time and psychosomatic self-regulation.
Results: In the nonrandomized matched-pair study, survival time of patients used PhI was longer for all types of cancer studied. In the pool of 2008 matched pairs, mean survival time in the PhI groups (6.52 years) was roughly 52% longer than in the control groups (2.95 years; $P < .001$). Synergies between PhI use and self-regulation manifested in a longer survival advantage for PhI patients with good self-regulation (68% relative to control group; $P = .05$) than for patients with poor self-regulation. The best results was observed in groups of patients with breast and ovarian cancer.
Conclusions: The use of PhI as a complementary remedy in palliative care can achieve a clinically relevant prolongation of survival time of cancer patients and appears to stimulate self-regulation.

284. Attitudes to Acupuncture among Patients and Physiotherapists in Oncology care

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The purpose of our two cross-sectional studies was to study how satisfied radiotherapy (RT) patients were with their antiemetics and if they had an interest in acupuncture (study A) and to explore oncology physiotherapists experience and attitude to acupuncture (study B). **Method** Study A comprised 368 RT patients. Study B included 117 oncology physiotherapists. All participants answered a questionnaire. **Result** 145 (40%) of the patients in general and 63% of those treated over pelvis/abdominal fields felt nausea. Of the145 nauseous patients, 25% reported good or moderate effect of antiemetics given. One third asked for additional antiemetics, while 40% rejected antiemetics. Of all patients, 145 (40 %) were interested in acupuncture for nausea and 136 (38%) asked for more information about the method. In study B, one third of the 117 physiotherapists believed acupuncture would be appropriate in 50% of oncology patients but only 8% answered that 50% of the patients actually received acupuncture. Sixty six (56%) gave acupuncture. The most common conditions were pain (42 % of the therapists), chemotherapy induced nausea (38%), vasomotor problems (28%), xerostomia (17%), RT- (16%) or morphine- (16%) induced nausea.
Conclusion Three quarters of the nauseous patients either asked for more treatment against nausea or rejected antiemetics. Both patients and physiotherapists seem to consider acupuncture as an appropriate method, but it seems to be underused in oncology.

285. An exploration of massage and communication, including recommendations for teaching strategies to enable colleagues to use touch in safe and therapeutic ways.

Lisa Smith

Sir Michael Sobell House, Nursing Services, Oxford, United Kingdom

This paper/poster presentation offers an exploration of how touch and massage may be used in palliative care to enhance communication and develop therapeutic relationships. Critical analysis of an incident from practice will identify and analyse how touch may be used therapeutically to create an environment in which trust may be initiated and developed. The roles of trust, touch and massage in the mindful development of therapeutic relationships will be explored. An attempt will be made to distil the elements of what might be taught to colleagues in the palliative care setting to enable them to appreciate and use touch in therapeutic and safe ways for the benefit of people nearing the end of their lives.

286. Use of blood transfusion in palliative care patients. Health-Related Quality Of Life.

Feliks Blaszczyk, Anna Oronska

Lower Silesian Oncology Center, Palliative Care Team, Wroclaw, Poland

Bacground:
Anemia is defined as an abnormally low haematocrit or hemoglobin concentration in peripheral blood; it also is defined as multi - symptom syndrome with fatigue being the primary symptom characterized by low hemoglobin level. Anemia occurs frequently in patients with cancer and is associated with impaired health - related quality of life. Treatment of anemia results in significant improvement in energy and day - time activity.
Material and method:
25 patients in palliative care were asked a few questions in a questinnaire. Questions considered patients condition and well being after blood transfusion being undertaken.
Results:
Health Related Quality of Life (HRQOL) has improved in 17 patients (68%), among them, 9 (53%), felt less fatigue, better vitality claimed 7 patients (41%), better appetite - 4 subjects (~ 24%),psychological improvement in 9 patients (53%). Difference between patient's evaluation of their own health improvement (68%) and doctor's evaluation of the same patient's quality of life improvement (64%) was not significant.
Conclusions:
Blood transfusion improves HRQOL in most cases (68%). Treatment of anemia improves quality of life in patients with cancer. Apparently the first administration of blood is more effective than sequent ones.
Key words: transfusion,anemia,cancer,health - related quality of life (HRQOL)

287. Cancer as an Anticipated Form of Loss

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Objective: According to our research spanning all the five cancer centres of Hungary and a total of 924 patients, 45% of Hungarian cancer patients suffer from clinical depression while 44% suffer from symptoms of extreme anxiety. Our psycho-oncology service seeks to improve patients' coping mechanisms and quality of life. Better psychological condition, in turn, helps accept the difficulties of treatment, alleviate side-effects and increase the expectance of recovery.
Method: Our psycho-oncology service offers psycological assistance to cancer patients from the moment of diagnosis on. The therapy is adjusted to the special needs and condition of the patient due to a psychological diagnosis. Beside the exploration of psychological problems it is inevitable to assess the patients' various resources that can serve as basis for the development of individual coping strategies.
Results: Due to our experience, the psychological state of many patients might be identified as anticipated bereavement. According to our therapeutical experience, about 95% of the patients report to have an improving quality of life. Sleeping disorders and depressive symptoms are relieved or even lifted, the relationship with their family members improve, their everyday life remains balanced even during the period of treatment.
Conclusions: The bad psychological condition of cancer patients and their reaction to a shocking loss can be improved through the means of psychotherapy. This is why we have to make psychological assistance available to all oncology patients.

288. Sexual Dysfunction and Cancer: a Behavioral Intervention Study

Karin Stinesen

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Sexuality and cancer at any stage is today a fairly well mapped field. We know quite a lot about the sexuality issues associated with cancer. However, our knowledge of how to actually help these patients is so far very limited. Therefore, this study focuses on behavioral interventions, using both educational as well as psychotherapeutic methods in order to target cancer related sexual dysfunction. Purpose: The purpose of this study is to, based on the women's own words, approach a way to ameliorate their suffering with interventions that are today much needed, but rarely offered.
Methods: We start by interviewing the patients about their needs in the area of sexuality. It is very important to base the interventions that follow on the patients' own words. Thereafter, we intervene with educational group sessions and also with psychotherapeutic sessions. If indicated, either intervention could include the partner of the patient. Result: This study has just started and the results are not yet available to us. However, the types of questions that come up at our clinic indicate that this is a much needed area to study.
Reserach implications: With the number of longterm cancer survivors increasing, quality of life issues become increasingly important to acknowledge. This study puts an important quality of life issue on the agenda in our multidisciplinary cancer team and will likely inspire further research.

289. HOW ART THERAPY IN PALLIATIVE CARE UNIT CAN HELP PATIENT AND FAMILY?

WADIH RHONDALI, AURELIE LAURENT, MARIO BARMAKI, ISABELLE BRABANT, MARILENE FILBET

CENTRE HOSPITALIER LYON SUD, Department for Palliative Medicine, Lyon, France, France

Art therapy is under developed in palliative care units (PCU) in France as are the complementary therapies in general. The palliative care team are often reluctant to

introduce new treatement or activities in this environnement.
A**ims:** the aims of this study was to explore the benefit of the art therapy in releiving suffering for patients and family in palliative care.
Method: Six cases studies will be described and will illustrate the use of the art therapy in a PCU. They are
-1-communication with patients unable to express their pain and suffering
-2-the patient is rebuilding self -confidence and self-esteem
-3-the patient start to take an active role in the relation ship
-4-the patient re-establishes their social position
-5-the patient is able to forget their disease during the therapy
-6-the patient is able to create a gift for the relatives and care givers
Conclusion: The experience of the art therapy in our PCU has been valuated by patients, relatives and staff.We plan a formal prospective study to evaluate the impact of the art therapy on quality of life and satisfaction of patients, family and staff.

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290. Efficacy of health food supplement for the patients treated by palliative care team

Yuuko Moriyama, Mikiko Kawaguchi, Youko Hashimoto, Aki Urakawa, Harumi Fujii, Kyoichi Adachi

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Aim
To clarify the efficacy of health food supplement served by the hospital nutritionists for the patients treated by palliative care team.
Subjects and Methods
Study subjects were 50 admitted patients with malignant diseases who were cared by palliative team and individually supported by the nutritionists between January 2005 and October 2006. All patients were interviewed whether they used supplements before admission and what they expected the supplements. The several kinds of supplements were served to adjust the condition of each patient.
Results
Forty percentage of patients used health food supplements before admission. The patients expected the supplements to improve their stamina, the immunological response and tasty sensation. The number of patients who were administrated by the nutritive liquids, dietary fibers, powder refreshing drinks which containing with glutamine, fiber and oligosaccharide, and nutritive drinks with trace elements were 80, 10, 30 and 55%, respectively. The mean percentage of served supplements intake and the mean period of supplement dosage were 73.3±31.8% and 28.5±33.0 days, respectively. The modifications of supplements dosage method by freezing, making jelly, etc. were effective, and the supplements improved stomatitis and taste disturbance.
Conclusion
The adequate administration of supplements had favorable effect for patients cared by palliative team.

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291. Use of complementary and alternative medicine in cancer patients: results of survey in the single cancer centre in Poland (Olsztyn)

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BACKGROUND: The aim of this study was to explore the use of complementary and alternative medicine (CAM) in cancer patients (pts) in the our cancer centre. PATIENTS AND METHODS: In the October 2006 descriptive questionnaires was collected from 56 pts in the out-patient clinic. All pts received chemotherapy as metastatic setting. The mean of age of pts was 54 years (range: 22 – 80), the male : female ratio is 1 :3. 42% of responders live in the rural area. RESULTS: Data suggest that CAM is popular among cancer patients. Current CAM use was reported by 58 % of responders. Most often shark cartilage and fish oil were used (46%). In the subsequent position mind-body intervention and herbs (Chinese herbs, Vilca cora) were placed. Energy therapies, acupuncture and homeopathy were used uncommonly. 10% of CAM-users reported that used more than one CAM therapy together.The analysis of responders group showed that the profile of the CAM user in our centre was that of elder people (mean of age: 57 vs 51) , female (68%) and city occupier (68%). It was interesting that only 76% of CAM-users discussed with their doctor about CAM therapy.CONCLUSION: In our centre more than half (58%) pts who received palliative chemotherapy, used CAM during conventional treatment. Health-care staff need to be aware of such use of CAM and to be able to educate pts appropriately.

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292. Is acupuncture a treatment option for hospice patients with xerostomia?

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Background: More than 70 % of severely ill patients with cancer suffer from xerostomia (mouth dryness), most commonly due to multiple drug treatment. Dryness of mouth has a profound negative effect on well-being and can apart from general discomfort lead to difficulties swallowing, chewing and speaking. Withdrawal from social life activities due to eating and communication problems is reported. Traditional treatments including candies, moisturizing products and saliva substitutes has shown short time effects. Research indicates that acupuncture might constitute a treatment option for xerostomia.**Aim:** To investigate if treatment with acupuncture is a viable option for hospice patients with xerostomia**Methods:** During a one year period 14 hospice patients with cancer reporting dryness of mouth and associated problems were offered acupuncture treatment. Ten acupuncture treatments were given in a five weeks period. To measure the effect of acupuncture, a Visual Analogue Scale (VAS), the Xerostomia Inventory and a measurement of saliva were implemented before, during and after treatment.**Result:** Since the data analysis is currently in progress the final result and the discussion will be presented at the conference. Preliminary result shows that the patients experienced some alleviation of mouth dryness, but that a five weeks treatment period may be too long for such a sick group of patients since six of the patients passed away before the series of treatment could be completed.

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293. THE PRESENTATION OF A SYSTEM TO NAVIGATE IN COMPLEMENTARY CARE (CC) AND TO SUPPORT THE CAREGIVER TO FIND A SUPPLY ON MEASUREMENT OF THE NEED OF THE PALLIATIVE PATIENT.

LUK NAVEAU, TINE DE VLIEGER, MYRIAM ARREN, LUT VAN DEN BOSCH

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Introduction: CC and complementary therapy (CT) want the increase of quality of life and to achieve the most possible optimalisation of symptom management. The purpose is to increase comfort, the feeling of well being and the quality of life. The nurses of the multidisciplinary homecare team of “Palliatieve Hulpverlening Antwerpen” give advice and support to the patient, the family and all involved actors in the care when they have needs concerning CC and CT with the development of a particular system that helps to navigate in this particular support. This system is a guide that geared all activities in the palliative care pathway to one another. Aims: Create an uniform step-by-step plan that support all caregivers and improve access to the patient perception concerning extension of comfort. Method: A 5 step by step plan. Results: Increase engagement, discussion about needs in CC, CT and palliative care; it check if CC CT is meaningful for the patient. The information is focused on improvement of well being, evaluation and report on the effect of the recommendations on well being. The nurse is the intermediary through all involved actors in care. Conclusion: This system make an uniform approach possible to geared CC, CT and palliative care and stimulate the caregivers to have attention for patient needs about CC and CT.

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294. DOCUMENTS TO EVALUATE THE IMPLEMENTATION OF COMPLEMENTARY CARE (CC) IN PALLIATIVE CARE (PC).

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Palliative Care Network Antwerp (PHA), Palliative Homecare services, antwerp, Belgium

Introduction: CC and complementary therapy (CT) wants the increase of quality of life and to achieve the most possible optimalisation of symptom management. The purpose is to increase comfort, the feeling of well being and the quality of life. The nurses of the multidisciplinary homecare team of “Palliatieve Hulpverlening Antwerpen” evaluate systematically the needs in CC and CT. Aims: The evaluation of physical symptoms and the psychosocial impact; CC can be a surplus in palliative care; evaluation improve communication between the patient and caregiver. Method: An evaluation tool based on the Edmonton Symptom Assessment Scale (ESAS). Results: Increasing possibilities in palliative care and creating possibilities to evaluate CC on physical and psychosocial effects. Conclusion: A systematic evaluation tool improve the well being of the patient through quality of care and the communication about the impact of CC in palliative care.

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295. Which place has complementary care for a palliative expert in a pluralistic network of palliative homecare?

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IntroductionComplementary care(CC) is improving the sense of well beingCC is seen as an adjunctive to conventional medical treatment.The nurses offer advice and support to all the patients and care givers who want to introduce CCBecause not all CC are founded on scientific research, it is often difficult to give CC a place within the mission of a networkAims Palliative experts are skilled partners whenever implementation of CC is requiredThese experts can place CC on the map of the palliative landscapeThey aren’t experts in practically-oriented ways but advisorsThey can, by means of their knowlegde of indications, counter-indications and general points of attention in the field of CC, give support to create a safe environment to and increase the wellbeing of the patientMethodOrganisation of internal educationObtaining a clear view into the types of CC, their scientific relevance and effectivenessDesign a mutual point of view and a clear image to cope with CC within the organisation by creating a policy noteResultsThe capability to cope with questions and to give advise concerning CC will get a forum within the given task of a palliative networkConclusionTaking in consideration the tasks of a network it is important to give CC a neutral place in the path of a healthcare route as the patient is free to choose any CC in addition to the existing healthcare servicesThis must always be supported by adequate knowledge

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296. REHABILITATION IN TERMINAL ILLNESS

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Introduction: Palliative rehabilitation improves the quality of survival. It is a matter of discussion the value of performance status as prediction of survival. **Objectives:** 1.To assess the convenience of suggesting rehabilitation treatment in terminally ill patients. 2.To establish objective diagnostic criteria in order to include these patients in treatment programs. **Method:**1.Descriptive qualitative study of medical consultations received from the PCU by the Rehabilitation Team. 2.Period of study: 01/01/05 to 31/12/06. 3.Statistical analysis of the results with the SPSS 11.5 program. **Preliminary results (2005):** A total of 79 medical consultations were received, 14 of them for patients in Palliative Care situation (18%) 6 out of the 14 (43%) were discharged home after improving their performance status. 8 of 14 (57%) died; 5 (36%) showed an improvement of their functional status; 2 (14%) presented complications that led to decease; 1 (7%) died before the beginning of rehabilitation. **Conclusions:** It is necessary to include rehabilitation in Palliative Care Units and to define protocols of treatment in Palliative Rehabilitation in order to identify the patients who would benefit the most.

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297. The Clinical Effects of Music Therapy in Palliative Medicine and Hospice Patients

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Background: There are few quantitative studies involving music therapy individuals with advanced illness. The differences in clinical effects in palliative medicine and hospice patients are unknown.
Aim: To assess the clinical effects of music therapy in palliative medicine and hospice patients.

Methods: 100 age and gender matched palliative medicine and hospice patients were prospectively evaluated. Visual analog scales, the Happy/Sad Faces Assessment Tool, and a behavior scale recorded pre- and post-music therapy scores. Symptoms included pain, anxiety, depression, shortness of breath, and mood. Behaviors were facial expression, body movement, and verbalizations/vocalizations.
Results: A paired t-test ($P<0.05$) demonstrated that with both programs combined all symptoms and behaviors improved and were statistically significant. Between programs, however, only mood, facial, movement and verbal were statistically significant ($P<0.05$, t-test). Comparing the goals between programs using the Chi-square test ($P<0.05$), decreased pain, anxiety, depression, shortness of breath, stress, increased mood, self-expression, decision-making, renewed interest in music, and positive family interaction were statistically significant.
Conclusion: There are differences in the clinical effects of palliative medicine and hospice patients.

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298. Music Therapy and Quality of Life of Cancer Patients in Palliative Care

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This project concerns the effect of music therapy sessions on the quality of life people suffering from cancer. Music therapy can improve the QOL by addressing the emotional, spiritual and physical needs.The sessions incorporated receptive music listening, imagery, singing, music improvisation, relaxation offered individually or in a group. In this study three groups of *Hospice Palium* patients participated, total of 75 patients diagnosed with cancer.QOL was measured by McGill QOL Questionnaire. T-test was used and the results differed significantly ($p<0.05$) before and after music therapy interventions. Music therapy influenced emotional symptoms that includes anxiety, depression, low self-esteem, feelings of isolation and also reduce stress, relieve discomfort, relieve muscle tension and reduce patient's experience of pain. The results suggest that music therapy is an essential component to improve the QOL of patients with cancer.

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299. The VILA-project

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A specialist end of life care team was included in the municipal care provided by Kävlinge municipality, Sweden. The aim of the project was to improve end of life care e.g. in terms of patient as well as next-of-kin participation and symptom control. The team consisted of five enrolled nurses, who had received special training before the start of the project. Registered nurses, a physician, dentist, occupational therapist, physical therapist and a priest were also connected to the team as an external resource. The project was ongoing for one year (2004-2005) and included 29 care recipients (age: 49-97 years; 13 women and 16 men) and their next-of-kin. All care recipients had an expected survival time of three months. The intervention group was compared with controls who received regular care. At the end of 2005, the project was evaluated by means of questionnaires sent to the next-of-kin of patients who had died as well as to all staff concerned. The result of the evaluation was for the most part positive and improvement was particularly noticeable in three specific areas: information provided by the health care professionals, symptom control (i.e. pain relief, handling anxiety and nausea) and follow-up/contact with the next-of-kin after death. The next-of-kin also stated that they felt more involved in care decisions. The general opinion among the health care professionals in the municipality was that the project had been a success and had led to higher quality care of the terminally ill patients. Thus, the introduction of the specialist end of life care team significantly improved nursing care in the municipality.

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300. The role of the Cancer Experiences Collaborative in the development of research capacity in supportive and palliative care: Older adults

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Background
In 2006, the Cancer Experiences Collaborative (CECo), a partnership between five UK universities, was funded for five years to develop research capacity in supportive and palliative care. One of the themes is "Care for the older adult towards the end of life". In the UK, over 80% of deaths and 75% of cancer deaths occur in people aged over 65. Care in the last year of life for older people is a key priority for palliative care and public health.
Aims
1. To identify older adults priorities in end of life care; 2. To examine end of life care decision making; 3. To understand preferences for place of care; 4. To explore and evaluate older adult's involvement in the design of palliative care interventions; 5. To develop common approaches to research methods.
Methods
A series of protocol generation events bring together collaborators (researchers, clinicians, service users) to develop research proposals for which funding will be sought. Capacity building occurs through "State of the Science" meetings focusing on different aspects of older adults experiences, to which novice and experienced collaborators are invited.
Outcomes
An interdisciplinary research programme reflecting the views of older people, using a range of innovative methods which enhances the quality of research in this field. To date, we have obtained funding for a seminar series on the "Psychological and Social Aspects of Dying in Old Age".

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301. The need for teachnig palliative care - dogmas and reality . Will Hungary's accession to the EU be implemented in the field of palliation?

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Medicine in the educational system of the former socialist countries is still taught on an organic basis, which excludes the study of the human psyche. This paternalistic, materialistic and treatment-oriented approach to medical training has resulted in underdeveloped palliative medicine. Altough advocates of palliative care (PC) have been trying to introduce PC to cancer centres in general, specific problems remain to be solved by each individual country. The authrs introduce a teaching model, which they have established in Hungary. The chapters are as follows. 1. Core courses (40 classes), including death and dying, hospice, pain management and symptom control, care of dying, and psychosocial family support. 2. Vocational courses (40 classes), including practical nursing skills, mental health of personnel, case studies, and physician's experience in palliative care. 3. Courses for skilled hospice nurses and co-ordinators (710 classes). The authors underline the importance of teaching PC for they believe that it is an extremely important issue in medical education.

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302. Factors that Influence the Completion of Advance Directive Among A Racially Diverse Population of Older Adults in the United States

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Background: End-of-life decision-making is often a difficult process and one that many elderly patients and their families are not prepared to undergo. While proactive planning for end-of-life care might be ideal, this process does not typically begin until late in the patient's illness trajectory. Several studies examining end-of-life issues have shown racial differences in across ethnic groups and there is evidence that black Americans are less likely to discuss their end-of-life care and complete advance directives such as living wills, durable power of attorney for health care (DPAHC), and Do Not Resuscitate Orders (DNR) than white Americans. However, these studies have not looked specifically at older adults. Although the lack of participation in APC among black Americans has been documented, factors that influence APC among older black Americans is poorly understood. This study describes the association between race and the completion of advance directives among black and white older adults in the U.S. It also addresses how beliefs and attitudes influence advance care planning practices across the racial groups.
Methodology: Black (n=102) and white (n=100) older community dwelling adults participated in an educational program about advance care planning and end-of-life care preferences. After being exposed to the educational module, elderly persons aged (55+) who spoke and understood English completed questionnaires about their end-of-life care beliefs, attitudes, and preferences. **Measures:** Dependent variable - completion of advance directiveAntecedent variables - age, gender, religion, marital status Independent variable − raceIntervening variables − attitudes and beliefs about the medical system and end-of-life care
Results: Unadjusted bivariate results found Black patients less likely to complete advance directives than White patients (odds ratio = 0.60; $P < .001$). Attitudes toward the medical system seem to have a negative influence on the completion of advance directives. The negative relationship between black older adults intent to complete an advance directive was unaffected when controlled for gender, marital status and religion.

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303. Flick the Trip : Falls Prevention in Palliative Care

Bronwen Hewitt, Alex Sydney-Jones, Stephen Turk, Kate Weyman, Stephen Brooker, Lesley Sinclair

Sacred Heart, St Vincent's Hospital, Palliative Care Centre, Sydney, Australia

The Sacred Heart Falls Project aimed to develop innovative and imaginative strategies to help minimise the falls risk for palliative care patients, either in the community or inpatient settings. PC patients are considered to be more at risk of falls due to increased frailty, the potential for decreased mobility and impaired cognition, polypharmacology and complex social situations. A multi-disciplinary working group was formed to examine current research, gather baseline data and pilot strategies to try to minimise the falls risk in this vulnerable population. The project has been active throughout 2006 and has carried out literature searches, liaised with other organisations and services dealing with falls prevention in elderly populations and gathered baseline data collection. It has also successfully piloted strategies to minimise risk such as a Colour Coding System for patient gait aids, the purchase of a high/low bed and promoted the involvement of staff by conducting a survey to generate innovative ideas which have included the use of fluorescent toilet seats and underfloor lighting (both to help prevent falls at night).

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304. Expert views on palliative care for older people. Results from two expert meetings of the Comprehensive Cancer Centre South (CCCS) in the Netherlands.

Thirza Olden

Comprehensive Cancer Centre South, Palliative Care, Eindhoven, Netherlands

In two expert meetings, twenty-five professionals working in geriatrics and palliative care were invited to discuss the WHO-publication " Better Palliative Care for Older People". Purpose was to identify important issues in palliative care for the elderly in the CCCS-region. Five major issues in palliative care for older people emerged as most critical:
- Because of *variability in the elderly*, it is difficult to make general comments or develop guidelines.
- It is *difficult to define the beginning of the palliative phase* of older patients, thus palliative care is under assessed.
- Older palliative patients suffer from *ageism;* prejudice, stereotyping and a general lack of interest in their situation.
- There is *lack of coordination* of care and adjustment of various medical treatments older patients receive.
- Many older people are *frail*.

The experts reported overall recognition of the WHO-publication and concluded that more knowledge and better access to palliative care facilities have to be developed to meet needs of older palliative patients. Based on these findings, the CCCS is developing several projects and studies to improve palliative care in the elderly.

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305. THE ROLE OF KINETIC THERAPY FOR PATIENTS WITH RHEUMATOID ARTHRITIS (RA) - LAST STAGE

Luminita Georgescu[1], Elena Nicolau[2], Cristina Necsoi[3], Andrei Dumitru[4]

[1−4] *University of Pitesti, Kinesitherapy, Pitesti, Romania*

Aim of study
The present paper is trying to asses the best kinetic therapy program for last stage RA patients (as part of the palliative care plan) in order to assure their independence in caring out the activities of daily living (ADL).
Methods
The study was realized at the Center for Social Assistance and Long Term Care Pitesti, on a lot of 4 patients with

RA stage IV, aged 70 to 78 years old (case studies model). For evaluation purpose we used the RAOS scale (Rheumatoid and Arthritis Outcome Score), the autonomy Katz scale for ADL and the Doloplus pain scale.Based on those evaluations and the functional assessment we established a personalized kinetic treatment program (massage, passive and active mobilization techniques, hydrotherapy, occupational therapy) associated with pharmacological therapy. The therapy sessions were held 2 h/day, 5 times /week, 6 months.

Results

The final testing showed an improvement of the patients' quality of life, who progressed from being totally dependent towards a partial dependence (a medium Katz scale improvement of 25%, amelioration of RAOS functional state) and from a continuous painful state towards just bearable painful episodes (initial medium score 28 and final 20).

Conclusions

A personalized kinetic program, as part of the palliative care plan, can markedly improve the patients' quality of life. The combined kinetic program and medical treatment lead towards an amelioration of dependence and a reduction of the pain level.

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306. A model of palliative care for nursing homes

Paul Paes[1, 2], Leonie Armstrong[2], Lilian Errington[1], Marianna Fischer[2], Sylvia O'Hanlon[3], Kath McMurray[0] [4], Wendy Prentice[5], Dorothy Reeves[1], Teresa Sanchez[4], Karen Torley[2]

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[5] *King's College London, London, United Kingdom*

Aim of study?To develop, implement and evaluate a model of palliative care for patients in nursing homes **Background** A significant number of patients with progressive, incurable diseases reside in nursing homes. This paper describes one model of care designed to meet their palliative care needs. **Method** In North Tyneside, most patients with continuing care needs are admitted to Princes Court nursing home. After a strategic review, the following changes took place and were evaluated:

- Weekly palliative care multidisciplinary meeting
- Regular input from a clinical nurse specialist, social worker and physiotherapist
- Educational programme
- Complimentary therapies programme
- Partnership with Marie Curie Cancer Care to enable a senior nurse to work alongside staff

Results The weekly meeting and input from specialist palliative care have enabled discussion of symptoms, psychological and social issues for each patient. Advanced care planning has happened and some patients have been discharged home. The Marie Curie inpatient nurse had a major impact in assessing and meeting the training needs of staff, and acting as a senior mentor. The model has successfully improved staff skills, governance, and morale when dealing with a large number of dying patients.

Conclusion

The provision of palliative care for nursing homes is an important priority. This paper describes a successful model of collaboration between the NHS, private and voluntary sector.

