10th World Research Congress of the European Association for Palliative Care (EAPC)

Invited Speaker
Abstract number: INV1
Abstract type: Invited Speaker

Integrating Palliative Care Aside Curative Treatment in Hematological Diseases
LeBlanc Thomas
Duke Cancer Institute, Durham, NC, USA

Patients with hematologic malignancies are much less likely to receive palliative care services, as compared to those with solid tumors. Yet hematologic malignancy patients appear to have similar palliative care needs, including a marked symptom burden, and significant psychological distress. In addition, those with hematologic malignancies are more likely to die in the hospital, receive chemotherapy in the last 2 weeks of life, or spend time in an intensive care unit at end of life. They are also less likely to utilize hospice care services at all, and when they do utilize hospice care, they are much more likely to die within the first few hours or days of enrollment as compared to those with solid tumors. In this lecture, a dual-trained oncologist and palliative care physician will: (1) review the evidence demonstrating marked unmet palliative care needs in hematology patients, (2) highlight differences in hematologic diseases (and hematologists) that call for a unique approach to palliative care integration, and (3) demonstrate opportunities to collaborate with our colleagues in hematology to address the unmet palliative care needs of these living with hematologic malignancies.

Abstract number: INV2
Abstract type: Invited Speaker

Emerging International Evidence: What’s New in Nursing Community-based Palliative Care?
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Palliative care should be provided to all in need irrespective of place. Evidence indicates that the majority of people would prefer to die at home and yet the majority of people are still dying in hospital. Global policy recommendations emphasize the role of community care for accessible palliative care provision. There is, however, an emerging evidence base for and global pattern towards death in the community setting, influenced by multiple factors including the role of nursing in the community context. However, various challenges remain, particularly questions and ambiguity around the role of the specialist and generalist nurse; linked to other considerations such as the need for early identification of patients, timeliness of referrals to SPC, and ongoing support and education for staff. Whilst various models of care have also been suggested to help inform the future development of community nursing in palliative care, questions remain around factors such as the impact on outcomes such as place of death, carer experience and patient quality of life. This presentation seeks to address some of these factors by posing the question: What is the emerging evidence in relation to community based palliative care and the implications for nursing.

Abstract number: INV3
Abstract type: Invited Speaker

Advance Care Planning: How Nurses Can Lead the Way in Research and Practice
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Advance care planning (ACP) is the process whereby individuals define goals and preferences for future medical treatment and care, and communicate them to their family and health care providers. ACP is an important area of research and practice for nurses in general but especially for nurses concerned with palliative care. Despite large-scale educational and legal efforts to promote completion of an advance directive, a recent review found that in the United States (U.S.), only about a third of adults have completed one. U.S. and EAPC investigators have recently conducted Delphi studies to reach consensus on the most important ACP constructs and metrics that can move the field forward. However, more evidence is needed to define best practices for implementing the processes and strategies that can address patient-level, provider-level, and system level barriers so that ACP can be more fully integrated as a routine part of adult health care. Nurse scientists and clinicians in all practice settings are in unique positions to influence how patients engage effectively in ACP. A critical antecedent to influencing patients to engage in ACP is for nurses to understand the ACP process and complete their own advance directives. Then, nurses in practice need to identify opportunities within their health systems to translate best practices for promoting patient awareness, completion, and visible / retrievable documentation of conversations and documents that will ensure that patients’ values and preferences are honored. This presentation will describe recent research and strategies for nurses to be advocates in helping patients and their families to engage in the ACP process.

Abstract number: INV4
Abstract type: Invited Speaker

Nursing Research at the End of Life – What Is the Evidence Telling the Practice
Teunissen Saskia
Center of Expertise of Palliative Care Utrecht, the Netherlands
University Medical Center Utrecht, Julius Center for Health Sciences and Primary Care, Utrecht, Netherlands

Background: Personalized medicine asks for a structured route from bench to bedside. Personalized end of life research often does not come from benches but from bedsides. Nevertheless a structured route is needed to apply valuable results from bedsides to evidence based personalized care for as many patients and families as possible.

Methods: A review of recent nursing research at the end of life and its applicability in daily practice.

Results: A lot of research with various methods and measures have been done in an continuously heterogeneous population; end-of-life seems still difficult to define in research and practice. Five themes are selected for
reflection on applicability in nursing practice in community-care, hospi-

tal- and hospice-care: 1) symptom management; 2) advance care plan-

ning (including improving hospital discharge, timely end-of-life care); 3) 

communication including personalized care plans, wish lists and multi-

disciplinary collaboration; 4) end-of-Life services (incl. early access and 

community-based support from hospices) and 5) nurse leadership and 

levels of competence.

Conclusions: Evidence to support end of life care asks for a worldwide 

implementation to ameliorate patient and family outcomes. The chal-

lenge is in the diversity of definitions and cultures around the world as 

well the diversity of organization of palliative care and the aimed out-

comes in relation to diagnostic categories.

Abstract number: INV5
Abstract type: Invited Speaker

So Palliative Care Works: What Now? Achieving the Routine Inte-

gration of Palliative Care in Clinical Practice
Collins Anna
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tal, Melbourne, Australia

Since its inception, palliative care practice has evolved in response to the 

emerging evidence base and the needs of the population it serves. This 

has resulted in the increasing health system focus on models of early 

integration of palliative care, enabling improved quality of life, preven-
tion of suffering, and the achievement of goals considered important by 

people with serious illness and their families. Yet, population data from 

international jurisdictions including those such as Australia with “advanced” systems of integrated care suggest a picture of missed opportunities, whereby patterns of care do not reflect the evidence for best practice. If palliative care represents “best quality care” for people with serious illness, why do many patients and their families engage late, or not at all?

This presentation will explore the next steps for achieving routine inte-

gration in practice: when to introduce palliative care, how to talk about it 

with patients and their carers, and the need to shift community perception 

of palliative care. Mixed methods data will be drawn upon to dis-

cuss key opportunities for health system change, public health 

communication, and the future promotion of palliative care. Achieving 

the routine integration of palliative care in clinical practice requires not 

only a health system focus, but also strategic community engagement.

Abstract number: INV6
Abstract type: Invited Speaker

Children and Young People with Palliative Care Needs: what do the 
data tell us?
Fraser Lorna Katherine
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The World Health Organisation’s definition of children palliative defini-
tion is clear that ‘it begins when illness is diagnosed, and continues 

regardless of whether or not a child receives treatment directed at the 
disease’. Palliative care services for children in the UK have developed 

over the last 30 plus years in a very organic and non-‘systematic way, 

with many of the services being provided by voluntary sector organisa-
tions. This has led to patchy availability of services and a poor under-

standing of the needs for these services. This presentation will summarise a programme of research, undertaken by the author, which has aimed to address some of these gaps in knowl-

dge. The results of studies which have analysed routinely collected 

health and administrative data from the UK to estimate the number of 

children with life-limiting or life-threatening conditions, the stage of 

condition of these children and the benefits of specialist palliative care 
input in this population will be presented. The need for continuous, spe-
cific and high quality data collection in this sector will also be 

discussed.

Abstract number: INV7
Abstract type: Invited Speaker

The Evidence of Need for Early Integrated Palliative Care from 

Diagnosis
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Usher Institute, Edinburgh, UK, 2Université Paris 13, Laboratoire Educa-
tion et Pratiques de Santé [LEPS], Paris, France

Background/aims: The WHO calls for a palliative care approach to be 
included in the care of patients starting from early diagnosis of a life-

threatening condition. To emphasise this point this timeous approach 
is now being called “early” palliative care. This talk will summarise the 
evidence which has been built up in the last 15 years concerning early 
integrated palliative care.

Methods: We will present primary research, systematic reviews and 

other peer-reviewed evidence concerning the need for and acceptability 
of an early palliative care approach in the following circumstances:

1. All illnesses: for people and their carers with all life-threatening illnesses.
2. All times: from diagnosis to death and bereavement
3. All dimensions of need: physical, psychological, social and 
   spiritual
4. All settings: at home, in care homes, and in hospital
5. All countries: in low, middle and high income settings

Results: Much evidence now exists for many life-threatening illnesses 
of multi-dimensional distress and palliative care needs from early in the ill-

ness trajectory. Furthermore intervention studies are starting to provide 
evidence of improved quality of life for patients and carers, and some-
times longevity.

Conclusions: Evidence now exists to justify widespread adoption of 
early integrated palliative care. Such care has more time to promote 
health and prevent unnecessary distress than the all-too-common late 
identification of patients for palliative care.

Abstract number: INV8
Abstract type: Invited Speaker

The Impact of Informal Caregiving: Challenges and Opportunities 
of Conducting Research
Grande Gunn
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Care, Manchester, UK

Informal carers play a major role in sustaining care at home for palliative 
care patients and preventing inpatient admissions. Our dependence on 


carers is likely to further increase in the future in light of projected demo-

graphic changes. Caregiving is associated with considerable negative 

impacts on carers’ health, but also brings rewards. This presentation will 

consider the scale and content of carers’ contribution to care for palliative 
care patients. It will also consider the impact on carers’ psychological 

health and general health during caregiving, and what may increase or 

decrease impact. It will cover some of the barriers involved in improving 

our support for carers and how they may be overcome. Finally, the pres-

entation will reflect on challenges of conducting research with carers and 

potential future developments of this research.
Abstract number: INV9
Abstract type: Invited Speaker

Intervention Studies Based in the Community/Primary Care
Engels Yvonne
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Background: General practitioners (GPs), having a long-standing relationship with their patients, should have an important role in early, anticipatory palliative care. Being generalists and no experts in palliative care, GPs ask for guidance in how to timely identify palliative patients and to structure anticipatory care.

Methods: In the past decade, key challenges regarding timely primary palliative care have been identified: when to start with timely palliative care, how to communicate the uncertain future with the patient, and how to plan anticipatory care. As a possible solution, identification tools, communication aids, and anticipatory care planning frameworks have been developed, which have been applied in all kind of studies.

Results: Several identification tools have been developed like the (double) Surprise Question, RAPDAC (NL), SPICT (Scotland), NcEpal (Spain) and GSF-Pig (England). In combination with interventions like training in communicating the uncertain future and in anticipatory care planning, these tools have been applied in prospective studies in primary care, with all kind of patient populations, and with mixed results.

Conclusions: In the past decade, important steps have been made to help GPs to provide anticipatory palliative care to patients living in the community. During this presentation, an overview of these developments, including future challenges will be provided.

Abstract number: INV10
Abstract type: Invited Speaker

Using Big Data for Health Economic Palliative Care Research
Cohen Joachim
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Background: Health economic evaluation in palliative care research is concerned with both the quality and costs of end-of-life care. The increasing availability and quality of population-level administrative databases provides new possibilities. These are illustrated in this presentation by demonstrating how the data can be used to: 1) assess appropriateness of end-of-life care using a validated set of quality indicators, 2) describe the medical care costs and components of these costs; 3) link the costs to the appropriateness of care.

Methods: A cohort study design is used, analyzing linked health claims, pharmaceutical, cancer registry and population databases for all deaths in Belgium, 2012. For the purpose of illustration the presentation will be limited to the cohort who died of cancer (N=26,464) as identified through the death certificate data. Scores for the different quality indicators (QIs) are calculated from the data; patient and health insurance expenditures of all medical care are costed into relevant cost components; and the influence of an increase in appropriateness of end-of-life care on the different costs components is evaluated.

Results: A large risk-adjusted variation is found between different care regions in the scores for QIs as use of specialized palliative care use or opioid prescription, hospital admissions, ICU admissions and diagnostic testing in the final month of life. The costs of end-of-life care are particularly generated by hospitalization, use of specialists, and (outpatient) medication. Cost-savings or expenditures associated with an improvement in the different QIs for the total cancer population will be shown in the presentation.

Conclusion: This presentation illustrates how big data can be a convenient and accessible source to not only evaluate the costs of end-of-life care but also to evaluate these costs in relation to the appropriateness of end-of-life care. QI score calculations can be used to set relative performance standards of end-of-life care. The impact of attaining these performance standards on cost-savings or expenditures can then be determined.

Abstract number: INV11
Abstract type: Invited Speaker

Mixed Methods Research and the Implementation of the MORECare Recommendations
Todd Chris
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Background: A scoping review in early 2018 of Medline identifies < 0.5% of palliative/end-of-life research uses mixed-methods. Yet palliative/end-of-life care research is an area which lends itself to such a research paradigm. In palliative/end-of-life care we commonly use complex interventions requiring multiphase development and evaluation. Such development per se requires use of mixed-methods if we are to fully understand and explain how interventions are effective (or are not). Although generic mixed methods approaches may be useful there may be specific challenges to implementation of mixed methods research in palliative/end-of-life care research. The MORECare project developed a statement and sets of recommendations on good practice in palliative/end-of-life research, including recommendations for using mixed-methods.

Objective: (a) To review the sorts of research questions that are amenable to mixed-methods approach in palliative/end-of-life research. (b) To describe the development of the MORECare guidance on best practice in using mixed-methods in palliative/end-of-life care research. (c) To exemplify the use of mixed-methods and demonstrate what can be learnt using this approach in palliative/end-of-life research compared to using either traditional quantitative or qualitative designs alone.

Methods: I present an overview of the MORECare Statement recommendations and focus on those recommendations for mixed-methods [1]. Based on these recommendations I review a series of research questions using quantitative and qualitative designs and how they may benefit from using mixed-methods approaches.

Results: I exemplify the strengths (and limitations) of mixed-methods with reference to a series of research projects in palliative/end-of-life care investigating service models, carer support, breathlessness, nutritional interventions, and prognostication.


Abstract number: INV12
Abstract type: Invited Speaker

Challenges and Opportunities in Registry-based Research in Palliative Care
Ekström Magnus
Institution for Clinical Sciences, Lund University, Department of Respiratory Medicine and Allergology, Lyckeby, Sweden

Background: Registry-based studies and routinely collected health care data are potential powerful tools to address and inform evidenced-based palliative care. The aim of this session is to discuss challenges and opportunities in registry-based palliative research.
Methods: Research areas and potential questions, available databases, cross-linkage analysis, and differences in advantages and disadvantages of different study designs will be reviewed. Examples from past and ongoing projects in Sweden will be presented. Particular focus will be on combining strengths of the Registry-based Randomized Controlled Trial (R-RCT).

Results: The R-RCT design offers opportunities for facilitating recruitment and follow-up of populations with advanced life-limiting disease. Inclusion of a large and representative sample of the target patient population, combined with randomization and complete follow-up of primary outcomes through cross-linkage with National registries, can yield high external and internal validity to a relatively low cost. There is growing experience on challenges and pitfalls in the design, conduct and analysis of registry-based data and R-RCTs that should be addressed by the investigators.

Conclusions: Registry-based studies and randomized controlled trials are important and powerful tools to take forward improved evidence-based palliative care.

Abstract number: INV13
Abstract type: Invited Speaker

How to report and interpret negative and borderline study results
Mogens Groenvold
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Publication bias is a well-known problem in all areas of research: positive findings are more frequently published, are published in higher-ranking journals, attract more attention from readers, and are more likely to have impact than negative or borderline findings. In medical research such publication bias is problematic as it may lead to the use of ineffective interventions.

To address these problems, it is important that negative studies are published, that they are published as well and in as much detail as possible, and that they are carefully read and quoted. In the reporting and interpretation of negative and borderline studies, the analysis and discussion should try to distinguish between two main categories of interpretations.

A ‘false negative result’ (negative result although the intervention had effect) may arise if the study was underpowered, had inadequate endpoints, was affected by selection bias, or had other methodological weaknesses. False negative results are problematic as they may prevent adoption of an effective intervention. The key issue in reporting and interpretation is to scrutinise the methodology and to identify the potential flaws; thus assisting future researchers in improving research and to obtain more correct results.

On the other hand, a ‘true negative result’ may be an important finding alerting researchers and clinicians that an intervention does not have the effect they had hoped for. This may reflect that the principle was wrong, that it was not delivered in the optimal way (e.g., dose, timing), that the ‘right’ patients were not selected, or that there were other unforeseen factors that prevented the desired outcome. The key issue in reporting and interpretation is to scrutinise the intervention, the delivery, and the patient population: a careful process evaluation is important, and all aspects of the intervention should be investigated in detail. The main goals are to learn from the failure how the intervention can be improved.

The challenge for researchers and readers is to distinguish false negative and true negative results, and this requires that both the methodology and the intervention and delivery are reported, and discussed in detail. Unfortunately, this may be difficult within the limitations of journal articles, but researchers reporting negative results should make an effort to follow up their primary publication with additional analyses and investigations, and journals and reviewers should value such efforts highly, as they may contribute new insights that may even be more important than replications of positive findings.
Introduction: The Netherlands has recognized the need for a national palliative care strategy. As result of a political lobby, a National Program on Palliative Care (NPPZ) started in 2014. This program encompasses governmental action, institutional cooperation in seven regional consortia spanning the country and the ZonMw research and implementation program Palliantie. The budget is around €50 million. At the end of the NPPZ in 2020, the Netherlands hopes to have significantly improved palliative care for Dutch patients. Palliantie plays a key role in achieving this goal.

Lecture: Following a brief introduction of the genesis of the national program in the Netherlands, the funding of research and implementation in Dutch palliative care through the Palliantie program will be discussed. Emphasis will be placed on ways to heighten the probability that knowledge and products will actually be used when projects end. How the results of the - until now - 61 funded projects and concurrent national and international developments in palliative care continually shape the future of Palliantie will conclude the lecture.

Target group: EAPC delegates who are interested to learn more about a national program and the development of knowledge to achieve noticeable improvements in palliative care for patients and their families.

Abstract number: INV18
Abstract type: Invited Speaker

National Funding in Germany - Palliative Medicine Research Streams
Ostgathe Christoph
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In Germany, palliative care has - albeit compared to other countries with a significant delay - tremendously evolved over the last 35 years. In the meanwhile a paradigm shift has taken place; palliative care has evolved from mainly service provision to a growing science-based discipline with increasing structures for research in palliative care. The “Evidenced-based Guideline: Palliative care for patients with incurable cancer”, published in May 2015, can be considered as an indicator for this change. The academic development of the field in Germany was rather gentle. The first chair for Palliative Medicine was introduced in 1999 in Bonn and initiated first studies. In the meanwhile with 9 chairs and their corresponding research teams there is a critical mass for progressing evidence in the field. Hence for many years there was no national funding for Palliative Care.

The main catalysts for an encouraging development in national funding in the field of palliative medicine over the last 5 years are at least three-fold. Firstly, the “German National Academy of Sciences Leopoldina” developed the statement “Palliative care in Germany - Perspectives for practice and research”. This was well perceived in public and politics. Shortly after distribution the first major call on palliative care from the Federal Ministry of Education and Research was published, including possibilities for single and joint projects and - most importantly - also a stream for promoting young researchers. Secondly, the above named Guideline fostered the awareness of the national funding organizations towards palliative care as a research issue. Lastly, the German legislation on Hospice and Palliative care from 2015, was an important milestone. Hence, the government funds annually 300 Million € on new services and health service research and a share of the projects are on palliative care. However in some areas the notion is not (yet) that positive. In the German Research Foundation the funding quota of palliative care is still low due to structural barriers. Many funded projects are on track now and the academic palliative care structures in Germany have to proof that they are capable to successfully perform major studies and develop better evidence aiming at a more appropriate support to patients in need in the future. If we fail the positive notion will diminish as fast as it appeared and national funders may withdraw their support!
Plenary I

Abstract number: PL1
Abstract type: Plenum

Efficacy and Side Effect Profile of Olanzapine versus Haloperidol for Symptoms of Delirium in Hospitalized Patients with Advanced Cancer: A Multicenter, Investigator-blinded, Randomized, Controlled Trial (RCT)

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Background: Delirium is highly prevalent in patients with advanced cancer. Patients experiencing delirium may require pharmacological treatment to reduce distressing symptoms. Atypical antipsychotics, like olanzapine, are potentially safer and more effective than haloperidol, but no phase III RCTs are reported in patients with advanced cancer.

Methods: Hospitalized patients with advanced cancer diagnosed with delirium (DSM-IV-TR criteria) were randomly assigned centrally (1:1) to olanzapine or haloperidol. Dosages were up-titrated. Primary endpoint was delirium resolution rate (DRR), defined as Delirium Rating Scale-Revised-98 (DRS-R-98) total severity score < 15.25 points and > 4.5 points reduction. Secondary endpoints: time to recovery, grade ≥ 3 side effects (Common Terminology Criteria for Adverse Events version 3.0), and distress (Delirium Experience Questionnaire). The study was powered to increase DRR with 25% for olanzapine compared to haloperidol.

Results: Between January 2010 and June 2016, 100 of the anticipated 200 patients were enrolled in the study from 6 sites in the Netherlands and randomly assigned to olanzapine (n = 50) or haloperidol (n = 50). Baseline characteristics were well balanced. Interim analysis showed a difference in DRR of -12.2% (95% confidence interval (CI) = -32.0%–7.4%); 45% for olanzapine (95% CI 31.0-58.8) vs. 57% for haloperidol (95% CI 43.3-71.0), P = 0.22. Time to recovery was 4.5 days in the olanzapine arm vs. 2.8 days in the haloperidol arm (P = 0.20). There was no difference in grade ≥ 3 side effects between both arms (OR 0.44, 95% CI 0.14-1.40; P = 0.16). Mean level of distress in patients was 2.1 (SD 1.4) for olanzapine vs. 2.3 (SD 1.4) for haloperidol (P = 0.80). Formal interim futility analysis indicated a conditional power of 0.086, implying a very low likelihood (8.6%) of reaching the expected DRR superiority rate of 25% for olanzapine. Therefore, the study was prematurely terminated.

Conclusions: No difference in efficacy and side effect profile was observed between haloperidol or olanzapine treatment for delirium in patients with advanced cancer.

Plenary II

Abstract number: PL2
Abstract type: Plenum

Timing of Referral to Hospice-based Specialist Palliative Care before Death: A National Retrospective Cohort Study in the UK

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Background/aims: Earlier integration of palliative care in advanced disease (around 6-12 months before death) is associated with better outcomes at the end of life within randomised clinical trials. However, there are few data to determine timing of referral to palliative care before death in current routine services. Existing reports of factors influencing timing of referral to specialist palliative care (SPC) are based on small sample sizes in a limited number of settings. We conducted the first large-scale national study to determine timing of referrals to SPC across the United Kingdom (UK) and factors that influence this.

Methods: 64/210 (30%) UK-based hospices providing community-based SPC supplied data on 42,758 people aged ≥18 years with a referral to a hospice at any point, with death occurring 1 January - 31 December 2015. For each patient, data were submitted on age at death, sex, ethnicity, diagnosis at referral, and number of days between referral and death. Each hospice provided data on total number of unique patient referrals received during 2015, number of in-patient beds, and staff capacity for community nursing teams and palliative care doctors.

Results: Across all cases, median time from referral to death was 48 days. 17,122 (40%) referrals occurred within 4 weeks of death; 30% of these were lung and upper GI cancers. Timing of referral differed for those with cancer (53 days) and non-cancer (27 days) (< 0.0001), and between younger and older patients: for those under 50 years (78 days), 50-74 years (59 days), and 75 and over (39 days) (P=0.0001). An adjusted multi-variable negative binomial model demonstrated increasing age, being male, and having a non-cancer diagnosis as persisting significant predictors of fewer referral to death days (P = p < 0.001). Regional variations in timing of referral to hospices were identified, with significantly fewer days received by patients in the North of England (35 vs 55 days, p<0.001).

Conclusions: This national study highlights that despite increasing evidence supporting earlier referral to palliative care, patients with advanced disease continue to receive referrals late in their illness trajectory. Known inequalities in the provision of SPC persist (age and diagnosis), alongside identified regional variations in provision. A reorientation of hospice care may be required to ensure effective and equitable access to SPC across the UK to meet the needs of older patients and those with non-cancer diseases.

Abstract number: PL3
Abstract type: Plenum

Early and Systematic Integration of Palliative Care in Multidisciplinary Oncology Care: A Randomized Controlled Trial

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Background: Studies have shown the benefit of early palliative care (PC) on quality of life (QOL) in advanced cancer. This is the first randomized controlled trial to examine whether early and systematic integration of PC alongside to standard psychosocial oncological care provides added benefit. Method: We randomly assigned advanced cancer patients with a life-expectancy of one year to either early and systematic integration of PC into oncological care (intervention) or standard oncological care alone (control). QOL was assessed at baseline and at 12 and 18 weeks with the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire (EORTC QLQ C30) and McGill Quality of Life (MQQOL). Frequency of contact with a psychologist, dietitian, social worker or a nurse specialist between baseline and 18 weeks was collected from the medical records.
Results: From April 29, 2013 to February 29, 2016, we enrolled 186 patients: 133 completed assessments at 12 weeks and 109 at 18 weeks. At 12 weeks, QOL was significantly higher in the intervention group than in the control group (mean score: QOL scale of the EORTC QLQ C30 (primary outcome) (range 0-100); Intervention: 62.0 [95% CI 57.02-66.95], P vs. Control: 54.4; 49.23-59.56), P = 0.03; mean score: MQOL Single Item (range 0-10); Intervention: 7.1 [6.59-7.50] vs Control: 5.9 [5.50-6.39], P < 0.001). Similar effects were found at 18 weeks (EORTC QLQ C30, Intervention: 68.2 [58.78-69.59] vs Control: 54.7 [49.09-60.32], P = 0.01; MQOL, Intervention: 7.0 [6.45-7.55] vs. Control: 5.5 [4.96-6.07], P < 0.001). The number of consultations with a psychologist was also significantly higher in the intervention group (Control: median = 0, IQR 0-0, Intervention: median=0, IQR 0-1.75, P = 0.02). We found four more significant effects in the secondary outcomes favouring the intervention group and one outcome (diarrhoea) favouring the control group.

Discussion: This study shows that a model of early and systematic integration of palliative care in oncological care increases the QOL of advanced cancer patients. It also shows that patients already receiving standard psychosocial support benefit from early and systematic integration of PC into oncological care.

Funding
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Plenary III
Abstract number: PL4
Abstract type: Plenum

The Impact of Supporting Family Caregivers Pre-bereavement on Outcomes Post-bereavement
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Background: The investigation of the situation of bereaved family caregivers following caregiving during the end-of-life phase of illness has not received enough attention.

Objectives: This study investigated the extent to which using the Carer Support Needs Assessment Tool (CSNAT) intervention during the caregiving period has affected bereaved family caregivers’ perceptions of adequacy of support, their grief and wellbeing and achievement of their preferred place of death.

Method: All family caregivers who participated in a stepped wedge cluster trial of the CSNAT intervention in Western Australia (2012-14) and completed the pre-bereavement study (n=322) were invited to take part in a caregiver survey by telephone 4-6 months post-bereavement (2015). The survey measured the adequacy of end of life support, the level of grief, the current physical and mental health, and the achievement of the preferred place of death.

Results: The response rate was 60% (152, intervention; 60 control). The intervention group perceived their pre-bereavement support needs had been adequately met to a significantly greater extent than the control group (d=0.43, P<0.001) and that patients have achieved their preferred place of death more often according to their caregivers (79.6% vs 63.6%, P=0.034). There was also a greater agreement on the preferred place of death between patients and their caregivers in the intervention group (p=0.02).

Conclusions: The findings provide evidence that the CSNAT intervention has a positive impact on perceived adequacy of support of bereaved family caregivers and achievement of preferred place of death according to caregivers. The benefits gained by caregivers in being engaged in early and direct assessment of their support needs pre-bereavement, reinforces the need for palliative care services to effectively support caregivers well before the patient’s death and consider the continuum of the pre- and post-bereavement phases. However, this will not be achieved until services are funded to enable them to fully adhere to their ethos of being there for the family caregivers as well as the patients.

Abstract number: PL5
Abstract type: Plenum

A Patient and Clinician Communication-priming Intervention Increases Patient-reported Goals-of-Care Discussions between Patients with Serious Illness and Clinicians: A Randomized Trial
Currie, J.; Randall, Dowsey, Lois, Back, Anthony, Nielsen, Elizabeth, Treece, Patsy, Engelberg, Ruth
Cambia Palliative Care Center of Excellence, University of Washington, Seattle, USA

Importance: Communication about goals of care is associated with improved patient outcomes and reduced intensity of end-of-life care, but it’s unclear whether interventions can improve this communication.

Objective: To evaluate the efficacy of a patient-specific communication-priming intervention (Jumpstart Tips) targeting both patients and clinicians and designed to increase goals-of-care conversations.

Design, setting, participants: Multi-center cluster-randomized trial in outpatient clinics conducted between 2012 and 2016 with 115 physicians and 9 nurse practitioners caring for 537 participating patients.

Intervention: Clinicians were randomized to the bilateral pre-conversation communication-priming intervention (n=65) or usual care (n=67) with 249 patients assigned to intervention and 288 to usual care.

Main outcomes and measures: The primary outcome was occurrence of a goals-of-care conversation during a target outpatient visit. Secondary outcomes included clinician documentation of a goals-of-care conversation and patient-reported quality of communication at 2 weeks, as well as patient assessments of goal-concordant care at 3 months and patient-reported symptoms of depression and anxiety at 3 and 6 months. Analyses were clustered by clinician and adjusted for patient characteristics.

Results: We enrolled 132 of 485 potentially eligible clinicians (27% participation rate) and 537 of 917 eligible patients (59% participation rate). The intervention was associated with significant increase in a goals-of-care discussion at the target visit (75% versus 31%; p<0.001) and increased chart documentation (62% vs. 17%; p<0.001), as well as increased patient-rated quality of communication (4.6 versus 2.1; p=0.010). There was no significant increase in patient-assessed goal-concordant care overall (70% vs. 75%; p=0.073), but there was increased goal-concordant care for patients with stable goals between enrollment and the target visit (73% vs 57%; p=0.017). There was no significant difference in symptoms of depression or anxiety at 3 or 6 months (p>0.1 for all).

Conclusions: This intervention increased the occurrence, documentation, and quality of goals-of-care communication during routine outpatient visits and may be associated with increased patient-assessed goal-concordant care at 3 months, with no change in symptoms of anxiety or depression. Understanding the effect on subsequent healthcare delivery will require additional study.

Integration of oncology and palliative care
Abstract number: FC1
Abstract type: Oral presentation

Indicators of Integration at European Society for Medical Oncology (ESMO) Designated Centres of Integrated Oncology and Palliative Care
Hui, David1, Cherry, Nathan1, Wu, Jimin1, Liu, Diane1, Latino, Nicola1, Strauss, Florian1

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A Review of Cancer-directed Treatments and Palliative Care Provided to Solid Tumour Oncology Patients in the 12 Weeks Preceding Death at an Irish University Hospital

Mallett, Victoria1, Linehan, Anna1, Burke, Orlaidh1, Laura, Healy1, Sarah, Picardo1, Ryan, Karen1, McCaffrey, John1, Kelly, Cathy1, Higgins, Michaela1
1Oncology, Mater Hospital, Dublin, Ireland, 2Palliative Care, Mater Hospital, Dublin, Ireland

Aims: This study’s primary objective was to identify the number of patients who received cancer-directed therapy in the last 12 weeks (w), 4w and 2w of life at our cancer centre. Secondary endpoints included number of hospital admissions, number of procedures and timing of specialist palliative care referral in the last 12, 4 and 2w of life.

Methods: We identified deceased oncology patients who received cancer-directed therapy from January 2015-July 2017. Retrospective chart and electronic chemotherapy prescribing system review was conducted for the last 12w of life. Fisher exact testing was used for analysis.

Results: 296 patients died during the study period. Results are summarised in Table 1. Patients who received chemotherapy in the last 12w of life were more likely to be admitted to hospital, to undergo a procedure, and to die in hospital than those who did not receive chemotherapy (P <0.01, 0.02 and 0.04 respectively). 173 (57%) patients were referred to palliative care. The median time before death of palliative care referral was shorter in those patients who underwent treatment than those who did not (45 versus 111 days). Patient demographics and further secondary endpoints will be presented.

Abstract number: FC3
Abstract type: Oral presentation

Everyone Wants to Contribute - A Focus Group Study of Inter-professional Collaboration and Integration in Oncology and Palliative Care

Lundeby, Tonje1, Grotmol, Kjersti S1, Wester, Torunn1, Loge, Jon Håvard1,2, Kaasa, Stein1, Aass, Nina1,3, Finset, Arnstein2
1Department of Oncology / PRC, Oslo University Hospital, Oslo, Norway, 2Department of Behavioral Sciences in Medicine, University of Oslo, Oslo, Norway, 3Faculty of Medicine, University of Oslo, Oslo, Norway

Background: Influential bodies recommend integration of palliative care (PC) and oncological care early in the cancer trajectory. Integration infers organizational changes and collaboration between health care providers (HCPs). In preparation of a cluster-randomized trial on integration of PC and oncological care (PALLiON) focus group interviews were conducted with HCPs.