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307. Observation about cancer in old patients

Constantin Bogdan, Gabriela Rahnea-Nita

Romanian Society for Palliatology and Thanatology, Oncology and Palliative Care, Bucharest, Romania

Palliative oncogeriatrics is a distinct teritory between oncology - palliative care - geriatrics. The arguments for palliative oncogeriatrics are: population ageing and increasing of life expectorancy, increasing of cancer at old patients, difficulties in active therapy (surgery, chemotherapy, radiotherapy), poor response at some treatments, comorbidity, changes due to ageing process, specifity of palliation intervention. In the year 2005, in St.Luke Hospital, Chronic Oncology-Palliative Care Ward were admited 1673 patients; 1177 were old patients. The incidence of main localisation of cancer in old patients was : women (> 55 years old): breast cancer, lung cancer, bowel-rectal cancer, head and neck cancer. The particularities of therapy in palliative oncogeriatrics are presented. In conclusion, palliative care of old patients has an important role, making posible a good quality of life.

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308. Let no such ending come to me, O God!* Being hospitalized and demented

Zsuzsanna Endrody

Catholic Services of Charity, Budapest, Hungary

Aim of project/study: Health- and social care systems in Hungary now are suffering from rapid changes. This presentation reports on Catholic Services of Charity's 15 years experience working with long term patients with dementia and their families. The presentation will involve review of characteristic examples, to attract the problems, the families, the patients, the nursing homes staff and the healthcare professionals facing with during a crisis situation, when the demented person should be hospitalized. The study shows the deep need for a dementia-friendly environment and well-trained in dementia-care healthcare professionals in hospitals. **Method:** Evaluation results of workshops. The participants of the workshops are caregivers (family members), long term care staff-members, family doctors, hospital nurses and doctors. During the workshop the participants according their experiences identify risk factors for people with dementia in hospitals. **Conclusion:** Much to do increase awareness to importance of proper care setting in hospitals and healthcare-institutions, importance of palliative care at the end-of life care for people with dementia. *These rows are from poem Alexander Petofi, the famous Hungarian poet.

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310. Living and Dying in Alternative Housing for People with Dementia - The Contribution of Palliative Care

Elisabeth Reitinger, Sabine Pleschberger

University of Klagenfurt, IFF-Palliative Care and Organizational Ethics, Vienna, Austria

Background Alternative Housing for people with dementia is gaining importance in current debates on caring for elderly people. Surprisingly innovative forms of housing for people with dementia do not seem to refer to issues of hospice and palliative care. People living there do have palliative care needs if death and dying should take place there. On the other hand palliative care for elderly people is yet in its beginnings and has rather focussed on nursing homes. **Aims** In light of this the ongoing study (10/06-07/07) explores how palliative care can contribute to care in alternative housing forms and vice versa, i.e. how expertise in caring for people with dementia can aid developments in palliative care. **Methods** Qualitative interviews with experts in the field of alternative housing for people with dementia as well as in palliative care from Germany and Austria are conducted (n=10-15). This perspective is completed by focus groups with professionals of alternative housing models and an interdisciplinary workshop that connects people from both fields. **Conclusion** Central issues are the way people are supported in their last phase, how ethical questions are dealt with and how "dying in place" through a better involvement of palliative care can be offered. First results will describe different forms of cooperation and integration respectively and outline perspectives on common strategies of these two innovations in care for elderly people with dementia.

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311. "Palliative Care in the Community- joint training initiatives for community and hospice nurses and doctors in St Petersburg, Russia"

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The role of the GP team in the management of patients with terminal illnesses is undergoing change.
Palliative care is an extremely important field for management of patients in the terminal stage of their illness, when all possibilities for curative treatment are exhausted, and a patient is preparing for the end-of-life stage. Traditionally palliative care has been associated with end-stage cancer care, although now it is accepted that many patients in the terminal phase of severe chronic illness have the same needs as cancer patients, eg for effective analgesia, for relief of distressing symptoms, psychological support, etc.
Currently, the majority of persons in Russia with palliative care needs are managed by doctors or nurses who have not had any special training in the care of such patients. Neither is there a unified policy or protocols for collaboration between different organisational structures, concerning shared decision-making between General Practice personnel, patients and relatives, hospices and hospital specialists caring for these patients, hence many patients come to the end of their life without adequate therapeutic, psychological, social, and spiritual support. There is a need to reform the rules and regulations surrounding the medical and non-medical care of persons admitted into hospice care and to develop 'hospice-at-home' type of services under the care of trained community nurses and doctors.

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312. Can the Liverpool Care Pathway (LCP) sucessfully be used within acute elderly care at the end of life?

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Leeds Teaching Hospitals Trust, Palliative Care Team, Leeds, United Kingdom

Background: The Liverpool Care Pathway (LCP) was primarily developed for use with dying cancer patients. Leeds Teaching Hospitals forms one of the largest Trusts in the UK with approximately 2000 beds within 6 hospitals and cares for just over 3000 deaths per year.
Aims: To explore how transferable the LCP is to elderly care within an acute hospital.
Methods: The pathway was implemented in all areas using identical paperwork and educational material. We undertook a prospective audit of patient deaths (n = 40) post implementation of the LCP within medical and clinical inpatient oncology wards (n =3) and compared it with an identical audit of patient deaths (n = 50) within medicine for the elderly wards (n = 5).
Results: The LCP has been met with enthusiasm within all clinical settings. The numbers of variances reported and achievement of goals between the two groups was almost identical with regard to symptom management, despite the noticeable differences in both diagnosis, age and length of time on pathway (see below). Also of note 40 % of the elderly medicine patients died from stroke.

Wards	**Age**	**Length of time on LCP**	**Diagnosis**
Oncology	61.5 yrs (23 – 81)	31.5 hrs (1-240)	Cancer n = 40
Medicine for the Elderly	85 yrs (70 – 100)	76 hrs (2 -360)	Cancer n = 9 Non cancer n = 41

Conclusion: The LCP can successfully be transferred for use within medicine for the elderly to guide end of life care delivery without adaptations.

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313. Espoused choices, marginalised voices: The paradox of prefered place of care for older terminally ill people

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Aim To identify factors influencing achievement of older people's preferred place of care (PPC) and implications for hospital palliative care teams.
Method Quantitative and narrative analysis of case notes of older people referred to a hospital palliative care service in 2005
Sample n=164 ≥70yrs diagnosis: cancer 77% non-cancer 23%
Results Irrespective of diagnosis our sample had complex health & social needs. PPC was achieved for 67% of whom 53% went home, 25% to nursing home, 9% to hospice, 3% to community hospital and 6% chose to stay in hospital. 8 people were too ill to identify PPC. The narratives demonstrate that older people's PPC is influenced by complexity of funding provision; bias towards malignant illness in this process; separation of social and health care providers; and a family member willing to be carer/care manager. Timely care planning is influenced by the ability to anticipate deterioration in older people.
Discussion Adopting the policy of PPC has strengthened older peoples' voices but revealed how these are paradoxically compromised by funding processes designed to support choice. To fairly represent older people's choices the palliative care team needed to embrace discharge planning and carer preparation and develop skills in recognising approaching death in older people.
Conclusion Achieving older people's PPC is a complex inter-relation between policy, health, social and professional issues.

314. Specialist palliative care as a preferred place of care for older people: prejudiced by caution?

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Background Older people are less likely to be admitted to specialist palliative care (SPC) compared to younger people yet perceive this as a positive option[1].
Aim To identify factors influencing achievement of older people preferred place of care (PPC) where this is SPC and their needs meet the referral criteria.
Method Quantitative and narrative analysis of case notes of all patients meeting SPU referral criteria referred to hospital palliative care team in 2005.
Sample n=33, ≥70yrs, diagnosis: cancer 85%, non-cancer 15%
Results Irrespective of diagnosis, our sample had high symptom burden and carer fatigue. SPC was perceived as a positive option and contributed to reducing patient/family distress by resolving tension associated with other choices (eg high care needs at home). 18 patients were transferred to SPC. Reasons for those not transferred include: continuing active management of disease or acquired infections; concern about ongoing care following SPC admission; SPC priorities for admission and waiting times.
Discussion Adopting the policy of PPC has confirmed that older people view SPC favourably and have needs that SPC can meet but that this choice is prejudiced by caution around ongoing care and how patients are prioritised on SPC waiting lists. Further, there is a need for a medical plan that is congruent with the plan for SPC to prevent delay in transfer. The high symptom burden raises questions around timing of referral and the recognition of approaching death.

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315. Moroccan Muslim Views on End-of-Life Decision Making in Antwerp, Belgium.

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Until now, Muslim views on end-of-life decision making form a hardly developed research area in Belgium and most European countries. This exploratory qualitative research (Grounded Theory Methodology) is based on in-depth interview techniques (n=30) with male Moroccan elderly (<60) Muslims living in Antwerp, with local imams, Moroccan GP's in Antwerp and with a Moroccan nurse working in an Antwerp palliative care ward in a hospital setting. We found an extremely dismissive attitude (*haram*) towards every form of active termination of life: Allah is the only one to decide upon the life of a patient. The majority of our respondents would permit withdrawing or refusal of life sustaining treatment only if every treatment alternative has been tried without cure as a result. To them every Muslim has the duty to look for treatment when sick, with treatment being the most important way through which Allah can cure the patient. From this research we conclude that all type of respondents share the view that 'patience' and 'consciousness' present the bottom line to every ethical decision at the end of life: the wellbeing of the patient is central, with an integration of both the physical – being without pain – and the spiritual – as shown in the importance of a good relationship with Allah – level.

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316. Palliative care in stroke - a critical review of the literature

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Stroke results in high levels of mortality and morbidity, and can cause a wide range of distressing symptoms and problems. Very little is known however about the nature and extent of palliative care services that are available to this patient group, the ways in which such services could be delivered and by whom. The aim of this literature review was to identify studies that have investigated the palliative care needs of stroke patients. Employing the principles of a systematic search, a review of six electronic databases (British Nursing Index, CINAHL, Cochrane Library, Medline, PsycINFO and Scopus), covering the last ten years was conducted. From a total of 6440 hits, seven papers were retrieved that explored the palliative care needs of patients diagnosed with stroke, only one of which was an intervention study. The major themes of those papers deemed as not relevant included epidemiological studies, biomedical investigations, studies of psychological morbidity after stroke, discharge strategies and comparisons of rehabilitation initiatives. The review highlighted three significant themes. First, the high levels of unmet palliative need experienced by both patients and caregivers. Second, the review showed there was a paucity of data in regard to the differentiation between provision of palliative care services for patients who die in the acute phase of stroke and for those patients who die later. Third, as a result of this limited research base, the preferences of stroke patients and their families in relation to palliative care services are largely unknown.

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317. Specialist palliative care and non cancer illness. Availability and access to specialist palliative care in hospices in Northern England for patients with non cancer life threatening illness

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Objective. Research looked at available specialist Palliative care in the north of england and access to these services by patients with non cancer illness. Methods. Triangulation with qualitative and quantitative methods. Purposive sample. Questionnaires and face to face interviewing. Multiple data sources utilised e.g admission policies, mission statements. Ethical approval granted Findings. Average percentage spread had a ratio of 85%cancer and 15% non cancer most referrals were for cancer. Staff felt poorly qualified to deal with non cancer patients, admission policies reflected that non cancer patients could be cared for Conclusions. Hospices actively marketing their services to non cancer patients despite haveing funding difficulties. Hospices were aware of national guidelines and were developing services to meet these. Staff still found that the majority of referrals were for cancer patients which may be because health care professionals are not referring these types of patients or that patients themselves do not wish to avail themselves of the services

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318. Palliative care and intellectual disability - exploring the knowledge of specialist palliative care providers in Kent

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Aim
As people with intellectual disability (ID)live longer their health and social care needs increase, particularly with progressive illnesses, such as cancer or dementia. The involvement of specialist palliative care (SPC)services with this group of patients appears to be small and this study aims to investigate the knowledge of health care professionals working in SPC in the care of people with ID.
Methods
Focus groups will be held in 7 hospices and SPC providers in Kent. Topics for discussion will include levels of professional experience in the care of people with ID, as well as areas of concern and barriers to care provision.
Results
Initial focus groups discussions with senior doctors in palliative medicine within Kent have suggested that the involvement of SPC services with people with ID is small, even though the population of this patient group is large. Specialists stated that their knowledge, training and experience in the care of people with ID was low. It is expected that the focus groups will show similar results, indicating reasons for gaps in knowledge and training needs.
Conclusions
It is anticipated that SPC providers have little contact with or training on the care of patients with ID. Whilst there is no obvious discrimination there is a need for greater awareness of ID amongst staff so that the needs of people with ID can be addressed adequately and appropriately.

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319. End of life care for patient with motor neurone disease / amyotrophic lateral sclerosis

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[6] *St Wilfrid's Hospice, Chichester, United Kingdom*

Aims
The aim of this study was to look at the experience of specialist palliative care (SPC) services in the UK in the end of life care for people with MND/ALS.
Methods
A retrospective audit of 47 patient notes was undertaken in 6 different hospices. The data were then analysed together.
Results
47 patients' notes were analysed – 24 male and 23 female.
7 (15%) received non-invasive ventilation and 1 (2%) had received tracheostomy ventilation. 17 (36%) had a gastrostomy.
Most patients, 42 (89%) died from respiratory failure. 16 (34%) deteriorated within 24 hours and the majority, 34 (72%), deteriorated within 3 days.
The majority of professionals (83%) and families (81%) had anticipated that death was imminent, but only 70% of patients were felt to be aware.
62% received a subcutaneous infusion of medication in the last few days (mean 2.9 days) – commonly morphine (mean dose 44mg/24 hours), midazolam (mean dose 54mg/24 hours) and glycopyrronium (mean dose 1.0mg/24 hours).
Discussion
The end of life of patients with MND/ALS had often involved SPC and the services were often involved in decision making throughout the disease progression. Death was usually following a short period of deterioration, and this was usually anticipated by families, but not always by patients. The use of medication is important in the management of symptoms and minimising distress at this time, and is commonly given by subcutaneous infusion.

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321. An evaluation of use of symptom control guidelines for end stage heart failure in cardiac network

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Background
In response to local need a joint initiative between palliative care and cardiac networks in Merseyside & Cheshire in 2005 developed referral criteria and symptom control guidelines for professionals caring for patients with end stage heart failure.Cheshire & Merseyside Cardiac Network (CMCN) distributed the guidelines via heart failure nurses in community and acute trusts.Guidelines were also downloadable from both network websites.
Methods
Questionnaire designed and distributed to heat failure nurses within CMCN to evaluate use and effectiveness of guidelines
Results
Guidelines are being used within both acute and community settings but were of greater use to heart failure nurses in community who had less contact with other professionals of their own discipline and from other teams.
However despite network acceptance of collaboration, there was evidence that some heart failure nurses had not yet used them
Conclusion
Guidelines were valued by cardiac teams and despite some areas reporting low usage there was evidence of a willingness for collaborative working. However lack of awareness of guidelines amongst wider health community, particuarly General Practioners and district nurses was apparent. Further work needs to be carried out on sucessful dissemination methods of network guidelines

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322. Exploring the palliative care needs of service users with neurological conditions

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Aim:
To explore the palliative and end of life care needs of adults with progressive long-term neurological conditions.
Background:
Progressive long-term neurological conditions require palliation from diagnosis. This study focuses on the most common conditions: Motor Neurone Disease (MND), Multiple Sclerosis (MS), Parkinson's disease (PD), with a special focus on Huntington's Disease (HD)

Methods:
The research is in progress. It uses a multi-method design in three sites in the UK; 1) six neurological care centres run by a Charity; 2) an independent hospice in an urban, multi-ethnic city; 3) an NHS specialist out-patient clinic. Methods of data collection include:

- Observation of staff and service users (n=2 care centres)
- Case studies of service users and their informal carers (n=5)
- Focus groups with health and social care professionals (n=50)
- Interviews with bereaved informal carers (n=15)
- Huntington's Disease Quality of Life Battery for Carers (HDQoL-C) (n =200)
- Audit of deceased patients' notes (n=100)

Proposed Outcomes: The study will enable better understanding of:

- The views and educational needs of staff;
- The experiences and expectations of patients and families;
- The experience and quality of life of informal carers;
- The range of patterns and circumstances of death and dying of people with long-term neurological conditions;
- Issues encountered in delivery of end of life care to people with long-term neurological conditions.

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323. The prevalence and management of diabetes in a specialist palliative care unit

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Aim: To determine the prevalence and management of diabetes in a specialist palliative care unit(SPCU)
Method: Consecutive patients admitted to a SPCU during a 7 month period were examined for diabetes. Those identified were asked to complete a questionnaire which assessed 8 domains including a 10 point quality of life (QOL) visual analogue scale (VAS). A score of 4 or more was considered to have a moderate to severe effect on QOL. Their subsequent course was monitored until death or discharge.
Result: Of the 177 new patients ,15(8.55) were diagnosed as diabetic. Nine patients developed diabetes whilst on steroids, 6 had type 2 diabetes. 11 were female and 4 male, mean age 73 (range 58-88). 14 patients had a diagnosis of cancer and 1 had COPD. The following symptoms were reported: thirst (4), polyuria (2), weight loss(1), lethargy (7) and neurological disturbance(3). Dexamethasone doses ranged from 4-40 mg/day. 6 patients did not receive anti-diabetic treatment, 4 were on oral hypoglycaemics and 5 on insulin. Four patients had a VAS of 4 or more indicating a moderate to severe impairment in QOL and 8 were too ill to complete this part of the evaluation. Nine patients were discharged. Of the 6 patients who died during the audit, one became hypoglycaemic in the terminal phase requiring IV glucose and the remaining five had blood sugars ranging from 5-15 not requiring treatment.
Conclusion: This audit suggests that the prevalence of diabetes in an inpatient population is approximately 3 times that of the general population. The majority of the patients would appear to have developed symptomatic diabetes as a result of corticosteroid therapy highlighting the need for a consensus on the management of diabetes in these patients.

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324. Developing a neurological palliative care service in Turin - a literature review and needs assessment

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2 *University of Kent, Canterbury, United Kingdom*

INTRODUCTION: There is increasing involvement of palliative care within neurology but there is a little evidence for the efficacy of Specialist Palliative Care Services (SPCS) in improving outcomes.
AIMS: Three groups of patients with advanced neurological disease will undergo assessment of their needs: ALS (amyotrophic lateral sclerosis), MS (multiple sclerosis), and PD (Parkinson's disease and related disorders).A new SPCS which aims to meet the needs of neurological patients is being developed and a formal evaluation will be undertaken.
METHODS: A literature analysis has been performed showing concerns about unsatisfactory pain management and symptom relief, psychological and spiritual unmet needs, barriers to the palliative approach, high rates of request for assisted dying, gaps in knowledge of neurologists on clinical, ethical and legal aspects of the care of dying patients, and a lack of a clear model of SPCS for these conditions. Further needs assessment has been undertaken with discussion with European SPCS and neurologists involved in ALS, MS, and PD care in Turin. A qualitative assessment of a sample of patients and relatives will start in 2007.
RESULTS: The preliminary data from the needs analysis and the assessment of the patient group will be presented.
CONCLUSIONS: Neurological patients are able to benefit from palliative care involvement, in collaboration with other neurological services.

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325. How can we best provide palliative care in advanced dementia? Assessment of need and development of an intervention.

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The end of life care received by patients with advanced dementia is often inconsistent with principles of palliative care. Patients are hospitalised repeatedly, receive inadequate pain control and the use of artificial feeding is commonplace despite contrary evidence of its efficacy. This study aims to define the palliative care needs of these patients.A qualitative methodology was applied using semi-structured interviews. Twenty carers of patients with advanced dementia, and 20 health care professionals involved in their care, were interviewed. The main themes identified included attitudes towards end of life care, communication and decision making. Relatives had conflicting views, recognising patients' poor quality of life but would encourage artificial feeding as 'starving to death' was unacceptable. Most had very little information regarding illness progression. Nurses and professional carers recognised the terminal nature of dementia but encouraged active treatments such artificial feeding as "All patients deserve a chance". Doctors were against artificial feeding but were often guided by relative's wishes in their decision making. Advance care planning discussions may be beneficial, keeping relatives better informed and supported in their care decisions. Better education for health care professionals around end of life care may also be useful as this could lead to more appropriate care and a reduction in hospital admissions.

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326. An international survey of end of life care of people with MND/ALS

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[6] *Niigata National Hospital, Neurology, Akasaka Kashiwazaki city, Japan*

Aim To examine the similarities and differences across countries in the care of people with ALS / MND, in relation to:
Attitudes to end of life discussions

- Ventilatory support
- Gastrostomy feeding

Method Questionnaire, sent to six hospices in the UK, a palliative care team in the US and a special interest neurology group in Japan, completed for at least the last 10 MND patients who had died.
The questionnaire covered:
Evidence of cognitive impairment?Use of non-invasive and invasive ventilation?Use of gastrostomy feeding?End of life discussions?Mode of death?Duration of the final phase of the illness?Medication used in the final stages of life
Results: 112 questionnaires were returned (47 UK, 10 USA, 55 Japan). Most patients died from respiratory failure or pneumonia. The length of disease progression was greatest in Japan, associated with a higher use of invasive ventilation. Discussion about end of life issues varied: ??More discussions on gastrostomy in UK

- More discussion on advance directives in the USA.
- Opioids were widely used, although the use varied between centres

Conclusion

- There are differences from country to country and from unit to unit within a country in the assessment and management of ALS / MND. There are widespread discussions about the management of disease progression, although this varies between countries.
- These discussions should occur early in the disease progression, as cognitive loss may subsequently alter the ability of the patient to be fully involved.
- These differences will impact on patient care, as patients increasingly have contact with patients, families and professionals from other countries and cultures via the internet.

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327. What are the key issues identified by Heart Failure Nurses in the UK working with patients at the end of life?

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Aim: To identify key issues raised by specialist nurses providing care to heart failure patients at the end of life as part of the baseline evaluation of the Marie Curie 'Delivering Choice Programme' in the UK.
Method: Specialist heart failure nurses working in the community and hospital settings within three UK sites were invited to participate. Three focus groups (n=15) took place between October 2005 and November 2006. A semi-structured aide memoire was designed to seek information about the nurses' roles, referral processes and working relationship with local palliative care services. The data were thematically analysed.
Results: The provision of good end of life care and the capacity for patients to plan and discuss end of life choices is dependent upon the skills, knowledge and experience of heart failure nurses. The uncertain trajectory of heart failure and the possibility of sudden death are challenges to the traditional model of palliative care. Experienced nurses can identify the terminal phase and discuss end of life choices with patients. They report that regular contact with patients for symptom management prevents unwanted hospital admissions and provides carer support. Lack of out of hours support leads to crisis admissions and changes in end of life care plans. Good palliative care for heart failure patients can be achieved through the development of collaborative working relationships and education initiatives between heart failure and palliative care services.

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328. How do the levels of physician contact differ between cancer and heart failure patients in Scotland during the last four weeks of life?

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Aim: To assess the level of physician contact with cancer and heart failure patients during the last four weeks of life as part of the baseline evaluation of the Marie Curie 'Delivering Choice Programme' in the UK.
Method: We took a random sample of patients who died in hospital or at home from cancer or heart failure between January and June 2005 in Tayside, Scotland. For patients who died at home (n = 70), we studied their GP records for up to four weeks before death. For patients who died in hospital (n= 100), we studied their hospital notes for up to four weeks before death. We did not have the resources to cross reference notes where patients moved care settings. Using a structured pro forma we recorded the number of doctor-patient contacts, investigations and the prescribing of strong opioids.
Conclusion: 50 cancer patients died in hospital, and 50 at home. 50 HF patients died in hospital, and 20 at home. Heart failure patients who died in hospital received more physician contacts and investigations in the four weeks prior to death than cancer patients who died in hospital. Among all patients who died at home, cancer patients received more General Practitioner contacts and out of hours support than heart failure patients. In the final week of life all patients received increased clinical contacts. The results show that the focus of care for heart failure patients in hospital at the end of life remains primarily life prolonging rather than supportive.

329. Adapting the Liverpool Care of the Dying Pathway for patients dying of End Stage Renal Disease: A National Pilot

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Introduction In February 2005 the UK National Service Framework for Renal Services (Part 2) was produced. A significant proportion was dedicated to End of Life Care and recommendations were made that tools such as the Liverpool Care of the Dying Pathway (LCP) should be used to enhance care for the patient dying with End Stage Renal Disease (ESRD). Thus a National Steering Group was established, consisting of health professionals from Renal and Palliative Medicine. The aim was to adapt the generic LCP to accomodate patients dying of ESRD.
Methods Nine pilot sites within England were nominated and a retrospective case-note audit on 20 patients who had died in each renal unit was performed. This looked at documentation of care around death. As patients with renal failure are susceptible to drug toxicity, a subgroup was formed to propose new LCP symptom control prescribing guidelines, according to current evidence and best practice.
Results The goals of the generic LCP were found to be transferable for patients dying with ESRD. The most challenging area was producing safe and practical guidelines for the management of pain, as the evidence for the use of opioids in renal failure is poor. However, a consensus was reached and symptom control prescribing guidleines for the patient dying with ESRD have been produced and piloted. These guidelines will be discussed.

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330. An audit of referral practice of patients with end stage renal disease to the Royal Liverpool University Hospital Palliative Care Team

Alistair McKeown, Ruth Agar, Heino Hugel, John Ellershaw
PMarie Curie Palliative Care Institute, Liverpool, Palliative Care, Liverpool, United Kingdom

Aims
This retrospective survey assessed the referral practice for patients with end stage renal failure (ESRF) from the nephrology wards to the palliative care team in a large teaching hospital in the North-West of England. In addition symptoms in this group were assessed.
Methods
49 referrals with "renal" as a primary diagnosis over a two-year retrospective period were identified from computerised referral data. General and palliative care notes were reviewed by the researchers and a data collection tool designed and completed. Data was analysed with SPSS.
Results
Most common reasons for referral were for "placement" (38.6%) and "dying/distressed" patients (22.7%), although psychological support was also prevalent (15.9%). Renal teams discussed stopping dialysis in the majority of cases (89%), but documented preferred place of care less frequently (48.3%) and rarely achieved discharge to these locations (21.4%). There was a broad symptom complex, with fatigue and anorexia the most frequent dominating problems.
Conclusion
While renal teams are thorough when discussing dialysis and prognosis, there seem to be issues regarding discharge to preferred place of care. Increased usage of the LCP and regular usage of the place of care documentation from the end of life initiative may improve this situation.

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331. Interface of Palliative Care and Renal Services : Impact of an Action Learning Set?

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Aim: To assess the effect of a multi-professional action learning set on access to palliative care for renal patients/carers across Gr Manchester,UK.
Method: 9 renal and palliative care practitioners and a carer met monthly using action learning to share experiences,took action and learnt from that action to meet the following objectives:?Enable renal and palliative care teams to work together to influence access to palliative care;?Enhance care for patients managed conservatively or withdrawing from dialysis;?Extend use end-of-life care tools.
Results: *Sharing of information*:- documentation of multi-disciplinary team decisions in a supportive care register/database; use of out-of-hours hand-over forms;community patient- held records and supportive care directories.Increase profile of conservative management via local kidney patient associations.
Identifying gaps in care:- use of Care of Dying Pathway in all care settings; improve communication between services by the Gold Standards Framework, and access to palliative care services.
Education:- communication skills training for renal teams and renal failure management for palliative care teams.
Service development:- renal conservative management clinics.
Conclusion: Action learning has initiated new and enhanced existing resources for patients/carers by improving skills across the interface of renal and palliative care services.

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332. Delivering effective end-of-life care for people with advanced heart failure

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Aims of the study
1.To explore the experiences of patients with advanced heart failure and their informal carers, and assess the extent to which services meet their needs from diagnosis to death.
2.To integrate the perspectives of key professionals and formulate needs-led models of care for patients with end-stage heart failure
Methods
- Serial, longitudinal interviews were conducted with 30 patients with advanced heart failure (NYHA grade III/IV), their informal carers (n = 25) and professional carers (n = 39)
- Four focus groups were held with professionals and patients/carers to develop recommendations about service models

Results
Models of care explored included heart failure nurse specialists, palliative care, primary care and geriatrician-led care. Key features of effective models include: good quality relationships; continuity of care, with integrated assessment and case management; regular monitoring; supported self-management; flexible role boundaries; anticipatory care planning; carer support; and a range of psychosocial support services.
Conclusion
End-of-life care for people with heart failure is currently inequitable; effective care can be provided by any service. Training in chronic disease management, supported self-management and the palliative care approach is essential if generalist health professionals are to coordinate heart failure palliative care in the community.

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333. 'Equity of Access'. Provision of a Palliative Care Nurse Specialist Service for Non Malignant Disease

Barbara Morgans, Karen Groves

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Specialist Palliative Care Services are often concerned that if they open their doors to those with non malignant disease they will be inundated with referrals and overwhelmed with work. They also fear that their knowledge and skills will not be sufficient to meet the needs of these patient groups.

This poster describes the experience and achievements of a New Opportunities Fund funded Palliative Care Nurse Specialist, working across hospital and community within an Integrated Specialist Palliative Care Service, to respond to referrals for patients with non malignant disease and to build a service suitable to their needs.

The three year project figures demonstrate the appropriateness and timeliness of the referrals made, the development of a manageable non malignant service within the already existing integrated service and the working relationships developed across boundaries with respiratory, cardiology and neurology specialist services and others, providing continuity of care.

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334. Complementing the Community - developing a commmunity complementary therapy service for patients living with end-stage non-malignant disease

Nigel Hartley, Elaine Syrett, Sally Hood

ST CHRISTOPHER HOSPICE, Allied Health, London, United Kingdom

Complementary therapy has proved to offer significant benefits to people affected by terminal cancer. Recognising these benefits, and it's suitability to those affected by non-malignant end of life diseases, St Christopher's carried out a three month review of Complementary Therapy Resources available for people living with end-stage non-malignant disease within the St Christophers catchment area. As a result of the initial findings of this review, we developed and provided a Complementary Therapy service for those living with, or affected by, non-malignant disease, as part of the St Christopher's community outreach programme. A group of specialist palloiative care nurses provided aromatherapy, hypnotherapy, relaxation and stress management, through individual and group sessions to patients, family members and carers, who were referred into the St Christopher's Hospice Home Care nursing team, or who were accessible via direct referral through their GP or related organisation. The service was provided within the patients home and also within GP surgeries.

This presentation will outline the project, highlight the benefits of such therapies being delivered by dual qualified nurses, and also present findings from a research study carried out by Kingston University alongside the programme.

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335. Changing Perspectives: From Care of incurably ill to chronically ill - Experience form Northern Kerala, India.

Anil Paleri

Institute of Palliative Medicine, Palliaitve Care, Calicut, India, India

Palliative care teams may not be able to stay away from caring for chronically ill along with incurably ill when there is community participation, as its priorities will reflect in the program and issues are similar. 2 examples are discussed.
1: Participation by a Local Self Government Institution (LSGI) in palliative care programme. In Kerala the responsibility of health is with LSGIs so they could take decisions locally. In Kizhuparamba Panchayath (a LSGI), with a population of 15000, 23 have cancer, 16 are bedridden, 8 have psychiatric illnesses, 8 on antituberculosis therapy & 30 have chronic diseases. The LSGI has evolved a long term care and palliative care program for them.
2: Community Psychiatry Program: Stigma, poor social support and compliance etc. make care of psychiatric patients difficult. Palliative care initiatives in Malappuram District responded to this by having a community psychiatry program. Volunteers are trained to follow up and support these patients. Now there are regular psychiatry OPDs in 9 places, home care and rehabilitation programs. 180 patients are cared for of which 7 are rehabilitated.
The examples show that with active community participation the scope of palliative care may be widened to include other chronically ill. Governments can be made to participate in the process when the community has the power to decide for them selves.

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336. Improving end of life care for patients considered unsuitable for admission to the ICU: is there a role for the Integrated Care Pathway for the Dying Patient?

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Aims
To evaluate whether quality of end of life care, in this patient group, can be improved by the use of the Integrated Care Pathway for the Dying Patient (ICP).
Methods
A prospective controlled trial comparing care of patients placed on the ICP with those who were not. All patients at the Royal Preston Hospital considered unsuitable for ICU admission, as they were unlikely to survive, were potentially eligible. Using the ICP as a gold-standard, notes were reviewed and family satisfaction with end of life care was rated using a questionnaire which was sent to the patient's next-of-kin 4 to 6 weeks after death.

Results
Nineteen patients were eligible, all within the control group. Seven (39%) questionnaires were returned. The median survival following ICU review was 13 (1-126) hours. Patients often had several co-morbidities. High levels of intervention continued in the majority of patients with poor anticipatory prescribing of PRN subcutaneous medications. High levels of satisfaction were reported by respondents for all aspects of care. Discussion regarding the terminal nature of their family member's illness was less satisfactory.
Conclusion
This study has been thought provoking, despite not entirely fulfilling the original aim. Although respondents reported high levels of satisfaction with care, the median survival and high levels of intervention suggest the potential for further improvement in care through the introduction of the ICP.

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337. Improving end of life care for chronic heart failure patients: let's hope it'll get better, when I know in my heart of hearts it won't?

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AIM Chronic heart failure (CHF) has high mortality and symptom burden, but scant evidence to guide clinical practice. This study aimed to determine the problems/preferences of CHF patients/families to improve end-of-life CHF care. **METHOD** Semi-structured qualitative interviews with 20 patients (NYHA functional classification III-IV); 11 family carers; 6 palliative clinicians & 6 cardiology clinicians. Transcripts imported into NVIVO & coded line-by-line, coding frame reviewed by research team. **RESULTS** Patients' left ventricular ejection fraction range 22.5-50 (mean 34%, SD=8.3). Patients & families reported a wide range of end-of-life preferences, primarily determined by age and functional/cognitive status. None had discussed these with clinicians, and none aware of future care modality choices. Patients & carers reported fear and anxiety, and were uninformed of the implications of diagnosis. Only 2 carers had discussed end-of-life preferences with the patient. Cardiac staff confirmed they rarely raise such issues with patients. Disease-specific barriers (e.g. uncertainty and public perception of the benign nature of CHF) and specialism-specific barriers (Cardiology focus on curative approaches and need for communication training) to improving end-of-life care were identified. **CONCLUSION** The integrated data provides 3 recommendations to improve care in line with policy directives: sensitive provision of information & discussion of end-of-life; mutual education of cardiology/palliative staff; mutually agreed palliative care referral criteria.

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338. MANAGING ADVANCED MOTORNEURONE DISEASE (MND) AT HOME

NURIA ARRARAS[1], MARTA LLOBERA[1], EVA BARALLAT[1], RAMONA GONZALEZ[1], CONCEPCIO TAMARIT[1], JUDIT PUIG[1], ANGELS RAMOS[1], JAUME CANAL[2]

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Introduction
Terminal MND patients can be looked after at home if there is a good relationship between primary health care, home care teams and relatives.We describe the interdisciplinary daily working with MND patients by two home care teams.
Methods
Retrospective and descriptive study. Data were obtained from medical records over a period of one year.
We study the following items:1. Social and demographical:Age,gender,diagnosis,distance from home to the health centre. 2. Time from diagnosis. 3. length of follow up. 4. Most prevalent symptoms. 5. Number of visits carried out by each team member. 6. Reason of discharge. 7. Scales: Barthel, Pfeiffer, Karnoffsky. 8. Emotional impact on caregivers evaluated with a categorical scale.
Results
27 patients were included . 10 m/17 f.Age from 46 to 78 years.14 patients were diagnosed less than 12 months before first visit. Main symptoms:dysphagia (20), neuropathic pain (15), shortness of breath (15), weakness (24), depression (18). discharge: Death (9), acute hospital (4), nursing home (1), long term unit (4), symptom controlled (4), other (3). Main caregiver: wife/husband (12), brother/brother-in-law (10), others (5). Mean of emotional impact among caregivers 7,67/10.
Discussion
Admission on the home care programme was not related to the time from diagnosis but of the functional impairment, symptoms and caregivers burnout. Symptom control in terminal MND patients did no differ from oncological terminal patients. MND patients with longer survival receive more specific attention, mainly from physioteraphist

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339. A Network Approach to the Formulation of Guidelines for the Management of End-Stage Respiratory Disease

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Aim Patients with end-stage respiratory disease frequently have uncontrolled symptoms and unmet needs.The holistic approach has much to offer.Within Merseyside and Cheshire respiratory medicine,specialist palliative care and primary care have worked collaboratively to improve palliative care (PC) provision.
Methodology A "think-tank" event was held,attended by medical and nursing staff from primary and secondary care,patient and carer representatives and managers,to identify PC services of possible benefit to patients with end-stage respiratory disease and effective models of service delivery.This highlighted the need to develop symptom control and referral guidance for appropriate patients and to formulate a regional directory of PC services available for them.Difficulties introducing the concepts of palliative and terminal care to patients and carers and determining prognosis were acknowledged.The need for a joint educational event was identified.A working party with representation from both specialities and primary care was set up to realise the work identified.
Results Symptom control and referral guidelines and a regional service directory have been developed.A joint education event was held and was very well received.
Conclusion A further educational event and development of information leaflets for patients and carers introducing the concept of PC are planned.

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340. The attitudes of critical care staff towards end-of-life care guidance: A survey questionnaire

Laura Chapman, Maureen Gambles, Kate Richardson, Tamsin McGlinchey, Deborah Murphy

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Staff working in Intensive Care units (ITU) are frequently exposed to dying patients, but this is not reflected in the protocols and guidance available to them. For this reason the Liverpool Care Pathway for the Dying Patient (LCP) was amended through a process of action research for use on ITU, and implemented following an education programme.

Aim To assess the attitudes of ITU staff towards the ITU LCP.
Method A validated survey questionnaire was distributed to 100 ITU staff of all disciplines and grades. The questionnaire had been developed for use on health care professionals using any integrated care pathways. Responses to statements were recorded on a Likert scale, where 1 = strongly disagree and 5 = strongly agree. The dimensions examined included whether the LCP had a positive effect on clinical practise, its role as a risk management tool and the appropriateness of the format.
Results The view of the LCP was positive in all dimensions, with similar scores to those given by hospice nurses completing the same questionnaire.
Conclusion The LCP is transferable to an ITU environment, and is seen as positive tool by ITU staff. The questionnaire has also highlighted areas of educational need which can be addressed.

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341. Comparisons of the nature and outcomes of referrals to a hospital specialist palliative care team between patients with cancer and non-cancer diagnoses.

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Aim This project reviews the nature of referrals to a specialist palliative care team in a teaching hospital. We have compared the referrals between patients with a malignant disease and those with a non-malignant disease from 2001 to 2006.
Method Data is collected regarding diagnosis, reason for referral, symptoms reported and the outcome of the episode of care. Comparisons have been made between the two patient groups.
Results There were 2672 referrals over five years. 16% of referrals had a non-malignant disease. 26.5% of patients with a cancer diagnosis were referred at the time of diagnosis of their illness compared to 16.4% of those with a non-cancer diagnosis. Patients with malignant diseases were most commonly referred for pain control (28.7%). Patients with non-malignant disease were most commonly referred for management of the dying phase (46.8% compared to 12.7% of those with cancer). Patients with a non-cancer diagnosis were more likely to die in hospital (61.3%) than those with a cancer diagnosis (32.7%) and less likely to be transferred to the hospice (3.2% compared to 17.5%).
Conclusion
This review shows there is a difference in the type of referrals to the palliative care team for patients with cancer and non-cancer diagnoses. There is a role for education of general healthcare providers about the role of specialist palliative care in the management of patients with a non-cancer diagnosis.

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342. A study of British Heart FoundationHeart Failure nurse and their current Palliative Care skills and knowledge

Deborah O'Hanlon

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In 2003 NICE guidance recognised the complexity of the needs of heart failure patients and recommended that patients and their carers have access to professionals with palliative care skills within their own heart failure teams. The WHO in 2004 further supported this and suggested that it would be unrealistic to expect the current palliative care workforce to further expand and meet the needs of this increasing patient's population. **Aim.**The aim of this study was to explore the palliative care and symptom control knowledge currently held by British Heart Foundation Heart Failure Clinical Nurse Specialist's in the UK. Identifying gaps in knowledge and educational needs for both the field of palliative care and heart failure were key outcomes.**Method.**The identified sample was contacted via email informing them of the study. The BHF also informed their nurses of the research and the need for their participation.All were then posted (via first class postage) a survey with a SAE for returning completed to researcher, with the deadline date specified as two weeks.They were then re-contacted via email two weeks after the survey was posted, reminding them to return ASAP and were then re-sent the survey.Response rate was 65%.**Conclusion.**BHF heart failure nurses felt it is their role to provide palliative care to their patients but lack the communication skills, symptom control knowledge, confidence and support to be able to do this effectively.

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343. Letter on future care

Helen Herz

Calvary Health Care Sydney, Palliative Care, Sydney, Australia

Motor Neurone Disease (MND) is a relentlessly progressive neuromuscular disease for which there remains no cure. It presents in varying ways, robbing people of the ability to speak or swallow, or of the ability to walk or to breathe independently. cognitive changes may develop. MND progresses and death is usually due to respiratory failure or aspiration pneumonia. It presents a predictable although patient-specific course for which planning is possible.

A disease-specific individualised advance directive or 'letter on future care' has been in use by the multidisciplnary MND service at Calvary since 2001. It value is as a tool to facilitate discussions on planning future care. The process for discussion was adapted from Oliver et al PalliativeCare in Amyotrophic Lateral Sclerosis however, the end product, the 'letter on future care' is not known to be in use elsewhere.

The study aims to determine whether the 'letter' helps in planning and preparing for death and whether it assists the carer during the bereavement phase.

Semi-structured interviews will be held in February/March with two groups of 17 former carers where the person with MND has died. All carers participated in discussions on future care. In one group a 'letter' was produced. The interviews will be audiotaped, transcribed and coded using standard qualitative research methods. Themes will be elicited. Characteristic quotes will be identified.

344. CAL and Palliative Care - Responding to Diversity

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THIS POSTER depicts a project undertaken by the palliative care multidisciplinary team in a specialist palliative care unit, working with the acute respiratory team, to determine the palliative care needs of CAL patients and their carers.
AIM : firstly, to establish whether there is a diversity of needs distinct from patients with malignancies. Secondly, to identify whether peculiar knowledge and skills development or particular resources and provisions are indicated, to provide best palliative care needs of this non cancer group.
CONTENT covers data collected on reasons for referral, interventions by health professionals, utilisation of the service, family/carer involvement, patterns of need - physical and psychosocial. An audit tool to assess these aspects was developed -results are tabulated. Collaborative co-investigations by the acute respiratory service are reported, from a survey of CAL patients perceptions of their palliative care needs, towards an interdisciplinary approach at the interface with palliative care.
FINDINGS indicate CAL patients with palliative care needs have more episodic events of illness, are more socially marginalised, less resourced, more prone to access acute settings, less likely to have End of Life Care discussions.
THE OUTCOME is a projected model for linking palliative care for CAL patients through stages and diverse places of care and service delivery options.

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345. Manageability of referrals to hospice projects for non-cancer patients

Jane Frankland, Angie Rogers, Julia Addington-Hall

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Aim
One documented concern about the expansion of palliative care to non-cancer patients is that existing services will be overwhelmed. Using data from a formative evaluation of innovative hospice projects in the United Kingdom for non-cancer patients, funded by Help the Hospices, this paper will consider what can be learnt about the manageability of referral rates to such services.
Method
The evaluation comprised 4 case studies, where qualitative data were collected from a range of personnel, both within and without the hospice, plus data from 16 further projects, collected from one or two key informants. Semi-structured interviews were tape recorded, fully transcribed and analysed using a framework approach.
Results
Early concerns were common among hospice staff and management regarding the possibility of large numbers of referrals of non-cancer patients and the impact on other patients. Referral rates have proved to be varied. When projects experienced high early demand they were able to find ways to adjust to and manage the demand. Initial analysis suggests that issues important to referrals include the project's aim, background work, development of relationships with potential referrers, referral criteria and other health professionals' knowledge of the service.
Conclusion
These data indicate that hospice projects for non-cancer patients are not necessarily overwhelmed with patients, and that high levels of demand can be managed.

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346. Issues in education provision for new hospice services for non-cancer patients.

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AimA potential barrier to the extension of specialist palliative care to non-cancer patients is the skill base of current palliative care specialists, which is commonly oncology related. Data from an evaluation of innovative hospice projects for non-cancer patients in the United Kingdom, funded by Help the Hospices, are used to consider the education and training needs of and provision for project staff. **Method** Qualitative interviews were conducted with a range of personnel within 4 case study projects, plus with key informants from a further 16 projects. Interviews were tape recorded, transcribed and analysed using a framework approach. **Results**Data show early concerns about non-cancer skills and knowledge to be common among staff taking on this new role. The hospice projects provided education to their staff in a variety of ways, both formal and informal. Initial analysis suggests that on-going and informal education and support in practice are vital to knowledge and skills provision and confidence building. **Conclusion**Hospices who are working to extend palliative care to non-cancer patients need to set up mechanisms for continued education and support for staff in practice, to reinforce and extend formal education. Specialists from other relevant disciplines have an important role to play in this provision.

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347. Cardiac Medicine Prescribing In A Specialist Palliative Care Unit - A Prospective Audit

Graham Whyte

Beatson Oncology Centre, Clinical Oncology, Glasgow, United Kingdom

Intoduction: Deciding when a cardiac medication is no longer essential in a palliative care setting is a difficult decision.Many drugs felt to be appropriate and well tolerated earlier in the course of a patients illness may no longer be beneficial. The decision on stopping these drugs is made easier in the last few days of life but the area that is unclear is those patients that still have a few weeks or months to live.
Aims: To obtain a baseline of the number of cardiac medications patients wre still prescribed on admission to a local hospice and to ascertain their views on discontinuing these if proposed.?Methods: A Prospective audit was carried out of all admissions to a local hospice over a 3 month period. Interviews were carried out to assess drug history and cardiac risk before proposing to discontinue certain drugs. Patients views on discontinuing these medicines were also recorded.
Results: 76 patients were recruited. 39% of patients were prescribed at lest one cardiac drug.Of this group only 10% had any ongoing symptoms.16 out of 76 patients were taking anti-hypertensives however 36% of these patients had a systolic blood pressure of under 100mmHg. 95% agreed with discontinuation of their medicines if proposed.
Conclusion:This evalution shows that a number of patients are still taking perhaps unecessary cardaic medications towards the end of life.Greater awareness and education is required in the community and hospital setting to address this issue.

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348. Right to dye is not right to kill : the French approach on end of life policy

Bernard Devalois, Arnaud Leys, Laurence Geneston

USP, 92, Puteaux, France

The new French law (2005) concerning end of life policy is strongly in opposition with the Dutch or Belgian approach. It recognizes the right for everyone to refuse medical futilities. But it denies everyone, including MDs, the right to kill another person, even if this one asks for it. It details strict procedures for decisions concerning limitation of treatments at the end-of-life.

* **If the patient is able to decide for himself**, he is the only one who can appreciate if the treatment can be considered as a medical futility or not. It's true for an end-of-life patient or for a patient receiving an active life-sustaining treatment (including artificial nutrition or hydratation). Medical staff must stop the active treatment if it is the patient's decision, even if the consequence is the patient's death.

* **If the patient is unable to decide for himself**, it's the medical staff who has to decide about a therapeutic withholding or withdrawal. At least two MDs have to decide what they think to be the patient's best interest in their own opinion. They have to consider many factors: advanced directives, surrogate (if he exists) and relatives' opinions.

In all cases, palliative care is necessary until the death, including treatment for pain, suffering, anxiety and any uncomfortable symptoms. Relatives must be cared for. In any case, medical staff cannot act to speed up the dying process (*ie* euthanasia).

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349. Palliative Care in Public Health Research

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Aim: To examine to what degree palliative care is represented in the pertinent academic journals of public health, and what the major subjects are. **Method:** We analysed the European journals in the Journal Citation Report (categories *Health Care Science & Services, Public Environmental & Occupational Health, Health Policy & Services;* years 1996-2005; search terms *palliative care, palliative medicine, terminal care, hospice care*). Using qualitative (inductive category development) and quantitative procedures, the material was thematically encoded. **Results:** 82 journals with 57,737 articles were found. 166 articles were on palliative care (0.3%), with the majority (55%) concentrating on a small circle of journals (4%). The absolute quantity of palliative publications and their percentage among all publications have continuously increased from 0.1% in 1996/97 to 0.4% in 2004/05. The largest group of papers (42%) appeared in journals with impact factors less than 1, and the largest group of all papers in journals with impact factors of 1 to 1.999 (51%). 17 subject-related categories were generated; the largest category consisted in patients' and relatives' perspective (12% of the publications), followed by the health care professionals'education (10%) and perspective (9%). **Conclusions:** There is need for more Public Health research in palliative care in terms of reach and top-level impact and a broader topical spectrum.

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350. The Effects of Hospice Share-care Program in Taiwan

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Background: There are only about 12% patients who die in cancer accept the hospice care in Taiwan, in order to expand the hospice care, the Bureau of Health Promotion Department of Health constructed a hospice share-care program, to push a hospice-palliative care team and a non hospice-palliative care team care the survival expects less than 6 months cancer patients together outside the hospice ward. **Methods:**The search instruments included (1)Hospice share-care record: Collect the data that the patient looks after each time.(2)Patient and family members' satisfaction investigates form.(3)Original diagnosis and treatment team investigates form.**Analysis:**The description covariance and Chi-Square design were used in this study. The purpose is a study whether the implement of the hospice share-care program can promote hospice utilization, the patient's caring need and physically caring situation, patients and family members accept caring satisfied situation, and whether the hospice-palliative care team can help original diagnosis and treatment team to care a terminal cancer patient.**Results:**The major findings were: (1) there were 7205 cancer patients to accept hospice share-care, so in 2005 at least 19% terminal cancer patients accept the hospice care in Taiwan.(2) the satisfaction of the patients and family members is 4.87(The full marks is 5)(3) 90% medical members think the hospice share-care can promote the quality of the condition of illness control. **Conclusion:**The hospice share-care program is successful of promote the hospice and palliative care to outside the hospice ward. In the future, it will need to develop the indicator for quality of care.

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351. FIT FOR PURPOSE:MODERNISING THE MINIMUM DATA SETCOLLECTION IN THE UNITED KINGDOM

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BACKGROUND
The Minimum Data Set for Specialist Palliative Care services was developed in 1995 to provide annual data on services in the U.K. The development of payment by results and health resource groups,together with identified limitations of the current MDS including missing data, the potential for double counting and a 68% return rate, resulted in a current collaborative project to revise and update the MDS.
METHOD
Action research was utilised for the study as a group activity that focuses on partnership between researchers and participants involved in the change process. Purposive sampling was used to invite key stakeholders including multidisciplinary specialist palliative care services involved in completing the MDS from across England and Wales.38 respondents attended 3 workshops, where each section of the MDS were discussed and revised. Revised sections were returned to participants for review.
RESULTS
A consensus existed that the MDS did not completely reflect current patient workload, extent of services provided or development of integrated services.Additionally, with the development of regional Cancer Network Groups, some data was more appropriately collected regionally.
CONCLUSION
An action research approach enabled a national consultation process to be completed effectively.Involving a wide sample of stakeholders ensured revisions were made based upon a national consensus of opinion and met the changing provision of Specialist services. Further information regarding the

action research process,the changes made to the MDS and the second stage of the action research cycle piloting the revised MDS will be presented.

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352. Use of Continuous Subcutaneous Infusions (CSCI) via a Syringe Driver within St Helens and Knowsley Specialist Palliative Care Service

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Introduction Specialist Palliative Care Services within the locality aim to provide an integrated service with regard to CSCI via syringe drivers.
Objectives To undertake an audit of the current practice of CSCI via syringe drivers.
Method This prospective study reviewed relevant health records and medication charts. The investigators completed a proforma for each patient; a target of at least 20 patients for each location was set.
Results Proformas were completed for 23 (community), 20 (hospital) and 20 (hospice) patients respectively. For all locations, the commonest reason for introducing a syringe driver was for the control of symptoms at the end of life (42 out of 63 patients, 67%). The patient had been referred to the specialist palliative care team in 65% of the cases in both the community and hospital. Syringe drivers were used for less than 7 days in 70% of the cases and 78% of the patients died whilst the syringe driver was in situ. There was clear variation in the way that CSCI via syringe drivers were monitored in each of the three sites.
Conclusions This study identified that syringe driver use is poorly monitored within the hospital and community, exposing patients to risk of over -infusion, under-infusion, unrecognised site reaction and solution problems. There was inadequate prescribing practice in these two sites, increasing the risk of drug errors.

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353. Out Of Hours (OOH) Prescribing in Palliative Care Units: A Survey of Current Practice in the U.K.

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A review of the Out of Hours (OOH) prescribing policy at an independent hospice in the U.K. led to the development of a postal questionnaire to establish the current accepted practice in palliative care units throughout the U.K. One hundred and forty four units were sent the questionnaire;94 units responded (65.3%). All responding units had non-resident on-call medical cover. The mean recommended travel time from the unit for on-call cover was 34 minutes (median 30 minutes, range 15–60 minutes). Although verbal orders appear to be the most popular communication method for OOH prescribing (84.1%), other systems were in use including email, fax and BlackBerry®. Anticipatory prescribing, use of patient group directions and further development of nurse prescribing, should minimise the need for remote prescribing. However, there still needs to be a system in place to manage an unexpected change in a patient's condition, requiring prescription of a medicine, when there is no medical cover on site. In a culture where there is increasing emphasis on clinical governance, clear policies for managing risk should be in place. Guidelines currently available from professional bodies are open to interpretation. This was demonstrated in the survey by the wide variation in accepted prescribing practice. There is a lack of clarity relating to the use of remote prescribing. Legislation has not kept up with changes in working patterns and technology - this will need to change.

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354. Network Palliative Care Amsterdam/Diemen. A result of the Dutch policy on pallitive care.

Wim Jansen

Network Palliative Care Amsterdam, Amsterdam, Netherlands

Formation of local networks palliative care is one of the main objectives of the national policy on palliative care. The country is now fully covered by 73 local networks. The government finances network coordination. Development of the network palliative care Amsterdam/Diemen started in 1999, as one of the ten pilot-projects in the Netherlands. In 2005 twelve organizations participate in this main-city-network. With a population of 765.000 inhabitants and 39 places for specialized palliative care, the network offers five places per 100.000 inhabitants, which is in accordance with the guideline of the national health insurance companies. In 2005 in total 332 patients were admitted for intramural terminal or respite care. This is about 20% of all patients who died from cancer in Amsterdam. The average stay was 35 days. Before admission to specialized intramural palliative care, 64% of the patients were in a hospital and 29% were at home. Main objectives of the network are (1)to improve the quality/continuity of care, (2) development of written and electronic information to patients, relatives and caregivers and (3) implementation of a local education program. This program focuses on the professionals within the network and all other professional caregivers in Amsterdam and Diemen.

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355. Specialist Palliative Care Out-of-hours Advice in Lancashire and South Cumbria

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Aims To establish the practice of specialist palliative units providing telephone advice out of hours and compare with national standards. To establish a policy for provision of a quality service across the region.
Method There are 7 units in the area staffed on a 24-hour basis. All policies and / or protocols were assessed in addition to 25 samples of documented telephone calls from each unit. Each unit was compared to its own standards and to best practice as outlined in the National Institute for Clinical Excellence (NICE) Guidelines for Supportive and Palliative Care[1].
Results The level of service provided varies considerably. Only 2 units have a formal advice line. All advice lines are nurse led. There is variable medical support available. A wide range of professionals and non-professionals use the services. There is no standard funding.
Conclusion None of the units currently meet the national standards, including the NICE recommendation of specialist advice being available 24-hours a day. A good practice model has been developed. The model contains recommendations for staffing levels, training requirements, protocols, documentation, audit and funding.
Reference: 1. NICE (2004) Supportive and Palliative Care: The Manual

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356. Should adult specialist palliative care in-patient units have automated external defibrillators (AEDs)? A survey of policy and practice in the United Kingdom.