Aim: To study what HCPs perceive as influencing inter-professional collaboration and integration in the treatment of patients with advanced cancer.

Methods: Six focus group interviews were conducted with oncologists, PC consultants, oncological residents, PC nurses, and two with oncological nurses. An interview guide including the following topics was used: challenges in treatment of patients with advanced cancer, inter-professional collaboration, patient involvement and personal learning needs. The interviews were audiorecorded and transcribed. Primary analyses were performed using thematic analysis.

Abstract number: FC2
Abstract type: Oral presentation

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1Oncology, Mater Hospital, Dublin, Ireland, 2Palliative Care, Mater Hospital, Dublin, Ireland

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Abstract type: Oral presentation

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1Department of Oncology / PRC, Oslo University Hospital, Oslo, Norway, 2Department of Behavioral Sciences in Medicine, University of Oslo, Oslo, Norway, 3Faculty of Medicine, University of Oslo, Oslo, Norway

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Table 1. Treatments and interventions in last 12 weeks of life.

<table>
<thead>
<tr>
<th>Treatment/interventions</th>
<th>In last 12 weeks</th>
<th>In last 4 weeks</th>
<th>In last 2 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=296</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Any systemic anti-cancer treatment</td>
<td>153(52)</td>
<td>52(18)</td>
<td>21(7)</td>
</tr>
<tr>
<td>Cytotoxic chemotherapy</td>
<td>111 (38)</td>
<td>31 (10)</td>
<td>11 (4)</td>
</tr>
<tr>
<td>Immunotherapy</td>
<td>60 (20)</td>
<td>20 (7)</td>
<td>9 (3)</td>
</tr>
<tr>
<td>Targeted oral therapy</td>
<td>55 (19)</td>
<td>14 (5)</td>
<td>6 (2)</td>
</tr>
<tr>
<td>Invasive procedure</td>
<td>80 (27)</td>
<td>36 (12)</td>
<td>19 (6)</td>
</tr>
<tr>
<td>Admitted to acute hospital</td>
<td>206 (70)</td>
<td>151 (51)</td>
<td>140 (47)</td>
</tr>
</tbody>
</table>
Results: Three main themes were identified as influencing inter-professional collaboration and integration in the treatment of patients with advanced cancer. The first theme was **treatment focus**; a focus on the tumor directed treatment more than on the patient. Treatment focus may delay referral to PC as well as limit inter-professional collaboration between oncologist and the PC team. It may also cause futile treatment all towards end of life. Treatment focus was more often a label put on others’ approach in patient care, than on one’s own. The second identified theme was a **focus on the whole patient** including their understanding by tailored information provision and shared decision-making. A patient-centered approach was considered desirable. HCPs more often labeled own behavior as patient-centered compared to other HCPs’ behavior. The third identified theme was **organization**, and was related to barriers and how to facilitate collaboration and integration at a system level. Continuity of care and areas for inter-professional communication were highlighted. HCPs expressed that physician-nurse communication was lacking, whilst communication between oncologists and PC physicians was described as well-functioning.

Conclusion: The interviewed HCPs are eager to contribute with their specific skills in patient care. However, perceiving own behavior as more patient-centered than others’, could in addition to perceived organizational barriers, hinder integration and inter-professional collaboration.

Abstract number: FC4
Abstract type: Oral presentation

Development and Evaluation of Digital Curriculum in Palliative Care for Oncology Fellows

**Von Roenn, Jamie1, von Gunten, Charles2**
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2Hospice and Palliative Medicine, OhioHealth, Columbus, USA

Background: Program Directors of Oncology Fellowships cite lack of adequate faculty to teach communication skills, prognostication and symptom management to oncology fellows as a barrier to ensuring oncologists integrate palliative care into their own practice. We partnered with the American Society of Clinical Oncology and its Training Program Directors Committee to develop, evaluate and disseminate a PC curriculum using an innovative format.

Methods: All of the fellows in a program were randomized as a single group to one of 3 cohorts: digital education, digital education plus a 4-week palliative care rotation or delayed digital education (control). In the intervention, each fellow received 2 multiple choice questions (on their phones or other device) focused on a particular teaching point, every other day. If answered incorrectly, focused education material was forwarded to the learner and the testing point was retested at a later date. Fellows in cohort 2 also participated in a clinical rotation with a clinical palliative care program. Cohort 3 received the same training as cohort one, but beginning fellowship year 2, as a delayed control. Fellows’ palliative care knowledge was assessed during the in-training exam pre- and post-intervention. Opioid prescribing behavior was tracked after graduation and compared with a control group (group 4) of fellows trained prior to this project.

Results: 283 fellows from 71 programs were quasi-randomized. The average score on the examination ranged from 70-73% correct across all groups and all years, for pre- and post-test scores. All fellows randomized to the palliative care rotation completed it. Prescribing data was based on their phones or other device) focused on a particular teaching point, every other day. If answered incorrectly, focused education material was forwarded to the learner and the testing point was retested at a later date. Fellows in cohort 2 also participated in a clinical rotation with a clinical palliative care program. Cohort 3 received the same training as cohort one, but beginning fellowship year 2, as a delayed control. Fellows’ palliative care knowledge was assessed during the in-training exam pre- and post-intervention. Opioid prescribing behavior was tracked after graduation and compared with a control group (group 4) of fellows trained prior to this project.

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Conclusions: Spaced education via a hand held device is acceptable, efficient, effective and cost-effective. All groups showed acceptable knowledge on the in-training examination. Opioid prescribing behavior in the year after training improved as a result of the education intervention.

Perplexingly, the favorable impact on opioid-prescribing behavior was extinguished by the palliative care rotation, raising the question about the role of a palliative care clinical rotation for oncology fellows.

Abstract number: FC5
Abstract type: Oral presentation

Association between Palliative Care Follow-up and Aggressiveness of Cancer Care Near the End of Life

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1Clinique de Soins Palliatifs, Université Grenoble Alpes, La Tronche, France
2Santé Publique, Pôle Information Médicale Évaluation Performance - Hôpitaux Champagne Sud, Troyes, France

Objective: Improving quality of life is the goal of palliative care. Studies highlighted association between Aggressive Cancer Care (ACC) near the End of Life (EoL) and lower quality of EoL. This study aimed to evaluate the impact of palliative care team (PCT) follow-up on ACC near the EoL in a teaching hospital in France. The secondary objective was to evaluate the association between ACC and the type of cancer.

Methods: 561 inpatients were enrolled in this observational retrospective study from January to December 2015. Patients over 18 years old, with an active cancer diagnosed at least one month before death were included.

Patients followed by a PCT at least one month before death were enrolled in the PCT group. Patients without any PCT intervention or less than a month before death were enrolled in the no-PCT group. The studied ACC were hospitalizations within the last month of life in the Emergency room (ER), Intensive Care Unit (ICU) and Sterile Room (SR), location of death (ICU, ER and SR), the use of chemotherapy in the last two weeks, a new line of chemotherapy within the last month and hospice admission within the last 3 days of life.

Results: 89 patients were followed for one month or more before death. The no-PCT-group included 320 patients without any PCT intervention and 152 patients with a PCT follow-up of less than a month. 22% (n=124) of patients received chemotherapy in the last two weeks, 20% (n=110) died in an ACU. 395 patients (71) received at least one ACC. In the PCT-group, ACC were significantly less frequent (50.6% Vs 74.7%, p<0.0001), patients died less frequently in an Acute Care Unit (5.6% Vs 22.3%, p=0.0003), and had less chemotherapy during the last two weeks of life (11.2% Vs 24.4% p=0.0062). Patients with digestive cancer received less ACC than patients with lung cancer (OR 0.44 (0.26-0.74), p<0.01).

Conclusion: This study highlighted the association between a PCT follow-up and fewer ACC but a multicenter study seems to be necessary to confirm our result. Early integrated PCT intervention needs to be include as a care routine in order to improve quality of life of patients with cancer.

Abstract number: FC6
Abstract type: Oral presentation

Integrated Oncology and Palliative Care: Analysis of a New Service for Cancer Patients

Kano, Yakie, Nevin, Julie, Stevens, Anna-Marie, Wood, Jayne, Kennett, Alison, Kamal, Laila, Halley, Angela, Droney, Joanne

Symptom Control and Palliative Care, Royal Marsden NHS Foundation Trust, London, UK

Background: There is growing evidence to support the benefits of early integrated palliative care (PC) for patients with advanced cancer. Within a tertiary referral cancer centre we set up a new Integrated Symptom Control and PC service. The aim of this service is to proactively identify patients who would benefit from PC review and to offer PC support to...
patients earlier in their cancer journey. The aim of this study is to assess the feasibility and outcomes of this service.

Methods: This pre-post design study was approved by the hospital Committee for Clinical Audit and was part of a national programme to develop integrated PC. A baseline audit was carried out, followed by implementation of the new service with prospective analysis. Appropriately patients with incurable disease were identified in the oncology outpatient clinics. Two tumour groups were selected due to their poor prognosis; renal cell cancer (RCC) and gynaecological cancer (GC). The prospective evaluation was conducted between October 2016 and September 2017. 316 patients (RCC 111/ GC 205) were assessed as part of the new Integrated Symptom Control and Palliative Care Service. 286 of these patients (RCC 100/ GC 186) were formally assessed for PC needs using the validated Integrated Palliative care Outcome Scale (IPOS). Data were analysed using descriptive statistics.

Results: 12 months after initiation of the new Integrated service, the proportion of patients with GC and RCC reviewed by PC at diagnosis of incurable disease had increased from 26% and 16% to 80% and 93% respectively. 79% of patients with RCC and 72% of patients with GC had severe or overwhelming psychosocial needs. 18% of patients with RCC and 25% of patients with GC had severe or overwhelming physical needs. 47 patients had died at time of analysis (16 RCC and 31 GC). Median time between review by the Integrated Symptom Control and PC team and death was 134 days (range 20-318 days). This compares to a median time between PC referral and death in the baseline cohort of 98 days (GC) and 83.5 days (RCC).

Conclusions: The Integrated service proactively identifies patients with PC needs earlier and has highlighted the high burden of psychosocial needs in this patient group. This project will underpin service development and improvement initiatives to include proactive intervention to address some of these issues.

This project received no external funding.

Category of research design: pre-post design

Public health research

Abstract number: FC7

Abstract type: Oral presentation

What Matters Most for the Dutch Public in Palliative Care: A Survey van der Velden, Annette1; Engels, Yvonne2; Nanninga, Marieke3; Francke, Anneke4; Fritsma, Jolanda5; Boddaert, Manon6; Krabbe, Paul1; van der Heide, Agnes7; Reyners, An8

1UMC Groningen, Groningen, Netherlands, 2Radboud MC, Nijmegen, Netherlands, 3Zorgbelang, Groningen, Netherlands, 4NIVEL, Netherlands Institute of Health Services Research, Utrecht, Netherlands, 5IKNL, Netherlands Comprehensive Cancer Organization, Utrecht, Netherlands, 6Erasmus MC, Rotterdam, Netherlands

Introduction: Various studies with regard to the quality of care at the end of life are available. However a reliable and comprehensive system to get insight in the quality of palliative care is lacking. Moreover the opinion of the general public regarding the quality of palliative care is unknown.

Aim: We aim to develop a limited set of registration items that can be used to assess the quality of palliative care. To develop this set, the opinion of the Dutch public with regard to the most relevant aspects of quality of palliative care was investigated using an online survey.

Methods: A nationwide survey was conducted, by using an online ‘health fan’, in which 59 attributes (distinct aspects of palliative care as identified from the literature) were presented. People that visited the website with the ‘health fan’ were asked to select their top three of the most important attributes of high quality palliative care in the last weeks of life. Additionally, participants selected their top three attributes with regard to care in the last year of life.

Results: The survey was filled out by 2411 persons between May and August 2017. Most participants were women (69%), aged 46-67 years (52%). 45 (2%) respondents received palliative care themselves, 324 (14%) had relatives receiving palliative care, 849 (35%) had a recently deceased relative who got palliative care, 953 (40%) were palliative care providers and 579 (24%) had no experience with palliative care. The top three of most important items in the last weeks of life were: no pain (45%), being able to make your own healthcare decisions (31%), attention to personal wishes (28%), no anxiety (15%), skilled health care providers (13%) and attention to relatives (12%). The results for the last year of life were: being able to make your own healthcare decisions (34%), no pain (27%), attention to personal wishes (20%), meaningful life (19%), skilled health care providers (12%), attention to relatives (10%) and being informed of the disease trajectory (10%).

Conclusion: For the Dutch public the most important items with regard to high quality of palliative care are adequate pain management, being able to make your own healthcare decisions and attention to personal wishes, besides receiving care from skilled healthcare providers. These results will be used to select items to assess the quality of Dutch palliative care.

Abstract number: FC8

Abstract type: Oral presentation

End of Life Care Sustainability and Transformation Partnership Tool: Informing Decision Making and Planning of End of Life Care Services through Partnership Working Verne, Julia; Pring, Andy; Malilis, Robert; Sheppard, Shivam; Mehta, Hiral; McKenzie, Maria; Bowtell, Nicola

Public Health England, Bristol, UK

Background: Sustainability and Transformation Partnerships (STPs) are place-based plans for improving health and care services in 44 areas of England. They mark a shift away from the focus on competition as a means of improving health services by requiring NHS organisations to collaborate with each other and with local partners. About 495,000 people died in England in 2015. Research suggests that improved recognition of end of life care (EoLC) needs, as well as optimised provision of services outside the hospital setting, could enable a potential reduction in hospital costs as well as improving patient choice.

Aim: Review and provide data for EoLC to inform STP commissioning and service planning, and produce an interactive EoLC STP tool.

Methods: 24 indicators were selected for importance for services providers and commissioners of health and social care. These included: number of deaths, the age, cause and place of deaths, data describing hospital admissions near the end of life together with information on the number of care home beds and the use of palliative care registers by GP practices. Each indicator was compiled for the 44 STPs and 207 local health Clinical Commissioning Groups (CCG), together with England as a whole. Statistical differences between local area and England values were calculated.

Results: End of life care can vary in different ways: in its quality, equity, outcomes and the types of services used. Every one of the 24 indicators shows geographical variation between and within STPs. The EoLC STP Tool identifies where opportunities to address unwarranted variation exist for STPs and where service configuration could be improved. For example, we saw a 1.51 fold difference in the proportion of deaths in usual place of residence for STPs. The range was 35.46 to 53.39 %. The fold difference across STPs for three or more emergency admissions in the last 90 days of life was 2.32. STP values ranged from 4.47 to 10.38%. It is also important to understand contextual patterns in cause of death and demography when planning services. The proportion of deaths in people aged 85 years and older (33.82 to 48.47% for STPs) illustrates how contextual indicators in the tool can be used alongside outcome indicators to better understand variation.
Conclusions: The STP EoLC tool will have a radical impact, providing local commissioners with vital data to inform decision making and planning of EoLC services through partnership working across their STP.

Abstract number: FC9
Abstract type: Oral presentation
Support for Family Caregivers in Specialized Palliative Care: A Cross-sectional Survey Study
Vermorgen, Maarten1, De Vleminck, Aline1, Leemans, Kathleen1, Van den Block, Lieve1, Van Audenhove, Chantal2, Deliens, Luc1,3, Cohen, Joachim1
1End-of-Life Care Research Group, Vrije Universiteit Brussel (VUB) & Ghent University, Jette (Brussels), Belgium, 2LUCAS Center for Care Research and Consultancy, University of Leuven, Leuven, Belgium, 3Department of Medical Oncology, Ghent University Hospital, Ghent, Belgium

Background/aims: Family caregivers are the main providers of end-of-life care. Practical and emotional support from healthcare providers addressing their various needs may help to support their caregiving role and reduce or prevent some of the burden and negative consequences of caregiving at the end of life. This study aims to evaluate to what extent bereaved family caregivers of persons supported by palliative care services have received adequate information, support and aftercare and whether their evaluation varies with patient characteristics, type of palliative care service and length of enrolment.

Methods: A national cross-sectional survey was conducted in Flanders among the prime family caregivers (n = 1,504) of persons who had died under the guidance of a specialized palliative care service. Respondents were recruited through 3 mobile palliative home care teams, 17 palliative care units and 14 palliative support teams in hospitals between November 2014 and May 2016.

Results: The majority of family caregivers indicated that they were frequently asked by professional caregivers how they were feeling (77.7%) and what caring for the ill person meant to them (66.8%). They also affirmed to have received the support required to provide care for their relative (86.1%). A majority indicated having received the right amount of information about the patient’s condition (75.3%), impending death (74.2%) and the pros and cons of treatments (75.9%). More than half (56.1%) were notified of available bereavement support and 91.4% felt affirmed to have received the support required to provide care for their relative (86.1%).

Conclusions: Family caregivers of persons supported by palliative care services seem to have a positive evaluation of the assistance received at the end of life and during bereavement. However, this evaluation was substantially more positive when care was received in a palliative care unit where palliative care professionals are available 24/7. The family caregiver support in this setting could become a benchmark for all health care services providing care for dying persons.

The study was supported by Flanders Innovation & Entrepreneurship (SBO-IWT grant no. 140009).

Abstract number: FC10
Abstract type: Oral presentation
Feasibility of Different Action-oriented Techniques Used with Patients, Family and Staff in Sweden to Improve the End-of-Life Care Environment in an Action-research Project
Goliath, Ida1, Lindqvist, Olav2,3, Tishelman, Carol1,3, the Space and Place in Eol, Care Research Group, in the Dilbra Research Program
1LIME/Medical Management Center, Karolinska Institutet, Stockholm, Sweden, 2Dept of Nursing, Umeå University, Umeå, Sweden, 3Center for Innovation, Karolinska University Hospital, Stockholm, Sweden

Background/aim: Care facilities are generally designed for medical/technical functionality rather than the experiences of those who spend time in the facilities. In this transdisciplinary action research project, part of the Dilbra research program (see also Tishelman et al and Lindqvist et al), we aimed to engage patients, family and staff in a series of workshops based on their experiences of EoL care environments, as part of a process to both prioritize and implement change. In this presentation, we aim to discuss the feasibility of different action-oriented techniques used in this process.

Methods: Initially participants were recruited from acute care hospitals, specialized palliative care (PC) inpatient and home care, and residential elderly care homes. Patients/residents (n = 23), family (n = 33), and staff (n = 11) took photographs they felt depicted meaningful aspects of their EoL care/work environment and reflected on them in an interview. Inductive thematic analysis of the database of 138 photographs with interviews was used to create three 6-7 minute “trigger films” on topics salient in the data. These films focused on Space/Place, Relationships and Movement, respectively, and were used to stimulate reflection in a modified Experience-based Co-design (EBCD) process.

A total of 34 people took part in EBCD at one specialized PC unit with both inpatient and homecare. The trigger films were shown in two workshops facilitated by design and PC researchers, with patients, family and staff participating together to share experiences, suggest, and prioritize improvements to the EOL environment. A working group including all perspectives crystallized; other action-oriented techniques used in the continued EBCD process included walk-through audits, drawing and prototyping. All techniques will be illustrated in this presentation.

Results and conclusions: We found that most, but not all, of these action-oriented techniques enabled interactive discussions on intangible and complex phenomenon within EOL care, and have helped to facilitate ongoing improvement processes. However the timing of their use was of key importance.

Funding
Competitive grants from FORTE, FORMAS and National research school in health care sciences

Abstract number: FC11
Abstract type: Oral presentation
The Impact of Bereavement on Health and Mortality among Older Adults: A Nationwide, Matched Prospective Cohort Study
Morin, Lucas, Wastesson, Jonas, Agahi, Neda, Johnell, Kristina
Aging Research Center, Karolinska Institutet, Stockholm, Sweden

Context and aims: Providing psychosocial and bereavement support to family caregivers is an important mission of palliative care. However, we lack robust evidence to evaluate the health consequences of bereavement. This is especially true among older adults, since previous studies have often focused on younger age groups. The present study aimed to investigate the effects of spousal loss on health outcomes and mortality among older adults.

Study population: All surviving spouses of older adults (>65 years) who died in Sweden in 2013-2014 were matched 1:1 (sex, age) with married older adults who did not experience spousal loss.

Study design: Nationwide, longitudinal matched cohort study. Data was extracted from national registers with full-population coverage in Sweden. Using the date of spousal loss as index date, cases and controls were followed-up for 1 year.
Statistical analysis: The risk of adverse health outcomes was estimated using adjusted Cox proportional hazard regression models with stratification on the matched pairs. We calculated hazard ratios (HR) with 95% confidence intervals (CI).

Results: A total of 42,941 bereaved older adults were included and matched with an equal number of married controls. Mean age was 78.4 years (SD= 7.2), 68.3% women. Mortality rate was significantly higher among bereaved older adults (49.3 per 1000 person-years) than among controls (30.7 per 1000 person-years). The adjusted Cox regression showed a risk of 1-year mortality 1.66 (95% CI 1.54-1.79) times higher for bereaved older adults, with a greater excess risk among men (HR 1.82, 95% CI 1.62-2.03) than among women (HR 1.52, 95% CI 1.37-1.70). We found an increased risk of stroke (HR 1.27, 95% CI 1.13-1.44), injurious fall (HR 1.30 95% CI 1.23-1.37), hip fracture (HR 1.48, 95%CI 1.30-1.68), and unplanned hospitalization (HR 1.27, 95% CI 1.23-1.31) during the first year after spousal loss. Bereaved individuals were also at increased risk of nursing home admission (HR 2.01, 95% CI 1.89-2.13). During the first 90-day period after index date, we observed a 65% increase in the use of benzodiazepines and a 10% increase in the use of selective serotonin reuptake inhibitors among cases while no variation was noted in the control group.

Conclusions: Our findings confirm that bereavement has a significant and rapid impact on both fatal and non-fatal health outcomes among surviving spouses. This demonstrates the need for appropriate support of recently bereaved older adults.

Abstract number: FC12
Abstract type: Oral presentation

Integrated Palliative Care from the Perspectives of Palliative Patients with Advanced COPD, Heartfailure, and Cancer: A Social Network Analysis in Five European Countries

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Background: Palliative patients are often confronted with a diversity of caregivers. Examining perspectives of patients on integrated palliative care provision is essential, but the available literature is largely based on administrative data or healthcare professionals’ perspectives. In this abstract we aim to

(1) give insight into the composition and quality of care networks of patients receiving palliative care, and
(2) describe perceived integration between healthcare professionals within these care networks, from a patients perspective.

Methods: Social network analysis with a cross-sectional design. Patients were recruited from 23 integrated palliative care initiatives in Belgium, Germany, the United Kingdom, Hungary and the Netherlands. Data collection consisted of the following questionnaires: palliative outcome score (POS), a predefined Social Network questionnaire, CanhelpLite. Data were collected between June 2014 and August 2015. Ethical approval was obtained in the participating countries.

Results: We recruited 157 patients (62% cancer, 25% COPD, 13% CHF, mean age 68 years and 55% female) Thirty-three percent of the patients reported having contact with a palliative care specialist and 48% with a palliative care nurse. Relationships with palliative care specialists were rated significantly higher compared to other physicians (p< 0.001). Compared to patients with cancer, patients with COPD (OR=0.16, CI [0.04;0.57]) and CHF (OR=0.11, CI [0.01;0.93]) had significantly lower odds of reporting contact with palliative care specialists. Patients with COPD reported less contact with palliative care nurses. In addition, patients reported to have contact with a physiotherapist (26%), a spiritual worker (18%), a psychologist (14%), a social worker (11%), or a volunteer (9%). Perceived friction (negatively) and well-connectedness (positively) were significantly associated with overall care satisfaction.

Conclusion: Patients positively value their relationships with palliative care professionals. However, Palliative care professionals (physicians, nurses) are not always present or recognized as such in a patients care network, in particular for noncancer patients.

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Care for people with dementia

Abstract number: FC13
Abstract type: Oral presentation

Attitudes of Carers of Nursing Home Residents towards Palliative Care in Dementia: Results of the EU FP7 PACE Cross-sectional Study in Six EU Countries

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Background: While the European Association for Palliative Care (EAPC) widely recommends that palliative care is an approach highly applicable for people with dementia, we know little about carers’ attitudes towards this recommendation.

Aim: Therefore, we studied the attitudes towards palliative care in dementia of relatives, general practitioners (GPs), and care staff of nursing home residents in six EU countries and studied differences between carer groups and countries.

Method: Cross-sectional survey in representative samples of nursing homes in Belgium (BE), Finland (FI), Italy (IT), Netherlands (NL), Poland (PL), and United Kingdom (UK) (2015). We distributed questionnaires to relatives and GPs, who were involved in the care of deceased residents, and to care staff (nurses/care assistants) working in the facility during the survey. We assessed the extent of carers’ agreement with two statements:

(1) Alzheimer’s disease or dementia is a disease you can die from and
(2) Palliative care is important to older people with Alzheimer’s disease or dementia, using a 5-point Likert scale truncated to ‘agree’, ‘neutral’, and ‘disagree’ categories.

Results: In the 322 nursing homes that participated, 1455 relatives, 1657 GPs, and 3392 care staff were surveyed, with response rates of 58%,
Consensus on Treatment Decisions for Residents at the End of Life in Long Term Care Facilities: Results of a Cross-sectional Study in 6 European Countries (PACE)

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Research aims: When care providers cannot reach consensus in treatment decisions, the relation between care providers may be harmed and care for the patient can get more complicated. In long term care facilities (LTCFs) often many care providers are involved in care for a resident, which could make it difficult to reach consensus. This study describes and compares in 6 European countries, for residents at the end of life, the degree of consensus on treatment among all involved with the resident. Another aim was to assess which factors were related to indicating full consensus on treatment among all involved, according to nurses and relatives.

Study population: Of residents (1707) in LTCFs in Belgium, England, Finland, Italy, the Netherlands and Poland, subsamples were included: 1284 and 790 cases on the degree of consensus among all involved according to nurses and relatives respectively.

Study design and methods: In each country, a random sample of representative LTCFs retrospectively reported all deaths of residents in the previous 3 months. Concerning these residents, nurses were asked: To which degree were those involved in care in agreement (consensus) on care and treatment in the last month of the resident’s life? Relatives were asked: To what degree did all those who were involved in the treatment(s) decision(s) (LTCF staff, family members, others) agree about the best treatment(s)? Answer categories included: full consensus/consensus on major issues/no consensus.

Method of statistical analysis: Generalized estimating equations were used to account for clustering of data on facility level.

Results and interpretation: Full consensus according to the nurses ranged from 59.5% (FI) to 86.1% (EN), while according to the relatives, full consensus ranged from 40.7% (FI) to 68.0% (EN). The odds of full consensus as perceived by nurses were higher when residents had a high degree of symptom control or a contact person in their record. The odds were lower when residents showed resistiveness to care or when they had impaired cognition. For relatives’ responses, odds on full consensus were higher if staff had explained palliative care to them, their relation to the resident was other than child or partner and they were satisfied with the provided care. Thus to enable full consensus among all involved, close monitoring of the resident’s wellbeing and open communication between staff and relatives may be of importance.

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Abstract number: FC14
Abstract type: Oral presentation

A Collaborative Approach between Clinical and Academic Experts in Dementia Care to Improve Clinical Effectiveness and Priorities for Research

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Background: There is a global drive to provide cost effective evidence based end of life care (EoLC). Our ageing population means increasing need for care, and for care to be tailored better to common conditions, notably dementia. Traditionally such evidence has emerged through audit, service evaluation and research. These activities are usually undertaken separately. Organisations either initiate new knowledge (academic institutions) or measure their practice against such emergent knowledge (clinical organisations). Integration, rather than separation of these activities, may better achieve evidence based cost effective care.

Aims: To understand how best to implement outcome measures into EoLC services for people with dementia across clinical settings using an integrated, collaborative approach to inform clinical effectiveness and build future clinically relevant research.

Methods: An academic institution setup a collaborative baseline audit over six months with eleven clinical settings providing services to people with dementia. Those in the clinical settings wanted to improve the quality of EoLC they provided and be able to evidence that they had done this. Prior to data collection Data Sharing Agreements were developed and training on the outcome measures undertaken with the nominated leader/s for each clinical setting. The clinical teams assessed for each patient, and repeated at points of change that they identified, the following areas and measures:

1. Phase of illness (Palliative Care Phase of Illness)
2. Functional status (Australian modified Karnofsky Performance Scale)
3. Dementia severity (Functional Assessment Staging)
4. Symptoms/concerns (Integrated Palliative care Outcome Scale for Dementia - IPOS-DeM) and four staff questions
Results: The completion of outcome measures in routine practice will be reported in terms of data quality and completeness. Challenges with implementation, solutions and benefits will be highlighted. The findings will inform future research studies on EoLC for people with dementia using a co-design approach to work with the clinical teams and service users.

Conclusion: The joining together of expertise across systems offers huge potential for moving expert knowledge into clinical practice and ensuring that clinical practice contributes to the generation of new knowledge. A baseline audit enables increased understanding of the realistic implementation of such measures into practice.

Abstract number: FC16
Abstract type: Oral presentation

A National Retrospective, Cross-sectional Study of End of Life Clinical Quality and Symptoms for Those with Dementia in Residential Aged Care in New Zealand

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Background: In New Zealand (NZ), approximately 45% of people over 65 years old live in residential aged care facilities (RACF) at time of their death. This represents one of the highest rates worldwide. Relatively little is known in NZ about the end of life care experience for people in RACF. Worldwide there are relatively few cross-sectional national studies of quality of dying for those that are cognitively and/or physically frail. The aim of this research is to describe the quality of death in RACF for those with dementia.

Methods: This is a retrospective cross-sectional study with random cluster sampling of representative facilities across NZ. Deaths were monitored for three months in each facility. For each decedent, the facility medical officer recorded if they had a dementia diagnosis. The stage of dementia was rated by both medical officer and registered nurse using the Global Deterioration Scale. Questionnaires about quality of death were administered to the registered nurse and healthcare assistant most closely involved in the death. Questionnaires included standardised scales for symptom management and comfort assessment at the end of life for those with dementia (SM-EOLD and CAD-EOLD), and quality of life in late stage dementia (QUALID) as well as other questions such as advanced care plans, functional ability and sentinel events.

Results: There were 61 participating facilities (53% response rate, 3,709 beds) with 286 deaths recorded during the study period. Of these, 55% (n=158) had a primary diagnosis of dementia. In the last month of life there were high rates of anxiety (51%), depression (55%) and pain (55%) for those with dementia. In the last week of life there were high levels of discomfort (61%), swallowing problems (60%), pain (57%) and restlessness (53%). In the last month of life, the SM-EOLD results showed significant rates of physical symptoms (5.00(SD 3.61)) as well as other symptoms (18.61(SD 8.50)). High levels of distressing symptoms were also recorded by the CAD-EOLD (34.14(SD 5.44), range) the last week of life. Hospice was involved in only 5% of cases.

Conclusion: RACF dementia end of life care in New Zealand requires adequate resources and training to provide the complex comprehensive gerontology and palliative care needed for this growing population.

Abstract number: FC17
Abstract type: Oral presentation

Quality of Palliative End-of-Life Care in Patients with Dementia Compared to Patients with Cancer - A Population-based Register Study

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Background/aims: Dementia was the 7th leading cause of death globally in 2015, and the yearly number of deaths by dementia is expected to increase. Patients dying from dementia are reported to suffer from similar symptom burden as patients with cancer, but they have seldom access to specialised palliative care. The dementia group receive less medication against symptoms and to have a lower probability of palliative care planning, compared to other diagnosis groups.

The aim of this study was to describe palliative end-of-life care quality for patients with dementia compared to patients with cancer, and for patients with Alzheimer’s dementia compared to other types of dementia.

Methods: The Swedish Register of Palliative Care (SRPC) database was searched for adult dementia and cancer deaths in nursing homes, hospitals, specialised and general palliative home care and hospices during a three-year period. Fourteen end-of-life care quality markers collected by the SRPC were compared between patients dying from dementia and cancer. The analysis was performed using a multivariable logistic regression model, adjusted for age, gender and place of death. The groups of patients with Alzheimer’s disease and other types of dementia were compared using the same method.