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Introduction/aims
AEDs (automated external defibrillators) are widely available in public places but there is no consensus on their use in specialist palliative care (SPC) units. Many SPC units now accept patients with non-malignancy and less advanced disease. The aim of this survey was to establish how many units possess and have used AEDs, to examine access to training and experience with ICDs (internal cardiac defibrillators).
Methods
Questionnaires,developed with feedback from members of the Association of Palliative Medicine science committee, were posted to medical directors of adult SPC in-patient units across the United Kingdom.

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357. Incorporation of Palliative Care in National Health Plan (From private to Governmental financing)

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Aim: To analyze the experience of the first steps of Palliative Care (PC) development in Georgia for elaborating of strategy for its further integration overall the country. **Methods:** Comparative analysis of PC development in Georgia with the analogues of Eastern European countries was used.**Results:** In 2001-2004 PC development in Georgia passes the similar way as the most Former Soviet countries did: trained staff preparation, creation of special literature in native language, promotion of ethical environment; implementation of home-based PC mobile teams and first hospice (in Tbilisi) has been accomplished under financial support of different NGOs and foundations (OSI, SOCO, OSGF and etc.). Since 2005 PC programs are financed by Governmental and Municipal budgets (one hospice, 3 mobile teams in Tbilisi) supporting PC of 120 patients simultaneously. As pain management still remains the most unresolved problem legislative basis regulating opioid prescription and drug availability is under preparation.**Conclusion:** Integration of PC in National Health plan overall the country necessitates: incorporation of PC in medical and social educational programs, increasing of Governmental financing as well as financing from regional budgets, optimization of relevant legislation.

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358. Developing guidance for advance care planning: a consultation exercise

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In the UK, advance decisions to refuse medical treatment have been legalised under the Mental Capacity Act of 2005. They are one aspect of the wider process of advance care planning. We report on a process of consultation which led to guidance for Advance Care Planning (ACP) being developed for health and social care professionals working in England.
Aim: to develop clear guidance for health and social care professionals in England about ACP and associated terms, including advance decisions.
Method: a consensus building activity involving consultation and collaboration with experts in the field and front line staff.
Outcomes: a paper which will be distributed to health and social care professionals providing the following information: 1) Definitions of: advance care planning; statement of wishes and preferences, advance decisions and lasting power of attorney; 2) Key principles and professional responsibilities in Advance Care Planning; 4) Principles of record making; 4) Core competencies; 5) Recommendations for future work.
Conclusion: The consultation exercise revealed a number of areas of confusion which can impede the development of practice in ACP. These are mirrored in the research literature. The paper produced provides practical guidance on core competences, education and training of different professional groups and related ethical and legal implications.

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359. Possibilities of Fundraising in A Country Without the Tradition of Donation

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Hungarian Hospice Foundation, Budapest, Hungary

Objective: The Hungarian Hospice Foundation has been working for fifteen years. Each year, it has to cover 50 percent of its budget from donations. Since Eastern Europe has got no tradition of donations, the Foundation has drawn up its own strategy of fundraising.
Method: Three factors form the basis of this strategy of fundraising:1.Tenders: Projects proclaimed by the government or various national and international organizations.2.Donations: Individuals as well as companies offer not only financial assistance but also through different regularly managed services. A new form of financial assistance is the online donation page on the website of the Foundation.3.Personal income tax: In Hungary, individuals can offer 1 percent of their personal income tax to NGOs. This is in fact the main source of income for most organizations, including our Foundation which lays special emphasis on memorable campaigns that successfully address its target groups.
Results: One percent of the personal income tax and the tenders invited became the main means of fundraising. Out of the campaigns of some 23,000 organizations (2004), the one of our Foundation ranks among the 30 most successful.
Conclusions: PR and communication became an integral part of the functioning of the Hungarian Hospice Foundation. Nowadays, these are inevitable elements in the functioning of any NGO in Hungary.

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360. “The 6 S” - key words as a palliative care strategy

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Aim: To describe the use of “The 6 S”- key words at a palliative care unit with both a palliative ward and home care services. Background:Six questions, developed by Weisman (1974), have been transformed and redefined into six criteria to evaluate a good death. Rinell Hermansson (1990) selected six key words beginning with the letter S, to represent each of the six items. The six keywords were Self-image, Self-determination, Social relations, Symptom control, Synthesis and Surrender. These six key words were suggested to be suitable to use for care planning, nursing documentation and evaluation of the care (Ternestedt 1998).These "6 S" key words may be used as a guideline to secure the intention of the palliative care. This method regards the patient as an individual human being. Method and result:We started in 1999 to use "the 6 S" as a structure for conversation when meeting relatives after a patient's death. Since 2002, the use of the keywords is routine even in care planning and documentation.To evaluate the usefulness of the 6 S as a palliative strategy a questionnaire was used. The keywords were easy to use in care planning situations but more difficult in nursing documentation.

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361. Influencing Nursing Policy in Hungary

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The Council of the Hungarian Paramedical Professionals established in 2004. This new regulatory body will play a key role in the professional development of paramedical workers and in the consruction of the national health and nursing policy. The Council was being formed to represent almost all paramedical health care workers, such a community and hospice nurses in Hungary and to help professional workers in their more independent work both professional and ethical way. The Council supposed to represent health care workers individually and to contribute to health policy through maintaining health care workers' social, economical interest in order to improve health care for the Hungarian population. ?The responsibilities of the Council include individual management of professional matters through directly elected bodies and officials, within the framework defined by legislation, definition and representation of professional ethical, economic and social interests, and contribution of the formulation of health policy, and improvement of the provision of health and nursing care of the population in accordance with their importance in society. ?The Section of the Community and Hospice Care Nursing of the Council is taking part in the work of some steering and ad hoc committees. For instance, we work in the committee examining professional competence and nursing education. We also make technical proposals for the portfolio in regards of the legislative decisions.

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362. THE PROCESS OF EVALUATION THE CATALONIAN WHO DEMOSTRATION PROJECT AT 15 YEARS.

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[6] *Palliative Care Unit, Lleida, Spain*

Department of Health. Government of Catalonia The Catalonia WHO demonstration project started to implement in 1990, due to cooperation between the Catalan Department of Health and the Cancer Unit at the WHO (Geneva), as a formal WHO Demonstration Project.

Method

Formal evaluation process was carried out, which included a quantitative and a qualitative part, which consisted in a semi-structured survey with a Delphi-EFQM methodology.

Results

In 2005, 21,400 patients (59% cancer and 41% non-cancer) were cared. Estimated coverage for cancer was 79.4%, and for non-cancer of 25.0 to 56.5%. The geographical coverage was >95%. Specialist resources include 63 Palliative Care Units , with 552 beds (79 /million inhabitants), 34 Hospital Support Teams, 70 Home Care Support Teams , 16 Specialist reference Outpatient's clinics and specific teams for pediatrics and aids. There are 140 full time doctors working in palliative care. The cost of the specialist palliative care network is over 40 millions ¤. Estimated global savings is 48 millions ¤. Strong opioid consumption has increased from 3.5 kg/million inhabitants by 1989 to 21. After qualitative analysis 10 specific projects to be implemented in the next 10 years were chosen.

Conclusions

After 15 yrs. we consider that Catalonian Palliative Care system has been properly developed but still exist room for improvement.

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363. A Hospices experience of introducing an organisation wide Incident and Near Miss Reporting system.

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"tackling patient safety collectively and in a systematic way can have a positive impact on the quality of care..." (National Patient Safety Agency 2004). 'An Organisation with a Memory' (DoH 2000) noted that "Many incidents could be avoided if only the lessons of experience were properly learned." An incident reporting system was introduced into a UK Hospice. Training on the benefits of incident reporting and the promotion of a *'learning'* rather than a *'blame'* culture, was followed by the development of an incident reporting form and supporting guidance. Subsequently, quarterly and annual reports summarise trends, agreed actions and subsequent changes in practice. In 12 months, 384 incidents were reported, comprising 214 accidents (180 involving patients and 34 non patients), 61 other health and safety incidents (18 related to security risks) , 50 communication incidents (32 related to written or verbal communication), 47 drug errors (22 related to drug administration) and 12 incidents relating to general clinical care. 9 'near misses' were also reported. Introduction of an incident reporting system has facilitated an open and learning culture. Examples of resulting actions to improve care will be discussed and include revision of the drug prescribing sheet and mandatory drug management training for all nurses and the introduction of a falls risk assessment. Future development plans include auditing resulting changes in practice.

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364. Removing regulatory barriers to opioid availability in Serbia: A step forward

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Overly restrictive national drug control policies are a barrier to opioid availability. In 2004, consumption of morphine in Serbia was 2.08 mg per person, among the lowest in Europe (11.79 mg per person). Oral morphine is currently not available. One health professional from Serbia was awarded an International Pain Policy Fellowship (IPPF) Grant to learn how to evaluate national policy and work with government to remove regulatory barriers. As a part of IPPF,a preliminary evaluation of national drug control laws and regulations was undertaken using WHO Guidelines for Achieving Balance in National Opioids Control Policy. The following regulatory barriers were identified: 1) outdated terminology that defines opioid analgesics only in relation to addiction and health impairment, 2) restrictions to opioid dose or duration of therapy, depending on the diagnosis (cancer vs. other diseases) and 3) prescription (Rx) related barriers (restricted amount and number of opioids per Rx, unduly short validity of Rx, use of a duplicate Rx form). In addition, there is no recognition in law that it is the government's obligation under internatinal narcotic conventions to ensure adequate availability of opioids while preventing abuse and diversion, or that opioids are indispensable for the relief of pain and suffering. An Action Plan was developed to facilitate acknowledgement of the medical value and necessity of opioid analgesics, and to remove regulatory barriers to their availability.

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365. Palliative Care in the National Cancer Control Programme in Hungary

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Objective: Expanding and improving palliative care through the National Cancer Control Programme.
Method: The main topic of the conference meeting organized in 2005 by the OSI and the WHO was the integration of palliative care in the National Cancer Control Programme. Afterwards, we did a lot of lobbying for this purpose.
Results: Due to the appropriate legal regulation, the appearance of minimal professional conditions and the frameworks of financing established in 2004, the number of organisations involved in palliative care has doubled, with a current figure of 54. As a result of our lobbying activity, palliative care became part of the National Cancer Control Programme in 2006, which, in turn, is part of the National Development Plan. The plan aims at the development of the palliative network throughout the regions of the country as well as the integration of palliative training into gradual education in the period between 2006 and 2011. The reform process of medical care also includes a change in the structure of hospital beds with more beds for palliative care. The Hungarian Hospice-Palliative Association became a member of the National Medical Board.
Conclusion: The commitment of the state to palliative care means the potential of growth and development in the following years.

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366. Integration of palliative care into the health care system - the role of participation and organizational development

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The integration of palliative care into the national health care systems is a priority of health care policy in the European Union. Nevertheless it can be observed, that top down strategies and straight-line political planning concepts are facing limitations. ?Over the past years an alternative type of research projects, to develop palliative care concepts and structures, has been established and implemented in different regions of middle Europe; e.g. Styria, Vorarlberg, Upper Austria, Burgenland (A), South Tyrol (It), Grisons (CH) and Luxembourg. The meta-analysis gives a review of different ways of participation and the role of organizational development in these project processes.?The approach based on the understanding, that implementation of palliative care in health care systems can only succeed through developing organizations, their subsystems and their local structural environments. Of particular importance is the mindfulness for local and cultural distinctions and a broad participation of the local actors: the health care professionals and those who are concerned, the patients and their relatives. ?The project processes result in regional specific concepts of palliative care, where the multiple perspectives of the local actors are integrated, and which refer to the existing health care strutures. The implementation processes enable cooperation and sustainable regional development of palliative care.

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367. Fund raising for a home-care palliative service in a little area in Hungary

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Introduction: The home-care-palliative service is the basic need of the terminally ill cancer patients.To create and manage a foundation was the goal of the authors. The process of changing in financial support is reported by experience of the last 15 years.
Methods: The authors used the method of a retrospective statistical analysis of cancer mortality in their area as the indicator of the need of palliative care.
Dicussion: In the beginning by the support of Soros Foundation they provided palliative care for 4-20 patients in a year, but the need was 10x more. After a very systematic campaign in the local newspaper, radio and TV, authors were lobbying in the local government for support. The people had a chance to make an offer of 1 % of their tax for the foundation. At least they asked for competitions from other foundations, organizations and collected donations in concerts of local orchestra. The team is providing care for >100 cancer patients per year. The NHS provides the 60%, the local government 10 %; the 1 % of the tax of the people of the area is also 10 % of the budget in a year. The absent support is coming from different competitions and donations.
Conclusions: The home-care palliative service is well-known and acceptable for the people of the area. The service is free of charge for the patients.

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368. Policy decision-making strategies in palliative care planning

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Background: In Slovenia emerging new initiatives for palliative care in different settings of health care and

hospice are not enough to foster development on the national level effectively. Beyond conventional action-oriented, grant-giving and capacity-building activities, more rigorous policy-design is urgently needed. Professional networks are needed to implement comparative and applied policy research for development of national palliative care.
Methods: The policy context of palliative care in Slovenia was analysed and possible policy strategies were examined. As a result of this process, the authors offer a methodology and knowledge of a policy decision-making process through the work conducted on the issue of palliative care in the cases analysed.
Results: Different approaches for specific cultural and political conditions are needed to predict the outcomes of implementation of different palliative care strategies. Strategies must meet fundamental criteria: equity, effectiveness, efficiency, continuity, cost, technical capability and political feasibility. Political conditions may skew the prioritisation of some of those criteria, resulting in tradeoffs in the selection of feasible policy solutions between the core principles and values of palliative care versus the economic and political feasibility.
Conclusions: Through this type of rational decision-making methodology, strategic solutions can be developed, which are feasible and applicable for health care systems.

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369. Palliative Care: The public Health Strategy

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Why a Public Health Stategy:
A public health strategy offers the best opportunity for implementing knowledge through cost effective intervention that can reach everyoneThis strategy will be most effective when it involves the society through collective and social action. The problem addressed must be of significance for large populations and there must be available scientifically valid interventions that are acceptable and maintanable at community level. There are four key components that must be established for a WHO public health approach in palliative care. They are: 1) appropriate policies, 2) adequate drug availability, 3) education of healthcare workers and the public and 4) implementation of palliative care services at all levels throughout the society and empowerment of the community. The four components must be addressed in a coordinated way to be effective.
The results from the first 16 countries, both high income-, middle- and low income countries, that have established or are establishing National or State Palliative care Programs have been analyzed and Outcomes, divided into immediate, intermediate and long term will be presented in detail. This covers also institutionalisation of palliative care into the Health care systems and patient coverage achieved through the Goverment and the Community approaches.
Reasons for successes as well as failures and lessons learnt will be presented and conclusions for strategies and were to go next will be discussed.

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370. Coordination of the World Hospice and Palliative Care Day in Hungary in 2006

Eva Varga, Agnes Zana, Katalin Hegedus, Katalin Munk

Hungarian Hospice-Palliative Association, Budapest, Hungary

Aim: To present the PR and policy activity of the World Hospice and Palliative Care Day: the way how became from 3-4 planned to 17 realized events in Hungary within 2 weeks
Method: Online and phone communication with member associations to prompt, inspire, give ideas to them, continuous promotion of the events on our and international homepages, preparation an online newsletter on the passed off events and information permanently the policy-makers and the press. An additional goal was to connect the separately working hospice units with each other and with the umbrella organization (Hungarian Hospice Palliative Association) and inspire them used the internet for a rapid change of information.
Results: Our small team had been working with 52 member associations to help them to realize that communication with civil society is the base of a close co-operation, charity and volunteer work in the future. Remarkable events were organized throughout the country: concerts, theatre performances, masses, painting auction, exhibition of children drawings, charity ball, radio programme etc.
Conclusion: PR activity and publicity can do a lot in familiarizing hospice and palliative care and supporting the social role in the future.

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371. The CEE & FSU Palliative Care Monthly Email Newsletter

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Hungarian Hospice-Palliative Association, Budapest, Hungary

Aim: To present the Newsletter as an online palliative information and communication form for Central and Eastern Europe and Former Soviet Union, and also to inform the world about the regional palliative efforts.
Results: The Newsletter is published in English and Russian, distributed to 760 e-mail addresses. From February 2005 to November 2006, 20 issues of the Newsletter released so far introduced detailed country reports of 14 countries. We have found Eastern-European key-personalities in every country who help us to publish news in the Newsletter and we involved Western-European and US consultants. We regularly publish reports on model-programs of a region or city, report on important international and national congresses, professional and informal events; and publish declarations of those congresses.
Conclusions: The Newsletter - supported by the OSI and EAPC - became one of the taskforces of the European Association for Palliative Care, continuing the work of the EAPC East.

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372. Focusing on essential pain medication accessibility for palliative care: APCA's response to policy implications

Faith Mwangi Powell

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To promote the availability of essential pain medication in the continent, the African Palliative Care Association held an innovative regional drug accessibility workshop in June 2006 in Entebbe, Uganda to: (i) improve participants knowledge of the policy changes necessary to make opioids available and (ii) support their development of tangible action plans to facilitate policy change.
Method
The workshop focused on six African countries, each sending a six-person technical team. Participants completed a pre-workshop self-assessment checklist and the Barriers to Opioid Availability Test, and received workshop presentations on pain control, drug conventions, and access to analgesics.
Results
Common and unique barriers to opioid and other essential medications accessibility were identified. These informed the interactive development of country-specific action plans by participants and expert workshop facilitators that aimed to address recognized policy impediments. Subsequently, significant movement on appropriate drug availability for pain management has been noted by the participating countries. Consequently, the APCA Entebbe workshop has been acknowledged as a best practice in Africa by OGAC and the USG Palliative Care Technical Workgroup.
Conclusion
This innovative workshop format has proven a critical lever to changing palliative care drug policy agendas; its success has resulted in the exploration of similar workshops in southern and western Africa in 2007.

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373. Bisphosphonates for bone prophylaxis in a palliative day care setting. The value of audit and re-audit in service development.

Pola Grzybowska

Princess of Wales Hospital, Y Bwthyn, Bridgend, United Kingdom

Aims To evaluate a clinical pathway developed for the monitoring of infusional bisphosphonates. **Setting** A specialist palliative day care hospital adjacent to a district general hospital. **Method** A clinical pathway was developed and put into use in 2006, following audits in 2004 and 2005. These allowed standards to be set and demonstrate areas of concern clinically. All audits were retrospective case note audits. The standards set related to documentation of renal function, blood calcium and calcium supplementation. **Results** 15 patients were assessed in the first audit. In the 2005 audit there were 29 patients and in 2006, 20 patients, with 94, 105 and 92 treatment cycles respectively to analyse. Unrecorded renal function was 70%, 40%, and 0% in consecutive years and unrecorded corrected calcium 59%, 8%, 0%. Deferred treatments, because of abnormal biochemistry 2005 (21%), 2006(1.1%). **Conclusions** The implementation of standards allowed the process of pathway development. Documentation improved as did the quality of results and the consistency of actions of the multi-professional team. More patients are had their treatments as planned. The team, the patients and the GP were aware of the treatment, its complications and its monitoring.

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374. How and where will we die by 2030: An analysis of future needs in an ageing population

Barbara Gomes, Irene Higginson

King's College London, Palliative Care, Policy & Rehabilitation, London, United Kingdom

Aim: *Ageing* societies have growing needs for end of life care but these have rarely been projected in detail. We have analysed future dying trends by place of death for England & Wales.
Method: Mortality trends and forecasts were obtained from official statistics on the numbers of annual deaths by age and place of death. Different scenarios were modelled using past trends to estimate numbers of deaths by place of death to 2030.
Results: The number of annual deaths fell by 8% from 1974 to 2003 but will rise by 17% from 2012 to 2030. People will die increasingly in advanced age, with the deaths of the 85's and over rising from 31.9% in 2003 to 43.5% in 2030. The national proportion of home deaths stands currently at 18% (2003) and has been falling since 1974. Long-term projections show that if this past trend continues, the number of home deaths can reduce further by 46-75%. This will mean that less than one in ten will die at home. Alternatively, if recent trends of inpatient deaths continue, numbers of home deaths will nearly double from 100,000 to 200,000 people dying at home by 2030.
Conclusion: The projections underline the urgent need for planning of structures and resources to accommodate a large increase of deaths. Either inpatient facilities increase substantially or twice as many people will need community end of life care by 2030. Our model for projecting future trends can be used for analysis in other countries.

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375. Using the Korea declaration to advance international palliative care

Sharon Baxter, Nick Pahl

Help the Hospices, Palliative Care, London, United Kingdom

At the 2nd Global Summit of National Palliative Care and and Hospice Associations held in Seoul, Korea, 2005 the Korea Declaration was prepared by Sharon Baxter from the Canadian Hospice and Palliative Care Association for the Worldwide Palliative Care Alliance

The Declaration is a useful document for palliative health services who have little insight into palliative care and the benefits that can be achieved through good palliation. It has been used in global advocacy by providing a basis for organizations (particularly national associations) to make their case to policy makers and Governments.

The declaration will be evaluated in early 2007 as to its effect and the areas in which it has been used although it has already demonstrated to be an important step forward in placing palliative care firmly on the agenda of all health services across the world.

This poster will describe the declaration, how it has been used and the results of the evaluation of the benefits of its use.

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376. Retrospective Audit of the Approach to all In-patient Deaths in an Australian Teaching Hospital

Katherine Clark, Paul Glare

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Background
The majority of deaths in our society occur in hospitals. Previous authors suggest that despite the high numbers of deaths, the care of dying hospitalised patients is not always optimal. (1). From this, it is reasonable to extrapolate that all nurses and doctors who work in hospitals do not possess the core skills necessary to provide basic comfort at the end of life.

The needs of dying patients have been considered by Ellershaw et al (2,3, 4) and these have worked these into the excellent Liverpool Care Pathway for the Dying guidelines to steer care at the end of life (5). The guidelines indicate that basic to the care of dying patients and their carers is the need to ensure that:?*
The correct diagnosis of dying has been made and communicated to the carers (formal and informal) involved in the care of this patient,
* Measures to address physical and spiritual comfort are clearly charted and readily available,
* Clear documentation of all these issues is available.
Aims
This chart review will report the quality of care provided patient deaths at RPAH over a period of two months from all units in the hospital from 1st July to 31st August 2006 inclusively, excluding deaths that occurred in the A&E, ICU and operating theatres. This will be based on a retrospective review of all the charts of patients who died over this period by the two palliative care

physicians based in the hospital.
Specially, the aims are:

* To consider whether inpatients regardless of diagnosis died receiving good basic end of life care as suggested by the Liverpool Care Pathway for the Dying (5), * To consider the complexity of the deaths and of the patients who required complex end of life care, to consider the number actually referred to palliative care,
* To use the collected data to identify the hospital's standard of end of life care and consider further changes based on the results of the audit.

Methods
Data will be retrieved from the hospital files by either of the two palliative physicians of RPAH, using a proforma designed for the purpose of this audit.

Conclusions
The results of this audit will be used to define the quality of care provided to patients at the time of death in a teaching hospital. This audit will provide the first audit of all groups of patients, which to our knowledge has not yet been reported in an Australian hospital. It is hoped this audit will support the Palliative Care team when considering the need to improve hospital-wide quality of care offered at the time of death.

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377. PALLIATIVE CARE WORK, BETWEEN DEATH AND DISCHARGE

Margaret O'Connor

Monash University, School of nursing, Midwifery and Social Care, Melbourne, Australia

This paper discusses a small quality improvement study that was undertaken in a palliative care unit (PCU), to demonstrate reasons for the lengthy patient turnover time after the death of a patient. There is a dearth of literature describing the role of the nurse in providing care of the family and others after the patient has died.

The aim of the study was to undertake a post-death survey from the nursing perspective, of activities and the time required to complete tasks associated with follow-up care to the deceased patient and his/her family unit. Details of the post-death episode for all patients who died in the PCU over two time periods were collected using a newly designed tool.

Study findings demonstrate that most deaths in this Unit occur out of business hours. In addition, the study has highlighted the protracted nature of post-death care, because of a variety of factors. Nursing work after death is complicated by a lack of multi-disciplinary and ancillary support, particularly out of business hours. These factors prolong the time between patient death and removal of the deceased, thus delaying admission of new patients. This project has provided important information both from a quantitative viewpoint as well as giving some insight into the role of the nurse after death occurs.

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378. LINKING THE PARTS:- ARTICULATING THE ROLE OF CONSULTANT PALLIATIVE CARE NURSES IN ACUTE HOSPITALS.

Margaret O'Connor

Monash University, School of Nursing & Midwifery, Melbourne, Australia

Palliative care nurse consultants (PCNC) in acute hospitals have become integral to service delivery. Despite little literature that describes the role, anecdotal reports indicate that it is pivotal – in connecting services, in liaison and advocacy, both within the hospital and to other services. ?A three phase study explored the roles to ascertain strengths and limitations, to provide direction for further development. The study's primary aim was to describe and evaluate the role of PCNC in acute hospitals. ?The design incorporated:

- interviews with the PCNC, to explore aspects of the role;
- 2 weeks of data collection to measure the activities undertaken;
- open-ended interviews with managers to ascertain their perspectives of the role.

The study articulated the role of the PCNC for the incumbents and will be a resource for newly developing roles. The PCNC were well regarded by their managers. PCNC's perform a vital role, especially providing individualised care within acute care settings and in many instances, being the first point of introduction of palliative care to patients and families. The integration of palliative care and acute approaches is important so that palliative care is not a last minute consideration.

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379. Obstacles to alleviating the suffering of palliative care patients: healthcare providers' point of view

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Backround
Suffering related to serious illness is considerable and sometimes intensified through the provision of healthcare services. Since obstacles to the alleviation of suffering remain as yet insufficiently researched, the present study aims to document them from the healthcare providers' perspective.

Sampling frame
Setting : general and teaching hospitals
Subjects: Healthcare providers (93): 43 physicians, 34 nurses, 12 non professional workers, 4 social workers, all involved in full or part-time care with terminally ill patients.

Methodology
Qualitative study using in-depth interviews transcribed for content and conceptual analysis, and focus groups for validation of emerging theory. Coding, comparative analysis and interpretation of data were conducted by several coinvestigators.

Results
Healthcare providers point to many obstacles, which can be subdivided into four main categories: 1. Obstacles stemming from shortages (of funds, personnel, and time); 2. Those related to the system's organization (erosion of accountability, insufficient teamwork or support for caregivers); 3. Those pertaining to the dominant philosophy of healthcare (favouring interventions focused on survival at the expense of care); 4. Lastly, obstacles stemming from our healthcare system's sociocultural environment.

Conclusions
Obstacles to the alleviation of suffering represent a major challenge for the palliative care movement, requiring its input so that the healthcare system as a whole can be mobilized around this fundamental aim.

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380. Nurses' experiences of caring for dying patients outside special palliative care settings

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Background: It has been increasingly common that patients are dying in different care cultures and settings.This places great and partly new demands on organizations, staff and relatives.Nurses have also different possibilities to prepare end of life care.
Aim: To describe nurses' experiences of caring for dying patients outside special palliative care settings.
Methods: Tape-recorded qualitative interviews were conducted with a total of nine nurses in home care, community care and hospitals. The interviews were analysed according to phenomenological methodology.
Results: Three structures were found:ambition and dedication, everyday encounters and satisfaction/dissatisfaction. The results describe the nurses'ambitions to give dying patients and their relatives high-quality care.In the 'everyday encounters' the following key constituents emerged: responsibility, cooperation, experience and knowledge, feelings, time and resources. Despite the nurses' high ambitions they experienced greater or lesser degrees of dissatisfaction in caring because of insufficient cooperation, support, time and resources.But the contact with patients and relatives, functioning collegial cooperation as well as increasing knowledge, experience and personal growth, gave the nurses satisfaction in their work.
Conclusion: The results elucidate the need for discussion about the conditions for giving palliative care outside hospices and other special palliative care settings.

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381. Prospective pricing of palliative care for patients with non small cell lung cancer in Germany

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Background: Five year survival of patients with non small cell lung cancer (NSCLC) is below 15%. Therefore an early integration of palliative care according to the 2002 WHO definition is indispensable. Methodical and financial aspects of prospective pricing of palliative care within a program of integrated care for patients with NSCLC are demonstrated. **Methods:** Four areas of service were defined: Hospital support, home care, day care and in-patient care. Resource use was estimated, using real cost data from the University Hospital Department of Finance. Resource use for patients with NSCLC was forecasted on the basis of operating experience, data of the core documentation in Germany and recommendation from the European Commission. **Results:** Expected average hospital support team services were priced at 483 euros and budgeted for 10% (stage 1) to 90% (stage 4) of patients. Home care (60 visits, 4573 euros) and day care (5 visits) services were budgeted for between 5% (stage 1) and 30% (stage 4). The resulting prospective reimbursements range from 393 euros (stage 1) to 2503 euros (stage 4). In-patient care was excluded from the prospective payments and is reimbursed separately. **Conclusions:** For the first time, global reimbursements covering palliative hospital support, home care and day care for patients with NSCLC were prospectively calculated and negotiated. The contractual specification of palliative care services may contribute to transparency and quality in cancer care.

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382. Implantable cardioverter defibrillators (ICDs) at the end of life

Paul Paes, Pamela Ransom

North Tyneside Palliative Care Team, North Tyneside, United Kingdom

Aim
The development of guidelines for managing implantable cardioverter defibrillators (ICDs) at the end of life.

Background
An increasing number of ICDs have been inserted into patients at risk of developing ventricular arrhythmias. These patients often have progressive cardiac or other co-morbid conditions. As patients near the end of life, the use of ICDs may no longer be appropriate. The latest version of the Liverpool Care pathway now includes a section on ICDs.

Method
A literature review was conducted to explore the issues of ICDs at the end of life. In addition, a series of consultations took place with cardiologists, ICD technicians, primary care, secondary care, palliative care and the Northern Cardiac Network to develop clear guidelines.

Results
Dying patients are at risk of receiving inappropriate and unpleasant electric shocks if they develop an arrhythmia in the terminal phase of illness. Indications for deactivation of ICDs are identified, the appropriate time to discuss this with patients and the procedure for deactivation.

Conclusions
With an increasing number of patients with ICDs anticipated, the need to address issues at the end of life is important. This paper describes the formation of guidelines to cover some of these issues.

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383. Revision of the document "Changing Gear: Managing the Last Days of Life in Adults"

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Aim
The project reviewed the document, *Changing Gear: Managing the Last Days of Life in Adults* which was published originally in 1997 by the National Council for Palliative Care.

Method
A multi-professional steering group was formed to lead the review of the document. The literature was reviewed and a new document drafted.

Results

Changing Gear reviews the national documents that have been published in recent years. The End of Life Care Programme is introduced and its aims outlined. The value of the end of life care tools (Preferred Place of Care, Gold Standards Framework and Liverpool Care Pathway) is highlighted. In particular the importance of advanced care planning and communication between healthcare professionals, the patient and their family is described.

Healthcare professionals who are caring for patients in all care settings can use the guidelines. Advice is given on the assessment of the symptom control needs of patients and on managing physical, social, psychological and spiritual symptoms. The document provides advice on the use of drugs in the last days of life to achieve symptom control.

Conclusions
Guidance is provided on care so distinct from the palliative care given earlier in the patient's disease that it

resembles “a gear change”. The guidelines empower the general healthcare provider caring for patients in the last days of life.

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384. The first year activity of a pharmacists group in Japan : symptom control studies on patients with cancer

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Cancer is the number one cause of death in Japan. Over 300,000 people die from cancer annually, and over ninety percent of them die at general hospitals. Though Japan is one of the major industrial powers, it consumes an extremely small amount of narcotics for medical use. The majority of cancer patients who receive treatment at facilities other than those specializing in the treatment of cancer succumb to the illness without receiving the proper palliative care. One of the causes of this is the lack of useful information on palliative care for general hospitals. The Symptoms Control Research Group (SCORE-G) was established in July 2003 to provide useful and comprehensible information for the medical staff and patients at general hospitals. Presided over by Motohiro Matoba MD, SCORE-G consists of doctors, nurses and pharmacists in Japan. Subsequently, SCORE-G Pharmacists (SCORE-G Ph.) was established as the pharmaceutical research section of SCORE-G in January 2005. Comprised of 21 professors of pharmacology and pharmacists employed at various sized hospitals, it takes a pharmacological approach to relieving cancer pain and symptoms and provides significant information to hospitals nationwide. SCORE-G Ph. continues to work toward its goal of making proper palliative care available to all cancer patients in Japan, and hopes to share its many new findings in Japan and the rest of the world. Activities of SCORE-G Ph. to date shall be presented at the academic conference.

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385. The Northern Territory Indigenous Palliative Care Model - its evolution, implementation and integration with existing services.

Mark Boughey

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Providing culturally appropriate and best practice palliative care to Australian Aboriginal and Torres Strait Islander people has been a particular challenge to palliative care services in the Northern Territory of Australia. With its overall population of 200,000 people dispersed over one-sixth of the Australian land mass, Aboriginal Australians comprise 29% of this population and make up 45% of Territory Palliative Care’s caseload with 81% living in remote, non-urban areas.

The past three years has seen the evolution and development of the Northern Territory Indigenous Palliative Care Model which has been developed in conjunction with & the implementation of a population needs- based public health approach palliative care service provision in the Northern Territory.

I will be presenting the main elements and structure of the Northern Territory’s Indigenous Palliative Care Model, how this has been implemented to engage indigenous communities, give case studies to demonstrate how it is operating and show how it is placed and works within the existing palliative care services of the Northern Territory of Australia. The integration of both models and development of resource material has allowed for considerable cross-cultural education, learning and understanding.

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386. HIV/AIDS Palliative Care Program in the Nizhny Novgorod Region

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Issues: HAART has not been available for most patients until recently and HIV/AIDS in Russia for many people remains a fatal illness and the global burden of this disease continues to grow exponentially. Marginalized communities bear an increased burden with regard to limited access to comprehensive, quality care addressing this wider range of needs and end-of-life care. Skilled palliative and end-of-life care is important to the total care of patients with HIV/AIDS. **Description:** A pilot regional HIV/AIDS palliative care project started in Nizhny Novgorod region in June 2005 and was supported by the Global Fund. A multidisciplinary palliative care team was set up. Palliative care is provided in the outpatient and day care departments at the AIDS Center, in the inpatient infectious diseases department for HIV-patients, in a city tuberculosis hospital, and in the community. The mobile team consists of a doctor, a nurse, a social worker, a psychologist, and a driver. **Lessons learned:** Our experience has showed an unmet need for palliative care of HIV/AIDS patients. The projects success can be attributed to the services engagement of HIV/AIDS and tuberculosis primary care providers. Different patients need both comprehensive inpatient and home care. **Recommendations:** A multidisciplinary model, which incorporates HIV, tuberculosis and end-of-life care expertise, both inpatient and home care, is a replicable example of comprehensive palliative/hospice care delivery for people living with HIV/AIDS. The projects experience is very important for further palliative care development in different regions across the country.

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387. Palliative home care of cancer patients in Estonia and Finland: differences and similarities on the example of 6 months.

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Aim of study: observe and compare the differences and similarities of palliative home care in Turku, Association of Cancer in south-western Finland and in Tartu, Association of Cancer in south of Estonia.
Methods: the investigation used the medical documents of patients treated within the programme of palliative home care between 01.01.2006– 31.07.2006 in the area of Turku and Tartu. We compared the patients’age structure, diagnosis, applied pain care and facts connected to their death.
Results: During the before mentioned period there were 59 patients in Tartu and 97 patients in Turku. Comparing the patients’ age structure we can say that most patients (61% in Tartu and 65% in Turku) were born in the years of 1920-1939.
The most common type of cancer among the treated patients in Tartu was intestinal cancer and in Turku prostate cancer.?29% of the cancer patients in Turku and 15% in Tartu did not get regular pain care. Strong opioids were used similarly. 17% of the patients were taking weak opioids in Tartu and 8% in Turku.
94% of the patients in Tartu and 13 % in Turku died at home.
Conclusion: On the basis of this retrospective analysis there were no considerable differences between the patients of palliative home care in Turku and in Tartu. The interesting differences came evident in the percentage of deaths at home and pain care with non-opioids, possibly reflecting differences in cultural background and local traditions in managing palliative care.

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388. The impact of a partnership between a specialist palliative care unit and a nursing home

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[3] *Princes Court Nursing Home, North Tyneside, United Kingdom*

Aim
To describe the impact of a partnership between a specialist palliative care inpatient unit and nursing home to improve the quality of palliative care.
Background
In North Tyneside, most patients with continuing care needs are admitted to Princes Court nursing home. There are a number of challenges in end of life care here: high staff turnover, shift length/patterns, skills mix and the stress of caring for dying people.
Method
A partnership with the Marie Curie Hospice enabled a senior inpatient nurse to work in Princes Court, identifying the needs of the unit and implementing changes to improve care.
Results
The hospice in-patient nurse worked across all shifts to work with every member of staff. A training plan was developed and implemented. This included use of pathways; team-working; syringe drivers and other equipment; communication skills and care of the dying. Princes Court was linked in with the out-of-hours palliative care advice line. Staff at the nursing home valued having the hospice nurse, both personally and professionally. Confidence and job satisfaction increased. Patients and families perceived an improvement in holistic care.
Conclusion
This paper describes a successful partnership between a nursing home and a specialist inpatient unit to improve the skills of staff, and meet the palliative care needs of patients. Ongoing funding is being secured to make this partnership permanent.

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389. EXPLORING THE PREFERENCES OF CANCER PATIENTS REGARDING PLACE OF DEATH: PRELIMINARY RESULTS FROM A PROSPECTIVE STUDY

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Objective: Determining and meeting preferences for place of death has been proposed as an important outcome for services. We wished to determine the preferred place of death of patients referred to a specialist palliative care homecare team and to examine whether preferences changed over time.
Method: Over a one year period, patients referred to the homecare service, were asked their preferences regarding place of death. Patients were followed longitudinally and preferences checked until death approached. Preferences were only sought if it was felt to be appropriate to do so.
Results: Of 120 patients who have died to date, 69 (57.5%) were asked their preference regarding place of death. 37 patients were asked more than once: 12 (32%) did not change their preference; 7 (19%) changed their preference over time; 4 (11%) were asked initially, then became too unwell to ask again; 14 (38%) were not asked initially but were asked over time.
64% of patients who were asked succeeded in dying in the place of their choice.
Documentation of reasons why patients were not asked was very helpful in understanding more about this issue.
Conclusion: Exploring preferences for place of death is important in facilitating patient choice and in examining how effective a service is in meeting that choice. Healthcare professionals must explore preferences for place of death longitudinally, as preferences can change over time and opportunities for asking can change with changes in the patients condition.

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390. Workplace stress and social support among nurses working in palliative care and nurses caring for elderly patients

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Aim and hypothesis: The aim of the survey is the comparative investigation of palliative care nurses and nurses caring for elderly patients in terms of vital exhaustion, social support and the degree of workplace stress. Hypothesis: due to interdisciplinary approach of the service and regular supervisions nurses working in palliative care are in a more favorable situation than nurses caring for elderly patients.
Methods: A cross-sectional study was performed among nurses working in palliative care (N=25) and nurses caring for elderly patients (N=50) using a self-assessment questionnaire. The inventory comprised test battery satisfaction (Rahe, Tolles, 2002), vital exhaustion (Appels, Mulder, 1988), social support (Caldwell, 1987), and workplace stress (Siegrist, 1996) questionnaires.
Results: In terms of social support palliative care nurses are in a more favorable position (P=0.048). Vital exhaustion tended to be higher among nurses caring for elderly patients (P=0.068), and the values of workplace stress are significantly higher for them than for nurses working in palliative care (P=0.034 on outer effort scale, P=0.035 on inner effort scale).
Conclusions: Interdisciplinary approach of palliative care, regular trainings and supervisions may promote nurses’ acceptance and appreciation, and greater social support may reduce nurses’ vital exhaustion and the degree of workplace stress. This model might be applicable for other groups of nurses as well.

391. Morphine prescribing by nurses. An evaluation of the impact of a morphine prescribing programme in Sub Saharan Africa

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Background: Nurse prescribing is undergoing major reforms in the western world expanding the prescribing powers of nurses, although still met with some resistance. In sub Saharan Africa nurses have been prescribing morphine since 2003. A lack of access to doctors coupled with large numbers of patients with cancer and HIV resulted in a programme to allow nurses to prescribe morphine. Following policy changes in 2003 nurses completing a 9 month Community Palliative Care Course at Hospice Africa Uganda can prescribe morphine. The study aim was to evaluate the impact of this prescribing.
Methods: A qualitative methodology using focus group interviews was adopted. A purposive sample of members from clinical, educational teams and current students from Hospice Africa Uganda were recruited to the study. 24 volunteers participated in 3 audio taped focus groups. Data was analysed for emerging themes using thematic analysis.
Results and Discussion: There was a general consensus nurses? being allowed to prescribe morphine was beneficial for patients, families and the clinical team. Benefits including pain relief and enhancing patients quality of life were noted. Economic impactof reduced travelling costs to obtain the morphine were stressed. Course students referred to initial concerns surrounding prescribing morphine and the importance of the course in preparing them for the role. This paper discusses these findings and potential explanations given.

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392. '24 hours a day'. Perceived need for 'out of hours' specialist palliative care advice

Karen Groves

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One of the key recommendations (15) of the National Institute for Clinical Excellence (NICE) Palliative and Supportive Care Guidance (Mar 2004) suggests that Specialist Palliative Care Advice should be available on a 24 hour, 7 days a week basis. Cancer Networks (of which there are 34 in England) are charged with the responsibility of drawing up specifications for this service for their own network area.

The Integrated Services Subgroup of Merseyside & Cheshire Cancer Network, Palliative Care Clinical Network Group, included in its workstream consideration of how this guidance might be met. As a preliminary to writing a specification, the group sent out a survey of all hospital and community services to ask about their experience of needing specialist palliative care advice out of hours and surveyed community and hospital specialist palliative care services to ask what "out of hours" services should look like and how they should be provided.

This poster presents the results of the survey and perceived need for "out of hours" specialist palliative care advice from both sides.

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393. 'Home or not home?' Documentation of Preferred Place of Care in Specialist Palliative Care

Catherine Wilcox, Alison Meehan, Karen Groves

West Lancs, Southport & Formby Palliative Care Services, Southport, United Kingdom

Specialist Palliative Care Services in West Lancs, Southport & Formby area use shared multiprofessional electronic clinical records. As a service we had recently agreed a standard place and way of recording the preferred place of care.

A three month retrospective audit was undertaken early on to establish whether team members were routinely recording the preferred place of care as had been agreed. Of 206 referrals to hospital, community and hospice during this period overall only 23% had the PPC correctly recorded.

This poster outlines the audit results and the actions which resulted from it to improve PPC recording.

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394. Hospital Consultant views on Palliative Care in the acute sector

Maire O'Riordan, James Adam

Marie Curie Hospice, Palliative Care Medicine, Glasgow, United Kingdom

Hospital Palliative Care Teams(HPCT) provide a liaison service and therefore much of their activity depends on how palliative care is perceived and used by hospital colleagues.?Aim: The aim of this project was to ascertain the views of hospital clinical consultants on palliative care in the acute sector.?Method: A postal questionnaire exploring consultants views on their own palliative care skills, on specialist palliative care provision and on the future direction of palliative care services was sent to 197 consultants in 2 Scottish teaching hospitals with 109 replies received (55%)?Results: 53% of consultants were caring for patients requiring palliative care. They were less confident in managing dyspnoea, psychological and spiritual distress. The main reasons for referring to the HPCT were symptom control (53%) and terminal care (47%). 91% believe that the HPCT has a role in the management of many non-malignant diseases. 73% believe that the HPCT should be involved with all dying patients.?Conclusions: Hospital consultants caring for a significant number of patients requiring palliative care are less confident managing psychological and spiritual distress but use the HPCT more for management of physical symptoms. They would like HPCT involvement with non malignant disease and for all dying patients. More evaluation and debate is needed on the state of general palliative care in the acute sector and on the future of hospital specialist palliative care

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395. Use of a Template to improve Documentation of Assessment

Niaz Memon, Karen Groves

West Lancs, Southport & Formby Palliative Care Services, Queenscourt Hospice, Southport, United Kingdom

Standardised assessment is a requirement of the NICE (National Institute for Clinical Excellence 2004) and Cancer Peer Review measures in the U.K.

West Lancs, Southport & Formby Palliative Care Services share multiprofessional electronic clinical records. A method of standardised recording using a template was agreed by all members of the clinical team to help to meet the requirements and to aid the easy retrieval of information quickly by any clinician.

Assessments should be recorded in a standard format of time : place : people present : physical : psychological : spiritual : social : insight/information : carers needs : plan : follow up (who, when, where).

A retrospective audit of the assessment records of 131 referrals were identified for a 2 month period May – Jun 2006.

60% had documentation as the agreed template. 26% had documentation under the majority of the headings suggested.

The poster displays the finding s of the audit and the actions taken to improve the recording using the assessment template.

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396. A nine month survey of home care vs. hospice care at the St. Lazarus Hospice in Krakow, Poland.

Tomasz Gradalski [1], Barbara Burczyk Fitowska [2], Ewa Nalezna-Chmielek [3]

[1-3] *St Lazarus Hospice, Krakow, Poland*

The St. Lazarus Hospice was founded in 1993. Since 1998, when the 30 bed hospice was opened, patients, who had been previously cared for at home only, have had the possibility of being admitted and spending their last days in the hospice. The aim of the study was to compare a group of 201 home care patients (HP) with 315 in-patients (IP) who died between Jan 1st and Sept 30th in 2006. Retrospective evaluation of their files revealed that both groups were comparable within the gender (56,7% females in HP vs. 52,4% in IP), age (mean 68,4 (32-96), median 71,0 vs. 69,4 (29-97), 71,0 years) and the longer length of care in the HP group (mean 45 (1-323), median 22 in HP vs. 29 (1-712), 13 days in IP). In the HP group there were more colon/rectum primary cancers (14,4 vs.7,0%) but less CNS (4,5 vs. 9,5%), head and neck (2,0 vs. 6,7%) and also non cancer patients (0,5 vs. 8,9%). The most common physical complains noticed were: pain (73,6% HP vs. 67% IP), weakness (73,6 vs. 93,7%), anorexia (35,3 vs. 70,2%), general discomfort (19,9 vs. 62,5%), dyspnea (28,4 vs. 35,6%) and depression (14,4 vs. 48,3%). There were marked differences between the most common drugs used: Morphine (55,7 vs. 49,5%), Tramadol (22,9 vs. 27,3%), Fentanyl (14,9 vs. 28,3%), steroids (29,4 vs. 56,5%), anxiolytics (37,8 vs. 49,8%), antibiotics (17,9 vs. 49,2%) and Haloperidol (14,4 vs. 25,1%). The small differences between HP and IP do not explain the marked disparities in physical complaints and the drugs used.

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397. Factors Influencing Referral to an Integrated Specialist Palliative Care Service

Jennifer Balls, Rachel Quibell, Anne Pelham, Andrew Hughes

Gateshead Hospitals and Primary Care Trust, Integrated Palliative Care Team, Gateshead, United Kingdom

Aims
To explore barriers to referral in order to improve equity of access to an integrated specialist palliative care service.
Method
393 questionnaires were sent to four groups of referrers - general practitioners, district nurses, hospital doctors and hospital nurses. The questionnaire sought both quantitative and qualitative information to explore understanding of specialist palliative care, practical barriers to referral and understanding of the integrated team structure. The study was approved by the Local Ethics Committee.
Results
The response rate was 51% of which 63% of respondents had previously made referrals.

Interim analysis of understanding of palliative care revealed that 26% of respondents did not know which patients to refer and 62% were unaware of the team's referral criteria. 22% believed that the palliative care team would only see cancer patients, and 27% were unaware that palliative care could be involved before the last 6 months of life

Practical barriers included a poor awareness of the referral form system and that telephone referrals would be preferred.

Analysis of understanding of the integrated team showed widespread misunderstanding of team composition, however the majority of respondents understood the concept of an integrated service.
Conclusion
This study has identified several areas which could be addressed in order to improve equitable access to specialist palliative care.

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398. Developing a breathlessness intervention service using the MRC framework for the development and evaluation of complex interventions.

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[2] *Addenbrooke's Hospital, Palliative Care Team, Cambridge, United Kingdom*

Aim of study:
To describe the role of the MRC framework in developing and remodelling the Breathlessness Intervention Service (BIS).
Method:
Phase I data (qualitative interviews with users of the pilot BIS: patients, carers, and referrers) were presented to the BIS to facilitate remodelling of the service. Following a period of remodelling, individual service providers submitted written evidence of service changes. These were mapped against Phase I data and a consensus statement on resulting changes to the BIS was developed.
Result:
Phase I found the pilot BIS to be a highly valued service by users (patients, carers and referrers). It identified aspects of the service that users regarded as positive, but also some that required further development. The resulting remodelling of the service addressed: redrafting of the patients' introductory letter to BIS; the location of care; the format of individual patient plans; the development of quality assured and accessible patient information leaflets; carer support; guidance regarding seeking medical assessment for changes in breathlessness; and enhanced inter-professional liaison. The remodelled service is being evaluated by a Phase II randomised controlled trial.
Conclusion:
The process of remodelling and identifying changes to the BIS provides a trail of evidence for the service's development made possible by the use of the MRC framework. This approach is recommended for other service developments.

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400. Minding the step between ward and home: A multidisciplinary team makes it safer

Rosmarie Pohjanvuori, Camilla Wedenby

Sahlgrenska University hospital, Department of Geriatric Medicine, Gothenburg, Sweden

Minding the step between ward and home:
A multidisciplinary team makes it safer
Occupational therapist Camilla Wedenby, Physiotherapist RosMarie Pohjanvuori Sweden We work as fulltime team members in Sahlgrenska hospital

palliative care unit. The persons admitted to the ward have usually made a significant loss in autonomy compared to earlier on in their illness.
In our assessment and training we from the start consider the possibilities for the person to return to their home. The timing of interactions is of big importance likewise how we present the solutions we see possible. We often make a visit to the person's home during the stay in our ward. Assessing the person in their home gives the team, the person and the family a platform to plan from. Often adjustments to the home environment and aid equipment can make living easier. We strive to find the best possible solution for the person and for the caretakers right now, in a few weeks and in the future.
The whole teams resilience makes adjusting the plan or the timing for discharge smooth, as well as our knowledge of resources the persons district have regarding palliative care. We find participating fulltime in the team process of great value, making it easier to help in making the step between hospital and home. This is demonstrated by a case study.

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401. "I wanted to die at home" A description of patients experiences of palliative home care at the end of life

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Background:
Many cancer patients wish to live and dye at home. The palliative home care team need to provide a well-organized structure of care to enable these patients and their relatives to feel secure and in control of the situation during the last period of life.
Aim:
The aim was to describe the patient's experiences of palliative home care.
Method:
This study includes seven patients. The Glaser & Strauss method "Grounded Theory" was used for analyse of interviews. They had all disrupted the home care and moved to a palliative inpatients ward.
Results:
The patients regarded the home care as equivalent to a job and it was very important to have a Self-image of being capable. It was also important to have control over the disease and knowledge of how the disease develops. All these factors had a positive influence to the palliative home care regime.In contrary no control over the disease or insecurity in the relationship with relatives or nursing staff decreased patient's self-image and made it difficult to stay at home.

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402. Should respite care be offered in a Specialist Palliative Care setting?

Joanna Bowden, Jennifer Pond

Marie Curie Hospice, Newcastle upon Tyne, United Kingdom

Aim:
To evaluate the respite service in a Specialist Palliative Care Unit.
Method:
A questionnaire was devised following a survey of professionals working within the service. Patients and carers were interviewed about admissions that had taken place over a six month period. The questionnaire covered several domains, including the reason for referral, how it had been beneficial, how things could have been done better and whether there were acceptable alternatives to respite in a specialist unit.
Results:
Two distinct groups of patients emerged from the survey. There were those who felt that their needs could only be met in a specialist unit, and often these patients had complex needs and advanced disease. Others saw the main benefit of their stay as the company and support, and felt that they could be cared for adequatley in a non-specialist setting.
Conclusions:
There is clear controversy about whether respite should be offered in a Specialist Palliative Care Unit. This survey highlights a group of patients for whom it may be both appropriate and justifiable, given the complexity of their needs.
We plan to undertake a more comprehensive, multicentre study to investigate this further and hope that from this we will be able to offer some local, and potentially national guidelines.

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403. The impossible challenge? Palliative care in the Emergency department

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[2]*University Hospital, Palliative Care Team, Bobigny, France*
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One of the main issues concerning the quality of care at the end of life is rising in the Emergencies hospital Departments (ED). This is a frequent place of death to day.

The aim of the paper is to assess the main palliative care issues and present a local response.

The method is based on the review of the scientific press on "palliative* care in the ED and on various fieldworks we conducted.

Scientific literature is poor on this subject.

Who are the "palliative patients"? Are clearly identified as "palliative patients" those at the terminal stage of a chronic illness and/or near agony. In the literature as well as in our fieldwork observations, the main physician's concern is then to define gravity index to anticipate the death time.

What are "palliativepractices»»? ED physicians are concerned by the risk of futility care.

Palliative care means pain treatment, most of the time via morphine and palliative sedation. There is no collective decision making on palliative care among doctors and nurses. Moreover the attitudes of individual physicians differ strongly on this matter.

These results highlight a restrictive P C. representation linked to the culture, the education and the work organisation in the ED. These issues have led ED caregivers and the Hospital Pain Control Committee to constitute a working group to advance improvements of the end of life care in the ED.

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404. Dying of occupational cancer :what effects has the compensation process on the caregivers ?

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Since March 2002, SCOP 93 has been a multidisciplinary network investigating occupational exposures to carcinogens of cancer patients in a suburb of Paris, through job history reconstitution and expertise, then providing an Initial Medical Certificate necessary for the patient to claim for recognition and compensation.
Aims: to assess the impact of the compensation process on the care trajectory till death and on the socio-economic family situation and bereavement process.
Method
1. Reconstitution of the care trajectory till death: national mortality register enquiry, medical sheets and interviews with the various care givers.
2. Interviews with families, 3 months after the death, to assess the impact of the compensation process on the financial situation and on the bereavement process, according to the stage of the compensation process.
Results :
The mortality rate is high. At the end of 2005, 31% of the 457 patients exposed to cancerigens were dead, 50% had died before the compensation process achievement; 41% did not claim for compensation.
We will present the results of the caregivers' survey : reconstitution of the care trajectory till death, knowledge of the compensation process of the caregivers and impact according to the caregivers at the end of life (cancer specialists, GP or palliative networks).

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405. The Preferred Place of Care patient assessment tool: Findings from the first 100 cases undertaken in England

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

Background: Preferred Place of Care is an intervention promoted within the NHS End of Life Initiative for England. In offering terminally ill patients, their carers and healthcare professionals the opportunity to consider, discuss and record preferred priorities for care, PPC aims to support patient choice and preferences at the end of life. **Aim**: To analyse the first 100 PPC assessments undertaken by healthcare professionals. To summarise emerging patterns and variations in the implementation of PPC. To consider the implications of findings for national policy. **Method**: A quantitative & spatial analysis of a Cancer Services Network PPC dataset, along with a qualitative thematic analysis of free text data from a 20% sample of returns. **Result**: PPC identifies patients' and carers' preferences for care location at the end of life. 73% of patients expressed the wish to only die at home, of which 68% did so. 30% of those assessed died within a week of assessment, 68% within a month and 81% within 2 months.
Conclusions: Discussion about choice at the end of life, personal wishes over place of care and death, and issues of service access have far reaching implications for healthcare providers and models of palliative care. Findings have implications for consideration of the stage of a terminal illness trajectory at which a PPC assessment should be implemented, as well as how PPC could be undertaken. PPC provides healthcare professionals, patients and carers, internationally, with an adaptable tool that could promote patient choice and preferences.