Results: A total of 4,862 deaths from Alzheimer’s disease, 12,030 deaths from other dementia and 53,369 deaths from cancer were included. Worse outcomes for the dementia group compared to the cancer group were shown for ten out of the 14 examined quality markers, including markers concerning symptom assessment, specialised palliative care consultations, bereavement support to next of kin and prescription of pain medication. Two of the 14 examined quality markers showed better outcomes for the group with Alzheimer’s disease compared to the group with other types of dementia.

Conclusions: Patients dying from dementia receive less high quality palliative end-of-life care compared to patients dying from cancer. In the dementia group, some care quality differences for the benefit of patients with Alzheimer’s disease are seen.

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Abstract number: FC18
Abstract type: Oral presentation

Barriers and Facilitators for GPs in Dementia Advance Care Planning: A Systematic Integrative Review

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Background: Advance care planning (ACP) is recommended for people with dementia at an early stage due to the disease’s progressive and life-limiting nature. General practitioners (GPs) should initiate ACP because of their early involvement and longstanding relationships with people with dementia. GPs however seldom apply ACP for people with dementia.

Aim: To determine the barriers and facilitators faced by GPs related to ACP with people with dementia.

Data sources: Relevant databases systematically were searched for papers published between January 1995 and December 2016 using the terms: primary healthcare, GP, dementia, and ACP. We conducted a systematic integrative review following the methods of Whittemore and...
Early palliative care interventions

Abstract number: FC19
Abstract type: Oral presentation

A Structured Early Palliative Care Intervention for Patients with Advanced Cancer - A Randomized Controlled Trial

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Background: The clear benefit of early palliative care (ePC) demonstrated in Temel’s pivotal trial was limited by a restricted study population, a single-center approach, and a failure to replicate the results in trials with more generalizable designs. In addition, a definition of the effective component and preferable setting for ePC is missing.

Aim: To investigate the effectiveness of ePC structured by a systematic, problem-based assessment approach in patients with advanced cancer.

Methods: We performed a multicentre randomized controlled trial comparing ePC integrated with standard care versus standard care alone. Participants were ambulatory cancer patients newly identified as not being amenable to curative treatment (lung, colorectal, pancreatic, and bladder), or with new hormone-refractory status for prostate cancer, or with new visceral metastasis for breast cancer. The intervention consisted of a one-time face-to-face interprofessional interview structured by a prompt-sheet based assessment of four distinct domains: symptom management, end-of-life decisions, network organization, and support of caregivers (SENS). Distress level and quality of life were assessed at baseline and at two, four, and six months with the use of the National Comprehensive Cancer Network Distress thermometer, and the Functional Assessment of Cancer Therapy-General (FACT-G). Symptom burden was measured with the Palliative Outcomes Scale (POS). The primary outcome was a change in distress over a six-month period.

Results: Between December 2013 and August 2017, we recruited 150 patients from three study sites. Patient characteristics and baseline measurements for distress and quality of life did not differ between the groups. A preliminary evaluation shows a clinically significant decrease on distress at two months after intervention, Post-intervention follow-up at four and six months will be completed in February 2018. Final analysis of the primary end point will take place in March 2018 and will deliver results on secondary endpoints.

Conclusion: This ePC trial successfully reached targeted recruitment in August 2017. Preliminary results show a significant reduction in distress two months after a one-time, clearly defined ePC intervention. Our results agree with Temel’s 3-month final results for quality of life. Our study will evaluate the effect of ePC at four and six months, thus prolonging the assessment timeframe.

The Swiss National Science Foundation funded the study.

Abstract number: FC20
Abstract type: Oral presentation

Differences between Early and Late Involvement of Palliative Home Care in Oncology Care: A Focus Group Study with PHC Teams

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Background: In Belgium, as in many other countries, PC is not only provided in hospitals or in outpatient clinics, but also, and especially, at home. To date, no randomised controlled trials on the integration of specialised palliative home care (PHC) in oncology care have been identified. Existing models of integration of early PC in the hospital setting might be useful to develop a model for PHC; however, information on whether these existing models are applicable to the home care system and on how working procedures and skills of the PC teams request adaptation when involved earlier in the disease trajectory is missing.

Aim: To gain insight into differences in being involved early or late in the disease trajectory, as perceived by the PHC teams, and the effect of these differences on existing working procedures and skills of the PHC teams.

Method: Six focus groups were held with PHC teams in Flanders, Belgium. The focus group discussions were transcribed verbatim and analysed using the method of constant comparative analysis.

Results: Six themes emerged from the data when analysing the experiences of PHC teams on the involvement of PHC; differences concerning

1) reasons for initiating PHC,
2) the follow-up of the care,
3) focus on possibilities versus problems,
4) opportunity to provide holistic care,
5) empowerment of patients, and
6) empowerment of professional caregivers.

A shift from a medical approach focusing on pain and symptom management to a more holistic approach when involved earlier is the most noticeable difference. Being involved earlier also results in a more structured follow-up and in empowering the patient to be part of the decision process. Importantly, early involvement creates the need for transmural collaboration, which leads to the PHC teams taking in more supporting and coordinating tasks.

Discussion: This study reveals that PHC teams experience important differences between early and late involvement of PHC into oncology care. Being involved earlier leads to different tasks and working procedures for PHC teams, and also to the need for transmural collaboration, which is an important difference with the integration of early PC in the...
hospital setting. Future research might focus on the development of an intervention model for the early integration of PHC into oncology care. To develop an integration model applicable to the home care system, components of existing models might need at some point adaptations or extensions.

Abstract number: FC21
Abstract type: Oral presentation

Suffering Begins Early: Symptoms and Needs of Head and Neck Cancer Patients at Diagnosis of Incurability - A Prospective Longitudinal Multicenter Cohort Study
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Introduction: Early integration of a palliative care (PC) perspective has been demonstrated to effectively influence quality of life and realization of patient preferences at the end of life. Therefore, 53 cancer guidelines as well as modern PC concepts demand early PC, beginning from the diagnosis of incurability. Very little, though, is known about physical symptoms and psychosocial burden of patients early at the time of diagnosis.

Methods: Therefore, the Palliative Medicine Working Group (APM) of the German Cancer Society (DKG) initiated a prospective longitudinal multicenter cohort study, assessing symptom burden and psychosocial needs of patients suffering from incurable cancer using validated questionnaires (FACT, SEIQoL-Q, PHQ-4, modified SCNS-SF-34, Distress Thermometer) at diagnosis and after 3, 6 and 12 months. Here, we present final subgroup results of patients suffering from head and neck cancer.

Results: 502 patients were enrolled after formal consent and assessed during 2014 and 2015 in 23 study sites. Of those, 55 patients suffered from head and neck cancer (42 male, 13 female; mean age: 62.6 years). ECOG performance scores varied broadly between 0 (8 patients) and 4 (2 patients) at first visit. Global distress scores (0-10 NCCN distress scale; mean value: 4.7). Further, patients described a broad spectrum of physical symptoms and psychosocial needs; the inability to eat, difficulties to phonate and the feeling of dry mouth were most often addressed symptoms. Family support was ranked most supportive, but for many patients, psychosocial circumstances were dismal. Only 34 patients (61.8%) of the enrolled patients were still alive at 3 months.

Conclusions: A substantial proportion of head and neck cancer patients suffers from physical symptoms and psychosocial needs from the very beginning of an incurable course of disease, even before palliative anticancer treatment was initiated. Attrition rates were extremely high, notably due to poor prognosis and death during the study period. These findings underline the need for early, pro-active symptom and distress screening and provide further rationale for early palliative care concepts, starting at the time of diagnosing incurability, at latest.

Abstract number: FC22
Abstract type: Oral presentation

Palliative Care Early and Systematic (PaCES): Barriers to Providing Palliative Care to Advanced Colorectal Cancer Patients. A Systemwide Survey of Gastrointestinal Oncology Clinicians’ Perceptions
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Background: Health systems struggle to systematically provide early and integrated palliative care (PC) to cancer patients. In Alberta, Canada, the PaCES (Palliative Care Early and Systematic) project is addressing this need by building an early PC pathway for advanced colorectal cancer (CRC) patients. In planning for PC-oncology practice improvements, we sought to identify barriers to providing PC, as perceived by oncology physicians, nurses, and allied healthcare staff.

Methods: This observational, knowledge translation questionnaire study collected both quantitative and open-ended responses from clinicians working with advanced CRC patients in Alberta, Canada. We used Michie’s Theoretical Domains Framework (TDF) and COM (Capability, Opportunity, Motivation) Behaviour (COM-B) Change Wheel, and knowledge of previously identified barriers, to guide the development of a 31 question online survey. The strength of this framework is that it identifies behavioural factors behind perceived barriers, and maps out suggested solutions to addressing these barriers.

Results: The survey response rate was 43% (65/150), 89% of the respondents were physicians or nurses with Medical Oncology as their primary discipline. The most frequently cited barriers were Opportunity-related (i.e. factors outside the clinician impede the behaviour). Clinicians identified their lack of time (>60%), lack of clinic space for consultations, and lack of access to specialist PC staff or services. Qualitative responses revealed that limiting resources differed by cancer centre location. In urban centres, time and space were key barriers. In more rural centres, access to specialist PC was the main limiter. Self-perceived Capability to manage PC needs was a barrier for 40% of physician and 30% of nurses. Motivation was rarely a cited barrier, with 89% of clinicians perceiving that patients benefit from PC, and stating that they would be “likely to” recommend early PC consultation to patients.

Conclusions: In Alberta, the main barriers to early PC integration are no longer attitudinal, with over 89% believing that early PC is beneficial for their patients. The time needed to address PC needs in a busy oncology clinic is a barrier. A pathway to improve clarity around referral processes and role confusion when working with PC teams will be developed to address these barriers.

Abstract number: FC23
Abstract type: Oral presentation

The Effects of Early and Systematic Integration of Palliative Care in Caregivers of Patients with Advanced Cancer: A Randomized Controlled Trial
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Background: Early palliative care (PC) is beneficial for patients with advanced cancer. Previously, we found that early and systematic integration of PC alongside to standardly offering psychosocial oncological care improved the overall quality of life (QOL) of cancer patients (primary outcome) compared to oncological care alone. Here we report the caregiver-reported outcomes of this trial.

Aim: To determine the effect of early integration of PC in oncology care on informal caregivers (ICs) of patients with advanced cancer in Belgium.

Method: We randomly assigned advanced cancer patients with a life-expectancy of one year and their ICs to either early and systematic integration of PC into oncological care (intervention) or standard oncological care alone (control). ICs QOL was assessed with two scales of the Short Form 36 Health Survey (SF-36); the Physical Component Summary (PCS) and the Mental Component Summary (MCS). Satisfaction with care was measured with the FAMCARE and mood was measured with two subscales of the Hospital Anxiety and Depression Scale (HADS); depression subscale and anxiety subscale. All were measured at baseline, 12 and 18 weeks. A multivariate regression analyses adjusted for baseline scores was used to test whether there was improvement in the intervention group relative to the control group at 12 or 18 weeks.

Results: A preliminary analysis showed that a total of 115 caregivers completed baseline measures; 83 ICs completed a follow-up assessment at 12 weeks and 66 ICs at 18 weeks. At 12 weeks, no significant improvements were found in PCS (mean score; intervention: 56.4 vs. control 54.4; P=0.21) or MCS (mean score; intervention: 52.1 vs. control 51.5; P=0.76) of the SF-36. At 18 weeks, MCS was significantly higher in the intervention group versus the control group (mean score: 55.5 vs. 50.9; P = 0.02). No difference was found in PCS (mean score; intervention: 55.5 vs. control 54.5; P=0.67). No significant differences were found in the HADS depression subscale, HADS anxiety subscale or in the FAMCARE at 12 or 18 weeks.

Discussion: Early integration of PC in oncology care for patients with advanced cancer leads to improvement in caregivers’ QOL, more specifically emotional QOL. This preliminary analysis shows that early, integrated PC models in oncology care are not only beneficial for patients but extend to the wellbeing of ICs.

Funding
The Research Foundation Flanders and the Belgian cancer society “Kom Op Tegen Kanker”.

Abstract number: FC24
Abstract type: Oral presentation

Need for Early Identification of Palliative Patients in the Emergency Department to Decide Best Supportive Strategies
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Background/aim: Although the Emergency Department (ED) is not the ideal place to begin palliative care, in reality, it is frequent that palliative care patients present in the ED and need urgent care. Therefore, the aim of this study is to investigate the median overall survival of ED patients who need palliative care, their risk of in-hospital mortality and the need for further treatment strategies.

Methods: In a retrospective analysis, we enrolled consecutively ED patients who needed inpatient care due to an end-stage disease and were transferred from the ED to the palliative care unit in a tertiary care hospital between April 2014 and March 2016.

Results: We identified 194 ED patients who were in a palliative situation when admitted to the ED. Fifty-four patients (27.8%) did not know about their palliative situation. Of those, 21 patients knew about their underlying disease but not about the end-stage situation. Thirty-three patients (17%) received the initial diagnosis during the ED presentation. The median overall survival was 27 days (IQR 11-96 days). There was no survival benefit knowing about the palliative situation when admitted to the ED (HR 1.1, 95% CI 0.7-1.5, p=0.75). 54.6% of patients (106 of 194) died during the same course of hospital stay. The multivariate logistic regression analysis showed a significantly increased risk for in-hospital mortality in ED patients presenting with abdominal pain or distension (RR 5.0, 95% CI 1.3-18.4, p=0.016). Patients who did not know about their palliative situation, showed an increased risk of in-hospital mortality if they were older than 67 years (RR 7.0, 95% CI 1.8-26.8, p=0.005) or presented to the ED with dyspnea (RR 6.7, 95% CI 1.4-31.6, p=0.017). They also had a significantly increased risk to be referred to the intensive care unit compared to those patients who knew about the palliative situation (RR 11.0, 95% CI 4.1-29.8, p< 0.001).

Conclusion: More than half of ED patients in a palliative situation died within one month after ED admission. Patient presenting with abdominal pain or distension, dyspnea and increased age are at high risk for in-hospital mortality during the same course of hospital stay. Therefore, there is a need to initiate promptly best supportive treatment strategies in cooperation with palliative care physicians, patients and their relatives during the ED stay, to avoid unnecessary ICU referrals and to ensure fast transferal to the palliative care unit.

Minority groups & social inequalities

Abstract number: FC25
Abstract type: Oral presentation

Dying in Prison: The Impact on Prison Officers in the United Kingdom
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Background: The UK prison population has doubled in the past 20 years, and the fastest growing group is aged over 60. With longer sentences and compassionate release rarely granted, greater numbers of older prisoners face dying in custody. Prison officers, whose focus is usually on maintaining safety and security, now have to consider the needs of frail and dying prisoners, and this unplanned role shift has practical and emotional consequences for staff with no background or training in healthcare.

Aims: This paper draws on findings from the ‘Both sides of the fence’ study, which aimed to improve the provision of palliative care for older prisoners. The paper reports findings from a cohort of prison officers and highlights some of the challenges they face in providing safe custody for prisoners at the end of life.

Methods: In the first ‘situational analysis’ phase of a participatory action research study, individual and group interviews were conducted with a range of prison officers, including uniformed officers, middle/senior managers and governors. Interviews were audio recorded and transcribed, and data were analysed using a thematic networks approach to identify basic, organising and global themes.

Results: A total of 18 prison officers took part in eight individual and two group interviews. Data analysis identified key themes including staffing, prison facilities and resources, proximity to illness and death, changing roles, and defence and coping strategies. Some respondents reported
difficulty coping with the emotional aspects of their changed role, and although senior officers believed that adequate support structures were in place, this was not always the experience of more junior staff. **Conclusion:** The number of older prisoners is projected to continue to rise across Europe. Where prisoners remain in custody at the end of life, officers of all grades need adequate training and support to equip them to care appropriately for those at the end of life.

**Abstract number:** FC26  
**Abstract type:** Oral presentation

**“Dying with a Clear Mind.” Views of Moroccan Muslim Women in Antwerp (Belgium) on Palliative Sedation**  
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**Objectives:** This paper seeks to describe the beliefs and attitudes of Moroccan Muslim women in Belgium toward palliative sedation. Second, we aim to identify whether differences are observable among the attitudes of elderly women (mainly uneducated and illiterate in Belgium) and middle-aged women (brought up in a western context, much more diverse socio-economically). Third, we seek to explore the role of religion (if any) in their attitudes.

**Design:** Qualitative empirical research was conducted with a sample of middle-aged and elderly Moroccan Muslim women (n=30) living in Antwerp (Belgium) and with experts in the field (n=15). All interviews were transcribed, coded and categorized using Grounded Theory methodology. Our results were compared with those of earlier studies of our research group involving Moroccan Muslim elderly men (n=10) and elderly Turkish and middle-aged women (brought up in a western context, much more diverse socio-economically). We conducted a total of 15 focus group and individual interviews. Results: Palliative sedation is strongly interpreted from within a theological and more specifically an eschatological framework by all our participants: God governs life and death; it is absolutely unacceptable to interfere with God’s divine plan (this will be punished at the day of judgment). Because they think it is life-shortening (and thus interfering and having eschatological consequences), a majority of the elderly participants reject palliative sedation. Moreover, to them dying with a clear mind is of utmost importance. The majority of the middle-aged participants and elderly participants that were personally confronted with a palliative situation, were showing a more tolerant attitude, based again on theological (respecting natural death, no interfering) and eschatological (no interfering, no punishment) arguments but also on the wish to have a good death. They stressed the importance of (i) the religious duty of seeking (palliative) treatment, (ii) the proportionality of a treatment and (iii) the intention of the physician. **Conclusion:** If it could be shown that palliative sedation has no life-shortening intention and does not interfere with the natural dying process and that there is no real alternative, most Muslim patients would probably accept this treatment, especially when the Muslim patient is encouraged to pronounce the Islamic creed before the start of the sedation.

**Abstract number:** FC27  
**Abstract type:** Oral presentation

**Spiritual Concerns among Muslim Cancer Patients in a Secular Society**  
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**Background:** Understanding spiritual concerns in multi-cultural populations was found to be a major research priority in the EAPC SC Taskforce survey. As spiritual concerns are related to culture and religion, ethnic minority patients’ concerns was explored to improve the provision of spiritual care in multi-cultural societies. **Aim:** To explore spiritual concerns among Muslim cancer patients within palliative care.

**Methods:** A thematic analysis was conducted of in-depth qualitative interview data from a PhD study of Christian and Muslim cancer patients in Denmark. The semi-structured interviews were conducted in Arabic, English or Danish with self-identified believers in a range of palliative care settings, recorded and transcribed. Interviews covered personal background, religious experiences, spiritual concerns and challenges on how spiritual needs were encountered within the health care system. The thematic analysis covered ethnic minority patients’ spiritual concerns and how the secular cultural context influenced these concerns.

**Results:** 16 cancer patients were interviewed, including 8 ethnic minority patients. 5 self-identified as Muslims. They were interviewed twice within three months. These interviews were supplied with interviews with a relative and a professional caregiver. Universal spiritual problems faced by ethnic patients were described (e.g. loneliness, meaninglessness, anger) and specific problems related to feeling different from the cultural context (mistrust, lack of social acceptance, fear of medical misconduct). The lack of spiritual or social support from relatives was also identified as a spiritual concern relating to being embedded in a secular society. **Conclusion:** Exploring spiritual concerns among ethnic minority patients helps to understand spiritual needs in multi-cultural society. Focusing on cultural context and relating it to spiritual concerns highlights the universal and culturally-specific features of the need for spiritual care.
interviews and for kidney care teams to include bilingual support for patients, both requiring cultural change in practice.

**Conclusion:** Exploratory action research is a useful vehicle for building a theoretical base with which to understand and improve access and cultural competency in context. In complex and sensitive healthcare scenarios such as end of life kidney care, action research could facilitate closer integration of research and practice and become a culturally competent element of care.

**Abstract number:** FC29

**Abstract type:** Oral presentation

**Social Inequalities and Symptom Burden within Palliative Care**

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**Introduction:** Social inequalities are known to impact on cancer diagnosis, treatment and access to services. However little research has explored the impact of social inequalities on symptom burden in palliative care patients.

**Methods:** Patients with advanced cancer attending Hospice services were recruited to a 24 week longitudinal study. Measures of depression (PHQ9) and symptom burden were collected at baseline, and at 8, 16 and 24 weeks. Patient post codes were allocated to census geographical unit, the lower-level Super Output Area (LSOA). A neighbourhood deprivation score of the LSOA containing the post code of each patient was generated. Analysis Chi-square was used to test statistical significance of association between baseline patient categorical variables, psychological and physical health outcomes and membership of deprivation categories. Logistic regression models were developed to estimate the independent effect of patients living in different areas of deprivation on the risk of being a PHQ-9 depression case or reporting a physical symptom at any time in the study (baseline or one of the follow-up points).

**Results:** 629 patients were recruited, 97% were ‘white British’, 67% were female and 29% lived in the most deprived of all neighbourhoods. 37% of all patients had been diagnosed with cancer in the previous 12 months. Higher proportion of patients diagnosed within the previous 12 months, were from most deprived neighbourhoods (52% vs 46% diagnosed more than 12 months previously) (P=0.20). 31% of all patients scored 10 or more on PHQ9 indicative of moderate to severe depression. Patients living in most deprived areas were significantly more likely to report receiving insufficient information at diagnosis (P=0.007); reported greater pain (P=0.02), more likely to report depression (P=0.04) and higher global symptom burden (P=0.04).

**Conclusions:** This longitudinal study has allowed socioeconomic disadvantage within palliative care to be explored via large data set of patient outcomes. Socioeconomic disadvantage is an important factor within palliative care and can influence both physical and psychological symptom burden. Palliative care addresses the holistic needs of patients including social factors. At the end of life, there is little that can be done to reverse socioeconomic disadvantage but much that can be done to identify and provide additional support for patients with socio-economic disadvantage accessing palliative care services.

**Abstract number:** FC30

**Abstract type:** Oral presentation

**Assessing Racial Disparity in Palliative Care Consultation and the Impact of Palliative Care Consultation on Hospice: A Multi-hospital Analysis**

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**Background:** Racial disparities in health care access and quality are well documented for some minority groups. However, compared to other areas such as disease prevention, early detection, and curative care, research in disparities in palliative care (PC) is limited.

**Objective:** The objectives were to

1. evaluate whether PC consultation and hospice use differed by race/ethnicity for hospitalized patients at the end of life, and
2. measure the association between PC consultation and use of hospice.

**Methods:** The sample included 3,980 patients admitted to three urban hospitals with an inpatient palliative medicine service and were discharged to hospice or died during their hospital stay from 2012-2014. A multilevel binary logistic regression model that accounted for hospital-level clustering of patients was fit to test the association between PC consultation use and race/ethnicity controlling for other patient and hospital characteristics. Another multilevel binary logistic regression model was fit to the association between discharge to hospice with race/ethnicity and PC consultation, controlling for other patient and hospital characteristics.

**Results:** The sample was 45% Caucasian, 39% African American and 17% Hispanic, and 17% (n =682) had a primary diagnosis of cancer. Thirty-four percent received a PC consultation during their hospital stay, and 40% were discharged to hospice. In the multilevel models, race/ethnicity was not associated with receipt of a PC consultation or discharge to hospice. Patients with a PC consultation were 5.0 times as likely to be discharged to hospice as patients without a consultation (p < 0.001).

**Conclusions:** Contrary to previous studies, no evidence of significant racial/ethnic disparities in the use of either PC or hospice was found. However, there was significant variation across hospitals in the use of both services. Future work should focus on increasing the use of palliative medicine consultations within the hospital for patients, regardless of race/ethnicity.

**Communication and information in older people**

**Abstract number:** FC31

**Abstract type:** Oral presentation

**End-of-Life Decisions for People Dying of Dementia: A Nation-wide Survey in Flanders**

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**Introduction:** Empirical data about end-of-life decision-making for people dying of dementia is scarce. However, these data are essential for evidence-based policy-making and the medical debate for the end of life of people with dementia. We aimed to assess the incidence of end-of-life decisions (ELDs) in people dying of dementia in 2013, e.g. withdrawing treatment or intensified pain and symptom alleviation, and to examine the decision-making process and the patient characteristics related to both the incidence and the decision-making process.

**Methods:** Nation-wide mortality follow-back study. From all deceased persons in Flanders in 2013, a representative sample (N=6116) was taken.
Understanding the Factors Associated with Patients with Dementia Achieving their Preferred Place of Death: A Retrospective Cohort Study

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Background: 60,000 people die from dementia yearly in the UK. Dying in the ‘preferred place of death’ (PPD) is considered a quality marker for end of life care (EoLC). ‘Coordinate My Care’ enables patients in London to digitally document and share their wishes for EoLC. Little is known about PPD, or the factors that might help achieve this, for people with dementia.

Aims: To determine the factors associated with achieving PPD in patients with dementia.

Population: Adult patients (>18 years) with a Coordinate My Care record, with a diagnosis of dementia, who died between December 2015 and March 2017.

Design: Retrospective cohort study.

Method: Association of patients’ characteristics with achieving PPD was assessed using univariate analysis. Variables found to be significant (at p<0.1) and of clinical interest were entered into a multivariate binary logistic regression model in a forced manner. SPSS version 24 was used.

Results: 1047 patients were identified; 64.0% (n=670) females and 36.0% (n=377) males. The mode age-band (28.3%) was 85-89 years. 181 and 63 people did not have PPD or actual place of death (APD) recorded, leaving 803 patients in the main analysis. PPD for these patients was most commonly care home (58.8%, n=472) or home (39%, n=313). APD was care home for 56.9%, (n=457), home (29.9%, n=240), hospital (10.1%, n=81) and hospice (3.1%, n=25). 83.7% (n=672) died in their PPD. Those with a primary diagnosis of cancer had lower odds of dying in their PPD compared with a primary diagnosis of dementia (O.R 0.407, %CI 0.208-0.795; p=0.009). Having a WHO performance status of 4 (most functionally impaired) increased odds of achieving PPD (O.R 2.386 %CI 1.260-4.518; p=0.008). Patients with a ceiling of treatment of ‘symptomatic relief only’ had greater odds of dying in their PPD (O.R 2.675;1.312-5.453; p=0.007) than those for active treatment. As the time between record creation and death increased, odds of achieving PPD reduced (O.R 0.998 (%CI 0.996-1.000, p=0.037).

Conclusions: As illness changes, so can preferences; our data suggest ongoing conversations are important to ensure patient wishes are realised. The association between ceiling of treatment and achieving PPD indicates the importance of these decisions. In this cohort, a high proportion of patients died in their PPD, which supports the use of electronic patient records. However, further research is needed to determine their impact.

Abstract number: FC32
Abstract type: Oral presentation

"If Your Heart Were to Stop...” - Physicians’ Strategies in Discussing Code Status Preferences with Newly Hospitalized Geriatric Patients

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Background and aims: According to international standards, physicians are required to note whether cardio-pulmonary resuscitation (CPR) is medically indicated and desired by hospitalized patients. Scant research exists regarding how CPR conversations are conducted with patients, in particular when advanced age and multimorbidity challenge the prospects of CPR.

Methods: In a multi-method qualitative study, we collect 50 audio-recordings of patient-physician CPR discussions on admission to a Swiss geriatric rehabilitation facility. Conversation Analysis is used to analyze how physicians initiate CPR conversations and deal with their patients’ decisions; thematic analysis is used to analyze the content of the conversations.

Results: Initial results (19 conversations) display that the topic of CPR is easily approached by patients but less so by physicians. Physicians often introduce the topic tentatively, using a depersonalized question (“we ask all our patients”), or building on previous occasions in which such decision was discussed (“maybe you talked about this”). Frequently, they describe the situation of CPR necessity as an extreme and unlikely situation (“if your heart were to stop, but it won’t happen”), which is at odds with the geriatric patients’ morbidities and sometimes palliative condition. Physicians then ask for the patients’ decision, failing to provide enough prior information on CPR, recovery prognosis, benefits, burdens, and alternatives.

It is especially when faced with patients who wish to forego CPR (11 cases) that physicians investigate and challenge their reasons for the decision, inform them on CPR process and outcomes, and ask for confirmations. In contrast, decisions in favour of CPR generate less dialogue. This preliminary observation shows that physicians may have an underlying bias in favour of CPR and might experience difficulties in talking about end of life with patients who are hospitalized for rehabilitation.

Interpretation: Appropriate communication is a core component of patient-centered healthcare, particularly when it comes to introducing sensitive matters to vulnerable populations such as geriatric and palliative patients. The results of the study inform on the training needs of physicians regarding how to approach and talk about sensitive issues such as CPR with aged patients who may also be seriously ill or in palliative condition.

The study is funded by the Chair in Palliative Geriatric Care (CHUV).
Abstract number: FC34
Abstract type: Oral presentation

Care Staff's Self-efficacy Regarding End of Life Communication in Long Term Care Facilities: Results of a Cross-sectional Study in 6 European Countries (PACE)

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Research aims: Communicating about end-of-life (EOL) matters is an essential part of providing care to older people in long term care facilities (LTCFs). When care staff do not feel competent to discuss these issues, they could fail in starting conversations about EOL issues. However, not much is known about whether LTCF staff feel competent to engage in EOL conversations. This research compares among 6 European countries the care staff’s level of self-efficacy regarding EOL communication in LTCFs. This study also assesses which country, facility and staff characteristics are related to care staff’s self-efficacy regarding EOL communication.

Study population: In total 2275 care staff members in 305 LTCFs participated in the research project, of whom 1680 in 290 LTCFs filled in all questions on self-efficacy and were included in the current study.

Study design and methods: A cross-sectional survey of care staff (nurses and care assistants) was conducted in a random sample of representative LTCFs in Belgium, England, Finland, Italy, the Netherlands and Poland. Staff rated their self-efficacy on a scale of 0-7 (cannot do at all—certain can do) on the communication subscale of the Self-efficacy in End-of-Life Care survey, which comprises 8 statements regarding EOL communication.

Method of statistical analysis: Generalized estimating equations were used to account for clustering of data on facility level.

Results and interpretation: The proportion of staff with a mean self-efficacy score >5 was 76.4% in the Netherlands, ranged between 55.9% and 60.0% in Belgium, Poland, England and Finland and was only 29.6% in Italy. Factors related to higher self-efficacy scores included: staff >50 years of age, working as a nurse (compared to care assistant), completed higher secondary or tertiary education, formal training in palliative care, >10 years working in resident care, working in a facility with onsite nurses and offsite physicians, working in a facility with guidelines on palliative care and working in the Netherlands or England. In general perceived self-efficacy seems to be a precursor to actually performing a certain practice. LTCFs could improve staff’s self-efficacy and practices on EOL communication by providing education and supporting staff with guidelines regarding palliative care.

Funding
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Abstract number: FC35
Abstract type: Oral presentation

Efficacy of Fact Boxes for Informing Decision-making on Burden-some Medical Interventions in Advanced Dementia

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Aim: Inappropriate end-of-life treatment decisions often result in unnecessary aggressive care in patients with advanced dementia. To test Fact Box (FB) decision supports to improve quality of decisions for end-of-life care of patients with advanced dementia.

Design: A randomized controlled study, including 232 decision-makers (Intervention Group (IG) 114, Control Group (CG) 118; including physicians, relatives and professional proxies) in the German-speaking part of Switzerland.

Intervention: Two FB decision supports on effects of antibiotics for pneumonia and artificial hydration for insufficient fluid intake, both in advanced dementia; review of FBs at 1 month before making hypothetical treatment decisions based on hypothetical scenarios sent at home.

Method: Primary outcomes at 1 month were the decision-makers’ decisional conflict (DCS-D, scale scored 0-100, higher score indicate greater conflicts), as well as the decisional conflict of physicians, relatives and professional proxies separately. Secondary outcomes at 1 month were decision-makers’ knowledge about treatment effects (questionnaire scored 0-7, higher score indicate higher knowledge), their hypothetical decisional conflict decisions, as well as their ratings of the acceptability of the FBs (e.g., appropriateness of content). Mixed effect models were used to assess changes in decision outcomes.

Result: With the FB decision supports, decision-makers reduced their decisional conflicts after making decisions on both, antibiotics (DCS-D, IG 28.7 vs CG 37.2; P = < .001) and artificial hydration (DCS-D, IG 30.1 vs CG 36.0; P = < .01). The FBs increased decision-makers’ knowledge about effects of antibiotics (IG 5.3 vs CG 3.0; P = < .001) and artificial hydration (IG 5.8 vs CG 2.8; P = < .001). After reviewing the FB on antibiotics effects, decision-makers were more likely to forgo administration (IG 69.0%, CG 50.8%; P = < .01). The FBs were found to be acceptable and almost all physicians (29 out of 30) would use them when communicating treatment options.