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406. Continuity of Care for Community Palliative Services

Frances Legault[1], Kevin Brazil[2], Sheila Bauer[3], Pippa Hall[4], Liliane Locke[5], Lynda Weaver[5], Barbara Cameron[3]

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[3]*Ottawa CCAC, Palliative Care at Home, Ottawa, Canada*
[4]*University of Ottawa, Faculty of Medicine, Ottawa, Canada*
[5]*SCO Health Service, Palliative Services, Ottawa, Canada*

The aim of this study was to implement and evaluate multiple interventions (service planning, physician referral and support, and communication) to optimize continuity of care in a community-based palliative care program in Ottawa, Canada. Three types of continuity were evaluated: 1) Management Continuity (consistency of care and responsiveness to changing needs of the client and family caregivers); 2) Relational Continuity (on-going client-provider relationships and consistency of provider); and 3) Informational Continuity (efficient and effective transfer of information and accumulated knowledge of the client). A case study research design was utilized to systematically collect and synthesize information to provide a complete description of the contribution of the specific interventions on continuity of care. Data collection included quantitative and qualitative approaches incorporating six primary sources: clients and family caregivers, home care nurses, family physicians, home care case managers, program documents, and client charts. Although there have been several initiatives to promote continuity of care, there has been little scientific research to develop and apply direct measures of continuity from the client and caregiver perspectives and to measure continuity over time and across organizational boundaries. Findings and recommendations for practice and policy will be presented. (Funded by the Canadian Institutes of Health Research.)

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407. A spatial analysis of regional inequalities in the location, organisation and availability of adult inpatient hospices, and hospice inpatient beds, across the United Kingdom and Ireland.

Justin Wood, David Clark

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Background: United Kingdom hospices have developed with the support of local communities, their national coverage unplanned. There has been criticism that such ad-hoc development has led to the inappropriate location of some services
Aim: To summarise the location, organisation type, availability and size (beds) of UK adult inpatient hospices by region and the broad geographic areas for which care is provided. To analyse regional variations in availability against population & death data. To link availability to measures of deprivation & hospice neighbourhood geodemographics.
Method: A quantitative spatial& GIS map analysis of adult inpatient hospices (an ongoing PhD).
Results: UK regions vary widely by geography, size, population density, diversity & health. Hospices, with notable exceptions, cover major conurbations. Wide regional variations or inequalities in adult hospice & bed availability are apparent, from 14.5 to 26.0 beds per 1000 cancer deaths across English regions. The proportion of hospices located in the most deprived 50% of a region varies from 18% to 71%; such inequities in availability, based on underlying deprivation, highlight unanticipated differences.
Conclusion: Hospice accessibility has implications for the establishment of further hospices and highlights the need to consider the remit of alternative palliative care services in areas without local access. The mapping of services & catchments, when combined with analysis of equity of access based on local need, provides policy

makers internationally with a powerful tool

408. Development of a Municipal Palliative Care Program in the Public Health Department in Rosario, Argentina.

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[2]*Palliative Care Program, Edmonton, Canada*

Introduction: Rosario is a city in Argentina with a million inhabitants. The municipal public health serves 300,000 people, with around 500 deaths per year due to cancer. The Municipal Palliative Care Program was created in 2004, consisting of the Adult Palliative Care Unit (UCPAR), Pediatric Palliative Care Unit (UCPP) and the Domiciliary Palliative Care Unit (UCPD). **Methods:** Data from all patients admitted to the program from 2004 to 2005 was reviewed. Opioid consumption was evaluated and compared to the year before the creation of the program. The percentage of the palliative care population seen, waiting time for admission to the program, symptom control using the ESAS and home death rate were also evaluated.**Results**: Opioid consumption increased 341%, with 41.6% of the palliative population seen by the Program. Waiting time for admission was one day (mean). Adequate symptom control was achieved in over 50% of the patients for pain, dyspnea, nausea, anxiety and mood. Home visits were provided to 41.82% of the patients, and home death was achieved in 66% of the patients admitted to the UCPD. Of note, 39% of the patients admitted to the UCPAR and 100% of the patients admitted to the UCPP died there.**Conclusion:** It was possible to provide interdisciplinary palliative care services with little waiting time, good home support and good symptom control, increasing opioid consumption. The goals are to increase access to the service and to extend this care to non-cancer patients.

409. Better Late than Never? The Impact of Late Referrals upon the provision of Community Palliative Care

Philip Macaulay, Sylvia Spicer, Trish Sutton, Kath Savona, Jane McGuire, Helen Vaz, Stephen Brooker

Sacred Heart, St Vincent's Hospital, Palliative Care Centre, Sydney, Australia

The Late Referral Project (LRP) is an initiative that commenced at the beginning of 2006 to try to minimize the often-stressful impact of a Late Referral to the Community Palliative Care Team (CPCT) upon the patient, the staff and the service as a whole. The LRP sought to ascertain the external pathways for LR's so that they might be monitored and the reasons for lateness examined. The assumption behind the LRP was that LR's are stressful for the staff involved, requiring complex coordination and sometimes have a less than optimal outcome for the patient . The aims of the LRP were to try and improve the quality of service provided by staff, and also the quality of support delivered ***to*** staff in difficult and stressful situations. The LRP carried out a literature search, a staff survey, a clinical file audit and together made a series of practical arrangements within the functioning of the team to deal with LR's when they arrive. In addition, the LRP, for the first time, collated the results and defined a LR to a Palliative Care Service as being *"14 days from referral to death"* and as*"the inability to optimally respond to the needs of the pt and family due to the limited time available for best practice planning and implementation prior to death."*

410. How do you persuade patients, staff and volunteers in a successful Day Hospice attached to an Acute In-patient Palliative Care Unit, that service delivery processes must change to accommodate a new economic reality?

Kate Thompson[1], Bee-Wee Leung[2]

[1] *Sir Michael Sobell House, Palliative care unit, Oxford, United Kingdom*

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MethodFollowing staff cuts, a step-wise iterative approach using process mapping, focus groups and working groups identified changes which are now being implemented. **Results** Process mapping identified bottlenecks, which interfered with patient flow, and issues of equity regarding access to complementary therapies and recreational activities. Whilst focus groups highlighted the supportive environment, the sense of belonging and the safe environment, they also identified areas for improvement. Specifically, there were opportunities for improvement in documentation (concerning referral criteria, expectations of placement and discharge), equity of access and staff skill mix. **Discussion**Whilst process mapping proved to be efficient in demonstrating bottlenecks in patient flow and equity, the process proved a challenging experience for the team. Although an invitation was made to all stakeholders to join relevant focus groups, bias may have arisen through self selection. Nevertheless, suggestions concerning changes in patient flow, practice and equity of access have been approved and implemented. This is a work in progress; new approved documentation (for referral, invitation and assessment) and a reorganisation of service delivery will begin in January 2007. Six month follow up outcome data will be available for presentation at the EAPC Congress

411. Support in palliative care for general practitioners (GPs): a telephone advisory service project by specialised GPs in the Netherlands (2000-2003)

Florien Heest van[1], Ilora Finlay[2], Renee Otter[1], Betty Meyboom-de Jong[3]

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Many patients with a life-threatening disease wish to die at home.
The region covered by the Comprehensive Cancer Centre North-Netherlands (CCCN), is a predominantly rural area with a population of 2.1 million, about 1000 GPs, 17 hospitals and 5500 cancer deaths per year. Access to cancer therapy and disease modifying therapy is well organised. 61% of all patient deaths in 1998-1999 occurred at home. In 2000 the area had neither hospices nor nurses or doctors working as specialists in palliative care.
The aim of this project was to organise rapid access to palliative care advice for all GPs caring for patients dying at home. We describe a novel type of support for GPs: the establishment and evaluation of a telephone advisory service for GPs, run by four regional working GPs with a Special Interest (and training) in palliative care (GPSI).
A growing number of GPs called for advice starting with about 100 calls in 2000 up to almost 600 in 2003; 10% during out of hours. Calls lasted 15 minutes (mean) and sought advice on patients of all age-groups (mean age 62 yrs, range 0-100), usually in the last phase of illness (prognosis days - weeks in 70%). Most advice sought concerned symptom management, discussion revealed more other problems. On evaluation, 85 % of the GPs followed the advice.For instance the use of subcutaneous infusions at home tripled.
Conclusion: the advisory service seemed to fulfil a need for support of GPs caring for patients dying at home.

412. Palliative Mobile Team in a Shelter for Homeless People

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[1] *Hungarian Hospice Foundation, Budapest, Hungary*
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Objective: After the fall of communism, the group of homeless people emerged in Hungary in the wake of radical changes in social life. This is the group in the perhaps worst physical condition where illness is often discovered at a highly advanced stage. The cooperation of the Hungarian Hospice Foundation and the Budapest Shelter for the Homeless is an effort to offer palliative and hospice care for homeless people in the terminal phase of their illness. Also, it seeks to change some of the widespread confirmed attitudes of nurses towards this highly disadvantegous group. **Method:** From 2004 on, members of the multi-disciplinary team of the Hungarian Hospice Foundation visit the Shelter once a week. Physicians, nurses, psychologists, physiotherapists and voluntary workers offer palliative care to terminally ill patients in an effort to preserve the dignity of life. Once a week, we organize art therapy sessions for outpatients of the night-shelter. We also organize trainings for the local staff and the Foundation provides the opportunity of field practice at the Budapest Hospice House. **Results:** In the last years we nursed a total of 76 patients. 45 persons took part in the art therapy sessions, and 10 professionals in our trainings and field practices in the Budapest Hospice House.
Conclusions: The palliative mobile team is a new and very effective kind of care for homeless people who belong to the perhaps most disadvantegous group in society. The palliative mobile team has established a new attitude in the care of this helpless group.

413. How does proximity to a hospital/hospice relate to place of death from cancer?

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Background: The percentage of UK home deaths has decreased with more deaths in institutions. Many factors, including social deprivation, which may influence this, have been reported. **Aim:** To examine relationships between place of death, deprivation index, and proximity to an institution, for cancer deaths in Sheffield, UK. **Method:** For the period 1997-2002, data was collated on deaths at home, in a hospice, or elsewhere, for the 29 Sheffield electoral wards. Deprivation indices and standard distances from each ward to the main city hospitals and hospice were obtained. Spearman's rho correlations were calculated. **Result**: The correlation between home deaths and deprivation index was weak (Spearman's rho: 0.312) and not statistically significant (p=0.099). There were significant negative correlations between death at the hospice and deprivation (Spearman's rho:-0.697, p=0.001); and death at the hospice and distance from it (Spearman's rho: 0.566, p=0.001). A weak but significant correlation was seen between distance to hospital and death in hospital or other institutions (Spearman's rho:-0.398, p=0.032).
Conclusion: Our findings did not confirm a negative correlation between death at home and deprivation index in Sheffield, but suggest that proximity to facilities, particularly hospice, may influence place of death. Wider ranging study may differentiate and quantify the influence of proximity of hospices and hospitals on place of death.

414. ONGOING PALLIATIVE CARE IN PRIMARY HEALTH CLINICS

Yifat Rave[1], Sharon Wynne[2], Rivka Golan[3]

[1–3] *clalit health service, Community Health Service, haifa, Israel*

Rational
Oncology patients throughout all stages of the disease suffer from a variety of symptoms requiring palliative care. Despite the fact that they undergo treatment in hospital, they spend most of their time at home.Contact with their primary health care givers is usually minimal at this time. Patients approach the hospital staff with all their problems. Not all oncology patients are known to the clinic nurses therefore the nurses are not able to meet all their needs.
Aim Improve the connection between clinic nurses and the oncology patients. Empower the nurses in taking care of oncology patients.
Process Nurses from community health clinics were chosen to manage the care of oncology patients. The nurses underwent courses in palliative care to acquire the required skills. Computer lists of oncology patients were sent to these nurses twice a year. The nurses coordinate the care according to the patients' special needs with the primary care physician and the hospital staff as necessary. Data on the nurses' activities is reported back to the Head Oncology Nurse once a year.
Conclusion This project is now carried out in all clinics in the region. Nurses report contact with about 90% of the oncology patients. They feel satisfied and empowered being capable of responding to most of the patients' needs. It was shown possible to give ongoing palliative care throughout all stages of the disease in the community.

415. Consultation in palliative care; how to improve quality?

Erica Witkamp, Mathilde Van der breggen, Pascalle Voerman, Janneke Koningswoud, Jorien Van der doel, Lia Van zuylen

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Introduction
In the Netherlands the Comprehensive Cancer Centres (CCC) organises consultation in palliative care. To develop and improve the quality of the consultation, the CCC of Rotterdam (CCCR) recently set up the Committee for Quality Improvement of Consultation in Palliative Care (the Committee).
Method
Consultants from the region ,a representative of the CCCR and the Erasmus MC participate in the Committee. Target is to monitor and improve the consultation by increasing knowledge and expertise of regional consultants and by optimizing the organisation.

Results
Main topic has been the operationalisation of three spearheads of the national framework for quality in palliative care consultation. A checklist for consultation reports, requirements of expertise of consultants and their team and guidelines concerning access to palliative care advice were elaborated by consultants supported by the Committee. Furthermore, activities were initiated to develop education for the regional consultants as well as for GPs and nurses. The Committee actively advised the CCCR about changes in the organisation of the palliative care consultation in the region.
Conclusion
The Committee stimulates the elaboration and implementation of the national framework and the development of educational courses. Initiative, structure and coöperation with regional consultants are keywords which make the Committee the motor of quality improvement of consultation.

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416. Old and Given up for Dying? Multidisciplinary Palliative Care Teamwork in the Nursing Home

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The palliative care unit in our nursing home (NH) opened June 2000 to ensure excellent palliative care for elderly with extraordinary needs and their relatives. Physician and nurse have ward rounds daily. Once a week, patients needs are discussed in a multidisciplinary team, consisting of nurses, physicians, physiotherapists, ergotherapists, priest, social worker, musictherapist and volunteers. On long-term units, ward rounds are organized once a week; palliative care needs are discussed in the multidisciplinary team on demand. *Aim:* A prospective study investigated multidisciplinary needs of patients admitted to palliative care (n=68) compared with those on long-term wards (n=82). *Method:* Demographic data, need for multidisciplinary teamwork and pain- and symptom management were registered. *Results:* Basic palliative care can be implemented on every NH ward. Patients with extraordinary needs benefit from specialised services of a multidisciplinary team. *Conclusion:* All NH patients should have access to basic palliative care. The challenge is the skill and training of the caring team and the need for teaching is imminent. NH staff must have basic knowledge and training in palliative care of the elderly. Special units with experienced physicians, nurses, etc. are helpful in caring for complicated cases and can prevent the need for hospital care.

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417. Family Physicians as an Enabler or BArrier to Palliative Supportive Cancer CAre

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Family physicians are in an ideal position to monitor the supportive cancer care needs of their patients. Considering this potential, it was questioned whether family physicians act as enablers or barriers to their palliative patients' supportive cancer care needs being met.

A mailed survey was sent to all non-oncologist physicians in a representative region of Ontario, Canada. The unadjusted response rate was 65% (91/140). Just over two-thirds 68.2%) of physicians reported assessing need and either providing or referring pecifically for palliative care. While a majority of physicians reported assessing need and either providing or referring for pain and symptom management (88.6%), emotional support (84.1%), nursing care (86.4%), and homemaker services (86.4%), this extent of care was not evident for needs such as hospice care (36.4%), group counselling (47.7%), or professional counselling (50.0%). A large number of physicians neither assessed, provided, nor referred for hospice care (43.2%), group counselling (27.3%), or professional counselling (25.0%). For the other SCC needs examined, most physicians reported assessing and either providing or referring for needs related to equipment (81.8%), nutrition (72.7%), treatment information (70.5%), and supportive care information (79.5%). Implications of these care practices as enablers or barriers to cancer patients accessing needed SCC services are discussed.

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418. Development of the Palliative Care (PC) in Latvia (2004-2006)

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Introduction. PC as a system in Latvia started in 2004. Data base analysis is needed to plan 1) the number of the in-patient beds, 2) outpatient service capacity, 3) the budget.
Sources of the study. 4 data base sources were used: a) Sickness Funds of Latvia, b) Registry of Cancer Patients, c) Department of Information, LOC, d) data from 7 PC units.
Results. In 2004 from all 52 022 cancer pts 9 395 or 18.05% needed active PC. From 9 395 pts, 1 132 or 12.1% were hospitalized at the PC units, not admitted 8 262 pts or 87.9%, receiving support either in general hospitals or within the primary care by GPies.
From 18 to 20% of all cancer pts needed active PC support; 4 000 pts in Riga, 6 000 outside Riga.
According the Masterplan until 2010 there should be 125 in-patient beds or 5 beds/ 100 000 inhabitants.
PC in-patient beds in Latvia:
2004 – 80 beds, admitted 1 132 pts,
2005 – 80, 1 588 pts,
2006 – 100, 1 503 pts (during 8 months),
2006– 2010 + 25 in-patient beds.
From 25- 40% of PC pts are planned to be admitted at the specialized units; from 60 to 75% should receive active PC on outpatient or primary care basis. In Riga about 25% out of 4000 pts were consulted on outpatient basis in 2004 and 2005.
The budget in PC:
In 2005 it was EUR 280 205. 71.
In 2006 - EUR 752 615.71. The increase in the budget is 37.2% per year.
Conclusions. PC model should be planned taking into account: 1) data base analysis, 2) current needs in PC, 3) motivated financial background, 4) in-patient and outpatient PC service balance.

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419. Trends in Place of Death of Cancer Patients in Taiwan

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Although many patients with cancer would prefer to die at home, most die in hospital. We carried out a study to describe the yearly trends in the place of death between 1981 till 2004 and to explore the associated factor of home death for adults with cancer in Taiwan. In this population-based study, we used administrative death certificates data for all adults in Taiwan who died of cancer between the periods. We used logistic regression analysis to identify the odds of dying at home over time and to identify factors predictive of home death. A total of 2,620,284 adults died of cancer during the study period. Among 563,153 who died of cancer (21.5%), 347,777 (61.8%) died at home, 204,952 (36.4%) died in hospitals, and 10,424 (1.8%) died at other places. Over the study period the proportion of people who died at home fell by 16%, from 66.1% in 1981 to 57.0% in 2004. Predictors associated with home death included year of death, female sex, age of death, tumor group, and region of death. Over time, more patients with cancer, especially women, elderly people and people who lived in the urban areas, would like die at home in Taiwan.

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420. Building up a palliative care (PC) service in Slovene cancer center Institute of Oncology (IO) Ljubljana

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Institute of Oncology, Ljubljana, Slovenia

Introduction: IO, established in 1937, is the only comprehensive cancer center in Slovenia with diagnostic, therapeutic (320 beds), research and education facilities. All of these followed the state of art treatments and technologies, but PC was neglected. To improve PC, we started to implement modern principles of PC in 2005. A multi professional team and consultation services were established. Guidelines for symptoms assessment and management were introduced. Our aim is to report the burden of PC pts. and the impact of PC programs.
Methods: We made a survey of the burden of PC pts. at the Department of Radiotherapy (DRT) and Department of Medical Oncology (DMO). We evaluated how symptoms were recognized, recorded and managed before and after the PC programs were established.
Results: In 2005 there were 30.000 inpatient admissions at DRT and 21.500 at DMO, of them 40 % and 30 % for PC, respectively. The median numbers of symptoms before 2005 and in 2006 were 2 and 4, respectively. Many symptoms that were neglected, underestimated and untreated in the past, were now recognized, recorded and treated. Some of them were managed significantly better. Great improvement was achieved in psychosocial and spiritual support for both, pts. and their families.
Conclusion: High proportion of pts. is admitted for PC, because a PC network is not in place in our country. With implementation of state of the art principles of PC, better assessment and management of symptoms can be achieved.

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421. Palliative Daycare in the Netherlands - a new initiative

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For some European countries palliative daycare is a well known service. In the Netherlands it is a new phenomenon. Agora, the Dutch support centre for palliative care organized an invitational conference on palliatieve daycare in May 2005. In 2006, five organizations that are planning the set up a palliative daycare service set out a questionnaire to investigate the attitude towards palliative daycare amongst referrers in their region.
Aim of the project: To determine the attitude towards palliative daycare amongst referrers (mainly general practitioners) and to determine their referral criteria.
Method: a questionnaire survey
Result: Amongst referrers is expected that daycare can be a positive contribution to the existing palliative care services in the region. They want to referrer patients to daycare in case of physical, psychosocial and spiritual needs and for respite for family and carers.
Conclusion: Referrers seem to have a positive attitude towards palliative daycare services in which attention is paid to physical, psychosocial and spiritual aspects.

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422. Palliative care consultation in a Psychiatric Department

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EMASP, CESCO, Rehabilitation and Geriatrics, Geneva, Switzerland

Aim of the study: To determine the main characteristics of patients hospitalized in the psychiatric Department seen by the palliative care consultation (PCC).
Method: review of the PCC records over a period of 6 years (2000-2006).
Results: 76 new consultations were reviewed. 53 patients were male. Mean age was 79 years (range 34-96). 63 patients had severe dementia, 26 had cancer (16 had also dementia, 10 severe depression or anxiety). Reasons to involve MPCT were the impact of pain on behavioral troubles in patient with severe dementia (37), symptom management (pain, dyspnea, anxiety and fatigue) (21) in patient with advanced cancer, transfer in a palliative care unit (10) and finally some ethical questions about artificial nutrition and hydration (3). Our recommendations concerned introduction (30) or adaptation (17) of analgesic treatment with careful pain assessment, introduction of drugs for symptom relief like dyspnea, death rattle, mouth care, constipation (19), transfer in palliative care unit (4) and organization meeting with the whole team to discuss the ethical questions (3)
Conclusion: These results should encourage the development of palliative care in psychiatric departments for patients for patients with severe dementia, but also for patients with an advanced oncological disease who suffer also from dementia or a concomitant psychiatric disease.

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423. Case Management in Palliative Care

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Aim of Project: Growing complexity of Palliative Care (PC) services and patient needs lead to the necessity of better coordination. Therefore a specific Case Management (CM) position was created. This study aimed to identify the range of tasks for CM in PC.
Method: A mixed methods approach was used:

problem centred interviews with PC professionals and Case Managers from other departments as well as case studies by participant observation (three respectively) were qualitatively analysed. Quantitatively, the new contacts to CM by telephone-hotline were analysed by descriptive statistics. **Result**: The range of tasks of CM in PC can be subsumed in the theoretical model of CM including intake, assessment, planning, intervention, monitoring and evaluation. However, specific features of CM in PC could be identified that result from limited life expectancy, rapid changes and the multiprofessional concept. The first 300 new contacts after implementation of CM came from internal staff (40%), patients/caregivers (38%) and external services (22%). The range of contents included: admission (43%), outpatient PC service (10%), hospital support team (17%), information about hospice and PC (15%), psychosocial problems (5%), pain and other symptomcontrol (10%). **Conclusion**: CM meets a wide spectrum of needs which has to be coordinated within a multiprofessional team. This coordination can be optimized by a specific CM position. The development of an adequate qualification for CM in PC is essential.

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424. A National Survey of Patient Satisfaction with Hospice Services in the UK

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National Minimum Standards for Independent Healthcare (DoH 2002), states hospices should conduct annual patient surveys. The NICE Guidance "Improving Supportive and Palliative Care for Adults with Cancer" highlights the importance of patients informing the delivery of services (NICE 2004).

A patient satisfaction survey was conducted across 53 UK hospice inpatient (IP) and daycare (DC) services, at discharge from service, or after 2 months attendance at daycare, for return to an independent academic institution.

1398 questionnaires were returned from DC patients and 926 from IP. High levels of satisfaction were reported for the general environment (84-86%), cleanliness (83-88%), catering (70-75%) and transport (84%). 53% of DC and 62% of IP reported that information leaflets were easy to understand and helpful. 75% of DC and 68% of IPs always understood explanations about their care, both expressing high levels of confidence in staff. 78% of IP reported sufficient opportunity to ask questions and 68% in making decisions about their care. 7% DC patients felt unsupported when a group member died or was discharged.

Overall, patients reported high levels of satisfaction with services, however hospices are encouraged to identify action plans for areas of lower satisfaction, compared to nationally benchmarked data. Examples of resulting actions for service improvement will be discussed. Future work includes development of a questionnaire for clients with learning disabilities.

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425. Open All Hours? A Study of Visiting in the Hospice Setting

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Introduction A policy of open visiting, where no restrictions are placed on visiting times, is often advocated within palliative care. The visiting policy may directly affect the care of a patient and may impact on the family and the multidisciplinary team. **Aim** To explore whether the current open visiting policy reflects the needs of patients and staff in an inpatient hospice unit. This abstract describes the patient strand of the study. **Method** A qualitative approach was adopted. Semi-structured interviews were carried out on a purposive sample of ten patients. The data was thematically analysed. **Results** Three main themes emerged: 1. The importance of visiting; 2. The effect of physical and psychosocial state on perception of visiting; 3. Control of visiting. In general, patients appreciated the benefits of visiting and the flexibility of open visiting. However, most patients felt the need for some control over visiting and for a degree of formal restriction to visiting times. There appeared to be some links between the first two themes: both concern factors that influence the enjoyment of the visiting experience, e.g. the relationship between the patient and visitor (theme 1) and the patient's state of wellbeing at the time of visit (theme 2).**Conclusion** The results suggest that the present visiting policy should be reviewed. The second strand of the study is in progress and will ascertain staff's perception of visiting.

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426. Home Zoledronic Acid (HZA) treatment in patients confined at home for bone metastases. An observational trial.

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Background. To assess safety and feasibility of HZA, an observational trial has recently concluded.**Methods.** All the patients with bone metastases and confined to home were included into the trial. All the patients were treated with HZA 4 mg and included in a comprehensive program of home care. Primary end point was safety of the treatment at home; secondary one was time to treatment failure (TTF) on the basis of patient's characteristics.**Results.** 42 patients were considered eligible and enrolled into the trial. 220 home treatments were administered in three years, with a median of 4 administrations per patient (range 1-28). TTF was 130 days; the main reasons of interruption were worsening of performance status (71.4%), length of treatment>24 months (4.8%), hypocalcemia (2.4%), renal failure (2.4%). No difference in TTF were observed between patients with breast cancer, multiple myeloma or the other tumors, nor a prognostic significance were observed for the kind of tumors, age, sex and number of extra-osseous sites of disease. No acute major side effects were observed during the treatment, and the treatment had to be interrupted for side effects in 2 patients (4.8%). Jaw osteonecrosis was observed in 1 patient (2.4%).**Conclusions.** Our experience seems to confirm the safety of HZA, suggesting a possible new setting of patients in which using the treatment. The identification of a criterion to select patients that really benefit by HZA will probably be needed to favor its appropriate use in clinical practice.

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427. Security box in out-of-hours palliative home care - how does it work?