Conclusions: The FBs are effective to improve decision-making outcomes in all decision-makers, constituting helpful decision supports overall. FB should be tested in real settings to examine their impact on decisions towards more comfort-focused care in advanced dementia.

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Abstract number: FC36
Abstract type: Oral presentation

It’s the Family That Matters: A Systematic Review of the Influences on Care Preferences of Older People with Advanced Illness

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Background/aim: The older population is growing rapidly, and increasingly people are living longer with advanced illnesses. To deliver person-centred care in line with the preferences of this growing population, we need to understand people’s care preferences and how these are influenced. Therefore we aimed to synthesise evidence regarding the influences on
Care preferences, of older people with advanced illness, and produce a model of influences on care preferences in this population.

Methods: Systematic review of published and grey literature, incorporating reference and citation list searching, using an evidence-based search strategy, and standard systematic review protocols in accordance with PRISMA guidelines. Included articles are quality assessed using the validated QualSyS criteria. Thematic synthesis of qualitative articles, and narrative synthesis of quantitative articles are integrated to produce the final model.

Results: Of 12,142 search results, 56 articles are included, with data from 15,164 unique participants. Our synthesis identifies Illness, Individual, and Environmental factors, which interact to influence care preferences. Support from family and informal caregivers, and concerns about burden on family, are demonstrated as key influences, often taking precedence over individuals’ own preferences. Mechanisms by which these three areas influence preferences include; the process of making trade-offs between different preferences; making choices based on prior experience, and expectations of care outcomes; level of individual engagement; and the ability of individuals to form and express preferences.

Conclusions: The model produced by this synthesis explains understanding of how care preferences are shaped and influenced, highlighting the great importance of family as an influence on preferences. Our model therefore strongly supports the involvement of family members in conversations about care preferences. Clinicians should consider the patient & family as the unit of care. More evidence regarding influences on the stability of preferences is needed to inform person centered approaches to care.

Abstract number: FC37
Abstract type: Oral presentation

Differences in Primary Palliative Care between People with Organ Failure and People with Cancer: An International Mortality Follow-back Study Using Quality Indicators

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Aim: To investigate differences in the quality of palliative care in primary care between people who died of cancer and those who died of organ failure using internationally applicable quality indicators.

Study design, methods and population: Mortality follow-back survey amongst general practitioners (GPs) in nationally representative Sentinel Networks in 2013 and 2014 in Belgium, the Netherlands and Spain and between 2013 and 2015 in Italy. GPs reported all their patients (18+) who died non-suddenly of cancer, cardiovascular disease or respiratory disease (n=2360). A standardised registration form surveyed sociodemographic data and questions about care received at the end of life, which were used to construct quality indicators selected through literature review and expert consultations. Nine quality indicators were constructed in eight domains of palliative care: regular pain measurement; accepting the approaching end of life; communication with patient and next-of-kin; repeated multidisciplinary consultations; involvement of specialized palliative care; percentage of patients who did not die in hospital; and bereavement counselling.

Method of statistical analysis: Logistic regression with robust cluster errors.

Results: In all countries, people who died of cancer (n=1416) scored higher on the quality indicators than people who died of organ failure (n=808), particularly with regards to pain measurement (between 17 and 35 percentage-point difference in the different countries), the involvement of specialized palliative care (between 20 and 54 percentage point), and regular multidisciplinary meetings (between 12 and 24 percentage points, no significant difference in Italy). The differences between the patient groups varied by country, with Belgium showing most group differences (8 out of 9 indicators) and Spain the fewest (2 out of 9 indicators).

Interpretation: The nature and magnitude of the differences in quality of primary palliative care for people who died of cancer and those who died of organ failure varies per country. Initiatives to improve palliative care should have different priorities depending on the healthcare and cultural context.

Abstract number: FC38
Abstract type: Oral presentation

Compassion without Borders: Palliative Care Providers’ Perspectives on Challenges and Facilitators to Compassion

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Background: Compassion is considered essential for quality care, especially at the end of life. While previous studies have described some barriers and facilitators to compassion from the perspectives of healthcare providers (HCPs), a comprehensive understanding based on direct reports from HCPs is lacking.

Aims: The aim of this study was to conduct a detailed exploration and analysis of HCPs’ perspectives and experiences of perceived barriers and facilitators to compassion.

Methods: This qualitative study was a secondary analysis of a larger grounded theory study which explored the construct of compassion from the perspectives of HCPs. 57 participants were recruited from 3 palliative care settings in Alberta, Canada. Semi-structured focus groups with front-line HCPs and individual interviews with peer-nominated exemplary compassionate care providers were audio-recorded, transcribed, and analyzed.

Results: Two broad categories containing specific themes and sub-themes emerged from the data. The first category, challenges to compassion, reflects participants’ antipathy to associating the terminology of ‘barriers’ to compassion and was comprised of the following themes: personal challenges, relational challenges, systemic challenges, and mal-adaptive responses. The second category, facilitators of compassion, included the themes of: personal facilitators, relational facilitators, systemic facilitators, and adaptive responses of intentional action.

Conclusion: While participants acknowledged that certain factors such as the healthcare system, time constraints, difficult patients and families...
Factors Associated with Symptom Relief in Residential Care Homes; A National Register Study
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Objective: The aim was to identify factors associated with symptom relief of pain, nausea, anxiety and shortness of breath, during the last week of life in persons living in residential care homes

Background: In Europe, residential care homes (RCHs) is a common place of death for older persons. Earlier Swedish studies reported high prevalence of symptoms in EOL care in RCHs.

Design: A retrospective national register study.

Methods: All expected deaths at RCHs, registered in the Swedish Register of Palliative Care (n=22855), were included. A univariate and multivariate logistic regression were conducted to identify explanatory variables associated with the outcome variables symptom relief of pain, nausea, anxiety and shortness of breath. The explanatory variables were: age, sex, number of days enrolled to RCHs, diagnosis, use of validated pain assessment scales, documented EOL discussion with physicians for residents and/or family members, consulting another health care specialist, examination by a physician during the last week, pressure ulcers and assessment of oral health and individual prescribed injection to be administered when required (PRN).

Results: All factors except examination by a physician during the last week, were associated with relief in one or several symptoms in the univariate analysis. Multivariate regression analysis showed that two significant factors were associated with symptom relief, i.e. using a validated pain assessment scale, and assessment of oral health. Medication PRN for pain, nausea and anxiety were significantly associated with relief of symptom, in the univariate and multivariate logistic regression analyses.

Conclusion: The results confirmed that use of a validated pain assessment scale and medication PRN for pain, nausea and anxiety could be a way to increase the quality of EOL care. This result is an important issue for the improvement of quality of end of life care in residential care homes.

Rehabilitation Goals towards the End of Life: Achieving what Matters to People with Advanced Disease in Hospice Care?

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Background: Rehabilitation is a key component of multidisciplinary palliative care that aims to maximise function that is meaningful to the patient. Goal setting, a core part of rehabilitation practice, can be used to understand what hospice patients want to achieve and direct rehabilitation in a manner that values patient priorities.

Aims:

(i) to determine the timescale and nature of patient identified rehabilitation goals within hospice services;
(ii) identify the overall level of goal attainment;
(iii) understand which patient, service and goal-related factors affect goal attainment.

Methods: Adults with advanced progressive disease attending 10 UK hospices set SMART (specific, measurable, attainable, realistic, timed) goals with hospice rehabilitation staff who had received standardised training. Goals were mapped onto WHO International Classification of Functioning, Disability and Health (WHO-ICF) codes by two independent raters, and categorised according to a focus on impairment, activity or participation in work, social life and society. Goal attainment was assessed as a binary outcome and using change in T-score (0-100, higher score=more attainment). The Patient, service, and goal-related factors influencing goal attainment were examined using chi-square test for trend.

Results: 355 patients (190 female, mean (SD) age 70 (11) years; cancer n=250) took part. The group set 632 individual goals (range per patient 1-4) that spanned 13 WHO-ICF domains. Goals had a median (range) timescale of 28 (1-196) days. 25% of goals had a primary focus on impairment; 52% on activity and 23% on participation. Goals frequently related to, mobility (WHO-ICF code d4, n=113), general tasks and demands (d2, n=99), community, social and civic life (d9, n=97), mental functions (b1, n=95) and self-care (d5, n=67). 302/632 goals (47.8%) were attained with a mean change in GAS T-score of 8.6 points (95% CI 7.6 to 9.7) following intervention. Factors positively associated with goal attainment were inpatient setting (p< 0.001), a short goal timeframe (<14 days, p=0.009) and minor difficulty level as perceived by staff (p=0.005)

Conclusion: Patients with advanced progressive disease, receiving hospice care, can set and attain functional goals including near the end of life. Most goals focus on retaining independence in life activities and situations, often by managing symptoms and emotions. Goal attainment in this setting is supported by setting shorter term and realistic goals.

Rank WHO-ICF code, domain n (%) 
1 d4, Mobility 113 (18) 
2 d2, General tasks and demands 99 (16) 
3 d9, Community, social and civic life 97 (15) 
4 b1, Mental functions 95 (15) 
5 d5, Self-care 67 (11) 
6 d6, Domestic life 45 (7) 
7 b4, Functions of the cardiovascular, haematological, immunological and respiratory systems 32 (5) 
8 d7, Interpersonal interactions and 25 (4) 
9 b2, Sensory Functions and pain 25 (4) 

[Goal mapping ranked by WHO-ICF code, domain].
Abstract number: FC41
Abstract type: Oral presentation

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Background: Palliative sedation is the deliberate lowering of a patient’s level of consciousness in the last stage of life with the aim of relieving refractory suffering. In the Netherlands, the use of palliative sedation is conditional upon the patient having a maximum life expectancy of one to two weeks.

Aim: To provide an update of developments in the practice of palliative sedation in the Netherlands.

Methods: We performed a questionnaire study among physicians who attended a patient who was included in a nationwide stratified sample of 7661 deceased persons in 2015. Physicians received a questionnaire about the last phase of life, including questions about the provision of continuous deep sedation until the patient’s death. Comparable studies were performed in 2010 and 2005.

Results: We found an increase in the percentage of deaths where palliative sedation was used, from 8% in 2005, to 12% in 2010 and 18% in 2015. In 2015, 55% of the cases of sedation were performed by general practitioners, 24% by clinical specialists and 21% by nursing home physicians. The increased frequency was mainly due to more involvement of general practitioners, who were responsible for 43% of cases in 2010. Further, the proportion of patients aged 80 years and above has risen, whereas the proportion of men and women, non-Western immigrants and patients with cancer has remained the same. In 2015, palliative sedation was in 93% performed through the administration of a benzodiazepine, in half of the cases combined with morphine. Patients died within 24 hours after the start of sedation in 53% of cases and within one to seven days in 45% of cases. In 1% of cases, sedation lasted more than one week. The data on the duration of palliative sedation are comparable with those from 2010. The same also applies to whether palliative sedation was used with hastening of death in mind. In 60% of cases, the doctor assumed that the sedation would not hasten death, but in 38% of cases, she took account of the possibility that the sedation would hasten death. In 2% of cases, hastening of death was the aim of the sedation.

Conclusion: In the Netherlands, palliative sedation has become a rather common practice in end-of-life care. The criteria of due care in the Dutch national guideline are adhered to in the large majority of cases. It can be questioned whether palliative sedation is currently only used as a last resort option to address severe suffering at the end of life.

Abstract number: FC42
Abstract type: Oral presentation

Quality of Death and Dying of Young Adult Patients with Cancer: Analyses of Combined Data from Three Nationwide Surveys among Bereaved Family Members
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Background/aims: Although little improvement has been made in the survival rate among young cancer patients over recent decades, their quality of death and dying (QODD) has never been systematically explored. We aimed to clarify the QODD of young cancer patients (aged 20-39 years), explore factors contributing to the lower QODD, and compare their QODD with that of middle-aged patients (aged 40-64 years).

Methods: We analyzed combined data of the three nationwide, cross-sectional surveys of families of cancer patients who died at inpatient hospitals in Japan (2007-2014). We assessed QODD with core 10 items of the Good Death Inventory short-version on a 7-point scale; and calculated percentages of “agree/absolutely agree” (i.e., good QODD), and the mean/total scores. Multivariate analyses explored determinants of the lower QODD (total score less than the average).

Results: Among responses of families of all adult cancer patients (n=22,451), we extracted those of young (n=245) and middle-aged patients (n=5,140). Less than 60% of young patients had good QODD in 9 of 10 core items. Gastrointestinal tract cancers were independently associated with the lower QODD (odds ratio=0.21; 95%CI=0.05-0.82; p=0.03). Young patients were significantly less likely to feel “one’s life was completed” (3.3 (2.0) vs. 3.8 (1.9); effect size (ES)=0.29; adjusted p-value=0.00;), and “not being a burden to others” (mean, 3.1 (SD, 1.5) vs. 3.5 (1.6); ES=0.24; adjusted p-value=0.010).

Conclusions: Overall, the QODD of young cancer patients were low. Future efforts are needed to improve quality palliative care for young patients, focusing specifically on psychosocial/spiritual suffering.

Delirium: Assessment and treatment
Abstract number: FC43
Abstract type: Oral presentation

SQiD: Can a Single Question Assist Clinicians to Identify Delirium in Hospitalised Cancer Patients?
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Background/aim: Delirium has notable negative impacts and is an important co-morbidity for hospitalised cancer patients. Despite the availability of effective screening tools, delirium is frequently undertreated, compounding poor outcomes for delirious patients, their carers, and staff. We compared a Single Question in Delirium (SQiD) in hospitalised, cancer patients using psychiatrist interview as the reference standard.

Methods: Patients admitted to the oncology wards of two comprehensive, cancer centres, were prospectively screened. Overnight admissions for chemotherapy or radiotherapy only, were excluded. The SQiD: “Do you feel that [patient’s name] has been more confused lately?” was tested against interview by consultant psychiatrist. The Confusion Assessment Method (CAM), was also compared to psychiatrist interview. The primary endpoint was negative predictive value (NPV) of the SQiD versus psychiatrist interview. Secondary endpoints included: NPV of SQiD versus CAM, and sensitivity and specificity of the SQiD.

Results: 120 patients were recruited between May 2012 and July 2015. Median age was 68 years, 49% were female. 65% were admitted under...
Delirium occurs in approximately 42% of patients with advanced cancer on admission to a palliative care (PC) unit or general medical ward. We evaluated the evidence for the pharmacological prevention and treatment of delirium in adult patients with cancer as part of the development of a new European delirium guideline.

Methods: Ovid Medline was searched using text words and MESH headings for (delirium or confusion or agitation) and (cancer or malignancy or oncology) to identify eligible studies in relation to both the pharmacological prevention and treatment of delirium in patients with cancer. The search was limited to English language and the years 2000 to September 30, 2017. We included studies of adults >18 years old with cancer and either at risk of delirium or with a formal delirium diagnosis; and hospital, inpatient PC/hospice and community settings. We excluded abstracts, studies evaluating alcohol withdrawal or peri-operative delirium, and studies in which the study population was comprised of <50% cancer patients. The Cochrane risk of bias tool was used to appraise randomised controlled trials (RCTs).

Results: The titles and abstracts of 581 citations were screened with 50 papers identified for full text review. No studies were found on delirium prevention. Of 15 included studies on delirium treatment, 3 were RCTs: 2 trials evaluated antipsychotics (APs), and 1 trial evaluated the addition of benzodiazepine (BDZ) to AP. Only 1 RCT included a placebo arm. Risk of bias was usually low. For the 7 retrospective cohort studies, 4 evaluated APs, 1 evaluated methylphenidate, and 2 evaluated opioid rotation. For the 5 retrospective cohort studies, 3 evaluated APs, 1 evaluated opioid rotation, and 1 evaluated AP and BDZ combination.

Conclusion: The evidence for the role of APs in managing delirium symptoms is variable: thus they should be used judiciously. BDZs provide sedation and may have a role for managing severe distress related to delirium. No studies were found on levomepromazine (methotrimeprazine), novel agents such as melatonin, or pharmacological delirium prevention. (This study received no funding).
and anxiety are more prevalent among both smokers and tobacco smoking has been associated with an increased prevalence of alcohol and substance use disorders. We aim to describe differences between nicotine addiction in an advanced cancer population attended at the outpatient clinic of a Catalan teaching hospital.

Population and methods: 211 consecutive patients with a history of smoking (current or not) were included in the study. Variables analyzed were: sociodemographic, BPI, DN4, CAGE test, MEDD and the need for opioid rotation. The ECS-CP was routinely collected. Nicotine addiction was measured with the Fag Drom test and scores ≥ 7 defined the highly addicted population. Statistical analysis: Mean ± standard deviation; Median (interquartile interval). Comparison between groups with the χ2 test and for continuous variables with the Kruskal-Wallis test was done. Statistical significance was assumed at a 0.05 level (p < 0.05).

Results: Highly nicotine addicted patients showed higher pain scores on admission (p = 0.044). DN4 and CAGE test scores were higher among highly addictive patients (p = 0.05 and p < 0.001, respectively). Regarding the ECS-CP, the addictive behaviour feature was higher among Fag Drom ≥ 7 (22.7% vs 59.6%, p < 0.001). Also differences were found between the variables related to the smoking pattern (age of starting, length of smoking and number of cigarettes per day) and the Fag Drom test (p < 0.001, p = 0.013 and p < 0.001).

Conclusions: Our study highlights the differences found among the two samples of advanced cancer patients regarding the level of nicotine addiction. Highly addicted patients were found to have higher VAS scores and a closer relationship with alcohol addiction.

Abstract number: FC47
Abstract type: Oral presentation

The Minimal Clinically Important Difference (MCID) for the Richmond Agitation Sedation Scale (RASS) in Patients with Agitated Delirium

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Background/aims: For patients with persistent agitated delirium, pharmacologic therapy needs to strike a balance between agitation control and over-sedation. The optimal level of sedation has not been established. Using an anchor-based approach, we determined the MCID for RASS.

Methods: This is a secondary analysis of a recently completed randomized controlled trial to compare the effect of lorazepam versus placebo as an adjuvant to haloperidol for persistent agitation in patients with delirium (Hui et al. JAMA 2017). The primary outcome was change in RASS (10-point numeric rating scale that ranges from -5 [unarousable] to +4 [very agitated/combative]) from baseline to 8 hours after study medication administration. Blinded bedside nurses and caregivers were asked if they agreed that the patient was more comfortable after the study intervention, which was used as the anchor. MCID was assessed using the sensitivity-specificity method (bootstrapping with 1000 replications) and within-patient change method.

Results: 90 patients were randomized and 58 (64%) received the study medication. The RASS at baseline was 1.6 (SD 0.6). 23 (61%) caregivers and 23 (55%) of nurses perceived that the patient was more comfortable after study intervention. Using the sensitivity-specificity method, the optimal RASS cutoff was ≤ -4 according to both the nurses (sensitivity 73%, specificity 84%; area under the curve [AUC] 0.78) and caregivers (sensitivity 61%, specificity 80%; AUC 0.71). The RASS cutoff based on within-patient change method was also highly consistent (−4.0 [SD 1.8] for nurses; −4.2 [SD 0.6] for caregivers).

Conclusions: For patients with persistent agitation, a reduction of 4 points in RASS was considered to be the MCID by both nurses and caregivers. These findings have implications for sample size calculation and interpretation of treatment effect in future delirium trials.

Family Carers
Abstract number: FC49
Abstract type: Oral presentation

Grief Trajectories of the Development in Grief Symptoms of Family Caregivers from Pre-loss to Three Years Post-loss.
A Population-based Longitudinal Cohort Study
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Background: The development of grief may vary greatly among family caregivers. This variation may challenge the supportive care initiatives of health professionals. No previous study has examined the development of grief symptoms in family caregivers over time from end-of-life caregiving until three years after bereavement. We aimed to identify the most common grief trajectories of specific patterns of grief symptoms among partners and non-partners and to investigate potential associations between socioeconomic characteristics and grief trajectories.

Method: We conducted a population-based, longitudinal cohort study of 1,123 partners and 597 non-partners (predominantly adult children) of terminally ill patients. Participants completed the grief scale Prolonged Grief-13 (PG-13) at three time points (before the loss, six months after the loss and three years after the loss). We modelled semi-parametric group-based trajectory models (GBTM) for repeated measurements of grief (TRAJ for GBTM in STATA) for both partners and non-partners. Odds ratios (ORs) with 95% confidence intervals (CIs) for associations between age, gender, educational level, patient’s survival time and grief trajectories were analysed using a multinomial logistic regression model.

Results: We identified five common grief trajectories for partners and four for non-partners. We identified a low grief response trajectory in 33% of partners (45% of non-partners), moderate declining grief in 30% of partners (31% of non-partners), high declining grief in 20% of partners (16% of non-partners), persistent high grief in 7% of partners (8% of non-partners) and a late grief response trajectory in 10% of partners. No late grief response was identified in non-partners. All trajectories that were not categorized as low grief were associated with a low educational level (i.e. an OR of =2.0 (95% CI:1.3;3.4) of partners in high grief trajectories).

Conclusion: This is the first study to describe the most common grief trajectories among family caregivers. We identified persistent high grief response trajectories in both partners and non-partners from before the loss to three years after the loss. Family caregivers with a low educational level seem to be particularly vulnerable. Family caregivers with persistent high grief may benefit from early identification during end-of-life care and intervention by health professionals.

Funding
The Novo Nordisk Foundation and the Danish Cancer Society

Abstract number: FC50
Abstract type: Oral presentation

Agreeing a Framework to Guide the Development of Bereavement Care in Palliative Care in Europe - A Delphi Study
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Purpose: Family caregivers of persons with cancer are at high risk for distress and may benefit from formal support services (e.g., professional counseling, education, organizational assistance). The purpose of this study was to describe distressed and underprepared family caregiver’s use of and interest in formal support services.

Background: The WHO definition of palliative care includes bereavement care. Our survey of bereavement care in palliative care found a lack of bereavement guidance and policy across European countries (Phase 1, EAPC taskforce, Guldin et al, 2015). Therefore, development of a framework is required.

Aims: Phase 2 of the EAPC bereavement taskforce:
1. Formulate recommendations for bereavement care principles, structures, processes and delivery based on current practice and evidence.
2. Establish consensus on these recommendations.

A Delphi process was deemed appropriate to formulate recommendations and to establish consensus and core shared priorities. Routine clinical practices and expert knowledge can be integrated through a Delphi process.

Methodology: A 4-round Delphi process was completed (R1 to R4). R1: Based on literature review and consultations with expert advisory group (EAG) and stakeholders, a Delphi survey of 54 Likert-scale statements (strongly disagree to strongly agree with a 1 - 5 score) under six dimensions was designed. Consensus criteria were agreed as >80% strongly agree/agree + median score of 5 = ‘Very Strong Consensus’; 75 - 80% strongly agree/agree + median score of 4 = ‘Strong consensus’. Statements <75% agreement were to be referred to EAG for review. R 2: Following a pilot trial, the survey was emailed to a panel of phase 1 survey respondents and nominated bereavement experts (n=376). R3: Items with low consensus/ requiring adaptation based on qualitative comments were re-sent to the panel to test agreement. Round 4: Final recommendations were discussed and confirmed by EAG.

Results/interpretation: Response rate: R2, 23% (87/376); R3, 79% (69/87).

After R2, 24 statements had ‘very strong’ consensus; 24 had ‘strong’ consensus and eight statements did not reach thresholds/ needed clarification based on open-ended comments. Out of six dimensions, full consensus was reached on three: definition of bereavement; definition of bereavement care; and integrating bereavement care in the community. The eight non-consensus statements concerned defining bereavement care, volunteer competence, professional coordination roles, point of referral assessment and practical bereavement support. All eight non-consensus statements were re-sent to R3 and consensus achieved. R4 classified ‘Essential’ and ‘Desirable’ features of bereavement care. These findings will be presented to Congress.

Abstract number: FC51
Abstract type: Oral presentation

Participation and Interest in Formal Support Services among Family Caregivers of Older Adults with High-burden Cancers
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Purpose: Family caregivers of persons with cancer are at high risk for distress and may benefit from formal support services (e.g., professional counseling, education, organizational assistance). The purpose of this study was to describe distressed and underprepared family caregiver’s use of and interest in formal support services.

Methodology:
1. Formulate recommendations for bereavement care principles, structures, processes and delivery based on current practice and evidence.
2. Establish consensus on these recommendations.

A Delphi process was deemed appropriate to formulate recommendations and to establish consensus and core shared priorities. Routine clinical practices and expert knowledge can be integrated through a Delphi process.

Methodology: A 4-round Delphi process was completed (R1 to R4). R1: Based on literature review and consultations with expert advisory group (EAG) and stakeholders, a Delphi survey of 54 Likert-scale statements (strongly disagree to strongly agree with a 1 - 5 score) under six dimensions was designed. Consensus criteria were agreed as >80% strongly agree/agree + median score of 5 = ‘Very Strong Consensus’; 75 - 80% strongly agree/agree + median score of 4 = ‘Strong consensus’. Statements <75% agreement were to be referred to EAG for review. R 2: Following a pilot trial, the survey was emailed to a panel of phase 1 survey respondents and nominated bereavement experts (n=376). R3: Items with low consensus/ requiring adaptation based on qualitative comments were re-sent to the panel to test agreement. Round 4: Final recommendations were discussed and confirmed by EAG.

Results/interpretation: Response rate: R2, 23% (87/376); R3, 79% (69/87).

After R2, 24 statements had ‘very strong’ consensus; 24 had ‘strong’ consensus and eight statements did not reach thresholds/ needed clarification based on open-ended comments. Out of six dimensions, full consensus was reached on three: definition of bereavement; definition of bereavement care; and integrating bereavement care in the community. The eight non-consensus statements concerned defining bereavement care, volunteer competence, professional coordination roles, point of referral assessment and practical bereavement support. All eight non-consensus statements were re-sent to R3 and consensus achieved. R4 classified ‘Essential’ and ‘Desirable’ features of bereavement care. These findings will be presented to Congress.
Methods: Cross-sectional mail survey conducted in communities of eight cancer centers in Tennessee, Alabama, and Florida (response rate: 42%). Family caregivers of Medicare beneficiaries with pancreatic, lung, brain, ovarian, head and neck, hematologic, and stage IV cancers reported support service use and completed validated measures of depression, anxiety, burden, preparedness, and health.

Results: Caregivers (n=294) were on average age 65 years and mostly female (73%), white (91%), and care recipients’ spouse/partner (60%); patients averaged 75 years, were majority male (54%) with lung cancer (39%). Thirty-two percent of caregivers reported accessing services while 28% were “mostly or “extremely” interested. Thirty-five percent of caregivers with high depressive symptoms (n=122), 33% with high anxiety symptoms, and 36% in the lowest quartile of preparedness were “mostly or “extremely” interested in receiving services. Being interested in support services was significantly associated with being a minority, shorter durations of caregiving, and with higher stress burden.

Conclusions: A large proportion of family caregivers, including those experiencing depression and anxiety symptoms and who were underprepared, are not using formal support services but have a strong interest in services. Strategies to increase service use may include targeting distressed caregivers early in their caregiving experience.

Abstract number: FCS2
Abstract type: Oral presentation

Trajectories of Depressive Symptoms among Bereaved Caregivers of Terminally Ill Cancer Patients and Pre-loss Psychosocial Resources Differentiate these Trajectories
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Purpose: A previous systematic review concludes that depressive-symptom trajectories in bereaved family members are heterogeneous with only one focusing on caregivers of terminally ill cancer patients, despite their greater burden than other caregivers. Therefore, we examined the depressive-symptom trajectories and the pre-loss factors influencing these trajectories for caregivers of terminally ill cancer patients.

Methods: Psychosocial resources (i.e., sense of coherence and social support) were measured among a convenience sample of 286 caregivers preloss. Depressive symptoms were measured by the CESD Scale over 1, 3, 6, 13, 18, and 24 months postloss. Distinct depressive-symptom trajectories and preloss predictors of these trajectories were identified by latent class growth analysis and multi-nominal logistic regression, respectively.

Results: Five trajectories (prevalence) were identified as ‘endurance’ (38%), ‘resilience’ (32.2%), ‘transient reaction’ (7.1%), ‘chronic grief’ (16.1%), and ‘chronic depression’ (6.6%). Endurance group had CESD scores <16 for 2 years postloss. Resilience group initially had moderate-to-high depressive-symptom levels, with a rapid return (6 months postloss) to normal. Distress of transient reaction lasted 7-12 months postloss, gradually returning to preloss level. Chronic grief group had CESD scores ≥16 within 1 year postloss, then falling <16 within 2 years postloss. Chronic depression group remained CESD scores ≥16 for 2 years postloss. Psychosocial resources are the most important preloss factors to differentiate bereaved caregivers’ different depressive-symptom trajectories (endurance vs all others; transient reaction vs all others; resilience/chronic grief vs chronic depression).

Conclusions: Most bereaved families adjusted to their pre-bereavement depressive-symptom levels within 1 year postloss (77.3%). Psychological resources are the internal and external resources that bereaved caregivers can use to adjust the grief reactions.

Abstract number: FCS3
Abstract type: Oral presentation

Measurement Properties of the Anticipatory Grief Scale in a Sample of Family Caregivers in the Context of Palliative Care
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Background: The Anticipatory Grief Scale (AGS) consists of 27 items and was developed to measure grief before the death of a loved one. Although it was originally developed to be used in the context of dementia, the instrument is relevant in palliative care where family caregivers often face a complex and difficult situation before the patient’s death. Because family caregivers with high levels of anticipatory grief might have need for more support both during ongoing palliative care and in bereavement, it is important to use valid instruments to measure grief reactions in anticipation of the patient’s death.

Aim: The aim was to evaluate the measurement properties of the AGS in a sample of family caregivers in palliative care.

Methods: In this psychometric study, data were collected in the context of ongoing palliative care and 270 family caregivers were included in the study. The family caregivers completed a questionnaire, including the AGS and demographic questions. The factor structure (construct validity) of the scale was evaluated using exploratory factor analysis for ordinal responses. Ordinal alpha (α) was used to estimate internal consistency.

Results: The results of the exploratory factor analysis suggested that there were measurement problems and inconsistencies concerning the original AGS. Further analysis supported that the number of items should be reduced from 27 to 13 items. Analysis of the remaining items suggested a two-factor solution. The two dimensions captured the Behavioral reactions and Emotional reactions of grief in family caregivers in palliative care. Internal consistency was satisfactory for both scales, α=0.83 and α=0.84 respectively.

Conclusions: This study resulted in a revised 13 item version of the AGS, including two dimensions. The instrument appears to be promising for use in palliative care and in research but the measurement properties of the revised AGS needs to be confirmed in further studies.

Funding
This study was supported by the Swedish Cancer Society.

Abstract number: FCS4
Abstract type: Oral presentation

Distress and Psychological Comorbidity in Family Caregivers of Advanced Cancer Patients Receiving Specialist Inpatient Palliative Care
Ulrich, Anneke1,2, Bergelt, Corinna2, Marx, Gabriella1, Benze, Gesine1, Dickel, Lisa-Marie1, Heine, Julia1, Wowretzko, Feline1, Zhang, YaoYou1, Hlawatsch, Cornelius1, Nauck, Friedemann1, Bokemeyer, Carsten1, Oechsle, Karin1
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Purpose: The measurement problems and inconsistencies concerning the original AGS are the internal and external resources that bereaved caregivers can use to adjust the grief reactions. This study resulted in a revised 13 item version of the AGS, including two dimensions. The instrument appears to be promising for use in palliative care and in research but the measurement properties of the revised AGS needs to be confirmed in further studies.

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Background: The Anticipatory Grief Scale (AGS) consists of 27 items and was developed to measure grief before the death of a loved one. Although it was originally developed to be used in the context of dementia, the instrument is relevant in palliative care where family caregivers often face a complex and difficult situation before the patient’s death. Because family caregivers with high levels of anticipatory grief might have need for more support both during ongoing palliative care and in bereavement, it is important to use valid instruments to measure grief reactions in anticipation of the patient’s death.

Aim: The aim was to evaluate the measurement properties of the AGS in a sample of family caregivers in palliative care.

Methods: In this psychometric study, data were collected in the context of ongoing palliative care and 270 family caregivers were included in the study. The family caregivers completed a questionnaire, including the AGS and demographic questions. The factor structure (construct validity) of the scale was evaluated using exploratory factor analysis for ordinal responses. Ordinal alpha (α) was used to estimate internal consistency.

Results: The results of the exploratory factor analysis suggested that there were measurement problems and inconsistencies concerning the original AGS. Further analysis supported that the number of items should be reduced from 27 to 13 items. Analysis of the remaining items suggested a two-factor solution. The two dimensions captured the Behavioral reactions and Emotional reactions of grief in family caregivers in palliative care. Internal consistency was satisfactory for both scales, α=0.83 and α=0.84 respectively.

Conclusions: This study resulted in a revised 13 item version of the AGS, including two dimensions. The instrument appears to be promising for use in palliative care and in research but the measurement properties of the revised AGS needs to be confirmed in further studies.

Funding
This study was supported by the Swedish Cancer Society.
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Objectives: This study aimed to determine distress and psychological comorbidity among family caregivers (FCs) of advanced cancer patients receiving specialist inpatient palliative care (SIPC) as well as potential FC, relationship- and patient-related influencing factors.

Methods: Within this observational multicenter study, a consecutive sample of FCs (N=226; 67% female, age 56±14.8) was recruited within 72 hours after patients’ admittance to the SIPC ward. FCs completed questionnaires including the Distress Thermometer (DT; plus adapted problem list), the General Anxiety Disorder scale (GAD-7) and the depression module of the Patient Health Questionnaire (PHQ-9). Analyses used hierarchical linear regression.

Results: Of 226 FCs, 216 FCs (96%) reported clinically relevant (DT > 5) and 148 (66%) severe (DT > 8) distress, with sadness (91%), sorrows (90%) and anxiety (78%) being the three most prevalent distress-causing problems. Moderate to severe anxiety and depression were prevalent in 105 (48%) and 83 (38%) of 218 FCs. Regression analyses revealed that a higher level of perceived patient’s sadness (B=-43, p<0.001) was associated with higher FCs’ distress. Female (B=1.93, p<0.018), non-spousal FCs (B=-79, p<0.001), who thought the patient to experience higher pain (B=-1.7, p<0.027), more sadness (B=1.36, p<0.002) and less inner peace (B=-0.62, p<0.008) reported higher levels of anxiety. Also, female (B=2.70, p<0.004) and non-spousal FCs (B=-71, p<0.009), who thought the patient to experience higher pain (B=25, p<0.006), more sadness (B=1.06, p<0.039) and less inner peace (B=-91, p<0.004) showed worse depressive symptoms.

Conclusions: In this large sample of FCs, distress levels were high and approximately 40% of FCs presented with relevant levels of anxiety and depression. Results underline the unique burden of FCs at time of the patients’ admittance to a SIPC ward and indicate the necessity to early identify FCs at risk for poor psychosocial well-being who may benefit from intensified support.

Advance Care Planning

Abstract number: FC55
Abstract type: Oral presentation

The Impact of Advance Care Planning on Hospital Deaths

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Background: Few patients want to die in hospital, yet this remains the most common place of death in UK. Reduced hospital use at the end of life (EoL) is both a measure of quality of care and a potential cost saving strategy. Advance Care Planning (ACP) opens up discussions between patients, carers and healthcare professionals about patient wishes at EoL. ACP often includes decisions about Cardiopulmonary Resuscitation (CPR) and patients’ Preferred Place of Death (PPD). Documentation of these decisions provides clear direction to healthcare professionals as they usually involve discrete categorical or binary options. Coordinate My Care (CMC) is London’s Electronic Palliative Care Coordination Service (EPaCCS). CMC provides a real-time digital service for sharing urgent medical and care information between patients and community, hospital, acute and emergency health care providers. Previous analysis has shown that having a recorded “Not for CPR” order, shared via CMC, is associated with a higher chance of dying in the PPD. However, a substantial proportion of dying patients do not have a recorded PPD. Analysis of death in hospital, rather than achieving PPD, provides an alternative metric of EoL care.

Aims: To explore the association between documentation of PPD and CPR status and likelihood of death in hospital in patients with a CMC plan.

Methods: Retrospective analysis of all persons with a CMC plan over the age of 18 between 31st March 2011 and 31st September 2016 with a recorded place of death. A multivariable logistic regression model was built to analyse the case-mix adjusted association between documentation of PPD and CPR status and dying in hospital. Multiple imputation by chained equations was used.

Results: Of all 11,839 persons, 1% wished to die in hospital. Only 18% of all patients died in hospital. Those without a documented PPD (N=2812) were 80% more likely to die in hospital (OR, 95% CI: 1.80, 1.61 to 2.01, p< 0.001; 31% vs 14%). Patients who chose to be “for CPR” (N=3479) were 89% more likely to die in hospital (OR, 95% CI: 1.89, 1.69 to 2.13, p< 0.001; 30% vs 13%).

Conclusions: ACP in the form of documentation of PPD and CPR decision making is significantly associated with dying outside of hospital. Discussion, documentation and sharing of decision making about these clearly defined aspects of ACP should be offered to all patients approaching EoL.

Abstract number: FC56
Abstract type: Oral presentation

Involvement in Medical Decision-making by a Cohort of Patients with Advanced Cancer across Six European Countries, the ACTION Study

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Background: Involvement in medical decision-making is both relevant and challenging for patients with advanced cancer. Patients’ degree of involvement is influenced by personal as well as socio-cultural factors.

Objective: To investigate the involvement in medical decision-making in patients with advanced lung or colorectal cancer, potential differences in involvement across Europe, and associations with patients’ personal characteristics.

Methods: In the context of the ACTION trial, a multi-country study on advance care planning, 1,028 patients from six European countries (Belgium, Denmark, Italy, Netherlands, Slovenia, United Kingdom) completed a baseline questionnaire on involvement in medical decision-making (APEC C - DEPS scale, range 0-100; higher scores indicate more involvement), emotional functioning (10 items from the EORTC item bank), and overall quality of life (EORTC QLQ-C15-PAL item). Patients also provided data on personal characteristics. Bivariate associations of involvement in medical decision making with personal characteristics and quality of life were assessed. Significant factors were included in a univariate regression model. Analyses were conducted in SPSS.

Results: Participants’ mean age was 66 years (SD 9.9). Involvement in decision-making differed by country, ranging from least 62 (Italy) to 69 (Belgium), 78 (UK), 79 (Denmark), 80 (Netherlands, p < 0.001). Further, patients identifying themselves as religious reported less involvement than those identifying themselves as
as non-religious (72 versus 80; \( p < 0.001 \)). Patients with better WHO performance status reported more involvement (77 to 62; \( p < 0.001 \)). Involvement in decision-making was positively related to years of education \( (R=0.118, p=0.001) \), emotional functioning \( (R=0.297; \ p < 0.001) \) and overall quality of life \( (R=0.282; \ p < 0.001) \) were positively associated with involvement in decision-making. After inclusion of the significant factors in a multivariate model, country differences remained significant \( (p < 0.001) \), and emotional function and overall quality of life remained positively associated with involvement in decision-making \( (both \ p < 0.001) \).

Conclusions: In this observational study, patients’ self-reported level of involvement in decision-making differed per country, with relatively large differences. Patients who indicated more involvement in medical decision-making also reported better emotional functioning and overall quality of life.

Funding
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Abstract number: FC57
Abstract type: Oral presentation

How Do Cultural Factors Influence Advance Care Planning in Progressive, Incurable Disease? A Systematic Review with Narrative Synthesis
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Background: Advance care planning (ACP) in end of life care can improve patient and family outcomes and experiences. However, low uptake indicates ACP is less acceptable to patients of some ethnic and cultural backgrounds. To inform clinical practice and education, we need to understand how cultural factors influence the acceptability of ACP, yet research in this area has not been comprehensively synthesised.

Aim: To synthesise the evidence regarding how cultural factors influence ACP and how to make ACP cross-culturally appropriate.

Methods: A systematic literature review using narrative synthesis methodology (Popay et al 2006) was conducted (protocol registered prospectively). Key words and subject headings of 6 databases (AMED, PsycINFO, Embase, Ovid MEDLINE, CINAHL, Cochrane) were searched without time restrictions. Eligible papers reported original research (of any study design), were in English, included adults with progressive, incurable disease or their caregivers, and measured, adjusted for, recorded and/or considered the influence of ethnicity/race, religion/spirituality, nationality or country of origin. Quality was dual assessed using the Mixed Methods Appraisal Tool. Tabulation, textual description, concept mapping and thematic analysis were used to develop and present the narrative.

Results: 757 records were screened. 33 studies were included: 23 quantitative, 7 qualitative and 3 mixed methods. All except 3 were conducted in high-income countries (mainly USA). All were moderate or good quality. 4 themes emerged: the cultural factors and ACP processes investigated; recommendations for a focus on communication in ACP; calls for clinician training and education in cultural-competence; and the importance of avoiding stereotyping. Many interconnected cultural factors influence the acceptability of ACP. In the USA, non-White ethnicity is associated with lower acceptability and formal ACP, mediated by higher levels of religiousity. A communication-focused approach that does not place undue importance on formal documentation is recommended to increase ACP acceptability/uptake. Clinician training in cultural competence is needed and should emphasise viewing patients as individuals within their broader cultural context to avoid stereotyping.

Conclusions: A communication-focused approach to ACP is needed to make it cross-culturally appropriate.

Funding
Conducted during an iBSc in Global Health by the first author, supervised by the last author.

Abstract number: FC58
Abstract type: Oral presentation

Prevalence of Advance Directives among Nursing Home Residents in Switzerland
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Research aims: The proportion of older people with advanced dementia who will die in nursing homes is constantly growing. Our objectives were to

(1) assess the prevalence and
(2) compare the variation in advanced directives (ADs) among Swiss nursing home residents by stage of dementia.

Study population: We enrolled 75,390 non-comatous residents of 357 nursing homes in Switzerland.

Methods: We collected data from the Resident Assessment Instrument - Minimal Data Set (RAI-MDS), Version 2.0, from 2005 to 2014. Based on medical diagnosis, residents were classified as having dementia or no dementia. Dementia severity was determined by cognitive performance score (CPS). The availability of ADs were determined by the relevant RAI-MDS items. Descriptive statistics were calculated for all measures.

Results and interpretation: A total of 66.9% of residents had no AD upon admission to a nursing home. Overall, 34.1% of patients without dementia and 30.5% with dementia had any AD, which is not surprising, since ADs are initiated by individuals themselves, typically before developing serious illness. Interestingly, we did not find an increase of ADs over time.

The fact that only 33.1% of residents had any AD is a cause for concern since prospective studies and randomized trials in ACP have shown significantly improved outcomes including an increased likelihood that clinicians and families understand and comply with a patient’s wishes, a reduction in hospitalization at the end of life, an increased utilization of hospice services and an increased likelihood that a patient will die in their preferred place.

A further reevaluation of current ACP practices is warranted.

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Abstract number: FC59
Abstract type: Oral presentation

The Conceptual Models That Underpin Advance Care Planning for Advanced Cancer Patients and their Mechanisms of Action: A Systematic Review of Randomised Controlled Trials
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Advance Care Planning Programs on the Web: A Scoping Review

Background: Evidence has shown that advance care planning (ACP) is an effective intervention to promote patient-centred care and improve healthcare outcomes. However, no review to our knowledge has specifically focused on conceptual models underpinning ACP for advanced cancer patients, nor critically considered the mechanisms of action in relation to the intended outcomes.

Aim: To explore the conceptual models underpinning ACP for advanced cancer patients in terms of the context, resources, theoretical underpinning, mechanisms of action, and linkage with the intended outcomes.

Method: A systematic review of eight English electronic databases and one Chinese database inception to March 2017 with reference chaining and hand searching (e.g. citation of key studies and key journals). Eligibility comprised randomised controlled trials (RCTs) of ACP for advanced cancer patients in the last 12 months of life at any care settings. Studies were excluded focusing exclusively on interventions for promoting advance directives completion rate. A narrative synthesis was used for data analysis.

Results: 1246 studies identified and 9 RCTs including 1172 patients met eligibility criteria. All the included RCTs were from Western countries; most were from the United States (n=5) and only 3 RCTs were conducted across care settings. Only 4 RCTs applied conceptual models for intervention implementation (two used Self-Determination Theory of Health-related Behaviour Change, one used Shared Decision-making Model, and another used Ecological Model of Patient-Centred Communication). The mechanisms through which ACP improve outcomes are by

1) Increasing patients’ knowledge of end-of-life (EOL) care,
2) Strengthening patients’ autonomous motivation,
3) Building up patients’ competence to undertake EOL discussions, and
4) Shared decision-making in a trustful clinician-patient relationship.

However, the majority of participants (628 patients) were well-educated (university or postgraduate) and White.

Conclusion: The use of conceptual models to underpin the implementation of ACP in trials is uncommon. When used, the models mainly consider the level of individual behavioural change, rather than considering a wider systems approach. The mechanisms of action focus on facilitating patient’s knowledge and motivation for medical decision-making. There is a requirement to explore applicability for different educational levels and ethnicities in non-Western countries.

Abstract number: FC60
Abstract type: Oral presentation

Advance Care Planning Programs on the Web: A Scoping Review
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Background: Advance Care Planning (ACP) is becoming increasingly important, especially in aging populations where many people have chronic conditions. In order to disseminate ACP, web-based programs might be useful since these can be accessed at any preferred time. Web-based programs might support patients during the process of ACP by providing tailored information, supporting them in their communication with care professionals and relatives, and in the recording of preferences in a document. However, an overview of web-based ACP programs and their effectiveness is missing.

Objective: To provide an overview of web-based and patient-centered ACP programs, the topics they address, their outcomes and their effectiveness.

Methods: In this scoping review, we systematically searched for empirical studies that evaluated web-based, interactive and patient-centered ACP programs, following the methodological framework for scoping reviews by Arksey and O’Malley (2005). We searched in Embase.com, Medline Epub (Ovid), Web of Science, Cochrane Central, PsycInfo (Ovid), Cinah EBSCO and Google Scholar.

Results: Of 3434 titles and abstracts, 25 studies were found to be relevant, and 4 studies were found by hand search. The 29 studies evaluated 17 different web-based ACP programs, developed in the US (15), Ireland (1) and Australia (1). Most ACP programs addressed clarification of values, preferences for medical treatments, options for medical treatments, communication of preferences, appointing a health care proxy and recording of preferences in a document. Most studies (27 of 29) had positive outcomes, while 2 studies had mixed outcomes. Examples of positively affected process measures are satisfaction with the program, knowledge of ACP and the program’s accuracy to reflect patients’ care preferences. Examples of positively affected outcome measures are ACP behavior change, documentation of preferences in documents, patient-physician decision concordance, and the level of decisional conflict, hope and anxiety among patients.

Conclusion: This study shows that web-based ACP programs can effectively support patients during the process of ACP. Since most web-based ACP programs were developed outside Europe, their feasibility and effectiveness in Europe needs to be established. The findings of this scoping review will be taken into account in the development of a web-based ACP program in the Netherlands.

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The Netherlands Organisation for Health Research and Development.

Public health & Policy
Abstract number: FC61
Abstract type: Oral presentation

A Population Study to Explore the Prevalence and Severity of Bowel Problems in Palliative Care
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Background: While constipation is common in palliative care the absence of population studies limits accurate reports of epidemiology. This study’s aim was to summarise the prevalence and severity of self-reported or proxy reported distress from bowel problems in a large cohort of palliative care patients. A secondary aim was to investigate whether correlations between routinely collected demographic and clinical features and the intensity of bowel symptoms existed.

Methods: The data of a consecutive cohort of palliative care patients who died during 1 January 2013 and 31 December 2015 was extracted from the Australian Palliative Care Outcomes Collaboration (PCOC) longitudinal database. This included demographic data (age, sex, main diagnosis, place of care) and point of contact assessments (phase, performance status, symptoms). Symptoms were summarised using the Symptom Assessment Scale (SAS) which summarises the extent to which palliative care patients find a range of physical symptoms acceptable including pain, dyspnoea and bowel problems. Descriptive statistics summarised demographic information, bowel problems, care setting, phase type and performance status. Linear mixed modelling explored the relationship between bowel problems and the other coefficients.
Results: 50,319 patients who had at least one assessment of bowel problems were included in the final analysis. More men were included (53.5%) with a mean age of 73.6 years (SD = 13.9). Nearly 80% had a cancer diagnosis (n= 38092) with colorectal cancer accounting for referral to palliative care for 8.9% (n=4455) of the total cohort. A total of 163,526 bowel problem assessments were analysed. The majority (63.8%) of bowel problems scored as 0 which equates with no distress for the person from this problem at this time with 3.6% of observations equating to severe distress. The mixed model analysis revealed that patients with higher SAS distress due to pain, breathing problems or nausea were more likely to report more distressing bowel problems with nausea displaying the most significant correlation. Other statistical correlations included place of care, a diagnosis of colorectal cancer and performance status.

Conclusions: The main finding of this work was that most people did not seem unduly distressed by their bowel symptoms. This does not mean that they were not constipated. The second most notable outcome was the strong correlation of bowel symptoms with nausea, pain and breathlessness.

Abstract number: FC62
Abstract type: Oral presentation

The Voice of European Volunteers: A Qualitative Analysis of Accounts of Volunteering in Palliative Care Contexts

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Background: Volunteers play a vital role in hospice and palliative care (HPC) in many countries. Too often others speak about volunteers and their work rather than encouraging volunteers to share their experiences. This project aimed to give volunteers a voice and to elicit their own words their personal stories of their involvement in HPC.

Aims: The aims were to gain an insight into the experiences of volunteers in HPC and to understand why they work in this field and what it means to them to be involved in this work.

Method: Key contacts in seven countries were asked to recruit five volunteers willing to write their story of volunteering in 400-500 words using their own language. The volunteers were asked to focus on two key questions: “What do you do as a volunteer?” “What does it mean to you?” The stories were translated into English and analysed using a qualitative framework approach.

Results: Thirty-seven stories were collected from eight countries: Austria, Finland, France, Germany, Italy, Netherlands, Norway, and UK. The majority of volunteers (37) were involved in providing practical, emotional and social support to patients and families, some with multiple roles. Most (32) were involved in different adult HPC settings including patient’s homes, hospices, hospitals and care homes. Two volunteered in children’s palliative care and two in hospice bereavement services. Practical and social activities included taking patients out, shopping for patients and families, and driving them to medical appointments. Some were involved in emotional support, listening to patients’ and families’ needs, sitting with those who were dying, whilst others provided bereavement support to families.

Volunteers derive significant meaning from their involvement. For many it is an important part of their life and their values. They talk of the privilege of being with patient and families at such a precious moment, of how much they learn from encounters around death and dying and the importance of ‘being there’ for patients during this period in their life. Others describe the challenges faced by working in this field and how their lives are enriched by their experiences.

Conclusion: The identification of personal stories of volunteers across Europe indicate some commonalities of experiences and shared values. An understanding of personal motivations and rewards can help HPC organisations to better support and utilize their volunteer workforce.

Abstract number: FC63
Abstract type: Oral Presentation

Understanding Patient and Carer Perspectives of Transitions between Different Specialist Palliative Care Settings: Where Do We Go from Here?

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Background: Transitions of care between palliative services can be challenging to navigate, particularly for those who undergo multiple. Despite this, transitions are an under-researched area of healthcare.

Aim: To explore transitions of care between settings for those receiving specialist palliative care, to understand how we might better negotiate these transitions and improve patient outcomes.

Design and methods: Face-to-face, semi-structured interviews with patients receiving specialist palliative care from hospital, hospice and community settings, who had undergone at least two changes of setting. Patient’s family carers were also invited to be interviewed. Purposively sampled by location and diagnosis. Data was handled in NVivo and analysed using thematic and narrative analysis.

Results: 28 interviews with participants. The main themes that emerged include:

(i) Uncertainty: saturating the data was a sense of not knowing, particularly around settings (what would it be like?), symptoms and how they would progress, and loss of independence and control;

(ii) Timing and waiting: participants spoke of both unhelpful timing (i.e. ‘the wrong time’ to move), as well as practical frustrations (i.e. ‘waiting around’ & logistical delays);

(iii) Continuity: participants spoke of the need to preserve normality, and praised healthcare practitioners who provided continuity and got to know them as individuals;

(iv) Emotional and practical support: participants specified a need for support not only in the practical realm but also in the emotional demands of making a move. Good communication was found to be essential and interwoven across all the main themes.

Conclusions: Qualitative exploration into transitions provides rich insights into specialist palliative care services and offers novel suggestions about how we might best support patients and their carers as they move across settings.

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Abstract number: FC64
Abstract type: Oral presentation

Evaluation of the Use of a Patient Held Record in Community Specialist Palliative Care

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Introduction: The Royal College of General Practitioners in Northern Ireland created a Patient Held Record (PHR) for patients with progressive, life-limiting illness and their families to improve communication with healthcare professionals (HCPs) and aid advance care planning. This study evaluates its usefulness in the specialist palliative care context.

Methods: A prospective longitudinal cohort study was undertaken through a hospice community service. Patients were given a questionnaire both with the introduction to the PHR and after 4-6 weeks. Hospice HCPs involved in using the PHR with patients completed a questionnaire and focus group after 8 months to gain insight into the usefulness of the PHR in this context.

Results: From Sept 2016- June 2017, 550 patients were screened, 347 (63.1%) were offered a PHR and 259 accepted it (74.6% of those offered). 238 patients accepted a research pack, with 105 returning questionnaire 1 (44.1% response rate), and 26 returning questionnaire 2 (24.8% of initial respondents). Questionnaire 1 (patients) - 40% found it difficult or burdensome repeating information to HCPs, and almost 70% were interested in a PHR to reduce repeating information. Questionnaire 2 (patients) - 74% found the PHR easy to use, but only a few (4, 15.4%) actually used it regularly. Over 40% felt it had helped them talk to family about their day-to-day care, with 53% feeling that it had helped them talk about this to their HCPs. In relation to future care, 55.6% felt it had helped them talk to their family, and 23.5% with HCPs about this, but few had recorded these wishes in the PHR. Over 60% stated the PHR was ‘very’ or ‘quite’ ‘useful’, and would recommend it to others. The questionnaire (n=18) and focus group (n=7) with HCPs indicated it was mainly patients and relatives who wrote in the PHR, not HCPs (excluding hospice HCPs). Half felt the PHR was initially well received, but only 4 (22%) felt it was used regularly by patients or their families. 50% found it helped facilitate discussion about future care wishes / advance care plan with patients.

Conclusions: While initial uptake of the PHR was high, use appeared low and due to a very low response rate to questionnaires it is difficult to draw firm conclusions on its usefulness. This evaluation does not support widespread use of a PHR in palliative care, but found a PHR may be helpful to individuals, especially those earlier in their disease trajectory.

Abstract number: FC65
Abstract type: Oral presentation

High Intensity of Healthcare Utilisation in the Last Phase of Life of Dutch Lung Cancer and Colorectal Cancer Patients

| de Man, Yvonne1, Atsma, Femke1, Oosterveld-Vlug, Mariska1, Brom, Linda1, Westert, Gert1, Groenevoud, Steef2 |

Methods: All Dutch insured (>98%) LCP and CRCP (diagnosis based on ICD-10 codes) deceased in 2013, 2014 or 2015 of whom hospital medical care was registered are included. We used an administrative hospital database containing all in-hospital healthcare activities in the Netherlands for the years 2013-2015 for LCP (N=25,553) and CRCP (N=14,911). After clustering healthcare activities into main clusters of care we calculated the number of patients receiving this care and, if they did, the intensity of care (average number of treatments per patient per month) during the last 6, 3 and 1 month(s) of life. We calculated crude odds ratios to investigate the association between chemotherapy or radiotherapy treatments and emergency room (ER) or intensive care unit (ICU) contacts in the EoL. We consulted 5 oncologists/palliative care experts to interpret the results.

Results: As death nears, the number of patients receiving hospital care decreases but the intensity of care increases. During the last month of life, the average number of CT scans, hospital bed days, ICU and ER contacts is strikingly high but the number of palliative consultations is low (table1). In the last month of life, chemotherapy and radiotherapy are associated with ICU and ER contacts in both CRCP and LCP. For ER contacts, this is also the case during the last 6 months of life.

Conclusions: There was a substantial amount of CRC and LC patients with a prolonged treatment in the last phase of life. Whether these treatments are inappropriately numerous or intense, requires further research.

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Abstract number: FC66
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Effect of a Model of Early Integration on Palliative Care Inpatients: Interrupted Time Series Analysis of Standardized National Outcomes

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Table 1. EoL HCUP for CRCP and LCP.

<table>
<thead>
<tr>
<th>Months before death</th>
<th>Colorectal cancer (N=4123)</th>
<th>Lung cancer (N=6643)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>Intensity</td>
</tr>
<tr>
<td>CT scan</td>
<td>56.0</td>
<td>0.3</td>
</tr>
<tr>
<td>Hospital bed day</td>
<td>55.2</td>
<td>1.8</td>
</tr>
<tr>
<td>ER visit</td>
<td>43.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>27.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>9.6</td>
<td>1.3</td>
</tr>
<tr>
<td>ICU day</td>
<td>6.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Palliative consultation</td>
<td>3.1</td>
<td>0.3</td>
</tr>
</tbody>
</table>
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Background: The management and evaluation of change is a key priority of healthcare, with attendant obligations to demonstrate improved population health, better patient experiences, and reduced per capita costs. The evolution of specialist palliative care from traditional hospice models to integrated services across health networks has required accountability and compliance with quality improvement systems.

Aim: To examine trends in routinely measured national palliative care outcomes over a 5 year period pre and post implementation of a new model of early integration palliative care into an inpatient specialist unit previously focused on end-of-life care.

Methods: A longitudinal study of the Palliative Care Outcome Collaboration dataset of patients admitted between January 2012 and December 2016. A piecewise regression model was used to undertake an interrupted time series analysis to estimate change in outcomes associated with the new service model. The data was split into three-month periods giving rise to 16 time points.

Results: 1,650 patients were admitted in the study period, collectively receiving 2,101 episodes of care (550 patient-new model of care and 1,084 patients post.) Post-implementation, a greater percentage of non-malignant patients received care (10.7% vs. 15.3%); mean patient age increased slightly (74.5 years (SD 13.1) vs. 75.3 years (SD 13.5)); mean length of stay decreased (12.3 days (SD 9.4) vs.11.6 days (SD 9.3)) and the proportion of episodes ending in death decreased (61.1% vs. 54.6% post-implementation). The new model resulted in sustained improvement of 2-14% in 3 of 4 pain management measures and all 8 casemix adjusted measures. While the fourth pain measure saw a small decrease of 0.5% at implementation, this was offset by the highest casemix adjusted measures. While the fourth pain measure saw a small decrease of 0.5% at implementation, this was offset by the highest casemix adjusted measures.

Conclusions: Outcome metrics can support change management processes undertaken by health services. By characterising baseline metrics, analysing benchmarks over time and conducting trend and post intervention analysis, services are able to track and monitor both progress and performance. This may potentially provide motivation for ongoing improvement; identify areas for further investment and education; and provide data to secure related funding.

Method discussion: Randomized Controlled Trials

Abstract number: FC67
Abstract type: ORCT

Placebo and Methylphenidate Are Both Effective in Relieving Moderate to Severe Asthenia in Advanced Cancer Patients.

Preliminary Results from a Multicenter Randomized Clinical Trial
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Background: Psychostimulants have been proposed as a treatment to relieve asthenia in advanced cancer patients. Recent randomized clinical trials (RCT) trials suggest that a more relevant effect could be seen in patients with severe asthenia.

Methods: We performed a multicenter double-blinded placebo-controlled RCT (METILAS) to define the impact of methylphenidate in asthenia. Patients with advanced cancer were included if the intensity of asthenia was 5 or more (NVS, 0 to 10). Patients were stratified according to the severity of asthenia: 5-7 moderate, and 8-10 severe. Starting doses was 10 mg am and 5 at noon. Doses were adapted to response and tolerance within a range from 10 to 25 mg/day. Assessment was performed on days 0, 3 and 6 with the subscale fatigue of ESAS and FACT-F. A decrease of more than 1.5 on ESAS-fatigue days 6 was considered as response. Also analysis for patients with moderate and severe asthenia was done.

Results: 100 patients were included in 5 Spanish Palliative Care Services. 45 received placebo and 55 methylphenidate. Characteristics of patients: age (median) 68 (range: 39-88). Gender: male 59 / female 41. Life expectancy (according to investigator): 3-months or less 47% / 4-months or more 53%. Primary tumor: digestive 52, lung 17, breast 11, others 20. Asthenia (median) 8 (range: 5-10) (mean 7.3); moderate 50, severe 50. FACT-F (median) 22 (range: 7-41). On day 6, mean improvement in asthenia was 1.88 with placebo and 2.26 with methylphenidate (p=0.38). With moderate asthenia, mean improvement with placebo was 1.47 and 1.30 with methylphenidate (p=0.82); and with severe asthenia 2.40 with placebo and 3.35 with methylphenidate (p=0.28). 17 (50%) of 34 evaluable patients achieved a clinically relevant decrease in asthenia (at least 1.5 points) with placebo and 27 (63%) of 43 with methylphenidate (p=0.26); in patients with severe asthenia a trend to a better response was seen: these proportions are 7 (47%) of 15 patients with placebo and 15 (75%) of 20 with methylphenidate (p=0.08). Both therapies were well tolerated, without relevant side effects.

Discussion: Both placebo and methylphenidate are associated with a relevant improvement in asthenia in of advanced cancer patients (with a NNT of 2). Our data suggest a possible stronger effect of methylphenidate in severe asthenia.

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Abstract number: FC68
Abstract type: ORCT

Effect of Sleep Hygiene on the Quality of Sleep of Patients with Advanced Cancer Referred for Palliative Care: A Randomized Controlled Trial
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Background: Poor sleep is common in advanced cancer patients. Effectiveness of sleep hygiene as part of many behavioral and non pharmacological interventions for poor sleep in cancer or palliative patients has been shown. Purpose of the study was to see effect of sleep hygiene, as a single modality, on sleep quality in advanced cancer patients on palliative care.

Method: An open-label randomized controlled trial, stratified to balance for gender, age and PSQI (Pittsburgh Sleep Quality Index) score was conducted in outpatient palliative care clinic from January 2016 to March
2017, with Institutional Ethics Committee approval. Advanced cancer patients registered with the clinic were screened and those meeting inclusion criteria [Adults ≥18 yrs, Eastern Cooperative Oncology Group Status 0-3, ESAS CS (Edmonton Symptom Assessment Scale) score for sleep ≥3, PSQI score ≥5, adequate cognitive status to understand nature of study] and giving informed consent were centrally randomized to intervention or control arm. Intervention arm received standard palliative care plus sleep hygiene education as compared to only standard palliative care in control arm. Compliance with sleep hygiene in intervention arm was assessed with phone follow up each day during 15 days study period. PSQI to assess sleep, ESAS-CS to assess sleep and other symptoms, demographic details and consumption of medications with sedative potential were recorded in both arms at baseline and on day 15.

Sample size of 50 participants, 25 per arm, provided 90% power to study with two sided type I error of 5%. Primary analysis was done using ANCOVA to compare day 15 PSQI scores in each arm, adjusted for baseline. All analyses were intention to treat and all p-values and confidence intervals, two-sided. Demographic, clinical and disease relate variables were presented as frequency and mean or median. Spearman’s rank correlation coefficient was used to assess correlation between change in ESAS-CS scores of sleep and other symptoms.

Result: Prevalence of poor sleep in screened advanced cancer patients was 73%. Mean PSQI score difference between intervention and control arm on day 15 was significant (p < 0.001) indicating improved sleep quality with sleep hygiene. Sleep quality correlated with pain and depression.

Conclusion: Sleep hygiene significantly improves sleep quality and can be used as non-pharmacological means for management of poor sleep, in advanced cancer patients, before starting complex interventions.

Abstract number: FC69
Abstract type: ORCT

Does Advance Care Planning (ACP) Affect How Relatives Use their General Practitioner?

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Background: Relatives to terminal ill patients may experience distress, which can be associated with poorer health status and adverse bereavement outcomes. Accordingly, bereaved relatives attend their GP more often than the background population. To support patients and relatives ACP has been developed to plan end-of-life care.

Objective: To investigate if ACP change how relative to terminally patients may use GPs?