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Aim of study
Our hospital based palliative care team provides palliative home care in collaboration with the community nurses. The team works office hours but there is a need for symtom management all around the clock. We designed a box containing drugs for pain, anxiety, nausea and excess secretions ie mainly morphine/hydromorphone, lorazepam, midazolam, metoclopramid and morphine-scopolamin. All drugs could be given non-orally and individualized. A written order followed the box. We wanted to know how the community nurses perceived the box and how it was used.
Method
A questionnaire was sent to the community nurses in our area with the following questions: Do you find the orders easy to understand? Do you miss any drug? Have the drugs had the desired effect? Do you have enough knowledge of the drugs? Have you received proper information by the palliative care team concerning the use of the box? We also recorded all used drugs.
Results and conclusions
77% of delivered boxes were used for symtom relief during the last days or weeks of life. The most common used medication was mouth-soluble lorazepam, followed by morphine, hydromorphone, morphine-scopolamin, midazolam and metoclopramid. No other drugs were asked for except for a few requests for diazepam due to unfamiliarity with midazolam. The majority of nurses were content with the box. A security box in the patient's home seemed to be a prerequisite for palliative home care and the content of the box appropriate.

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428. INPATIENT HOSPICE CARE FROM THE RELATIVES' POINT OF VIEW

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The aim of the study was to evaluate two in-patient hospices by interviewing relatives of patients who had died there. Relevant topics were the decision about the patients' referral to the hospice, the previous knowledge of family members of the cost sharing and the quality of care as seen by the relatives. For every patient who had died at the Albert Schweitzer Hospice and the Helga Treichl Hospice in 2005 a close relative was identified. Finally 100 available persons took part in the standardized interview which was performed by telephone in 2006.Results: 90% of family members were involved in the decision about the patient's referral to the hospice, 31% were pressed for time. In about half of the cases the in-patient hospice care had been recommended by the staff of a referring hospital. Almost all family members had previous knowledge of the cost sharing and more than 90% of the relatives were satisfied with the medical and emotional support the patient received. However, there was a lack of information on the support provided for relatives at the hospice in the period after the patient's death, so only the minority benefited from it. Although there is uncertainty about the extent to which the views of relatives reflect those of the patients themselves, there is evidence of the high quality of the patients' care, but more information has to be given to the relatives on the support provided at the hospice after the patient has died.

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429. Equity of access to community palliative care services

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Aim: Access to palliative care services appears inequitable, but for unclear reasons. This research explored influences on palliative care referrals within three UK primary care organisations.
Method: Three case study sites in NW England were studied. Multiple sources of evidence included 57 interviews with patients and palliative care providers, observation of referral meetings and analysis of case notes and other documents. Framework analysis techniques facilitated the development of a thematic framework, the amendment of theoretical propositions, and pattern matching within and across cases.
Results: Two issues appeared to affect professionals' perceptions of equity:
1) ***'I treat everyone the same'*** Palliative care professionals presented themselves as approaching everyone's care equitably, without overt discrimination. However, this approach did not mean that everyone received the same care, rather that their way of 'treating everyone the same' was to offer everyone individualised care.
2) ***'It depends what they want'*** Care given was individualised, based on both the professionals' assessment of care needs, and their interpretation of patient and carer choice.
Conclusion: Palliative care professionals offered different levels of care, conceptualised as responding to needs in an equitable, yet individual way. Inequitable access may therefore not be overt discrimination, but related to different care needs.

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430. "Ownership" of patients: does this affect access to services?

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Aim: Ownership is under-researched, yet could potentially confer advantages to caring professionals, or affect patient referrals. This research explored palliative care referrals within three UK primary care organisations.
Method: A qualitative case study strategy was adopted, purposively selecting three sites in North West England with different patterns of palliative care provision.

Multiple sources of evidence included 57 interviews with patients and palliative care providers, observation of referral meetings and analysis of case notes and other documents. Data were coded, charted, mapped and interpreted, developing a thematic framework and theoretical propositions. Framework analysis techniques facilitated pattern matching within and across cases. **Results:** Concepts of ownership were closely bound to the interrelated issues of responsibility for, and relationship building with patients. Medical professionals highlighted a sense of responsibility towards patients, whereas nursing professionals worked to develop a relationship with patients. District nurses in particular used possessive terms to outline ownership of patients. This had variable effects, either leading them to act to restrict others' access to that patient, or giving them a basis to share care.
Conclusion: Ownership was acknowledged as an important concept by healthcare professionals, and appeared to have an effect on how professionals referred patients onto other services.

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431. Hospice Casa Sperantei - A Beacon of Hope in Romania

Alison Landon

Hospice, BRASOV, Romania

Hospice Casa Sperantei has led the development of palliative care in Romania. It began as a local initiative but is now an Eastern European centre of excellence. The Hospice has evolved a range of local clinical services: inpatient units, outpatient clinics, day centres and home care teams for both adults and children; breast prosthesis clinic, stoma therapy clinic, children's education project; and hospital support teams. The education centre in Brasov and the national resource centre in Bucharest actively promote palliative care training for all members of multidisciplinary teams both from Romania and other Eastern European countries. The influence of the hospice on government policy has resulted in national palliative care standards; recognition of palliative care as a sub-speciality which is now included in medical undergraduate education; service contracts with local health authorities and most recently new legislation covering the prescription of opioids. Nationally palliative care services are expanding but a coherent national strategy is still urgently needed. Funding is the critical constraint.

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432. 'Home Sweet Home' Audit of all cancer deaths across all health care settings

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The NHS Cancer Plan 2000, included palliative care education for District Nurses to support its aim of trying to allow more people to die at home if that was their wish.

In West Lancs, Southport & Formby area, despite widespread education of District Nurses, GP Registrars, Health Care Assistants and others integral to home care, and good provision of community services, the number of home cancer deaths continued to fall whilst the number of hospital cancer deaths continued to rise.

A 6 month prospective audit was undertaken to look at all cancer deaths across hospital, home, hospice and care homes to establish the reasons why patients with cancer did not die at home and whether their preferred place of care was documented.

This poster outlines the results of this audit and the actions required to address some of the local issues arising from the results.

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433. The development of palliative care at University Clinic of Respiratory and Allergic Diseases Golnik

Andreja Peternelj, Anja Simonic

University Clinic of Respiratory and Allergic Diseases, Ljubljana, Slovenia

University Clinic of Respiratory and Allergic Diseases Golnik is an institution specialized in the treatment of pulmonary and allergic diseases. The chronic course of these diseases requires the implementation of palliative care, which in the past did not receive any special attention in our hospital or elsewhere in Slovenia. Our **objective** is implementation of organized palliative care and improvement in the quality of patient's and their family's lives. Implemented innovations (**results**) since 2003 are as follows: 1. Four beds set aside at the department for non-acute treatment for patients who need terminal palliative care; 2. Formation of a standing palliative team; 3. Regular informative meetings for patients and their families; 4. Establishment of a clinical path for patients with small-cell lung cancer; 5. Preparation of an educational programme for those who also participate in palliative care process. **Conclusions:** Organized approach to palliative care at our hospital resulted in: 1. Better recognition of the importance of palliative care among providers as well as patients and their families; 2. Improvement in the integral/team approach to treatment; 3. Increased amount of information that patients and their families have about the nature, course and treatment of the disease; 4. Stimulation of more active participation of patients and their families in the course of treatment and co-deciding about the treatment; 5. Improvement of cooperation with services at the primary level, and 6. Increased satisfaction of both patients, families and care providers.

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434. Integrated services to assure continuity of care for patients and their families

Cristina Ghiran

Hospice, Palliative Care, BRASOV, Romania

In providing high quality multidisciplinary care to patients and their families it may be overlooked that each member of the team is a new face and each place of care is a new setting where the patients and their families may be traveling without a compass, map or guide. To offer a safe journey, the organization must promote continuity of care and ensure patients feel that the team really cares about them. Hospice Casa Sperantei offers a range of services to adult patients. In each setting the team focuses on holistic care, striving to offer high quality care, which to a certain extent depends on continuity of care. This is achieved through specific actions and by following certain procedures. There is always scope for improvement and we have in mind to develop a 24 hours service and to perfect transfer of patients from one service to another. Not least, we must strive to follow up promises made to the patients and their families. Comprehensive coordinated care reflects the complexity of human life with in all respects: physically, socially, emotionally and spiritually and drives our organization to fulfill the needs of patients and families to a higher standard.

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435. Monitoring Quality in an Acute Hospital-Based Palliative Care Service - Adopting 'Universal' Indicators

Angel Lee, Huei yaw Wu, Koh Koh, Susan Chan, Tzer Wee Ng

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Mortality rates, unsheduled readmissions and length of stay are commonly used indicators to monitor quality of care in acute hospitals. We reviewed the their use in the context of a palliative care service. Mortality rates in themselves were not useful as death is not an unexpected outcome in the terminally ill. Instead, mortality rounds were modified with emphasis on determining (1) adequacy of symptom control, (2) whether psychosocial needs were met and (3) whether place of death was consistent with patient's preference. Lapses of care were addressed and staff debriefing in challenging cases were also conducted as appropriate. Unscheduled readmissions within 2 weeks were also deemed to be an appropriate indicator with 3 areas commonly found to contribute to readmissions (1) lapse in communication with community hospice services (2) poor symptom control (3) unmet psychosocial needs. Even as efforts to minimse readmissions were put in place, length of stay is concurrently monitored to ensure care remains efficient and provided at the most appropriate site.

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436. Good palliative care practice have impact on the place of death

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Background: It is difficult to measure the overall effect of establishing a new palliative care service. We wanted to find out the impact for the whole population, not only for persons dying of cancer. A simple way of investigation is to describe the place of death in the entire population. A well known fact is that many persons prefer to be at home when they die. Problems within health care, lack of relatives and limited access to palliative homecare in many countries, reduce the personal impact on preferred place of dying.
Method: In the town of Kungsbacka with 70 000 inhabitants a new palliative support team was established in 2005. The place of all deaths was studied in 2004 and 2005 (before and after the introduction of the new team). The facts were collected from death certificates. Places of death were categorized as in hospital, nursing home, palliative care unit, hospice and at home.
Results: The number of deaths in hospital and nursing homes diminished, while the number of deaths in a palliative care unit and at home rose. No great changes in health organisation, demography or economy where executed during the observation period. The data suggests that establishing the new team explained the observed changes.
Summary: In the palliative care it is interesting to study all deaths in society. The goal is not only to give good palliative care to persons registered in a palliative care service, but to all dying persons as well. Specialized palliative care services can have a strong impact. An easily performed investigation of death certificates can be used.

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437. Dying for information: an evaluation of a telephone helpline for patients with advanced disease and their families

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Introduction: Up-take of palliative care services is low among older people, black and minority ethnic groups (BME), and the poor. This reflects poor knowledge of relevant services. Telephone helplines (e.g. NHS Direct) have potential to increase awareness of health information and services. Research aim: To evaluate 'COMPASS', a free palliative care telephone helpline, aimed at increasing awareness of palliative care to patients with advanced disease and carers living in South London. Methods: Audit of all calls received by the helpline, measuring call patterns, caller demographics and service requests. Results: The helpline received 116 calls between Oct 05-Oct 06; call volume declined over time. 84% of callers were female, 38% were aged 45-65 years. 33% were from BME groups and 63% were from socially deprived areas. 41% of calls were made by patients and carers seeking information about issues including palliative care conditions, support groups and financial benefits. 20% of calls were made by health care professionals seeking information about local specialist palliative care services. Conclusion: COMPASS has been successful in providing an innovative information source to previously underserved population groups. It also provides an important source of information for local health care professionals, an unintended benefit. Dissemination of publicity about the line remains challenging.

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438. A learning curve: Developing and operating a telephone helpline for patients with advanced disease and their families and professional carers

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Introduction: Uptake of specialist and generic palliative care is related to low awareness among certain population groups. To address this, COMPASS, a telephone helpline was established in October 2005 by NHS Direct to provide information on end of life issues and services. **Research aim:** To explore the stakeholders' views on the feasibility, development and outcomes of the helpline. **Methods:** Semi-structured face-to-face and telephone interviews with COMPASS stakeholders including the management team, health information advisors, and relevant external parties. **Results:** Four main themes emerged from the interviews: (i) recruitment of suitably qualified staff; (ii) the challenge of developing an up-to-date database of local services along with 'response algorithms' for call handlers; (iii) while the service was widely publicised, call numbers during the helpline's first 12 months was lower than expected; (iv) changes to NHS Direct's working policies encouraged regular review and modification to the operational development of the helpline. **Conclusion:** The helpline has faced many challenges related to the nature of palliative care and to external operating circumstances. The development of this specialist telephone helpline has been an iterative process which has demanded COMPASS react and modify the service to a continually challenging external backdrop.

439. Social care interventions for hospice referral in a university hospital without palliative care unit

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The aim of this study was to evaluate the transfer rates to a hospice for palliative patients of all departments of our University Clinic Hamburg-Eppendorf without palliative care unit or palliative care team.

The data base of the social care department comprehends all in-patients in the year 2005 and from January to October 2006 who were referred from hospital to hospices or were advised about hospice care. In 2005 118 consultations concerning hospice care were performed.

20 patients received psychosocial and social judicial interventions concerning palliative care and information about the options of patient care outside the hospital. In 98 consultations the intention of the care givers was to discharge the patient to a hospice. 56 patients could be transferred to a hospice. 42 patients died prior to discharge or could be cared for in the family setting with the support of the social worker.

In 2005 32 patients and in 2006 (10 mths) 39 patients from the Department of Medical Oncology were referred to a hospice. For 8 patients in 2005 and 12 patients in 2006 an alternative decision was made.

From January to October 2006 the social worker received calls 118 times for hospice care, of these in 18 cases psychosocial and judicial interventions were required and from 100 calls for referral to a hospice 61 patients were transferred from hospital to hospice.

Palliative care interventions for assistance transferring patients to a hospice increased from 2005 to 2006.

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440. The problems of transition from voluntary hospice teams activities to modern hospice teams integrated into the existing health care system

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The Croatian Association of Hospice Friends (CAHF) was founded in 1999 to provide logistic support, first of all to the educative and promotive activities of the Croatian Society for Hospice/Palliative Care,CMA. CAHF endeavours to provide practical palliative medical, psychosocial and spiritual care during hospice home visits by interdisciplinary teams in Zagreb and Zagreb region. As soon as a provision about palliative care was included into the new health reform law in summer 2003, CAHF started the administrative procedure necessary to establish an Institute for Palliative Care. - All efforts were blocked by changes in the Government and by the subsequent radical personal and organisational reforms in autumn 2003. As. CAHF a civil association, can't conclude contracts with the Croatian Institute for Health Insurance, we had to start with the procedure all over again. Palliative care can't develop on an almost exclusively voluntary basis. It should be stressed that our palliative care team is the only palliative care unit in the modern sense in Croatia and has been functioning for almost 7 years continuosly in facilities rented by the city of Zagreb. So far, the Association's activities have been financed by projects and national and foreign donations. From 12/1999 until 06/2006, palliative care services were provided for 879 people and their families.

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441. Specialised palliative home care in Bonn - which factors lead to referral to inpatient settings previous to death

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Introduction: Specialised palliative home care services (SPHCS) aim at accomplishing that patients can die at home. It is well acknowledged that this is not achieved in all patients. This study analyses, which factors lead to referral to inpatient settings (IS) previous to death. **Methods:** Data of every patient of the SPHCS at the Malteser Hospital in Bonn is documented in a computerised data base. For this study, the period from 1/2002 to 6/2006 was analysed. Patients who died in IS were compared to patients who died at home (DH) by testing for differences (¯_Ç_) in symptom prevalence and availability of family members as informal carers.**Results:** Data sets of 567 patients were included, of these 362 (64%) died at home and 205 (36%) did not die at home. Higher symptom prevalence was detected in IS patients for dyspnoea (27%, DH 19%; p=.028) and nausea (13%, DH 7%; p=.019). No differences were found for e.g. pain. Relatives as informal carers were less common in IS patients (62%, DH 86%, p<.001). **Conclusion:** The presented study shows that certain factors have a significant influence on the place of death. Social preconditions like lack of family structures cannot be changed, but an improvement of symptom management in the outpatient setting, e.g. better qualification, closer cooperation (e.g. with physician) and better coordination, may increase the number of terminally ill patients in SPHCS in this area that can stay at home for dying. This can be a focus for further research.

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442. PROJECT FOR SAFE DISCHARGE AND HOME CARE SERVICE IN PALLIATIVE CARE BY THE 9th ONCOLOGICAL PROVINCIAL INTERCOMPANY DEPARTMENT OF LOMBARDIA (Italy)

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Project Purpose:
Most of the home care oncological patients don't need any specialized oncological therapy. It is therefore necessary to plan, set up and manage a service care programm which allows the patients to enter a national health insurance network with a territorial integration.
The network will provide the following :
the Hospital as promoter of safe discharge process
the Local Health Unit as guarantee of different territorial social and health levels
The Municipal Social Services
Volountary Service
The project is for adult and paediatric patients with oncological and oncohematological diseases. The aim of the project is to promote a continuative relation between the hospital and the region of the involved patients by a safe discharge process from the hospital and/or day-hospital or outpatient healthcare insurance.
Methods:
The continuity model of health care consists of:
-a computerized case report form . All the involved professionals in the assistance can communicate together easily and can be constantly updated.
-a specific training of all the involved professionals
-a pilot study for three years with a final inspection using suitable markers.
Results:
The Lombardia Region has approved and sponsored the project. Data processing systems have been implemented and training being performed. The effectiveness of the training will be evaluated after one year and also the case recruiting will begin at that time.

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443. Developing an early intervention supportive and palliative care pathway for adults with intellectual disabilities

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Despite policy/legislation the healthcare needs of British intellectually disabled people are poorly met and particularly so within palliative care.Thus service providers are often inexperienced in communicating with and meeting the needs of this client group when someone with an intellectual disability (ID) is referred to them. Research has demonstrated that many people with ID with life threatening conditions do not access hospices or the full range of palliative interventions. This is related to the late diagnosis of illness and a reluctance to 'hand over' care to non ID professionals. It is clear that late referral has a deleterious effect on all aspects of care, not least the ability to develop trusting relationships with the patient and those closest to them. This presentation will detail work undertaken within a London hospice to develop accessible and appropriate supportive and palliative care for people with intellectual disabilities. This endeavour is the consequence of developing partnerships between community ID and palliative care professionals; it has resulted in the development of a patient pathway for early referral and intervention across a continuum of supportive and palliative care. The implementation of the pathway has highlighted significant training and support needs for staff within each area of care. The model of care developed is transferable to a range of hospice and community palliative care settings.

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444. Accelerating Change In Complex, Public-Funded Health Systems: The Canadian Pallium Project

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AIM: From 2004 - 2006, the Government of Canada invested ¤ 2.8 million in the Canadian Pallium Project to improve patient access through primary care renewal. **METHOD:** The Project employed established social science and educational research from the literature, including; Action Research; Continuing Professional Development informed by Situated Cognition/Learning, Workplace Learning, Critical Reflection and Social Constructivism theory; Communities of Practice; Complexity Theory, and project management practices informed by international capacity-building models. Through development and change management projects in outreach education and continuing professional development; knowledge translation/ diffusion; and health delivery system change, the Project (Phase II) generated and catalyzed transferable lessons/innovations. **RESULT:** Phase II of the Pallium Project completed 72 projects in a 24 month period with results including demonstrable clinical practice change from local inter-professional education, a competency-based palliative care courseware package being used in medical schools, a nationally-validated, competency-based curriculum kit for Spiritual Care, 12 other national education resources and multiple innovations in e-learning and e-health to support improved palliative care in community setting. **CONCLUSION:** Phase II demonstrates the possibilities for inter-sectoral collaboration among academic, government, civil society (NGO) and health service delivery partners to produce demonstrable change and useful legacies for palliative care capacity-building.

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445. What Affects Adherence by Internal Medicine Nurses (IMNs) of Recommendations Made by Palliative Care Consult Nurses in a Swiss Tertiary Hospital

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Aim: The goal was to explore the factors that influence adherence by internal medicine nurses (IMNs) to recommendations provided by a palliative care consult nurses (PCN) in a Swiss teaching hospital. **Method:** A qualitative approach, using case study design, was applied. Following convenience sampling, IMNs were interviewed one-on-one (semi-structured questions). Two conceptual frameworks (Zay et al 1997 ; Sauve 2001) were used as a starting point for data coding. New categories and themes then emerged. **Results:** Data saturation was achieved after 5 interviews. 5 categories emerged, including alterity; transparency; communication; time; and sense of ownership. Adherence requires a personal rapport and trust between the IMNs and PCNs. Developing this requires time. Frequent staff changes hinders this. IMNs view the consultation at times as an intrusion by the PCNs and feel that they are better acquainted with the patients. Explicit recognition by the PCN of the personal distress that IMN experience when caring for palliative patients enhances the rapport. A focus on supporting the IMNs rather than focussing only on the patient enhances adherence. IMNs experience (whether real or perceived) a sense of inferiority during the consultation process. **Conclusions:** Our PC team needs to review its model of consultation, possibly adopting one that focuses more on supporting the primary teams. Formal and informal strategies to improve the rapport with IMN will be sought. Awareness by the PCN of the inferiority felt by the IMNs may enhance rapport building.

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446. CLINICAL AUDIT IN A HOME PALLIATIVE CARE SERVICE:Auditing the audit

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Clinical audit intends to improve current practice, use of resources and team education. Therefore, it is essential in the palliative care setting as a mean to reach an excelent care.
Objectives Ensuring the effectiveness of an audit project and discuss methodological issues able to impact in the efficacy of the audit.
Methods The Pallium-Hostal de Malta Home PC Service (HMHPCS), developed an organizational and clinical audit programme based on standards developed by the Trent Hospice Audit Group. In the first phase, the audit

was directed to the evaluation of outcomes related to symptom control and psychosocial and spiritual support. Patients and families assisted at home by the HMHCPC during a 15 month period, were interviewed in deep and through semistructured questionnaires.
Results Data from 42 patients and 50 relatives was audited and the outcomes analyzed under quantitative and qualitative means. Advantages and barriers of the audit method applied were identified, in terms of patient involvement, interpretation of satisfaction issues, participation/commitment of staff and resources
Discussion In spite of the highly positive reports of patients and families, we wonder if the audit tools used were appropriate for this low resource population. We conclude that an effective clinical audit requires not only detailed planning beforehand, but also continuous review of the process and careful selection of the instruments to use for collecting data.

447. National Palliative Care Outcomes Collaboration (PCOC) - can it contribute to improved standards and quality in palliative care?

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Aim: PCOC aims to develop and support a voluntary national benchmarking system to improve palliative care outcomes. PCOC is working with palliative care service providers to:

- Develop consistency in data collection
- Provide evidence through the collection and analysis of data
- Assist with quality and standards reporting
- Provide a benchmarking service
- Promote and support palliative care research

Methods: The PCOC dataset includes demographic, episode and phase data. When a service agrees to join PCOC, Zone Coordinators meet with senior administration staff followed by clinical staff. Discussions with service providers include an assessment of current data collection methods and how extraction and mapping issues can be resolved. Training programs ensure all data is collected in a rigourous and consistent manner.
Results: To date approximately 30 services have been recruited across Australia and have begun to collect data and as practices become established, additional services will be encouraged to join. Feedback from services providers has led the PCOC team to conclude that the Version 1 data set requires improved definitions and guidelines.
The first half-yearly reports were circulated in early 2007. providers.
Conclusion: The development of national benchmarking program for palliative care in Australia has the potential to make significant improvements on the way we take care of people with a life-limiting illness.

448. Activities of a Palliative Care Unit in Preah Ket Melea Hospital Phnom Penh, Kingdom of Cambodia

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Introduction: AIDS is one of the major public health problems in Cambodia. Even if there is a national program of antiretroviral therapy and prevention, the mortality is high. Objectives:Describe the activity of the only Palliative Care Unit in Cambodia. The Unit was founded in 2003, has an inpatient ward of 30 beds, a home care team and a Pain Clinic. It is part of a governmental hospital. Material and methods: Since it is openning, data has been prospectively collected on demographic characteristics, diagnoses and symptoms of all patients. Results :In 2005, the number of admissions was 488: 412 patients with AIDS, 65 with cancer and 11 with other pathologies. The mean lengtht of stay was 16 days. For patients with AIDS, the mean duration of their disease was 3 years. All these patients were hospitalized for one or several opportunistic infection and the most frequent reasons for admission were pain (75%) and respiratory problem (22%).The mortality rate was 24%. It is lower than in a classic palliative care unit because a majority of patients are very poor and arrive in very bad condition. After treatment with antibiotics, symptom control and three meals a day, most of them recover for a while and are discharged at home. There is a follow-up by our home care team.Tuberculosis and diarrhea are the most common presenting conditions of AIDS and also the most prevalent cause of death. Conclusion : The Palliative Care Unit has proven its utility. In this 3rd year of activity, we can see that the number of patient referred by other health structure increase a lot.

449. Palliative Care for People living at Home: Resources and Barriers

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Background: Despite a lack of systematic research data there is evidence that the majority of the population wishes to spend their last days and hours at home and to die there. Nevertheless figures show that in middle European countries only a minority actually does so. The qualitative research project involving home care services and families identifies resources and barriers to palliative care at home. Methods: In three Austrian pilotregions qualitative interviews with family members and group discussions with nurses and managers of home care services, family doctors and palliative care teams were conducted and analysed. Results: Increasing numbers of single households, the lack of experiences with death and dying among family members the lack of caring family, inadequate structures and resources of home care services are the principle barriers whereas cooperation between professionals (familiy doctors, palliative care teams and home care services), adequate processes and documentation of ethical decision making, and quality in management of patient's transfer between hospital and home are reported as important resources to enable people to die at home. Conclusions: Departing form the analysis of resources and barriers for palliative care at home the project is currently developing a plan of action for home care services as well as recommendations on a national and strategic health policy level.

450. INDIVIDUALIZED MULTI-DISCIPLINARY CASE CONFERENCES: CAN THEY BE PRACTICALLY ADDED TO SPECIALIST PALLIATIVE CARE?

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Objective: Case conferences are multidisciplinary meetings with the general practitioner (GP), patient, and palliative care clinician, convened to plan care for the patient. In a randomised controlled trial, the addition of a single case conference to usual specialist palliative care improved function and reduced hospitalisations. What are the characteristics of case conferences? Can they be incorporated into routine palliative practice? *Participants and Setting:* Eligible participants were adults referred to a regional specialised palliative care service in Adelaide and their GPs. *Results:* 47% (167) of 358 patients randomised to a conference had the intervention. 142 patients died before it could be arranged; 46 withdrew. Conferences occurred median 52 days (range 6-288) after enrolment, and 79 days (range 0-726) before death. 91% included patients/caregivers. 75% included 3 participants plus the patient/caregiver. Conference lasted mean 39±13 min. Symptom control, function, future care, social issues, and spirituality were discussed. 43% of conferences were claimed for GP reimbursement through Australian Medicare; 99% were eligible. Nurses reflected that conferences should be timed with deteriorating patient function; organisation of conferences was difficult and time consuming. *Discussion*: Case conferences can be practically incorporated into routine specialist palliative care. Organisational difficulties were overcome through administrative personnel.

451. HEALTH RESOURCE UTLISATION WITHIN PALLIATIVE CARE. FINDINGS FROM A PROSPECTIVE RANDOMISED CONTROLLED TRIAL

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Background: Up-to-date, accurate data on the type and costs of services provided in palliative care are required for service planning and successful negotiation of health system resources. *Methods:* The Palliative Care Trial was a 2x2x2 factorial randomised controlled trial that evaluated case conferencing and educational interventions. Eligible participants were adults referred to a regional specialised palliative care service in Adelaide, Australia, and their GPs. Longitudinal health resource utilisation data were collected for each participant from palliative care referral until death. Data included: 1) palliative care service; 2) Australian Medicare; 3) Department of Veteran Affairs; 4) private health insurors; 5) public and private hospitals; 6) aged care facilities; 7) home nursing services; 8) domicillary care services; 9) local ambulances; and, 10) hospital pharmacies. Data were combined using probabilistic and deterministic matching. Costs were attributed to all services and have been used in economic analyses. Resource utilisation mapping is underway. *Results:* 461 patients were enrolled. Data matching and health resource utilisation analysis will be completed by March 2007, enabling modelling of resource use by demographics and disease profile. *Conclusions:* These data will provide valuable insight into the current needs of people with a life-limiting illness in metropolitan Adelaide and can be used to inform the policy making decisions for palliative care.