Methods: The study was conducted as a register study based on an RCT. The intervention consisted of an ACP discussion with a doctor, the patient and a relative if possible. Patients were randomised into intervention (ACP + usual care) or control group (usual care) and register data on relatives’ GP contacts was compared. Data was analyzed for distribution and median number of contacts in three time-windows: the entire follow-up period (ACP to end-of-study), the caregiving period (ACP to patient’s death) and the bereavement period (patient’s death to six months after).

Results: 121 relatives were included (intervention group: n=61). The median number of GP contacts were 20 (10.0;36.0) in the entire follow-up period, and no significant difference between groups was found. In the caregiving period, however, there was a significant difference in the distribution of GP contacts: more relatives in the control group had no GP contact (p=0.036). Furthermore, the control group had more contacts to GPs out-of-hours (10 vs 5) than the intervention group.

Discussion: Relatives’ contacts with the GP may represent low health status but also their seeking of relevant psychosocial support why results of this study are ambiguous to evaluate. However, out-of-hour contacts to GPs may be interpreted as adverse events, which seems to be more common in the control group.

Conclusion: Participation in ACP did not affect the median number of GP contacts, but the distribution of contacts. However, ACP may encourage relatives to seek support from GPs in a less acute manner.

Abstract number: FC70
Abstract type: ORCT

Proactive Palliative Care for Patients with COPD (PROLONG): A Pragmatic Cluster Controlled Trial

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Background: Patients with advanced Chronic Obstructive Pulmonary Disease (COPD) have poor quality of life. We assessed the effects of proactive palliative care on the well-being of these patients.

Methods: A pragmatic cluster controlled trial (quasi-experimental design) was performed with hospital as cluster (3 intervention, 3 control) and a pre-trial assessment. Hospitals were selected for the intervention condition based on the presence of a specialized palliative care team (SPCT). To control for confounders a pre-trial assessment was performed in which hospitals were compared on baseline characteristics. Patients with COPD with poor prognosis were recruited during hospitalization for an acute exacerbation. All patients received usual care while patients in the intervention condition received additional proactive palliative care through monthly meetings with an SPCT. Our primary outcome was change score in quality of life measured with the St George Respiratory Questionnaire (SGRQ) at 3 months. Secondary outcomes were among others quality of life at 6, 9 and 12 months, readmissions, survival and having made advance care planning (ACP) choices. All analyses were by intention-to-treat.

Results: During the year 2014, 228 patients were recruited (90 intervention, 138 control) and at 3 months, 163 patients (67 intervention, 96 control) completed the SGRQ. There was no significant difference in change scores for SGRQ total at 3 months between groups (−0·79 [95% CI −4·61 to 3·34], p=0·70). However, patients who received proactive palliative care experienced less impact of their COPD (SGRQ impact subscale) at 6 months (−6·22 [-11·73 to -0·71], p<0·04), and more often made ACP choices (adjusted OR 3·26 [1·49 to 7·14], p=0·003). Other secondary outcomes were not significantly different.

Conclusion: Proactive palliative care did not improve overall quality of life of patients with COPD. However, after six months, the impact of COPD had significantly decreased and patients significantly more often made ACP choices which may lead to better quality of care towards the end of life.

Abstract number: FC71
Abstract type: ORCT

A Randomized Trial Examining the PISCES Intervention for Family Caregivers in Home Hospice
Family caregivers of hospice patients have multiple needs as they try to cope during a stressful time. Translatable interventions effective in improving caregiver outcomes are greatly needed. The objective of this study was to assess the impact of a problem solving intervention to support hospice caregivers (called PISCES) on caregiver quality of life and anxiety, and compare the effectiveness of the intervention delivered face-to-face and via video-conferencing. Caregivers in the study are the family caregivers (family members, spouses, friends or others) who assume the often unpaid caregiving role for a patient at the end of life. We conducted a four-year randomized clinical trial with three groups. Caregivers were randomly assigned to either a group receiving standard home hospice care with the addition of “friendly calls” (attention control—AC group), a group receiving standard home hospice care with the addition of PISCES delivered face-to-face (F2F), or a group receiving standard care with the addition of PISCES delivered via video-conferencing (VID). A total of 514 caregivers participated (172 in AC, 171 in F2F and 171 in VID). Caregivers were predominantly female (75%) and mean age was 60.3 years. PISCES motivates caregivers to adopt a positive attitude, define problems by obtaining facts, set goals, generate and evaluate alternatives. Caregivers in the F2F group interacted with the interventionist in-person, and in the VID group via video. The main study outcomes were quality of life measured by the Caregiver Quality of Life Index-Revised (CQLI-R) and anxiety measured by the generalized anxiety disorder scale GAD-7. Other measures included the caregiver reaction assessment scale, demographic data and an exit interview. Compared to AC, caregivers in the F2F condition had post-intervention reduced anxiety (−1.31 [95% CI, -2.11 to 0.50], p = .004), and improved social (.57 [95% CI, .19 to .95], p = .01), financial (.57 [95% CI, .21 to .93], p = .004), and physical quality of life (.53 [95% CI, .19 to .87], p = .01). There were no differences in caregivers in the VID condition compared to AC condition. The PISCES intervention improves caregiver outcomes, and the intervention is powerful when delivered in person. How to integrate technology to reduce the intervention delivery cost warrants further investigation.

Abstract number: FC72
Abstract type: ORCT

Different Impact of Early Integrated Palliative Care for Inpatient and Out-patient Treated with Antineoplastic Therapy.

Single Center Randomized Controlled Trial
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Background: Several studies have shown that early integration of specialist palliative care (ISPC) to standard cancer care has positive impact on various patient reported outcomes and the end of life care. The „added value“ of ISPC depends on the quality of „standard“ oncology care and there is a lack of information about how the care setting influences the outcomes. The aim of this paper is to analyze the benefit of ISPC between outpatient and inpatient cancer patients.

Methods: This study is a single center randomized controlled trial comparing the ISPC model to standard oncology care in patients with advanced solid tumors treated with palliative antineoplastic therapy in a tertiary cancer center. The ISPC intervention consists of consultations with palliative care team at least every 6-8 weeks. The endpoints assessed at baseline and at 3 and 6 months after enrollment are quality of life (EORTC-QoL-Q30), anxiety and depression (HADS) and structure and cost of end of life care. We report preliminary results of 100 patients enrolled between September 2015 and January 2017. 52 patients were treated on in-patient basis, 48 on out-patient basis.

Results: The QoL scores at 3 and 6 months were 67 vs. 62 (p=0.23) and 63 vs. 59 (p=0.12) for inpatients and 63 vs. 54% (p=0.02) and 66 vs. 52 (p=0.023) for outpatients in ISPC and standard care arm respectively. Prevalence of anxiety and depression at 3 and 6 months was 53% vs. 57% (p=0.12) and 52% vs. 58% (p=0.53) for inpatients and 44% vs. 59% (p=0.01) and 49 vs. 63% (p=0.018) for outpatients in ISPC and standard care arm respectively.

Conclusion: The benefit of early integration of specialist palliative care seems to be substantially larger for patients treated on out-patient basis than for inpatients. The standard hospitalization seems to provide time and opportunity for more complex intervention (communication, symptom control, nutritional and psychological intervention etc.) compared to standard out-patient oncological consultation. This may make ISPC model relatively less beneficial for hospitalized patients compared to outpatients. These results suggest the need for different timing and forms of integration of specialist palliative care in different settings of care.

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Abstract type: Oral presentation

Nationwide Cohort Study of the Aggressiveness of Cancer Care Near the End of Life for Children and Adults: Similarities and Differences
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Background/aims: There is growing concern about the aggressiveness of cancer care near the end of life (ACCEol) but there may be different patterns in children and adults, with implications for care. To our knowledge, this study is the first to directly compare ACCEol received by children and adults.

Methods: Nationwide cohort study of all children (0-17 yo) and adults (>18 yo) with ICD-9-CM diagnosis of cancer, who died in public hospitals in mainland Portugal (Jan’10-Dec’15), identified from the Hospital Morbidity database (HMD). HMD data including primary cancer site and a composite ACCEol indicator (presence of at least 1 of 14 individual indicators in the last 30 days of life and use of chemo and biological agents/immunotherapy) in the last 14 days of life - expansion of Earle et al 2004 framework). We compared children and adults ACCEol indicators using chi2 tests (p<0.05) and examined time trends in both groups (chi2 test for trend).

Results: 92,455 patients were included: 300 children (median age 9 yo, IRQ 4-14, 58.7% male) and 92,155 adults (median age 73 yo, IQR 62-81; 61.9% male). The prevalence of ACCEol was higher in children than in adults (87.7% vs. 71.1%, p<0.001), varying from 81.7% in CNS tumors to 91.5% in hematological malignancies (HM) for children and from 62.7% in breast cancer to 79.3% in HM for adults. In both groups ACCEol trends were stable over time during the six-year period analysed. All ACCEol indicators were more prevalent in children, except the use of biological agents/immunotherapy, vasopressor support, percutaneous gastrostomy and elective/definitive tracheostomies (no sign. differences). The largest differences were in endotracheal tube (41.1% children vs. 18.1% adults, p<0.001) and >14 days in hospital (most common indicator in both groups, 51.0% in children vs. 42.7% in adults, p=0.004).

Conclusions: There are similarities but also important differences in ACCEol between children and adults. The increased ACCEol in HM and high proportion of time spent in hospital were common in both groups but particularly in children. The use of endotracheal tube in 2/5 children in their last 30 days of life may reflect higher survival probability but also treatment toxicity. The findings suggest increased difficulty in stopping treatments in children and therefore the need for greater awareness of palliative care in paediatrics.

Funding
Calouste Gulbenkian Foundation and Portuguese League Against Cancer.

Abstract number: FC75
Abstract type: Oral presentation

“Striving for the Best against Time”: A Grounded Theory Model to Describe the End of Life of the Immigrant Hospitalised Cancer Patient
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Background/aims: Recently the increase of presence of migrants in Italy makes some new needs emerge for their end-of-life care, especially within the oncology field. Up to now, no comprehensive qualitative studies exist. We aimed to model a qualitative explanation of professionals and caregivers experience regarding assisting migrant cancer patients at the end of life.

Methods: We carried out a Grounded Theory (GT) through semi-structured interviews. We involved 27 participants (healthcare professionals, informal caregivers, and other stakeholders) from several hospitals and hospices in Reggio Emilia Province. We performed an initial and theoretical sampling, concurrently the data analysis. We inductively analysed data following the Constructivist GT approach.

Results: “Striving for the best, against time” is the core category (CC) which entails the theoretical explanation of the phenomenon. The care for these patients often occurs in extemporaneous ways, as professionals are not adequately trained to cope with it. Nonetheless there is a high commitment to providing the best care they could, fighting against the short time before death.

We identified three main linked categories: the role of the local context, cultural competence, “surrounding the patient”. These categories impact on four main dimensions: patient-related care needs, communication, logistics, and emotionality. The local context defines a sense of trust to the care providers, which induces a sort of health tourism. Professionals tend to minimise the cultural diversity, have a paternalistic approach toward patients and family members; they often feel communication like a problem. Morever this attitude reveals aspect of preconception. Professionals confuse cultural mediation with translation, causing inappropriate involvement of informal caregivers.

“Surrounding the patient” means the activation of resources from family members, third sectors, associations, which fulfils patients’ and family members’ needs.

Conclusions: Our model strongly highlights the the key-role of cultural mediation in the entire trajectory of cancer disease, and the importance of negotiating care needs with competent cultural operators. Moreover, it supports the need for empowering professionals’ cultural competence through specific training programmes. Finally, it suggests the importance of supporting family about end-of-life related bureaucracy, and of improving collaboration with voluntary and community organisations.

Abstract number: FC76
Abstract type: Oral presentation

Age Variation in the Care from Diagnosis to Death for Cancer Patients: A Retrospective Longitudinal Study in a UK Cancer Population
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"Surrounding the patient" means the activation of resources from family members, third sectors, associations, which fulfils patients’ and family members’ needs.

Conclusions: Model strongly highlights the key-role of cultural mediation in the entire trajectory of cancer disease, and the importance of negotiating care needs with competent cultural operators. Moreover, it supports the need for empowering professionals’ cultural competence through specific training programmes. Finally, it suggests the importance of supporting family about end-of-life related bureaucracy, and of improving collaboration with voluntary and community organisations.

Funding
Calouste Gulbenkian Foundation and Portuguese League Against Cancer.
Background/aims: Making informed decisions about appropriate treatments or end of life care provision for older cancer patients can be challenging. Evidence suggests that cancer care varies by age, however the association between age and care experiences for patients who died of cancer has not previously been examined in detail. This study aimed to evaluate the association between age and cancer care in a cohort of deceased cancer patients.

Methods: Retrospective cohort study linking cancer registry and secondary care data for 13,499 adult cancer patients who died between January 2005 and December 2011. Cancer therapies (chemotherapy, radiotherapy, surgery), hospital palliative care referrals, hospital admissions, and place of death were compared between age groups using multivariable regression models.

Results: Compared with adult patients under 60 years, patients aged 80 years and over were less likely to receive chemotherapy (OR:0.12, 95% CI:0.11-0.14), radiotherapy (OR:0.76; 95% CI:0.67-0.85), or a hospital palliative care referral (OR:0.53; 95% CI:0.47-0.60; be admitted to hospital (OR:0.73; 95% CI:0.65-0.82; or die in a hospice (OR:0.85; CI:0.74-0.97); but more likely to die in a care home (OR:13.07;95% CI:9.13-18.73). Trends suggest chemotherapy, surgery, and hospital admissions have increased overall. The percentage of hospital deaths have decreased while deaths at home have increased for patients aged 80 years. The percentage of patients dying in a hospice or receiving a hospital palliative care referral have remained fairly stable.

Conclusion: Older patients are less likely to receive cancer therapies or hospital palliative care before death and are less likely to die in a hospice. Further research is needed to identify the extent to which these results reflect unmet need.

Abstract number: FC77
Abstract type: Oral presentation

The Association of Financial Difficulties with Good Death among Patients with Advanced Cancer: Results from COMPASS Study
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Aims: In health care systems with large out-of-pocket expenditures such as in Singapore, advanced cancer and its treatment may cause financial difficulties in patients. However its association with patients’ experience of a good death are not fully understood. We hypothesize that patients’ financial difficulties will be adversely related to all aspects of a good death.

Methods: We used baseline survey data from a cohort study of patients with a stage IV solid cancer (n=484) attending outpatient clinics in public hospitals in Singapore. Financial difficulties were scored by asking patients how well the amount of money they had enabled them to cover the cost of their treatment, meet their daily needs and buy those little ‘extras’. Quality of life was measured through FACT-G, spiritual well-being by FACIT-Spiritual, psychological well-being by the PSQ, physical, social, emotional, functional and spiritual well-being, nursing care quality and health care coordination; had greater symptom burden; were more likely to experience anxiety and depressive symptoms and to give up costly life extending treatments (p< 0.05 for all).

Results: Patients with greater financial difficulties experienced poorer physical, social, emotional, functional and spiritual well-being, nursing care quality and health care coordination; had greater symptom burden; were more likely to experience anxiety and depressive symptoms and to give up costly life extending treatments.

Conclusion: Greater equity in financing of health care would reduce patients’ financial difficulties and likely improve their end of life experience.

Abstract number: FC78
Abstract type: Oral presentation

Meaning and Purpose (MaP) Therapy II for Individuals Living with Advanced Cancer: Feasibility, Acceptability and Preliminary Effects
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Background: Meaning and Purpose (MaP) therapy aims to integrate meaning-based coping with the sense of coherence that a person can make of their life, empowering them to live life out fully with true value, hope, purpose and determination.

Aim: To test the feasibility and acceptability of a 6-session model of MaP therapy against a wait-list control cohort and examine effect sizes on measures of adaptation.

Methods: Individuals with advanced cancer were randomized to MaP therapy or wait-list control, with measures administered at baseline and after 6-8 weeks. Wait-list patients then crossed over to receive therapy, with further measures collected post-intervention. Adherence to the manualized therapy was sustained through weekly supervision and fidelity coding of audio-recorded sessions. Generalized estimating equations were used to control for baseline and any correlation of data.

Results: From 134 eligible participants, 57 (43%) consented, and 40 of 45 (89%) offered therapy completed 6 sessions. Key barriers were poor health (15 refusers and 4 withdrawals) and death intervened in 6 participants. MaP therapy generated significant gains in posttraumatic growth [effect sizes for new possibilities 0.48 (95% CI 0.26, 1.46), appreciation of life 0.45 (95% CI 0.21, 1.40), and personal strength 0.33 (95% CI 0.004, 1.17)] and life attitudes [effect sizes for choices 0.50 (95% CI 0.29, 1.50) and goal seeking 0.52 (95% CI 0.34, 1.54)].

Conclusions: Delivery of this model of existentially-oriented therapy is feasible and acceptable to patients. An adequately powered randomized controlled trial is now needed to determine the efficacy of this intervention.

Quality of care in older people
Abstract number: FC79
Abstract type: Oral presentation

Large Differences Found in the Organisation of Palliative Care in European Nursing Homes: EU PACE Study Investigated Core Structural Quality Indicators in 305 Nursing Homes in Six EU Countries
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Aims: In a previous EU-study IMPACT, a core set of structural quality indicators to assess the organisation of palliative care was developed and validated. As part of the current EU-funded project PACE, we aimed to evaluate and compare the organisation of palliative care in nursing homes in Belgium, England, the Netherlands, Poland, Finland and Italy, using these structural quality indicators.

Methods: In representative samples of nursing homes in Belgium, England, the Netherlands, Poland, Finland and Italy, in 2015, a structured questionnaire evaluating the IMPACT structural quality indicators set, was filled in by nursing home administrators, covering important domains of the organization of good clinical palliative care practice:

1. access to palliative care,
2. infrastructure, and
3. quality processes.

Results: We obtained nursing home administrators’ questionnaires in 305 of 322 participating nursing homes across six countries (95% response rate).

Regarding domain 1 (access): specialist palliative care teams were accessible in the facilities, ranging from 6% in Poland to 49% in Belgium. Opioids were not available at all in the facility in 27% in Poland and between 2% and 9% in the other countries.

Regarding domain 2 (infrastructure): specialized equipment such as syringe drivers were available in 36% in Italy up to 84% in England. Single bedrooms were available for dying residents in 27% in Poland up to 94% in England.

Regarding domain 3 (quality processes): regular multidisciplinary meetings were held in 51% of facilities in Finland up to 98% in the Netherlands. The presence of guidelines for managing the last three days of life ranged between 10% of facilities in Italy and 51% in England.

Conclusion: We found large heterogeneity in the organization of palliative care across these EU countries using the structural quality indicators set. Countries can use these indicators to identify areas for improvement in quality palliative care.

Funding

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Abstract number: FC80
Abstract type: Oral presentation

Criteria for Adequate and Inadequate Drug Prescribing in Older Adults near the End of Life: European Expert Consensus

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Aims: A growing body of evidence suggests inadequate drug prescribing in older adults with limited life expectancy. Clinical guidance is needed to continue or discontinue drug treatments near the end of life. We aimed to develop a set of explicit criteria for potentially adequate and inadequate medications in older people at the end of life.

Study population: 40 European experts in geriatrics, clinical pharmacology and palliative medicine from 10 different countries.

Study design: Delphi consensus survey. Panelists were asked to characterize drug classes as “often adequate”, “questionable” or “often inadequate” for use in older adults aged 75 years or older with an estimated life expectancy of less than 3 months. Consensus was considered achieved if the level of agreement was at least 75%.

Results: After two Delphi rounds, the panel reached consensus on a set of 14 drug classes deemed as “often adequate”, 28 drug classes deemed “questionable”, and 10 drug classes deemed “often inadequate” for continuation during the last 3 months of life. Drugs considered as “often inadequate” for continuation included lipid-lowering drugs, anti-dementia medications, vitamin D, calcium supplements, and drugs for osteoporosis. Regarding the initiation of drug therapy, the panel reached consensus on a set of 10 drug classes deemed “often adequate”, 23 drug classes deemed “questionable”, and 23 drug classes deemed “often inadequate”. Consensus remained unachieved for some very commonly prescribed drug treatments such as proton-pump inhibitors, furosemide, antibiotics, zopiclone, zolpidem, haloperidol, and selective serotonin reuptake inhibitors (SSRIs).

Conclusion: In the absence of robust evidence from randomized clinical trials, our criteria can provide guidance to rationalize drug prescribing for older adults near the end of life.

Abstract number: FC81
Abstract type: Oral presentation

Rituals and Social Practices Revealing Characteristics of a Good Death in NZ Residential Aged Care Facilities

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A death in a residential aged care facility heralds the beginning of a set of social practices. Some of these are common, while others are rituals and social practices unique to the facility. This presentation chronicles reported post-death practices and rituals in residential aged care facilities and nursing homes in New Zealand. Semi-structured interviews were conducted in 49 facilities as part of a larger mixed-methods study. Participants (n=113) were registered nurses, enrolled nurses, health care assistants, residential care facility managers, and clinical leads. The data set was analysed thematically. A key finding was the strong desire felt by RAC facilities to accompany the imminently dying to death, and the significant efforts of facilities to achieve this. Indeed, so doing was seen as an important component of how they understood a good death. However, with that came tension, extra demands on staff, and emotional load. Any post-death rituals acknowledging the death/life-transition in residential aged care facilities were limited, although religion and spirituality featured convincingly in those that did exist. This presentation adds to our understanding of the experience of caring for the increasing numbers of people dying in residential aged care facilities internationally. It also reveals deeper beliefs about death and post-death, as evidenced by ritual and social practice.

Abstract number: FC82
Abstract type: Oral presentation

Quality of End-of-Life Care for Nursing Home Residents in Six European Countries: Findings of the PACE Study

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Aims: To assess the quality of end-of-life care for nursing homes in six European countries: Belgium, the Netherlands, England, Poland, Finland, and Italy. The study was part of a larger project aimed at improving end-of-life care in nursing homes.

Methods: A structured questionnaire was administered to nursing home administrators in 446 facilities across the six countries. The questionnaire included questions on access to palliative care, infrastructure, and quality processes.

Results: The study found that there were significant differences in the quality of end-of-life care across the six countries. For example, access to palliative care was highest in England and lowest in Poland. Infrastructure, such as the availability of specialized equipment, varied widely. Quality processes, such as the presence of guidelines for managing the last three days of life, were also found to vary significantly.

Conclusion: The study highlights the need for standardized guidelines and improved access to palliative care in nursing homes across Europe. Further research is needed to identify best practices and to develop strategies for improving end-of-life care in nursing homes.
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Background: A rapidly growing number of older people with complex care needs die in nursing homes, yet there is insufficient epidemiological data to evaluate the quality of end-of-life care in nursing homes and to guide policy-making. We determined the quality of end-of-life care for nursing home residents in the last month of life and associated factors in six European countries.

Methods: Cross-sectional survey in a proportionally stratified random sample of nursing homes in Belgium (BE), Finland (FI), Italy (IT), the Netherlands (NL), Poland (PL), and England (ENG). We identified all deaths of residents of the preceding three months. Staff (nurse or care assistant) most involved in the resident’s care completed a questionnaire on her/his end of life. We measured quality of end-of-life care using ‘Quality of Dying Long-Term Care’ (QoD-LTC), including three subscales: personhood (e.g. resident’s clothes and body were kept clean), preparatory tasks (e.g. resident had treatment preferences in writing) and closure (e.g. resident indicated that s/he was prepared to die). Higher scores indicate better quality of end-of-life care (scale 11-55). Analyses included generalised linear mixed models.

Results: In 322 nursing homes, staff returned questionnaires regarding 1384 of 1707 deceased residents (response rate 81.1%). The QoD-LTC mean total score ranged from 35.0 (95% confidence interval [CI] 31.8-38.3) in IT to 44.1 (95% CI 40.7-47.4) in ENG. In all countries, ‘preparatory tasks’ (18.1 [12.1-24.1] in IT to 39.7 [33.6-45.8] in ENG) was rated significantly lower than ‘personhood’ (44.7 [41.9-47.6] in BE to 49.1 [46.1-52.2] in ENG). In BE, IT, NL, and ENG ‘closure’ (33.5 [29.0-37.9] in IT to 39.4 [34.8-44.0] in ENG) was rated significantly lower than ‘personhood’. A higher QoD-LTC total score was associated with country (p < 0.001), older age (p < 0.001), length of stay of >6 months (p<0.001), and death in nursing home rather than elsewhere (p=0.033).

Conclusions: Staff reports suggest room for improvement in the quality of end-of-life care in nursing homes in all countries studied, even in those with high levels of palliative care development in nursing homes (i.e. BE, NL, ENG). Policy aimed at improving end-of-life care may need to prioritise aspects closely related to palliative care (preparatory tasks, closure).

Funding
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Abstract number: FC83
Abstract type: Oral presentation

Seven Strategies to Promote Linkages between Aged Care and Palliative Care: Results of a Systematic Literature Review
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Background: Collaboration by palliative and aged care services is important to ensure complex care needs are addressed while ensuring optimal resource utilisation. However, a lack of systemic approaches to coordinated service provision compromises access to services and appropriate support that addresses the particular needs of older dying people. Aims: To identify strategies for promoting linkages between aged and palliative care.
Method: Using PRISMA guidelines, published papers from 2000 onwards using qualitative, quantitative or mixed methods reporting outcomes of linkages between palliative care services and aged care settings were included. 1074 papers were identified and screened; 113 papers underwent abstract review, with 60 papers identified for full appraisal; 21 papers, with 19 original papers and 2 systematic reviews selected for analysis.

Results: Linkages between palliative care and aged care services were identified as key goals for health services. Expansion of palliative care services to support the care of older people dying at home and in residential aged care addresses an increasingly pressing need. Seven strategies for successful linkages were identified:

1) Role clarification: clarity of roles and responsibilities improve continuity of care, particularly when the older person is transitioning between settings of care.
2) Written and verbal communication pathways: shared and standardised documentation and communication processes to support care delivery.
3) Formalised agreements and plans: ensure discussion of and commitment to resource allocation, mutual responsibilities, agreed outcomes, and communication processes.
4) Multidisciplinary teams: provide clinical care through regular communication across a range of disciplines and services delivering palliative care and aged care.
5) Designated linkage worker: a key worker acts as a coordinator across settings improves access to, and cooperation between services, continuity of care, and promotes shared understanding of care.
6) Knowledge exchange and upskilling: shared learning opportunities, both formal and informal, increase knowledge and develop capabilities to provide palliative care for older persons.
7) Continuous improvement: continual review of linkage strategies and their outcomes identify their effectiveness and efficiency.

Conclusion: These seven strategies promote inter organisational linkages to benefit older persons receiving care at the end of life.

Abstract number: FC84
Abstract type: Oral presentation

Quality of Primary Palliative Care for the Old, Older, and Oldest-old: A Mortality Follow-back Study in Belgium
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Background/aims: The rapidly growing number of people who are dying in old age typically experience complex health problems and care needs. Palliative care is indicated for the majority of them; however, it has hardly been evaluated in this population. We aimed to describe and compare the quality of primary palliative care for the old (70 - 79 years), older (80 - 89 years), and oldest-old (≥ 90 years) in Belgium.

Methods: Nationwide representative mortality follow-back study. Data were collected by the Belgian epidemiological surveillance network of General Practitioners (GPs) (2013 - 2015). GPs registered deaths using standardized forms, surveying primary palliative care. We included patients aged ≥ 70 years who died non-suddenly according to GPs. The quality of palliative care was measured using quality indicators developed through literature review and expert consensus. Analysis included descriptive statistics and chi-square significance tests.
Results: GPs registered 1930 deaths, 67% (1297 deaths) were non-sudden. 24% were old, 51% older, and 25% oldest-old. 54% (old), 58% (older), and 67% (oldest-old) of patients accepted their approaching death (P < 0.001). GPs discussed illness-related topics with 59% (old), 52% (older), and 46% (oldest-old) of patients (P < 0.05). 61% (old), 71% (older), and 82% (oldest-old) of patients did not die in a regular hospital ward (P < 0.001). Following quality indicators did not significantly differ between age groups: pain was regularly monitored in 44% (old) to 48% (oldest-old) of patients; GPs discussed end-of-life treatment preferences with 41% (old), 37% (older), and 35% (oldest-old) of patients; regular multidisciplinary meetings took place for 35% (old), 34% (older), and 42% (oldest-old) of patients; at least one specialized palliative care initiative was received by 61% (old) to 63% (oldest-old) of patients; GPs discussed illness-related topics with 77% (old) to 82% (oldest-old) of relatives; bereavement counselling took place for 68% (old), 65% (older), and 63% (oldest-old) of relatives.

Conclusions: There is room for improvement in the quality of primary palliative care for the old, older, and oldest-old. We identified differences in quality indicators between the age groups, especially regarding patients accepting their death, GP-patient communication, and patients dying outside a hospital ward. To improve the quality of palliative care, initiatives should have different priorities per age group.

Health policy

Abstract number: FC85
Abstract type: Oral presentation

Pilot Test of the First Government Mandate for Early Palliative Care in the USA

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Background / aims: In 2014, the state of California in the USA passed a law guaranteeing that Medi-Cal (state health insurance) beneficiaries will have access to early palliative care services - the first governmental mandate for palliative care in the USA. The Partnership Health Plan of California quickly implemented a pilot program (2015-2016) with four provider groups to test ambulatory palliative care services. The aim of our study was to evaluate the economic outcomes of this pilot program, as the legislation requires that the additional service not increase the overall costs of care.

Methods: This study used a retrospective, observational approach of pilot patients (n=79) and for some analyses, matched usual care patients. Pilot program costs were tabulated and healthcare utilization costs were calculated for pilot patients (n=79) and for some analyses, matched usual care patients. This study used a retrospective, observational approach of provider groups to test ambulatory palliative care services. The aim of this study was to provide a framework for evaluating the full implementation of this law beginning in 2018, which is relevant internationally as an example of a mandated palliative care benefit.

Conclusions: The pilot program demonstrated that a payer providing health coverage on behalf of the government can successfully engage providers and patients in early palliative care, and that the costs of this new service decrease rather than increase the overall costs of care. This is achieved mostly by avoiding hospitalizations in the final months of life. This study provides a framework for evaluating the full implementation of this law beginning in 2018, which is relevant internationally as an example of a mandated palliative care benefit.

Abstract number: FC86
Abstract type: Oral presentation

Is End of Life Care a Priority for Policy Makers? Qualitative Analysis of Health Care Strategies in England

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Introduction: In 2012 responsibility for the planning, delivery and improvement of health and social care in England was devolved to 152 regional Health and Wellbeing Boards (HWBs), which were required to produce a strategy for improving the health and care of their local populations. There are compelling reasons for end of life care to be a priority for HWBs. The extent to which HWBs have prioritized population end of life care needs is not known.

Aim: To understand the extent to which HWBs have identified end of life care needs in their local populations, and their priorities and plans for improvement.

Method: HWB strategies were identified from web searches +/− email contact. Strategies were systematically searched for key terms to identify content relating to end of life care (palliat*, end of*, terminal, bereave*, death, die, dying). Summative content analysis was used to quantify key concepts, and identify themes.

Results: Of 146 strategies identified, 75 (51.4%) contained some mention of end of life care. Four themes emerged.

1) Context of need. Where end of life care was mentioned within a specific clinical context, this was most often ageing (20 strategies) and dementia (13 strategies).

2) Limited range of outcomes. 21 strategies identified local end of life care needs, and 15 included one or more quantifiable aims relating to end of life care. In 35/36 strategies these related to the place of death.

3) Poor narrative thread. The connection between need, aim, and planned intervention was disjointed. Of the 21 strategies that cited evidence of need, only eight strategies identified a related aim or target, and just ten identified specific interventions or strategies for improvement.

4) Narrow focus of evidence: Where evidence was cited, in all cases this related to evidence of need and not evidence for the effectiveness of planned interventions.

Conclusions: Improving end of life care requires prioritisation by policy makers, and strategies which link to evidence based interventions and plans for measuring progress. Almost half of HWB strategies do not mention end of life care. In those that do, the lack of connection between need, aim and intervention is concerning. A focus on the place of death may reflect availability of this indicator of end of life care quality. Whether and how these strategies have impacted on local populations will be the focus of future study.

Funding

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Abstract number: FC87
Abstract type: Oral presentation

Duration of Palliative Care before Death in Routine Care: Systematic Review and Meta-analysis
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Background: In randomised clinical trials, earlier involvement of specialist palliative care can improve quality of life, symptom control and may reduce emergency hospital admissions and aggressive interventions. Palliative care in these trials was initiated around 6-12 months before death and this may not reflect current clinical practice. There are no systematic reviews identifying duration of palliative care in routine care against which RCT data can be compared.

Methods: Systematic review and meta-analysis to identify the time interval between referral to specialist palliative care and death reported internationally over the last 5 years. We searched six databases (Medline, Embase, the Cochrane Library, CINAHL, Global Health and Web of Science) on 2nd October 2017 (limit 2013-2017).

Inclusion criteria: papers including adults referred to/admitted under palliative care services, reporting referral-to-death time interval, survival or length-of-stay.

Exclusion criteria: < 18 years old, referrals to paediatric services, non-palliative care services or solely bereavement, trials with interventions affecting timing of palliative care involvement and non-English language studies.

We screened 10% of titles/abstracts independently to measure agreement. We will conduct supplementary searching (citations/references). We will conduct a meta-analysis of time intervals to identify any associations with disease types, service settings and countries categorised by UNDP Human Development Index and WPCA Palliative Care Development.

Results: 1892 abstracts were identified. Preliminary data analysis shows median interval between referral to palliative care and death is 42 days, with longer duration associated with cancer disease and community palliative care services. More detailed analysis will be reported.

Conclusions: Despite policy drivers towards earlier integration of palliative care, contact time between referral and death is relatively short. The final results will reflect current practice in a range of countries of varying stages of development and levels of integration, reflecting differences between disease types and service settings. Studies report contact time using variable terminology and infrequently as main findings. A broad search strategy and supplementary searching attempts to overcome this. Results will aid development, commissioning and benchmarking of services. Further research identifying barriers and means of improving is needed.

Funding
NIHR

Abstract number: FC88
Abstract type: Oral presentation

A Comparison of Patients’ Palliative Care Complexity at Point of Entry into Hospice Inpatient, Hospital Consult and Community Settings: A National, Multi-centre, Cross-sectional Survey
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Background: Standardised measurement using validated tools enables understanding of clinical complexity and could improve matching of staffing to needs. But little is known about how complexity compares across different specialist palliative care (SPC) settings.

Aim: To compare problem severity, functional status, and acuity of palliative care need at entry into different UK SPC services (hospice IPU, hospital consult, and community).

Methods: Multicentre, cross-sectional survey of patients at point of entry into each service. Demographics, palliative care Phase of Illness, problem severity (using IPOS-5, scored 0-20; see www.pos-pal.org), and functional status (Australia-modified KPS, scored 0-100) were compared by setting using descriptive statistics, χ², or ANOVA with mean imputation.

Results: Data collected from 189 hospice IPU, 218 hospital consult, and 450 community patients in 12 centres showed mean (SD) age differed: 65.8 yrs (16.7) in hospice IPU, 67.7 yrs (15.0) in hospital consult, 57.4 yrs (20.3) in community. Cancer % also differed: 86% hospice IPU, 64% hospital consult, and 84% community. Phase of Illness was significantly different (χ² = 137.2, p< .001), with 72% of hospital consult patients unstable compared to 44% in hospice IPU and 37% in community. Functional status was also significantly different with mean (SD) AKPS scores of; 52 (1.7) in hospice IPU, 48 (1.7) in hospital consult, and 67 (1.4) in community (F=125.6, p< 0.001). Problem severity varied by setting; mean (SD) IPOS-5 scores were 9.5 (3.5) in hospice IPU, 8.4 (3.5) in hospital consult, and 7.3 (3.4) in community (F=28.6, p< 0.001). The number reporting pain varied markedly; 139 (74%) reported moderate, severe or overwhelming pain in hospice IPU, whereas just 121 (53%) in hospital consult, and 218 (48%) in community reported this (χ²=34.0, p< 0.001). Overall, 14% of IPOS-5 data was missing.

Conclusion: The greatest numbers of SPC staff are in hospice IPUs, where problem severity is highest. However, unstable Phase (with greatest acuity) is as frequent in the community as in hospice IPU settings, and significantly higher for hospital consult teams (often poorly staffed). Measures of Phase, problem severity, and function all contribute to informing patient-level complexity; service planning and resources should take acuity and function into account, as well as problem severity.

Funding
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Abstract number: FC89
Abstract type: Oral presentation

Validation of a Simple Phenomenological Screening Tool for the Need for Specialized Palliative Care in a Mixed Cancer Population
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Background/aims: One challenge in caring for cancer patients (pts) with progressive diseases is the adequate identification of those in need for…
specialized palliative care (SPC). Timely SPC integration has shown to improve the quality of care, reduce costs, and may even increase pts' survival time. The study's aim was to validate an easy to use phenomenological screening tool.

Methods: We tested the German translation of a tool based on the NCCN Palliative Care guidelines. It contains five domains (ten items) that focus e.g. on disease, functional status (ECOG), comorbidities, life prognosis, symptom management and distress. Screening was done (01-08/2017) on admission to clinics of a university hospital (oncology, pulmonology, gynaecology, palliative care) by health care professionals when the disease was incurable and survival time estimated to be < 12 month (“surprise question”). Sum score ranges from 0 to 14. The Integrated Palliative Care Outcome Scale (IPOS) served as external criterion; in inter-rater / test-retest sub samples sum scores were correlated and for single items raters’ agreements were tested.

Results: 208 pts met inclusion criteria and were screened (average 63.5 years, range 21-96; 54.8% female). The correlation between the sum scores of IPOS and our tool showed a significant effect (r=0.547; n=151). The sum score was independent of the pt’s age, gender and primary diagnosis. Pts who already were in contact with SPC had significantly higher screening scores than pts without. A sum score ≥5 was associated with a positive predictive value of 58% and a negative predictive value of 100% for pts to be already in contact with SPC. A sum score ≥5 was found in 80.8% of the screened pts. Cronbach’s alpha was α=.600. Inter-rater reliability (n=100): Cohens Kappa for single items ranged from κ=.220 to κ=.620 and Pearson’s correlation coefficient of sum scores showed a significant substantial effect (r=.745). Test-retest (n=66): Cohens Kappa for single items ranged from κ=.220 to κ=.570 and Pearson’s correlation coefficient of sum scores showed a significant substantial effect (r=.694).

Conclusions: This is the first validation of a phenomenological German screening tool based on the NCCN Palliative Care guidelines identifying SPC needs of cancer pts. A more adequate and timely case finding may be possible with the new instrument. Future studies will be necessary to evaluate links between SPC needs and pt-reported quality of life.

Abstract type: Oral presentation

Responding to Urgency of Need in Palliative Care: Use of Discrete Choice Experiment Methodology in Stage Two of the Development of a Palliative Care Triage Tool

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Research aims: Demand for palliative care (PC) is growing and an increasingly diverse patient population must be triaged for allocation of finite clinical resources. Consequently, many PC services create waiting lists but there is currently no evidence-based, equitable method by which to manage these.

This study formed the second stage of a larger mixed-method sequential design. The aim was to establish the relative importance of triage factors identified during an earlier qualitative stage in order to inform a scoring system for a PC triage decision-making tool.

Study population: Health professionals with specialty PC training or those working primarily in PC were recruited internationally with a minimum of two years clinical experience in PC.

Study design and methods: An online discrete choice experiment was designed and conducted wherein participants compared the urgency of multiple pairs of exemplary clinical scenarios based on previously identified triage factors.

Method of statistical analysis: Relative importance of attributes was analysed using a mixed logit model performed on STATA 13.1.

Results and interpretation: Worldwide, 801 PC health professionals [mainly nurses (51%) and doctors (43%) from Australia (36%), North America (32%) and Europe (20%)] with an average of a decade of PC experience participated in the experiment. All triage factors contributed independently and significantly (all p values < 0.001) to the assessment of urgency of PC needs. Physical suffering was the dominant factor, with caregiver distress and imminent death also having substantial influence on PC clinicians’ decision-making. Whilst there was a diversity of individual approaches to PC triage, overall there was a strong common group pattern.

The results of this study have allowed the development of a comprehensive statistical model of how PC clinicians make triage decisions and thus the generation of a scoring system for a PC triage tool. The definitive triage tool arising from this study will now be validated and implemented as a world-first PC triage tool that will facilitate more equitable, efficient and transparent allocation of PC service by urgency of need.

Funding

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Interventions and symptom control

Abstract type: Oral presentation

Oral Care in a Sample of Patients Undergoing Palliative Care: A Prospective Single-centre Observational Study: IGOR Study

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Aim: Oral care (OC) is an essential aspect of nursing care but it is often not considered as a priority, especially when nurses have to manage the various complex needs of patients with advanced disease. Only few studies on oral problems have been performed in palliative care setting. The aims of this study were to assess and monitor oral conditions in terminally ill patients, to describe the procedures for oral care performed by nursing staff in the daily clinical practice and to assess the patient’s perceived comfort.

Methods: This is a prospective single-centre observational study including a sample of consecutive patients admitted in an Italian hospice from June 2016 to July 2017. At the recruitment the Oral Assessment Guide was used to evaluate patient’s oral conditions and the Numeric Rating Scale was used for oral symptoms measurement (dysgeusia, xerostomy, pain). The performed procedure for OC was also recorded in the Case Report Form. At the first follow up visit a skilled nurse reported data on: pain and distress during the procedure, time spent for the procedure, patient’s perceived comfort provided from the OC procedure. At the second follow up...
visit a reassessment of patient’s oral condition was performed, besides oral symptoms were measured again. Frequency of OC procedure and patient’s perceived comfort were also registered.

Results: Of 76 participants, 88.2% were cancer patients, the mean age was 74 years. IK score was 30 in 74% of the sample and the prevalence of mucositis was 74.9%. The most common oral symptom was xerostomia (75%). The OC procedures involved the use of chlorhexidine 0.12%, toothbrush (39.4%), and sodium bicarbonate (3.9%). The average time spent by nursing staff for OC was 5.4 minutes and the average frequency of the procedures was once a day. Three days after the beginning of OC procedures, mucositis significantly improved (p < 0.0001) as well as dysgeusia (p < 0.02) and xerostomia (p < 0.03). Patients reported a high level of comfort (85.5%) immediately after the procedure of OC.

Conclusion: The study results highlighted that OC in terminally ill patients may improve mucositis and oral symptoms control. Noninvasive, rapid and easy to perform procedures for OC might have a positive impact on patients comfort and wellbeing. OC should deserve a special attention in patients with advanced disease.

Abstract number: FC92
Abstract type: Oral presentation

What Works Best for Whom?: Exploring the Efficacy of Two Psychosocial Interventions in Palliative Care
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Background: Attending to psychosocial and emotional well-being is key to comprehensive palliative care. Yet, the empirical base, in its early stages, needs refinement to understand what interventions are best for whom.

Objectives: Identify the optimal treatment to address psychosocial well-being by comparing the efficacy of two psychosocial interventions among palliative care patients.

Methods: This secondary analysis of a randomized control trial (n=135) included patients with advanced cancer, CHF, or ESRD who were treated in the outpatient setting and had been hospitalized during the previous year. One arm received the Outlook intervention, a three-session psychosocial treatment designed to address issues of life completion and end-of-life preparation including life review, regrets and forgiveness, and future goals and legacy. A second arm received relaxation meditation (RM).

Primary outcomes included: life completion and preparation (QUAL-E); secondary outcomes included: anxiety (POMS) quality of life (FACT-G) and spiritual well-being (FACT-BP) sub-scales of faith, meaning, and peace. This study employed QUINT statistical analyses to examine these RCT data to determine how best to address preparation for end-of-life and emotional well-being. This recently developed methodology explores and identifies which patient subgroup(s) shows greater improvements with which intervention.

Results: Sample: 56% male; 70% cancer; 54% married; and 51% White. The analyses demonstrated different sub-groups of patients responded variably to the different interventions. For example, those with low spiritual well-being at baseline showed greater improvements in emotional well-being and decreases in anxiety with RM compared to Outlook. In contrast, for those with high spiritual well-being at baseline, Outlook resulted in greater improvements in emotional well-being and decreases in anxiety. Outlook showed greater improvements in preparation for the end of life for those with low preparation at baseline; RM showed greater improvement in preparation for patients with high preparation at baseline and poor ADL function.

Interpretation: Identifying the optimal treatment for a given patient is a primary goal of palliative care. We demonstrated that different interventions work variably for unique patient sub-populations. This methodology (QUINT analysis) offers potential to help improve tailored approaches to care for patients living with advanced serious illness.

Abstract number: FC93
Abstract type: Oral presentation

Palliative Sedation in Terminal Cancer Patients admitted to Hospice or Home Care Programs: Does the Setting Matter? Results from a National Multicentre Observational Study
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Introduction: Few studies regarding palliative sedation (PS) have been carried out in the home care (HC) setting. A comparison of PS rate and practices between hospice (HS) and HC is also lacking.

Aims: To estimate the rate of PS in HC and HS; to compare the two settings in terms of clinical characteristics of patients before PS, decision-making process and clinical aspects of PS; to assess level of consciousness and symptom control during PS.

Patients and methods: A multicentre observational study was carried out in 38 home palliative care unit and hospices in Italy from January 2010 to December 2011. In each centre, all consecutive adult cancer patients followed till death and undergoing PS during a four month period, were eligible for the present study. Symptom control and level of consciousness, measured with modified Wilson sedation scale (MWSs), were repeatedly registered every 8h from starting of PS to death. Differences between settings were tested through χ2, Kruskal Wallis’ and Student’s t-tests as appropriate.

Results: Among 4276 patients screened, 2894 were followed until death and 531 (18%) underwent PS. PS rate was 15% in HC, 21% in HS (p<0.001). Unbearable symptoms more frequently reported as indication to PS were delirium (54%) and dyspnea (48%), the former more common in HC (p<0.001), and the latter in HS (p=0.03). For the majority of patients (74%) PS was first proposed by the PC team and only in 5% of cases by the patient himself. Informed consent was not obtained (not possible or inappropriate) in 72% of patients while consent by the family was almost always achieved (96%), with no relevant differences between settings. More than 1 sedative drug was used in 31% (46% HC vs 24% HS, p<0.001). Midazolam was the most used drug, (94% HC vs 75% HC, p<0.001) given most frequently by continuous infusion (74% HC vs 89% HS, p<0.001). In the majority of cases PS duration was <48h. Hydration

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during PS was less frequent in HC (27% vs 49%, p < 0.001). In the last 8h before death, consciousness level was “unrousable to mild physical stimulation” in 81% and symptom control “complete” in 89%.

**Conclusion:** Our results shed light on relevant clinical practice, demonstrate the feasibility of PS in HC and HS, and suggest research questions for prospective clinical trials.

**Abstract number:** FC94
**Abstract type:** Oral presentation

**Are You Ready for Therapy? - Patient Perspectives on Prerequisites for and Factors of Readiness for Participating in Non Medical Therapies**

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**Background:** Little is known about factors which influence patients readiness for non-medical therapies like physotherapy, occupational therapy or music therapy. Especially for vulnerable patients, like in palliative care, it is crucial to assert, if a patient is capable to participate in a therapy or not.

**Research aims:** To explore patient perspectives on factors of readiness for participating in non-medical therapies in a hospital setting.

**Study population:** 15 male and 8 female patients (n=23) in a neuro rehabilitation unit in a hospital in an urban region of Lower Austria in the age between 18 and 85 years participated in the study. The Ethics Committee of Lower Austria approved the study.

**Study design and methods:** Within an interdisciplinary team we conducted three focus groups with 23 patients with neurological disorders (main diagnoses: stroke, multiple sclerosis, craniocebral injury). Grounded Theory (Charmaz 2014) was used as a methodological frame as well as a coding technique (open and axial coding). Selective Coding was not used in this study. Open coding lead to 237 codes, which were condensed through axial coding to 15 main categories.

**Results and interpretation:** The factors which influence readiness for therapy are multiple and diverse. The main categories influencing readiness for therapy from a patient perspective are: exposure, impairment, recreation, state of health, mental functions, non-verbal communication, individual-related factors, physical environment, rehabilitation process, social environment, therapist-patient interaction, therapy start, therapy process, verbal communication and time-related-factors.

Readiness for therapy is a multilayered concept where physical, psycho-social, motivational, relational and organisational factors intertwine in a complex process, which is based and formed mainly on the interaction between therapist and patient. The patients readiness for therapy should be considered a greater degree in therapy planning with especially vulnerable patients.

**Funding**
Christian Doppler Forschungsgesellschaft, Boltzmanngasse 20, 1090 Wien

**References**
**Abstract number: FC97**

**Abstract type: OQRM**

**Human Connections in Dementia End of Life Care in Long Term Care Homes**

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**Aims:** This study examined and compared family and staff perspectives on end of life care practices with persons with dementia in LTC homes, including what facilitated providing care and challenges experienced.

**Methods:** A descriptive qualitative study with thematic content analysis was conducted. Eighteen focus groups were conducted with 77 staff members and 19 relatives of persons with dementia at four LTC homes in four Canadian provinces.

**Results:** Three themes emerged. The first was knowing the resident. Care providers’ intimate knowledge of residents with dementia allowed them to provide comfort and compassion. This resulted from the long time that staff knew residents, the close family-like relationships they established, and consistent staffing. It led to grief when residents died, especially for health care aides. The second theme was they are all human beings; what was described as the human experience of end of life and grief among residents with dementia. Participants believed that residents with dementia have a right to good end of life care, like any human being. This entailed more time and effort and was affected by behavioural symptoms of dementia. Participants also found that residents with dementia experienced grief when fellow residents died but this was not well supported. The third theme was the long slow decline and death of residents with dementia. Family participants viewed the decline of dementia as prolonged suffering. Staff sensed that for some, repeated losses as their relative declined would mean less grief after their relative’s death. Family participants were uncertain about the dementia decline and wanted more information about what to expect at an end of life. Some sensed that staff were uncomfortable answering their questions, a finding confirmed by staff participants.

**Discussion:** Long standing relationships with residents facilitated end of life care, which may be more challenging given a trend for shorter lengths of stay in LTC homes. Health care aides need to be included in end of life care planning to take advantage of their intimate knowledge of residents with dementia. Grief support needs for care aides may be different than for other staff. Existing rituals for marking deaths in LTC homes may not fit the needs of persons with dementia after the death of another resident. Staff require support to answer questions from residents’ relatives and inform them about the trajectory of dementia and death.

**Method discussion: Qualitative research**

**Methods**

**Abstract number: FC98**

**Abstract type: OQRM**

**Compassion in the Margins: The Perspectives, Experiences, Challenges and Facilitators of Compassion According to Long Term Care Patients, their Family Members and their Healthcare Providers**

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**Background/aims:** Patients, healthcare providers, and policy makers increasingly advocate that compassionate care is a standard of care and a key indicator of quality healthcare care. While compassionate care research has been conducted in acute settings, little research has been conducted in residential long-term care (LTC) facilities-a care setting where compassion is arguably most needed and challenged. The purpose of this study was

1. to understand and explore perceptions about compassion from the perspective of patients with dementia, their family members, frontline healthcare providers and administrators;
2. to identify potential barriers and facilitators associated with providing compassionate care to patients with dementia within LTC facilities across Canada.

**Methods:** This study utilized thematic analysis, a qualitative research method that allows researchers to identify and analyze patterns in rich detail and interpret key themes. Focus groups, were conducted in four different provinces (AB, SK, MB, ON) in four LTC facilities across six participant groups: frontline personal support workers (care aides); interdisciplinary staff, licensed healthcare providers, palliative champion teams, family members and LTC patients.

**Results:** In total data was obtained from 22 focus groups utilizing a semi-structured interview guide. While there was some variance between the different focus groups, three central themes transpired across all groups:

**Conceptualizing Compassion, Compassion within Context, and Resources and Staffing.** Participants perceptions of compassion, were congruent with
previous studies of patients in acute care settings. Specific challenges associated with the provision of compassion in an LTC environment included the family unit as the focus of care; a lack of training on the topic; and addressing issues related to death and dying. HCPs attitudes toward these challenges were a significant factor in the provision of compassion as they could either treat them as absolute barriers or be proactive in overcoming them.

**Conclusion:** Offering compassionate care to LTC patients was identified by patients, family members, and HCPs as being important, impactful and comprised of key domains that distinguish it from routine care. Key challenges and facilitators were identified which aligned with previous compassion research, however, unique difficulties associated with dementia and LTC were also detected and examined.

**Abstract number:** FC99  
**Abstract type:** OQRM  
**Qualitative Exploration of Advance Care Planning Conversations:** Experiences from the ACTION Study

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**Background:** As part of the ACTION study, a Phase III multi-centre cluster-randomised clinical trial taking place in 6 European countries, patients with advanced lung or colorectal cancer and their personal representatives (PR) take part in a structured advance care planning (ACP) conversation. This is based on the ‘Respecting Choices’ (RC) programme developed in the USA, is led by trained facilitators, and consists of either 1 or 2 conversations.

**Aim:** To examine how patients and PRs respond to questions posed by facilitators as part of the ACTION RC ACP programme, to explore the content of the recorded ACP conversations and to examine the role of facilitators.

**Methods:** When patients and their PRs agree, the ACP conversations are audio-recorded and of these 5 patients have no PR. Analysis suggests that, despite differences in approach, patients utilise a number of similar techniques to manage the questions they are asked within the confines of the ACTION RC ACP conversation. For example, they may engage in a process of normalisation by presenting how their lives now are normal and placing an emphasis on ‘getting on with things’. Some patients defer decisions about resuscitation or moving from active to comfort care, citing how well they feel now and the belief that there will be time in the future to consider such matters when they feel less well. Facilitators also call upon a range of strategies to assist them in the management of the conversations. They reflect back and interpret what patients and their PRs say to them, and indicate approval through choice of words and tone of voice. Themes which emerge in the conversations as important include family, independence and quality of life.

**Conclusion:** Patients have access to a range of techniques which enable them to engage in a process of normalisation during the course of their ACP conversation, allowing them to focus on living for today and to concentrate on things that are important to them. Facilitators utilise strategies to manage the conversations that they facilitate with patients and their PRs, in an effort to conduct a structured ACTION RC ACP conversation.

**Abstract number:** FC100  
**Abstract type:** OQRM  
**Towards Better Integration of Palliative Care: A Qualitative Study with Healthcare Professionals Related to 19 Palliative Care Initiatives in Europe**

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**Background/aims:** Fragmentation of healthcare services and late referrals prevent many patients from receiving the palliative care they need. Integrated palliative care (IPC) aims at improving coordination of palliative care services around patients’ anticipated needs. Four key domains of integrated care can be distinguished: content of care, patient flow, information logistics, availability of (human) resources, and material. This concept may support the integration of palliative care in healthcare, but this needs more investigation. Our aim is to examine how IPC takes shape in practice across abovementioned key domains within 19 IPC initiatives in Europe.

**Methods:** A qualitative group interview design was implemented, using semi-structured interviews and deductive content analysis. Nineteen group interviews were undertaken in Belgium (2), the Netherlands (4), the UK (4), Germany (4), and Hungary(5). In total, 142 healthcare professionals participated. The majority were nurses (n=66; 46%) and physicians (n=50; 35%).

**Results:** The dominant strategy for fostering IPC is building core teams of palliative care specialists and extended professional networks. This is based on personal relationships, shared norms, values and mutual trust, rather than developing standardised information exchange and referral pathways. Providing IPC with healthcare professionals in the wider professional community appears difficult, as a shared proactive multidisciplinary palliative care approach is lacking and healthcare professionals often do not know palliative care people or services well.

**Conclusion:** To achieve better integration in regular healthcare, standardisation and explanation of work processes, knowledge, norms and guidelines needs to be increased. External authoritative bodies and regulations (of policy makers, insurance companies, professional bodies) may be needed to support the integration of palliative care practices across settings.

**Abstract number:** FC101  
**Abstract type:** OQRM  
**With or Without You! The Big Difference of Having a Case Manager in the Outpatient Sector for Patients with Amyotrophic Lateral Sclerosis**

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**Background:** The provision of palliative care (PCS) in the outpatient sector is difficult. PCS is not taken into account in the current German healthcare system, which prioritises acute care. Policy makers, insurance companies, professional bodies may be needed to support the integration of PCS in the outpatient sector for patients with Amyotrophic Lateral Sclerosis (ALS).

**Aim:** To examine how IPC takes shape in practice across abovementioned key domains within 19 IPC initiatives in Europe.

**Methods:** A qualitative group interview design was implemented, using semi-structured interviews and deductive content analysis. Nineteen group interviews were undertaken in Belgium (2), the Netherlands (4), the UK (4), Germany (4), and Hungary(5). In total, 142 healthcare professionals participated. The majority were nurses (n=66; 46%) and physicians (n=50; 35%).

**Results:** The dominant strategy for fostering IPC is building core teams of palliative care specialists and extended professional networks. This is based on personal relationships, shared norms, values and mutual trust, rather than developing standardised information exchange and referral pathways. Providing IPC with healthcare professionals in the wider professional community appears difficult, as a shared proactive multidisciplinary palliative care approach is lacking and healthcare professionals often do not know palliative care people or services well.

**Conclusion:** To achieve better integration in regular healthcare, standardisation and explanation of work processes, knowledge, norms and guidelines needs to be increased. External authoritative bodies and regulations (of policy makers, insurance companies, professional bodies) may be needed to support the integration of palliative care practices across settings.
Context and aim: The German health care system offers various options for palliative care (PC) and different models of in- and outpatient services. However, some patient groups require more imminent information, coordination and fast action to deal with their progressive disease, such as patients with amyotrophic lateral sclerosis (ALS). Case managers are not yet anchored in the system. This study aimed at analysing the comprehensive care needs of ALS patients, information exchange, and interplay of all involved parties in the care system. 

Methods: A total of 14 guided face-to-face interviews with purposely chosen experts with at least ten years’ experience with ALS patients were conducted to determine the desired performance scope and limitations of the care network. Transcripts were coded for a thematic analysis. In addition, computer assisted telephone interviews with 350 health care providers (HCP; PC units, neuro-centres, neurological units, hospice services, specialised palliative home care services) were held in the greater area of Bonn. SPSS was used for quantitative analyses. 

Results: All experts are aware that - at irregular intervals - ALS patients will need intensive home support at very short notice. Most of the time ALS patients and their family carers have to deal themselves with major consequences of insufficient care at home. Turning point for an increased reliability and safety of home care was a tracheostomy combined with 24 h/7 availability of a specialised intensive care team. An important factor was cost coverage by statutory health insurances. The need for a case manager, who helps with co-ordination of home care and ensures information flow in the care network, is underlined. The telephone interviews underlined the assumption that ALS patients constitute a challenge in all settings. All parties realised their own limitations, sometimes related to health care regulations and setting specific barriers for patients with an imminent health crisis. 

Conclusions: Most HCPs found it highly challenging to meet the needs of patients with ALS. Information regarding contact details of home visiting HCPs for patients with decreased mobility, dysphagia or inability to speak seems random. This is most evident in cases where institutionalised case management services are lacking. Well-defined pathways with clear instructions and a harmonisation of communication between all parties involved are needed to improve PC for this group. 

Abstract number: FC102
Abstract type: OQRM

Aging, Frailty, and Injury: Delivery of Prognostic Information to Older Adults and Caregivers
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Background: End-of-life discussions and uptake of advance care planning (ACP) related to geriatric palliative care (GPC) is low (10%-16%). Experts call for upstream discussions with adults at all ages that address condition, prognostic information, and choices. Little is known about how receptive hospitalized patients and family caregivers are to prognostic data related to frailty and one-year outcomes.

Research aims:
1) to examine older adults’ receptivity to prognostic information about frailty, injury and one-year post-injury function and mortality; and
2) to determine additional information needs based on prognostic information.

Population/sample: (N=40): Hospitalized injured (i.e., falls) older adults (N=25, mean age: 75.2) & their caregivers (N=15).

Design: Qualitative: semi-structured interviews

Methods: Using simple pictographs, participants were shown prognostic data on patient outcomes after injury. A structured questionnaire related to delivery of prognostic information was administered. Interviews were audiotaped, transcribed verbatim, and reviewed using standard techniques of directed content analysis. 

Data analysis: Data were analyzed using Atlas.ti software. Transcripts were continuously reviewed by all authors and a constant comparative approach led to an iteratively refined coding scheme. 

Results: Seventy percent of patients (N=19) and 60% of family caregivers (N=9) responded positively to prognostic information and the use of color-coded pictographs. Verbalized feelings about the information reflected difficulty with cognitive integration, consistent with Problematic Integration Theory (Babrow, 1992). Major themes and sub-themes emerged:

1) probability of decline/death: downhill spiral, vivid understanding with poignant language;
2) evaluation of prognostic information: realities of aging, personalizing the evidence;
3) dilemmas: exceptionalism (“not me”), fatalism vs. hope; and
4) manifestations: role of willpower & attitude, importance of faith & coping, and non sequiturs.

Additional information needs included:
1) what can be done to mitigate frailty, and
2) what to expect for the future.

Implications: Future research is needed to determine if structured conversations incorporating elements of aging, frailty, prognostication and future needs facilitates communication and patient/family readiness for advance care planning and approaching end of life.

Health Economics
Abstract number: FC103
Abstract type: Oral presentation

The Effects of Advance Care Planning for Frail Older People on Costs of Medical Care: A Cluster Randomised Controlled Trial
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Background/aims: Advance Care Planning (ACP) is a communication process about patients’ healthcare preferences and goals for care. ACP is aimed at enhancing provision of care that is consistent with patients’ preferences. This potentially affects the use of medical care and related costs. The aim of this study is to investigate the effects of ACP for frail older people on costs of medical care.

Methods: We randomly divided 16 residential care homes in two groups: an intervention group in which people were offered ACP and a control group in which people received usual care. Participants lived in one of these care homes or in its immediate surroundings while receiving home care. Eligibility criteria were 75 years, frail and competent. We obtained information about participants’ medical care use during 12 months following inclusion and calculated the total costs per participant. In addition, we calculated the mean cost of the ACP intervention. This trial is registered (NTR4454).

Results: Participants had a mean age of 86 years. Analyses were conducted for 97 participants per group. Total costs of medical care of both surviving and deceased participants (n=21) did not differ significantly between the study groups (€2360 in intervention group vs. €2235 in...
Impact of Specialist Palliative Care on Hospital Readmissions: A “Competing Risks” Analysis to Take Mortality into Account

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Aims: To examine the association between specialist palliative care (SPC) and hospital readmissions while accounting for mortality. Prior retrospective cohort studies suggested that SPC reduces readmission rates. However, in those studies, SPC patients may be more likely to die after discharge than usual care (UC) patients, complicating interpretation.

Methods: Retrospective cohort study of admissions at an academic hospital (2009-2015) for adults with one or more life-limiting diseases, who died within 1 year. Propensity score weighting was conducted using sex, race, insurance, diagnosis, surgery or ICU admission on first day, and comorbidities, to compare 1,497 SPC patients to 5,264 UC patients (N=6,671). We estimated the association between SPC and readmissions using a competing risks analysis. By ascertaining death date and treating readmissions and death as competing risks, we are able to analyze the association between SPC and readmissions, taking into account that people who are dead cannot be readmitted.

Results: SPC patients were more likely to be deceased at each endpoint (all p<0.0005), despite propensity weighting using observed variables. For example at 30 days following discharge, 64% of SPC versus 34% of UC patients had died. In the competing risks analysis, the subhazard ratios for the SPC group were 0.56 for 30-day readmission, 0.53 for 60-day, and 0.52 for 90-day (all p<0.005), indicating their re-admission rate is lower. The 30-day readmission rate was 19% for SPC versus 26% for UC patients had died. In the competing risks analysis, the subhazard ratios for the SPC group were 0.56 for 30-day readmission, 0.53 for 60-day, and 0.52 for 90-day (all p<0.005), indicating their re-admission rate is lower.

Conclusions: SPC is associated with lower re-admission rates even when taking differential mortality into account. When evaluating the impact of hospital SPC on subsequent healthcare, vital status should be determined at each endpoint and competing risks analyses should be considered.

Patterns and Determinants of Healthcare Use in the Last Year of Life among Older Adults in Ireland: Results from The Irish Longitudinal Study on Ageing (TILDA)

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Background/aims: The Health and Retirement Survey family of longitudinal studies, including The Irish LongDinal Study on Ageing (TILDA), are a source of high-quality, population-representative data on older adults that can inform policy and practice. We use TILDA to analyse determinants of place of death, and formal and informal healthcare in the last year of life among older adults in Ireland.