452. End-of-life decision-making in Belgium, Denmark, Sweden and Switzerland: Does place of death make a difference?

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Objective: To examine differences in end-of-life decision-making in patients dying at home, in a hospital or in a care home.
Design: certifying physicians from representative samples of death certificates, taken between 06/2001 and 02/2002, were sent questionnaires on end-of-life decision-making preceding the patient's death.
Setting: Belgium (Flanders), Denmark, Sweden, and Switzerland (German-speaking part).
Main outcome measures: Incidence of and communication in different end-of-life decisions (ELDs): physician-assisted death, alleviation of pain/symptoms with a possible life-shortening effect, and non-treatment decisions.
Results: Response rates ranged from 59% in Belgium to 69% in Switzerland. Total number of deaths studied was 12492. Among all non-sudden deaths the incidence of several ELDs varied by place of death. Physician-assisted death occurred relatively more often at home (0.3%-5.1%); non-treatment decisions more often in hospitals (22.4%-41.3%), but also frequently in care homes in Belgium (26.0%) and Switzerland (43.1%). Continuous deep sedation until death was more likely in hospitals. At home, ELDs were usually more often discussed with the patients, but less often with other caregivers than in hospitals or care homes.
Conclusion: End-of-life decision-making is possibly related to the care setting where people die. This would call for development of good end-of-life care options and end-of-life communication guidelines in all settings.

453. HOME CARE AT THE END OF LIFE

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OBJECTIVES: Caregiver satisfaction of patients who has received palliative home care (HC) vs those who have not received it.

Design: Terminal patients were included in hospitals, primary care centres and HC teams. Follow-up study. Main caregiver interview after 1-3 month of patient death.
Setting: Majorca Island. Subjects: terminal cancer patients that spend almost 15 days at home in the last month of life, and caregivers.
Measurements: Caregivers satisfaction on health care with SERQUAD questionnaire, validated for HC based on likert responses (degree agreement 1 to 5).
RESULTS:107 patients, 88,8% caregivers women, aged 52.5 years (SD 10.6). 93 patients received some palliative HC and 14 never received it. Of those who NEVER received it 71.4% were totally satisfied with health services vs 82.6% of those who did received. 71.4% of caregivers of those not treated at home declared that patients were better attended at home than hospital vs 86.7% of those with palliative HC. 43% of patients with HC died at home vs 14.3% in those without HC. Caregivers of those with some HC, considered that the most important aspects were health professionals humanity and trust, and at lesser extent the capacity to offer safe health care, accessibility and techniques.
CONCLUSIONS: Those caregivers of patients who received some palliative HC were more satisfied with health care received and think patient has been better attended than in hospital. They value mainly humanity and trust of health professionals.

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454. Hospice-friendly-Hospitals: A national approach to mainstreaming hospice principles in hospital practice

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BackgroundThe care of dying and bereaved people in hospitals remains a challenge. Individual interventions may improve care for subgroups of patients, or for particular dimensions of experience. A "systems" approach is also needed which acknowledges the complex multi-dimensional nature of care and can be generalized across hospitals. In Ireland a national programme focuses on improving experience of hospital care at the end of life, building on local and international knowledge, a pilot study in one Irish hospital and a series of strategy workshops. **Aims**To develop interventions and demonstrate improvement in four areas of end of life care in hospitals: 1) Integrated Care 2) Design and Dignity 3) Communications 4) Personal Autonomy. **Actions**A 3 year plan has been devised and is in progress. 18 (50%) of Irish acute hospitals are participating. Systematic literature reviews on the 4 themes of the programme are underway. An evaluation strategy is being developed. Three national contextual studies have been commissioned covering: ethical framework for "a good death"; national review of quality of care for dying patients in hospitals and nursing homes; review of the economic imperatives impacting on end of life care. **Progress**Substantial funding (Euros 4.7m) has been secured and the programme has begun. The National Steering Committee has met. International partnerships are encouraged.

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455. Nurses work load with inpatients in a Palliative Care Unit (PCU) for cancer patients.

Cristina Pereira[1], Lília Costa[2], Catarina Simees[3], Miguel Tavares[4], Edna Goncalves[5], Cátia Ferreira[6], Margarida Alvarenga [7]

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Aim: To determine nurses work load with inpatients in a PCU of the Portuguese Cancer Institute of Porto **Method**: A prospective quantitative study, was conduted to analyze the nurses daily work with patients/family admitted in the PCU (capacity of 20 beds) between May and December of 2006. The study was performed in 4 phases: **First**- Identifying the main activities performed by the nurses; **Second** – Creating an information technological instrument to register and record these activities; **Third**-Computer registration of activities performed by nurses in their duties to the inpatients/family; **Fourth** – Evaluation of the results. **Results**: In a preliminary analysis, we concluded that the physical cares took on average 20,6 min, the bureaucratic activities 24,8 min, and psychological-spiritual support 19,6 min.. Still in the period of gathering data, the definite and more detailed results will be presented at the congress.

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456. Cost analysis of patients admitted to an inpatient Palliative Care Unit according to their clinical complexity

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Aim: To derive a mean cost per day per inpatient admitted to the Palliative Care Unit (PCU) of Portuguese Institute of Cancer on Porto classified according to five clinically meaningful "palliative care phases".**Methods:** Prospective study based on the detailed registration of the clinical and service utilization profile for each patient admitted to the PCU between 1 August 2006 and 31 January 2007. A purpose-designed software was created to measure direct patient care costs on a daily basis (staff time, drug treatment, diet and other resources consumption were registered) and patients were classified according to five "clinical phases of care" adapted from the Palliative Care Phases of the Australian Association for Hospice and Palliative Care ("acute", "stable", "deteriorating", "agonizing" and "social") **Results:** In a preliminary analysis of the first 2 months of the study the mean daily cost per patient admitted to the PCU was 352,41 ¤ (30% less than the mean daily cost per patient admitted to the IPO-Porto), ranging from 462, 91 ¤ for "deteriorating" patients to 204,80 ¤ for patients admitted predominantly for social reasons. Almost 27% of total costs were associated with therapeutics, 25% with staff, 25% with indirect costs and 23% with other costs. Final and more detailed results will be presented at the Congress

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457. The environmental factors that impact on quality of life in advanced cancer in-patients

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It has been suggested that the hospital environment impacts on patient outcomes and quality of life. Single rooms are standard in many hospitals and the design of future facilities. However, the literature favours single over multi-bedded rooms based on advantages with respect to noise levels, infection control confidentiality with very few studies addressing patient preference or quality of life. We explored the views of palliative care patients within a regional oncology centre.

Methods
Audio taped semi-structured interviews of palliative care inpatients were conducted. Recurring themes were identified and interviews conducted until theoretical saturation reached.

Results
Major themes suggested that patients favoured wards with a mix of single and multi-bedded rooms. Single rooms were favoured when patients felt unwell and needed quiet and privacy. Most patients found multi-bedded rooms offered additional support from patients, eased boredom and improved emotions. People placed in single rooms for due to infection control experienced boredom, loneliness and distress. They also worried that they would be forgotten and receive less attention.

Conclusions
Whilst single rooms offer several practical advantages in healthcare management, they may have a detrimental psychological effect on some palliative care inpatients. When "well" patients prefer multi-bedded wards and the interactions they offer. Unwell patients prefer the privacy and quiet of single rooms. Implications for future ward design are discussed.

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458. How Family Physicians see their own roles and that of palliative care specialists caring for their patients, after referral to a metropolitan home palliative care service

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The 2001 National Family Physician (FP) Workforce Survey showed that 62% of Canadian FPs provide after hours care. Those providing palliative care were twice as likely to provide after hours care. Purpose: To investigate how Family Physicians (FPs) see their own roles and that of palliative care specialists caring for their patients, after referral to our metropolitan home palliative care service. Method: From August 2005 to May 2006, we sent 1007 questionnaires to referring FPs, to ask whether they wanted our palliative specialists to: 1) only act as consultants, 2) share the care with FPs, or 3) act as primary professional. We also asked the referring FPs about after-hours service they could provide. Result: Sixty-seven per cent of 489 unique respondents wanted our specialists to act as primary attending (most responsible) physicians. Of another 27% who wanted the specialist to only consult or to share in care, 36% could do urgent house calls, and 82% could do scheduled house calls. Respondents' answers were unclear as to whether an effective after-hours coverage system was in place. Conclusion: Most FPs who refer patients to our home palliative care service see our role as that of attending physician. Other FPs who are willing to provide home palliative care to their patients may be hindered by the need to have an after-hours coverage system, or may defer to specialist service when it is available.

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459. Improving supportive and palliative care for adults with cancer: A pilot study of general practices in the UK

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Aims
The aim of this study was to measure validity, acceptability, and response rate of a questionnaire designed to assess progress in general practices towards implementation of the UK National Institute for Clinical Excellence guidance on supportive and palliative care of adults with cancer.

Method
A postal survey using a self-complete questionnaire was undertaken in 39 general practices of Rotherham, England. Introductory letters were sent to General Practitioners (GPs) before the study, followed by an initial mailing and three carefully timed reminders (2 weekly intervals). Practice managers were then sent an abridged version of the questionnaire using a similar protocol. Independent sources of information were used to access the accuracy of data. Respondents were asked to comment on the questionnaire.

Results
The pilot study response rate from practices overall (where either the GP or the Practice Manager, or both replied) was 69.2%. Response rates from individual groups were lower: 48.7% for GPs, and 43.6% for Practice Managers. Little ambiguity, inaccuracy or difficulty in answering questions was detected.

Conclusions
Respondents provided useful data and informed the design of a national survey of UK general practice. A combined approach and reminder letters yielded higher response rates. General Practitioners and practice managers were positive about the questionnaire design.

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460. Can the clinical nurse specialist make a difference for outpatients receiving palliative care?

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Introduction
To reach optimal palliative care structural involvement of a clinical nurse specialist (CNS) in the outpatient clinic is considered as a prerequisite. First, a literature review was done concerning the needs of outpatients receiving palliative care, the types of interventions applied by the CNS and the effect of these interventions. Secondly, a qualitative exploration of outpatients of the department of medical oncology, who have been seen by the CNS, concerning their needs and the nursing interventions was done.

Results
The literature revealed that outpatients have needs concerning symptom monitoring, dealing with symptoms, the effects of treatment in every day live, support in communication and emotional support. The type of interventions used by the CNS is not always well described. Interventions mentioned include emotional support and support in communication. No effect-studies were found. The qualitative exploration of 12 patients seen by the CNS confirmed the needs and interventions as found in the literature.

Conclusion
Research concerning the effect of the interventions by the CNS on symptom burden, patient control and quality of life of palliative care outpatients is needed. .Interventions on symptom management, emotional support, support in communication and support in dealing with symptoms and the effects of treatment in daily life must be included. A prospective study will be performed.

461. Evaluation of local palliative care teams - looking for a feasible concept to support care givers

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Background and aim: Within the northern part of the Netherlands several local palliative care teams exist. These multidisciplinary teams are made up of physicians and nurses from the local hospital, nursing home, home care organisation and general practitioners. They are supportive teams, which do not take over the care itself. The aim of this project was to evaluate the functioning of the teams, and investigate how they contribute to optimal palliative care for the patient, and support for care givers. **Method**: 8 teams participated in this evaluative study. In 2 questionnaires participants gave their view on several aspects of team functioning. **Results**: The most prominent finding was the great variety between teams in working method, team composition, connection to organisations etc. Whereas most teams aim to be palliative consultation team in their region, the majority receives only very few questions. Two teams do receive questions; however, these teams have a more limited target group. **Conclusion**: In the Netherlands we are looking for the best way to support regular professionals in giving palliative care. None of the teams in this study manages to support the full range of care givers involved in palliative care in their region. We propose a new concept for palliative support teams, made up of official representatives out of the organisations involved, with a role in enhancing palliative knowledge among professionals and promote optimal organisation of palliative care.

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462. Perceptions and practice of palliative care amongst junior doctors and nurses

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Aim
Many referrals to Palliative Care Services are requested too late or inappropriately, when earlier palliative care input could have made a significant difference. We decided to investigate and further understand factors that influence the nature of referrals amongst junior doctors and nurses.
Method
A semi-structured 16 item quantitative questionnaire was developed, utilising Likert scales. The questionnaire explored junior staffs' awareness of the Palliative Care Service, and their own individual and team practice of making referrals.
Results
104 junior doctors and nurses were approached and 99 returned questionnaires.Only 53% respondents thought that the PCS were contactable 24 hours a day.81% of doctors, but only 39% of nurses had referred a patient. To the question '*What proportion of patients do you feel would benefit from referral to palliative care*' most respondents stated between 10-25%
Discussion
Our Palliative Care Service provides an open 24 hour service to cancer and non-cancer patient with symptoms. From this study it has been identified that the PCS is *not* perceived as providing continuous 24 hour care. Doctors are currently more likely to refer patients than nurses. Only a small proportion of patients are *perceived* as potentially benefiting from palliative care and even lowers figures are actually referred.

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463. Retrospective evaluation of carer satisfaction: 10 years experience

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Carer satisfaction represents an important outcome variable in improving quality of care. Our hospice at home service sends an anonymous questionnaire inclusive of self addressed stamped envelope to the carer approximately 30 days following death.1351 questionnaires were sent from 1997- 4/2006, measuring specific domains: staff organization/coordination, communication, physical and psychological symptom control, place of death, overall satisfaction. Choices were "satisfactory/partially satisfactory/unsatisfactory". Response rate was 61%; caregivers were satisfied with care provided to 97%, partial satisfaction-dissatisfaction being reported respectively for 1,6 and 0,36%.
The opportunity to write feelings/advice was nearly always taken.Common suggestions/complaints ranged from: different time slots for daily visits/out of hour visits (5,7%); Waiting period for admission (2,8%); further family support (2,9%); treatment variation among staff physicians (1,3%). Results varied reflecting difficult periods in staff recruitment. Family members mostly underlined satisfaction for: being present at the patient's death at home (choice of place of death : 94,4%); greater consideration by staff for patient's comfort/family wishes; high levels of personal communication. **Conclusions.** The postal questionnaire is a useful audit tool; sources of "dissatisfaction" and the possibility to anonymously express opinions and concerns assists in planning and implementing change. As a result of this lengthy study a more comprehensive audit tool is being compiled.

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464. Satisfaction with Home and Hospital Palliative Care

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We aim to compare the satisfaction with care in cancer patients in two settings: home palliative care and palliative care unit.
A sample of sequential cancer patients from two hospital palliative care units (n=64) and from home palliative care of a community health centre (n=26) were assessed by the Portuguese versions of EORTC QLQ-C30 and EORTC QLQ-IN-PATSAT32 (a comprehensive, multidimensional assessment of satisfaction with care, rated on a 5 level Likert scale, with scales regarding doctors, nurses behaviour and services regarding technical, communication and interpersonal skills, availability and coordination, waiting time, access, comfort, kindness and helpfulness of health care professionals) validated for Portuguese population by the authors. There were no significant differences in satisfaction with care in what concerns the doctor's /nurse's items except a significantly higher availability of doctors in Hospital Palliative Care. In terms of organizational aspects, Hospital Palliative Care group showed a significantly higher satisfaction in all the items (comfort, information, and availability) compared with community home care. We discuss our results in terms of the differential socio-demographic and clinical characteristics of these two populations and we strongly recommend the use of this scale of satisfaction with care according to the good properties it showed on detecting discrepancies on quality of palliative care and helping to design and evaluate strategies to overcome some of the difficulties in providing palliative care.

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465. A new Palliative Care Counselling Service (PCCS) in the university hospital of Aachen - Germany

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Introduction: In April 2006 the consultation team of the palliative care unit was augmented with a fulltime specialist nurse to facilitate continuous counselling. **Methods:** First evaluation of the PCCS was performed after 6 month using a descriptive and evaluative analysis. In addition acceptance of the counselling service in other departments was assessed. **Results:** In the first 6 months of the **PCCS** 78 patients were treated (68 cancer, 10 non-cancer). The time of survival after admission to the PCCS was less than 14 days for 23 patients and more than 14 days for 27 patients (no data available: 25 pat.). Requests for consultation were for symptom control (32 pat.), psychosocial counselling (5 pat.) and requests for referral to the palliative care unit (32 pat.).

Agree	Rather agree	Do not know	Rather disagree	Disagree	
Satisfied with PCCS	30	5	0	0	0
Multidisciplinary PCCS is important	32	3	0	0	0
PCCS felt to be supportive	24	6	2	3	0
PCCS felt to be a barrier	2	1	1	6	25
Care of dying is better in PCU	22	6	3	4	0

Conclusions: Nursing service in the counselling team was met with high acceptance in other departments. Regular follow-up contacts with a specialist nurse builds up confidence for patients. The extension towards a multi professional team was a valuable endorsement for the palliative care unit's position in the environment of the university hospital.

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466. Why we do need palliative care

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Aims- To assess what happened in the last month of life to patients dying from an oncologic progressive disease in évora, Portugal. Methods- Death certificates, from 3/2003 to 2/2004 were retrieved and identified those who died of cancer.Those whose diagnosis was done prior to one month and the cause of death was progressive disease were selected. Retrospectively we studied admittances to the "Hospital do Espírito Santo – évora" (HES-évora), visits to the Emergency Department (ED), External Consultations (EC), symptoms, treatment, place of death.Results – From 235, 118 patients, 50%, obeyed the selection criteria: males, 82, 70%, and females 36, 30%, aged 69±11 years. The most frequent primaries were the digestive system, 31%, and lung, 20%.In the last month of life, 100 patients, 85%, were admitted to the HES-évora; 74, 62%, attended the ED, and 48, 40%, attended at least one consultation. The most common symptoms were: drowsiness, 74%, pain, 69% and dyspnea, 62%. Fifty-seven patients had an opioid prescribed, 60% of those with pain and 47% of those with dyspnea.The place of death was the HES-évora wards for 97 patients, 82%, the ED in 11 patients, 9%, nursing home in 2 patients, 1 patient at home and 1 patient in a private hospital.Conclusions- 91% of the patients died in the Hospital. The number of admittances and attendances in the ED was high.. Palliative care teams are needed in évora.

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467. PIA - Palliative Care Inventory of the region of Aachen

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Introduction: A Palliative Care Inventory of the region of Aachen has been finalised to offer a quick and comprehensive overview of care options for palliative patients and their relatives. **Methods:** Data about in- and outpatient palliative care (PC) options were collected by questionnaires. Key-persons in the field were interviewed about the quality of PC. Furthermore focus-groups of relatives of deceased patients were formed. Evaluation of the questionnaires and content analysis of the comments in interviews and focus-groups were performed differentiating between levels of PC specialisation. **Results:** In the greater area of Aachen one hospice and two PC units were found on a specialised level with an average of 56 beds per one million inhabitants, as well as 7 volunteers and one homecare service. On a basic level 76% of 25 nursing services and 63% of 16 nursing homes offered specific terminal care options, however, none of them had specialised nursing staff. Key-persons pointed out that PC developed well, however, with shortcomings in close coordination of collaboration. Relatives underlined the need of training in communication with their dying family members.
Conclusion: The underlying inventory is a first step to improve the quality of PC in the region of Aachen. Networking can be initialised and promoted. Continuous and regular work on the inventory will be necessary to reach and keep a high standard of PC in Aachen.

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468. NURSING COORDINATION OF A HOSPITAL SUPPORT TEAM OF PALLIATIVE CARE BASED ON COMPLEXITY LEVELS OF PATIENTS.

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Hospital support team activity is based in 2 premises:intervention based more on complexity than immediate prognosis;responsibility shared with referent team. PC nurse assesses the patient needs and agrees level complexity and shared responsibility.We defined 3 levels: Low complexity, basic/advance advice (Nurse Manag);Medium complexity, diagnosis-treatment adjust, make decision (PC Co-responsibility);High complexity (PC complete responsibility).**Objective:** Describe nurse coordination based on level agreement. **Method:** Observational, descriptive study. Comparative analysis of data stratified according intervention levels.**Results:**526 successive advanced cancer patients (Jan-Nov 2006), 65% men and 35% women, mean age 65. According complexity-intervention level, 21% patients were low, 49% medium and 30% high complexity. Analysis of data stratified per level didn't show significant differences between groups in sex, VAS of pain, insomnia, asthenia, anorexia and depressive trends. In medium complexity group we observed a decrease of performance status and higher probability of difficult pain (p< 0.01). In high complexity group we found younger patients with higher probability of comorbilty, impairment of performance status, difficult pain, anxiety, cognitive failure, psychosocial risk, complex nursing cures, and mortality <3 moths (p<0.01).**Conclusion:** Differences between groups demonstrate that is possible to define profiles of patient complexity using a structured-multidimensional record. An accurate nurse evaluation improves team organisation

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469. End-of-life care in a Swedish county during last three months of life

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This study aims to contribute to a broad understanding of of the nature of end-of-life and end-of-life care for individuals who access the health care system at this period of life. The study was undertaken through retrospective examinations of health care records in a randomly selected sample of adults who died in a Swedish county during 2001(n=229).

The mean age at time of death was 80 years. One-half, the less old, resided in private homes and one-half, the oldest old, in residential care facilities. Use of hospital care was higher in the former group than in the latter group. Dementia, was associated with lesser use of hospital care regardless of residence. Use of GP service was higher among residents in residential care facilities than among residents of private homes. Advancing age, ADL-dependency and living alone increased the use of care at residential care facilities. Specific diseases increasaed the use of care care in private homes. The most common places of death was hospitals. A range of highly prevalent problems was identified. A turning point reflecting onset of the dying process and reorientation of care was found in three-quarters of the records, of which two-thirds were documented within the last week of life.

The content of end-of-life care should be based on systematic insights into the identities of individuals who access the health care system at the end of life, where they receive care and the nature of their problems and needs.

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470. Community based palliative care services (CB-PC) in developing countries (DeCo): A systematic literature review

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Background: CB-PC may respond to local needs and priorities and use untapped societal resources. Information on variables of success and transferability is scarce. We aim to explore characteristics of CB-PC in DeCo.
Methods: A systematic literature search (Pubmed, Cinahl), amended by handsearch and snowballing, included as search strategy 1) PC [MeSH], 2) DeCo [MeSH] and 3) community participation (consumer participation, 'society taking part in decision making process', voluntary workers [free text]). Inclusion criteria were: 1. PC Services in DeCo, 2. CB-PC, 3. involvement of CB groups in organizing and running PC units.
Results: 38 papers (28 from 240 citations) were found, other databases (incl. grey literature) and experts are pending.
Characteristics of 32 CB-PC in Africa (8), south America (8), Asia (16):
- functioning: most CB-PC models are based at the charity organization level;
- financing: In Africa six hospices are financed by contributions, in south America one by government, most others by fee for funding, in Asia 4 by government, several by a microfunding system;
- difficulties: professional burn-out and opioid related issues;
- sustainability: few centers independently exist with local resources, frugal cost regimes could not be maintained;

Conclusion: CB-models are reported as appropriate for DeCo, lack of funding and low governmental priority reduced PC coverage. Desire and attempts to develop an indigenous sustainable model has persuaded groups to try new experiments in delivery of care.

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471. Where do People die at Portugal? Why? "Algarve"s survey.

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We are a multidisciplinary team, working in private practice in Palliative Care (CP) at Portugal. For our team, one of the biggest targets is the implementation of Palliative Home Care in our geographic area, assuming that it would be most people choice.

In the recent National Program for Palliative Care, various levels and models of care are illustrated. Thus, and giving the absence of data in Portugal about this issue, we propose to investigate where people usually die in this region of Portugal, what they prefer and what they think are the necessary conditions to die at home. Method: Phone questionnaires are applied to family members - the formal career - of people who died in the past 6 months with a diagnose of a chronic disease (cancer/non cancer). We chose a regional sample of 100 persons (no restrictions about age, sex, race, etc). Conclusion: We intent to have the profile of patients and careers (social-demographic data). Different nationalities are expected. Evaluation and analysis of the results depending on littoral and interior home location would be interesting.We expect to find that: 1) most people died at hospitals (first position) and in nursing homes (second position); 2) most people would prefer to die at home, if they have the necessary condition; 3) differences between Portuguese and foreigners living in Algarve; and 4) the most important conditions to die at home are: 1) the existence of medical home care, 2) 24h assistance, and 3) availability of non Professional careers.

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472. Identifying the 'key worker' for patients having palliative treatment - patient and professional views in relation to patients with bone metastases : A survey and prospective audit

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Multiple professionals care for advanced cancer patients. Both nurses and GPs think they are the "key worker" whose role is to help patients with issues they prioritised.
Method
300+ patients with bone mets prioritised their top issues. 40 professionals (10 disciplines) attended workshops and rated the importance of their role in addressing these issues. Service gaps were identified at interactive workshops with patients and professionals. An audit of 100 patients having palliative RT was conducted.
Results
Patient's priority issues included difficulties in conducting meaningful activity, worry about becoming dependent and financial burden. GPs and nurses scored their role as "very important" for the largest number of issues. Within-professional group variation was noted. Service gaps identified included Out of Hours care (OOH), information about finances, confusion as to "who is in charge", discussion about prognosis and poor experience of crisis admission. Preliminary audit results show that none recognise the term key worker, GPs were " first port of call" if symptoms deteriorated, <50% of patients knew who to call OOH, <10 % had received financial benefits information and only 50% of GPs had registered patients as palliative and put them on a supportive register.
Conclusion
The "palliative" phase of illness is confusing. Professionals do not share an understanding as to what is important for patients

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473. What is End of Life Care? Definitions from a national consultation and implications for practice

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Background:
The English Department of Health has defined 'end of life care' as care for adults with any advanced, progressive or incurable illness, in any care setting and in the last year/s of life. A national consultation exercise was commissioned to explore definitions and to identify research priorities for generalist services.
Aim: To identify and explore meanings that health, social care professionals and users attach to 'end of life care'
Methods:
Interviews and questionnaires to gain the views of policy makers, commissioners, health professionals, user groups and specialist palliative care; the 'nominal group technique' to identify priorities; a thematic analysis to identify key themes.
Results: Over 200 people are being consulted in the UK. Initial results suggest a range of definitions of 'end of life care' including the last days of life, the last 6 months, the last year, or following a poor prognosis. Definitions can relate to perceptions of palliative or terminal care and to specific patient groups. For some respondents, 'end of life care' is a more socially acceptable phrase than 'terminal care'.
Conclusion
Professionals and user groups vary considerably in what they understand by 'end of life care.' This holds implications for advanced care planning, including onward referral of patients to specialist support. The lack of shared understanding might perpetuate inequitable access. Definitions must be based in working practice if they are to be widely adopted.

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474. Complicated grief. A support group intervention for family members

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Abstract Complicated griefA support group intervention for family members Yvonne Hajradinovic, Eva Erichsen, Lars Sundberg, Monica Axmacher-Jonsson, Maria Jakobsson, Anna Milberg, Maria Friedrichsen
Complicated grief is a debilitating disorder associated with important negative health consequences. **Aim:** To illuminate bereaved family members' lived experience of participation in a support group intervention for complicated grief. **Method:** Participants were selected according to specific inclusion criteria. Eleven interviews were performed and analysed with Giorgi's phenomenological method. **Findings:** Five themes emerged: *Group cohesion:* Family members experienced the importance of sharing their experience with people in a similar situation who understood them. *Confirmation:* Family members felt confirmed when being in focus one by one in the group. The feeling of being respected, the frankness, and the allowing attitude in the group influenced the participants? courage to tell and to express feelings. *Emotional and physical distress:* Relatives felt distressed in varying extension before, during and after group meetings, for example palpitations of the heart, anxiety and ache. *Comprehension:* The process of work in the group involved an increased understanding of one self and a personal growth when learning from each other. *Release and strength:* Finally, most family members felt released and empowered after discontinuing the group. Some did not want to separate. The essence of the phenomena was described as a journey, travelling together over a stormy ocean to a calm haven guided by safe hands. **Conclusion:** The participants? felt satisfied with the group intervention that gave them an understanding, meaning and strategies to cope with their grief.