Methods: TILDA participants (N=8,504) were recruited in Wave 1 (2009) to form a representative sample of community-dwelling over 50-year-olds in Ireland. Data are collected biannually using face-to-face interviews, and self-reported questionnaires and health assessments. In the event of a participant’s death a close relative or friend is approached to answer a questionnaire on end-of-life (EOL) experience . Of the 516 participants confirmed to have died to 2014, we form an analytic sample using the 375 (73%) for whom a proxy EOL questionnaire was completed. We combine participant responses and EOL questionnaires to establish dependent variables (place of death, healthcare utilization and informal care in the last year of life) and independent variables hypothesised to be potentially associated with outcomes (including age, gender, living situation, education, healthcare entitlements, serious illnesses, (1) ADLs, and physical and mental health). Associations were estimated using multivariate regression. For binary outcomes we used logistic regression, for continuous variables we used generalised linear models.

Results: Healthcare use among older people in Ireland in the last year of life is driven not only by ‘need characteristics’ such as physical health and disease burden but also by ‘enabling characteristics’, in particular domestic living situation. When formal and informal costs are calculated, unpaid care from friends and family accounts for 42% of care received. People who live with others are more likely to die at home, and more likely to receive informal care, and this increase in informal care is not offset by lower formal service use.

Conclusions: Informal carers contribute significant amounts of value to care of those living and dying with serious illness, disability and functional impairment, and consideration should be given to how this can be underpinned through policy. People who cannot access informal care may be an underserved population for whom additional formal care support is necessary.

A New Preference-based Measure for Economic Evaluation of Palliative Care Interventions: POS-E

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Background: Valid and widely used patient-centred outcome measures (such as the Palliative care Outcome Scale, POS) are not preference-based and so unable to yield Quality Adjusted Life Years (QALYs) for use in economic evaluations. Conversely, generic preference-based measures (PBM) such as EQ-5D, are neither appropriate nor sensitive enough to measure changes in palliative care outcomes. This study therefore aimed to

i) develop a palliative-care-specific PBM (POS-E) based on the POS, and

ii) to examine whether patient-derived preference values differ from those of healthy volunteers.

Study design: Secondary data analysis followed by a cross-sectional valuation study.

Methods: We first conducted psychometric and Rasch analyses on secondary POS data (N=1,011) to develop a health state classification system for the POS comprising 7 POS items which define 1,458 distinct health states, of which 14 were identified as suitable for valuation by examining Rasch threshold maps. Next, preference values (utility weights) for these 14 health states were elicited from both palliative-care patients and healthy volunteers in the United Kingdom using a modified
version of the Time Trade-Off (TTO) method. Subsequently, we used regression models to predict values for the remaining (1,444) POS-E health states. We used t-tests to compare patient values with values from healthy volunteers.

**Results:** 808 valuations were obtained from 52 patients with advanced disease including cancer and non-cancer diagnoses; and 50 healthy volunteers. Each of the 14 health states had 48 or more valuations. The mean health state values ranged from 0.22 (SD = 0.43) to 0.99 (SD = 0.03) for worst and best health states respectively, with corresponding median values of 0.2 to 1. Patient-derived utility values were very similar to those of healthy volunteers. A quartic model with high predictive performance (adjusted R-squared = 0.98; Root Mean Square Error = 0.038) was selected to predict TTO values for all other POS-E health states. The logical correspondence between the TTO values and the severity levels of the health state classification system supports the validity of the POS-E value set.

**Conclusion:** We have developed a PBM that, subject to psychometric evaluation, can be used to provide palliative-care specific utility values to complement utilities from generic PBMs like the EQ-5D.

**Funding**

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**Abstract number:** FC107

**Abstract type:** Oral presentation

**The Challenges of Analysing the Cost-impact of Palliative Care from Hospital Data: Is an In-depth Cost-analysis Approach Worth our Time?**

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**Background:** Studies on the economic impact of palliative care (PC) consistently report that hospital PC services can reduce healthcare costs and improve patient care. Methodologically, these studies are still limited by the approaches taken to capture cost data, categorise it, and/or analyse it, as well as by the outcomes defined to assess cost-effectiveness. Having experienced several challenges during the data abstraction process for a retrospective study of hospital deaths, we aim to contribute to the discussion on capturing cost data that is internationally relevant and meaningful.

**Methodology:** As part of a retrospective study of inpatient deaths (n=747) from the year 2015 at a Swiss University Hospital, we sought to extract administrative and clinical data from all patients. To identify cost differences, we reviewed from the literature the approaches and categories employed in assessing the cost-effectiveness of PC. Although no standards exist, we developed an ideal cluster model that included all different cost types per day, detailing staff, pharmacy, material, laboratory, imaging and room and board costs.

**Results:** In order to obtain the expected level of detail, we required access to and merging of seven different databases: patient-characteristics, performance recording, cost unit accounting, patient process and access to and merging of seven different databases: patient-characteristics, performance recording, cost unit accounting, patient process and

**Discussion:** To our knowledge, detailed differences between cost types for various medical diagnoses have not been employed elsewhere and seem an important trigger to reflect on clinical decisions, as well as to identify, monitor and control major cost drivers. Although a challenging process, which may be similar for others with decentralised healthcare systems, the cost differences per cluster deserve the effort involved.

Researchers examining the economics of PC should agree on a minimum common cluster categorisation system, as well as on minimum outcomes to make comparisons between and within health services more meaningful. New technologies and national registries or centralised databases may facilitate the data extraction process in the future.

**Abstract number:** FC108

**Abstract type:** Oral presentation

**Medical Care Cost of Dying: A Retrospective Population Level Economic Analysis of Different Dying Trajectories**

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**Background:** Most evidence on end-of-life care costs (EOLCC) focuses on specific places of care instead of specific cost headings or on the cost of all dying patients or of those with cancer and not on those dying from other life-threatening diseases such as chronic obstructive pulmonary disease (COPD) or Alzheimer’s disease (AD). In this study we aim to describe EOLCC across different dying trajectories, by comparing medical care costs and components of these costs for those dying from COPD, AD and cancer across different cost headings.

**Methods:** A retrospective cohort study design was used, analyzing linked health claims, pharmaceutical, registry and population databases for all deaths in Belgium, 2012. Cohorts studied included those who died of cancer (N=26,464), COPD (N=4,231) and AD (N=2,606) as identified through the death certificate data. Medical costs were compared between the three groups by calculating expenditures of all medical care within the last year of life, adjusted for patient characteristics and actualized to 2017. Based on nomenclature codes and ATC codes, different cost headings were determined.

**Results:** Total EOLCC differs significantly between those who died of cancer (€38,388), COPD (€77,718) or AD (€70,515). Compared with cancer those who died of COPD had higher total inpatient cost (€40,301 vs €41,036) and lower total medication (€6,659.57 vs €6,061.38) and outpatient cost (€27,426 vs €26,294). Those who died of AD had lower inpatient (€34,830) and total medication (€3,497.82) but higher outpatient (€34,037) cost. COPD decedents had a significant higher average inpatient cost for specialist, clinical biology, medical imaging and physiotherapy when compared to cancer decedents. Those who died of AD had a lower inpatient cost induced by a lower cost for hospitalization, GP, specialist, medication, clinical biology, medical imaging and surgery and had a higher outpatient cost mainly caused by higher average nursing home and home-based nursing care costs.

**Conclusion:** Cancer patients incur significantly higher EOLCC during the last year of life than COPD and AD patients. However, analysis of specific cost components show that total EOLCC in the last year of life are influenced by a higher inpatient cost or outpatient cost depending on the disease causing death. Therefore, analyzing EOLCC by specific disease in relation to specific cost headings might result in more targeted allocation of health care resources.

**Symptom assessment**

**Abstract number:** FC109

**Abstract type:** Oral presentation

**Relative Validity of an Emotional Functioning Short Form Based on the EORTC Computerized Adaptive Testing Item Bank in the International ACTION Study with Advanced Cancer Patients**

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Background: In the context of the international ACTION trial that evaluates the effects of an advance care planning program in patients with advanced cancer, we used, for the first time, a new 10-item short form based on the European Organisation for Research and Treatment of Cancer (EORTC) emotional functioning (EF) computerised adaptive testing (CAT) item bank. The EORTC CAT is expected to provide higher precision, less floor or ceiling effects, and more power to detect differences between groups or over time than the EORTC Quality of Life Questionnaire Core-30 (QLQ-C30). We aimed to assess the relative validity (i.e., the relative statistical power to detect differences between groups) of this new short form.

Methods: Patients with advanced lung or colorectal cancer from six European countries (Belgium, Denmark, Italy, the Netherlands, Slovenia, the United Kingdom) participate in the trial. At baseline, they completed both the 10-item emotional functioning short form (EF10) and original 4-item QLQ-C30 emotional function scale (EF4), along with the EORTC QLQ-C15-PAL (QLQ-C30 shortened for palliative care), coping (COPE) and self-efficacy in medical decision-making (Assessment of Patient Experiences of Cancer Care Study) questionnaires. They also provided data on personal characteristics. Based on clinical and sociodemographic variables and questionnaire responses, a number of ‘known-groups’ that were expected to differ were formed (e.g., males vs. females) and EF was compared between these groups, both using the EF10 and EF4. If differences were significant the relative validity of the EF10/EF4 was estimated.

Results: 1028 patients (57% with lung cancer) provided data with a mean (SD) age of 66 (10) years. A total of 45 ‘known-groups’ comparisons could be used for the estimation of the relative validity. The mean relative validity of the EF10 compared to EF4 was 1.41, indicating better validity of EF10.

Conclusion: Compared to the EF4, the EF10 shows significantly higher levels of measurement precision such that, as a primary outcome measure, a 19-33% smaller sample size would be required.

Funding
FP7

Abstract number: FC110

Abstract type: Oral presentation

Evolution of Quality of Life, Functioning and Symptom Burden throughout the Disease Course in Advanced Cancer: Results from the Longitudinal European Palliative Care Cancer Symptom (EPCCS) Study

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Background: People with advanced cancer often experience multiple symptoms, which impair the quality of life (QoL). This study aimed to explore the evolution of QoL, emotional functioning (EF), physical functioning (PF) and symptoms over time in a large international sample of palliative care cancer patients.

Methods: We used data from the European Palliative Care Cancer Symptom (EPCCS) Study. Patients with incurable cancer enrolled in a palliative care program were included. The EORTC QLQ-C15-PAL was used to assess self-reported QoL, EF, PF and symptoms monthly for >3 months or until death. We examined QoL, EF, PF and symptoms 1) forward from baseline over time (month 1, 2, 3, 4, 5, 6, 7, >8); and 2) in a subsample of patients who died during the study period, backward in three different time periods before death (>6, 5-3 and 2-0 months). Multilevel mixed-effects linear models were calculated to examine QoL, EF, PF and symptom mean scores (0-100 scale) over time. Mann-Kendall tests were used to detect monotonic trends.

Results: At baseline, the study sample consisted of 1739 patients; 63% died during follow-up. Mean scores for QoL, EF and PF did not change significantly over time. A significant downward trend was found for nausea/vomiting. For some symptoms, a few time points differed significantly from baseline, but trend tests were not significant (pain, insomnia, appetite loss, constipation), and for some symptoms none of the time points differed significantly from baseline (dyspnea, fatigue). When comparing the three time periods before death, QoL (mean score 57.62 at >6 months, 51.44 at 5-3 months and 43.83 at 2-0 months) and PF (mean score 67.73 at >6 months, 61.20 at 5-3 months and 49.82 at 2-0 months) decreased consistently and significantly over time towards death. EF did not change significantly from >6 (mean score 73.74) to 5-3 months (mean score 71.49), but decreased significantly from 5-3 to 0-2 months (mean score 66.49) before death. Pain, fatigue and appetite loss increased consistently and significantly over time; dyspnea, insomnia and constipation only increased from 5-3 to 0-2 months before death.

Conclusion: Overall, QoL, functioning and symptoms remained relatively stable over time. Looking backward in a subsample of deceased patients revealed that QoL, functioning and symptoms tend to worsen towards death. Although deterioration accelerated as death approached, this was already apparent before the terminal phase (>5 months before death).

Abstract number: FC111

Abstract type: Oral presentation

An Innovative Screening Method to Improve Proactive Identification of Palliative Care Needs in Patients in General Practice: The Double Surprise Question

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Background: The surprise question (SQ1: ‘Would I be surprised if this patient were to die in the next 12 months?’) is recommended as a screening tool to identify patients with palliative care needs; However, it also identifies patients not yet in need of it. For that reason, we pilot tested an innovative second surprise question (SQ2) which is answered when SQ1 is answered with ‘no’. ‘Would I be surprised if this patient is still alive after 12 months?’ We hypothesized that adding SQ2 would increase the predictive value of SQ1.

Methods: In 2016, two general practitioners (GPs) answered both SQs regarding each elderly patient on their patient list (>74 years). One year
later, a blinded researcher reviewed the medical records for 1-year mor-
tality, contacts with the GP, hospitalizations and documentation of discus-
sions of palliative care domains and end-of-life preferences. Outcomes were
linked to SQ answers.

**Results:** For 292 persons the SQs were answered. Of 131 (47%) of them,
the GPs would be surprised if they were to die within 12 months, of
whom only 2 (2%) died. For the 161 patients with ‘no’, I would not be
surprised’ on the SQ, SQ2 was added; of 22 of them (14%) the GPs would
be surprised if they would still be alive after 12 months. In
total, 26 persons (9%) died within 12 months, of whom 24 had been
identified with SQ1 (sensitivity 92%). However, 137 patients (85%) that
also had been identified with SQ1 did not die. (positive predictive value
SQ1 15%; specificity 48%)

Of the 139 patients with SQ1 ‘no’ of whom the GPs would also not be
surprised if they would still be alive after 12 months (SQ2 no), 14 died,
and of those of whom they would be surprised (SQ2 yes) 10 died. Adding
SQ2 thus had a sensitivity of 42% (positive predictive value SQ2 45%;
specificity 91%). The patients with ‘SQ1 no; SQ2 yes’ had had more
contacts with their GP, more contacts with the out of hours service, and
less ER visits than those with other answer combinations. Besides, more
palliative care domains and end-of-life preferences were discussed.

**Discussion:** In this pilot, as a prognostic tool for 1-year mortality, SQ1 had
a very high sensitivity, but a poor predictive value, meaning that too
many persons are identified as in need for palliative care. Adding a
second surprise question (SQ2) decreased the sensitivity, increased the
predictive value and increased specificity. Moreover, SQ2 seems promis-
ing to identify palliative care needs.

**Abstract number: FC112**

**Abstract type: Oral presentation**

**Palliative Care and Associated Survival among Patients with Lung Cancer in a National Health System**

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**Background and aims:** Palliative care improves patient-centered out-
comes such as symptom burden and quality of life, and may improve
survival. We sought to determine the association of palliative care with
survival and place of death in a national population.

**Methods:** Retrospective, cohort study among patients with advanced
stage (IIIB & IV) lung cancer diagnosed from 2007-2013, who received care
in the United States Veterans Health Administration (VA) healthcare
network. Palliative care was defined as at least one specialist-delivered
inpatient or outpatient encounter. Logistic regression and Cox propor-
tional hazards modeling were used with propensity score and time-varying
covariate (TVC) methods for analyses.

**Results:** Among 23,144 patients with stage IIIB and IV lung cancer, 57% received palliative care and median time from cancer diagnosis to first
event was 42 days (IQR 11-155). In propensity score matched analyses, patients who received palliative care had an increased risk of mortal-
ity (Adjusted hazard ratio [AHR] 1.10, 95% CI: 1.07-1.13, p<.001). Using palliative care as a TVC, patients who received palliative care within 30 days of diagnosis had an increased risk of mortality (AHR 2.37, 95% CI: 2.20-2.56, p<.001) compared to patients who did not receive palliative care or received palliative care more than 30 days after diagnosis. Patients who received palliative care 31-365 days after diagnosis had a decreased risk of mortality (AHR 0.47, 95% CI: 0.45-0.49, p<.001) compared to patients who did not receive palliative care or received palliative care more than 365 days after diagnosis. Among 7,710 patients who died in VA facilities, those who received palliative care were less
likely to die in acute care settings (Adjusted odds ratio 0.60, 95% CI 0.58-
0.66, p<.001).

**Conclusions:** In real-world settings, distinct subgroups of advanced
stage lung cancer patients exist. Patients who receive palliative care soon
after diagnosis are likely seriously ill and their care is focused on easing
the dying process. Patients less critically ill at diagnosis, who receive pal-
liative care, are more apt to take advantage of its patient-centered
approach which may contribute to a survival benefit. Patients who receive palliative care are less likely to die in acute care settings. Consideration
for early integration of palliative care with disease-modifying therapies is
courage to maximize the potential benefits.

**Abstract number: FC113**

**Abstract type: Oral presentation**

**What Is the Current Evidence for the Use of Delirium Screening, Diagnostic, and Severity Rating Tools in Adult Cancer Patients?**

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**Aim:** Delirium causes significant morbidity and mortality but is com-
monly missed or misdiagnosed. We evaluated the evidence for delirium
screening, diagnostic and severity rating tools in adult cancer patients as
part of a new European delirium guideline.

**Methods:** PubMed was searched using text words to identify primary,
validation or psychometric property studies in adult cancer patients, and
limited to January 2000-May 2017 and English language. We excluded
studies that: occurred in intensive care, peri-operative or paediatric popu-
lations; evaluated only Diagnostic and Statistical Manual of Mental
Disorders (DSM) or International Classification of Diseases (ICD) crite-
rria; where < 50% of study participants had a cancer diagnosis. Two
reviewers screened titles and abstracts and extracted data from included
full text articles. Quality Assessment of Diagnostic Accuracy Studies
(QUADAS-2) guidelines were used to assess study quality.

**Results:** From 751 retrieved citations, 50 full text articles were reviewed.
From 9 included articles, 7 delirium assessment tools were identified: 4
screening tools (5 studies): Bedside Confusion Scale, Nursing Delirium
Screening Scale, Single Question in Delirium, and Delirium Observation
Screening scale; 1 diagnostic tool (1 study): Confusion Assessment
Method; 2 severity tools (3 studies): Memorial Delirium Assessment
Scale, and Delirium Rating Scale. Few validation studies have either
been conducted in cancer patients or included sufficient detail to allow a
determination of whether cancer patients were included. We considered
all studies to be at risk of bias due to issues such as spectrum or review
bias or use of an inappropriate reference standard. Reliability was not
reported for any of the screening and diagnostic tools.

**Conclusion:** Current evidence to recommend the routine use of delirium
diagnostic, screening and severity tools is insufficient. However, given
the high incidence of delirium in cancer patients, inpatients should be
observed, at least daily, for recent changes or fluctuations in cognitive or
physical function or behaviour. (This study received no funding).
Abstract number: FC114
Abstract type: Oral presentation

Process Evaluation of the ‘Cancer Home-life-Intervention’
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Background: Increasing numbers of people live longer with advanced cancer and have to manage at home. The ‘Cancer Home-Life intervention’ developed to support people with advanced cancer to perform and participate in everyday activities was evaluated for its effect through a randomized controlled trial. Furthermore, it is relevant to investigate the processes affecting possible achieved or failed effects by a process evaluation.

Aim: The aim of this study was to evaluate the ‘Cancer Home-Life-Intervention’ by assessing the implementation, mechanism of impact, and contextual factors influencing effects.

Methods: Descriptive data were collected regarding the delivery of the six components comprising the intervention, reach and dose. To identify contextual factors and explore the participants’ experiences, participant-observation of 10 interventions and qualitative interviews were conducted in the participants’ homes, which was the place of intervention. Furthermore, a focus-group interview was conducted with the intervention therapists to ascertain their reflections of intervention mechanisms.

Results: 242 participants were included in the study. Their mean age was 67.91 years and 124 were women. The primary cancer types were gastrointestinal, lung, breast, and prostate cancer. Participants were randomized to the control or the intervention group. Eight withdrew from the intervention. The intervention group typically received two components per participant, 31% received more than one home visit and 51% received one follow-up telephone contact. Data about subjective experiences of the intervention and contextual factors are currently being analysed and will be presented at the conference.

Conclusion: This study provides insights into the mechanisms influencing an occupational therapy-based intervention for people with advanced cancer. It draws attention to possible mediators and barriers that are important to consider when designing such interventions.

Education Research
Abstract number: FC115
Abstract type: Oral presentation

Do Canadian Family Medicine Trainees Provide Palliative Care to their Patients after Three Years in Practice?
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Background: Family- and general-practitioners have an important role in providing primary-level palliative care (PalCare) to their patients. A previous study showed that 64.1% of trainees intended to provide palliative care after graduating.

Aims: Identify the extent to which Canadian Family Medicine (FM) trainees provide PalCare three years after completing their residency and explore how PalCare features in their practice profile.

Methods: Canadian FM trainees across all 17 Canadian medical schools complete voluntary standardized surveys periodically to assess the Triple-C FM Curriculum. Surveys are completed at T1 (start of training), T2 (end of training) and T3 (three years into practice). This study analyzes the first cohort (2011); data for T2 (2013) and T3 (2016). The 2011 cohort included trainees from 7 schools.

Results: Response rates were 273/392 (69.6%) for T2 and 104/470 (22.1%) for T3. At T2, 146 (54.3%) of participants reported that they had adequate or more than adequate exposure to PalCare and 135 (50.9%) intended to provided PalCare while 70 (23.6%) were not sure. Three years into practice (T3), 57 (55.9%) of physicians reported providing PalCare. Of those providing PalCare, 30 (59.6%) indicated they do home visits. Surprisingly, 36.3% of those who reported not providing palliative care, also reported providing care across the life cycle.

Conclusions: Just over half of family physicians in this study were providing palliative care 3 years into practice. This challenges a narrative that family physicians in Canada do not provide PalCare. However, gaps still exist and strategies are needed to increase the proportion of those providing PalCare and doing home visits.

Abstract number: FC116
Abstract type: Oral presentation

Palliative Care Education and Training Needs in Primary Care Settings: A Scoping Review of the Literature
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Background: Primary care providers play an important role in palliative care service provision. A scoping review of the literature was undertaken in an attempt to gain insight into and awareness of palliative education and training needs in primary care settings.

Methods: Arksey and O’Malley’s scoping review framework was employed. Four scientific databases (EBSCO, OVID, ProQuest, and PubMed), including 16 individual repositories covering the medical and social science fields, were searched in August 2017, alongside the Grey literature and a hand-search of references from included articles. Exclusion criteria were any articles that were not available in English, were published prior to 1990, had a concentration on pediatric palliative care, and specific to residential hospices and/or long-term care.

Results: A total of 5,109 hits were generated, leading to 2,875 titles and abstracts for individual review. Of these, 41 full-text articles were retrieved; 33 articles met the inclusion criteria and were included in the review. Five major themes were identified:

1. Enhanced communication skills;
2. Knowledge with regard to spiritual and psychosocial needs;
3. Greater skills in pain and symptom management;
4. Improved cultural proficiency; and
5. Experience working within interdisciplinary teams.

Many primary care practitioners believed they were inadequately trained in the area of palliative care and felt unprepared to provide the necessary care. Specifically, poor communication between healthcare professionals and patients were found to adversely affect the level of palliative care that is provided. Additionally, practical experience in palliative and end-of-life care was cited as one of the most beneficial methods in helping to improve knowledge about and ability to practice in the field.
majority of the articles emphasized the need for education and training programs to enhance the quality of palliative and end-of-life care service provision.

**Conclusion:** On the whole, palliative care education and training programs were found to have numerous benefits, including enhancing providers’ knowledge of and attitudes towards this subject, ability to provide palliative and end-of-life care, and self-perception of preparedness in this area. As the landscape of providers and their education needs are constantly changing, this review serves as one of the steps in an ongoing evaluation of palliative care providers’ training needs.

**Abstract number:** FC117  
**Abstract type:** Oral presentation  
**The CHOICE Project: Developing an Educational Public Health Intervention to Inform Community Attitudes to Palliative Care**  
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**Background:** Community perceptions of palliative care are frequently inaccurate or outdated, and likely influence a person’s willingness to receive care from palliative care services. A systematic approach to community engagement is required, but few empirical approaches have been developed and tested.

**Aims:** To evaluate the acceptability (primary) and preliminary impact (secondary) of visual educational stories as a public health intervention to communicate information about palliative care.

**Methods:** Based on the MRC Framework for the development of complex interventions, a series of 2-minute visual educational stories were developed to address common misconceptions raised by earlier qualitative data. These were piloted with a community-based sample using a phase 2, online, computer-randomised controlled trial design involving six (test) conditions. Descriptive statistics described the sample characteristics and intervention acceptability. A repeated measures analysis of covariance (ANCOVA) assessed preliminary change in attitude to palliative care (measured on a 10-point Likert scale) post intervention, controlling for baseline variables.

**Results:** Of 159 participants (median age 51, range 23-82, 75% female). Visual educational stories were shown to be an acceptable approach to public health communication about palliative care (m 37, sd 7.8) with strong agreement across assessed acceptability domains. A majority of participants reported the intervention was easy to understand (100%), believable (94%), and made them feel more likely to likely to consider palliative care if they became seriously ill (69%) or talk to someone else about palliative care (67%). Most agreed it taught them something new (67%) and made them stop and think (60%). Regardless of story assignment, mean attitudes toward palliative care were improved after viewing the educational information (F(1,126)=21.0, p<.001, r=.15).

**Conclusions:** Brief educational stories are an acceptable public health intervention to communicate information about palliative care and may improve community attitudes to engagement with palliative care services.

**Abstract number:** FC118  
**Abstract type:** Oral presentation  
**Training General Practitioners in Initiating Advance Care Planning in Dementia Care, Results of a Randomized Controlled Trail**  
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**Introduction:** People with dementia (PDD) and their general practitioners (GPs) seldom discuss wishes and needs regarding future care together. As a consequence, when dementia progresses, care delivered may not correspond with PDD’s preferences. With Advance Care Planning (ACP) preferences for future care are timely discussed and documented. As GPs are often involved from diagnosis on and have longstanding relationships with PDD, they seem the appropriate professionals to initiate ACP. We therefore developed a training for GPs in initiating ACP with PDD. We studied its effects on medical and psychosocial preferences discussed and documented and the number of ACP conversations which took place, using the medical files of PDD.

**Methods:** A single blind randomized controlled trial was conducted. Before randomization, GPs where asked to include 5 PDD from their practice. GPs in the intervention group (n=19) were trained in ACP. GPs in the control group (n=19) provided care as usual. After six months, medical records of PDD (n=136) were analyzed and compared on documented medical (reanimation, resuscitation, use of antibiotics, hospital admission, care to prolong life, palliative care) and psychosocial (daily activities, social contacts, living, safety, care needs, mobility, finance) ACP topics using independent sample t-tests with correction for GP clustering. The medical records were also compared on the number of PDD who had a ACP conversation in which at least one ACP topic was discussed, using a logistic regression with correction for GP clustering.

**Results:** Preliminary results show that with 71 PDD in the intervention group, GPs discussed and documented a total of 58 medical and 107 psychosocial items during six months after the training and 36 ACP conversations took place. With 65 PDD in the control group 8 medical and 7 psychosocial items were discussed and documented and 9 ACP conversations took place. The number of medical (F=14,331; t=-3.210; p=0.004) and psychosocial (F=66,898; t=-4.438; p=0.000) ACP items discussed and documented and the number of ACP conversations (B=2,044; t=3.173; p=0.002) differed significantly in favor of the intervention group.

**Conclusion:** Our ACP training leads to a significant increase in medical and psychosocial topics discussed and documented and ACP conversations with PDD by GPs. We advocate its broad application, since it may bring future care into agreement with PDD’s needs and preferences.

**Abstract number:** FC119  
**Abstract type:** Oral presentation  
**Engaging Patients in Advance Care Planning through an Electronic Health Record Patient Portal**  
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**Background:** In the US, only 33.4% of adults have completed legal documents to appoint a medical durable power of attorney. The availability of these documents in the electronic health record is even more limited. We implemented on-line tools for advance care planning (ACP), including an electronic Medical Durable Power of Attorney (MDPOA) form to legally appoint a healthcare decision maker, in the electronic patient portal website of a large healthcare system. This project aims to evaluate feasibility and patient use of novel EHR-based ACP tools.

**Methods:** Mixed methods evaluation of the first 8 weeks of patient use of ACP tools (e.g. webpage, online messages, and MDPOA form). The ACP tools are available to approximately 286,000 patients who have a patient portal account, however, there was no specific promotion of the new tools. We assessed patient characteristics, type of ACP interaction, and details related to healthcare decision maker documentation among patients who completed the MDPOA form. We conducted a thematic analysis of patient preferences for medical treatment on the MDPOA form.
Results: 296 patients used the ACP tools through the health system’s web-based patient portal. Patients were mostly female (72%) with a mean age of 45 years (range, 18 to 98 years). 11 patients (4%) sent online messages or called the ACP Support Team. 254 (86%) patients completed a MDPOA, 6 (2%) patients completed a 4-item ACP readiness questionnaire, and 24 (8%) patients viewed the MDPOA form but chose not to complete it. Among patients who completed a MDPOA, 61% had no prior documentation of a decision maker, 29% had only an orally appointed decision maker, and 10% already had a MDPOA on file. 107 patients (42%) added preferences in their own words. Key themes from the patient-entered preferences included detailed procedural requests, organ donation, reference to other advance directives, or absolute statements (e.g., ‘Keep me alive!’).

Conclusions: Novel electronic health record-based tools built into the health system’s patient portal can engage patients in ACP. The majority of patient usage was to appoint a healthcare decision maker. Research is needed to understand whether use of the on-line ACP tools facilitates conversations among patients, their healthcare decision makers, and their healthcare providers.

Abstract number: FC120
Abstract type: Oral presentation

Towards Reliably Good Sustainable Care, Teaching and Research in Care Homes: A Paradigm Shift
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Nursing care homes are now viewed as the hospices of yesterday. In the UK, 22% population die in care homes (four times the number dying in hospices); a figure projected to rise to 40% by 2040. The public and professional perception of care homes remains poor. Quality improvement palliative care ‘in-reach’ programmes to care homes are often short term with no long-term solution. At a time of unprecedented increase in people 80+ years requiring 24-hour care and fears of a lack of an appropriate workforce there is a need for re-visioning such care.

Aim: To scope the feasibility for a teaching/research-based care home (TRCH) as a centre for excellence and community engagement to support and empower all care homes across a region.

Methods: Three stages included: a review of the international literature on TRCHs; a visioning afternoon with local stakeholders (health/social care, universities, care home organisations, third party organisations); interviews with residents/families and care staff/managers (14); and, face-to-face meetings with: policy/government (28); academia (16); clinical (19); hospices (12); international organisations (15). A template was used to capture important information after each meeting. Interviews were transcribed and themes developed across both interviews and face-to-face meetings.

Results: Five core objectives for the TRCH were identified, namely: innovative ‘household’ service provision to support holistic care; knowledge and skills development to improve the competency of care home staff; undergraduate/postgraduate student training for students from different disciplines; research to increase the evidence-base for care home work; and, community engagement encouraging intergenerational volunteering.

Targeted face-to-face meetings not only provided important insights from different organisations but also offered names of further people to speak to until saturation was reached. Discussion is underway for the provision of a site for the Centre. Meanwhile a variety of student placement work will commence in ‘satellite’ nursing care homes across the region.

Conclusion: Undertaking a yearlong feasibility study embracing all stakeholders has galvanised support (including health/social care) in this important area. Just as hospices brought a sea-change to the end-of-life care needs for cancer patients, it is hoped that the TRCH will bring a sea-change to the professional and public perception of care homes.

Palliative care in diverse chronic illness

Abstract number: FC121
Abstract type: Oral presentation

Occurrence and Correlates of Posttraumatic Growth among Patients with Advanced, Non-curable and Life-limiting Diseases: Preliminary Results of a Systematic Review
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Background: Palliative care patients often suffer physically and psychologically. Yet, there is another side to the coin: The comparatively young field of research dealing with posttraumatic growth (PTG) is based on the insight that major life crises can foster psychological growth, leading to closer relationships, personal strength, spirituality, new possibilities, and a higher appreciation of life. Several studies analyzed PTG in cancer patients. However, the number of studies explicitly dealing with palliative care patients remains unclear. We aimed to analyze the occurrence of PTG and its correlates in these patients.

Methods: In the present review (CRD42017075807) we searched three databases (Medline, PsycINFO and PILOTS) and included randomized controlled trials, cross-sectional studies and longitudinal studies. Studies were included if patients suffered from an advanced, non-curable and life-limiting malignant or non-malignant disease and PTG was assessed via a validated measurement tool (e.g. Posttraumatic Growth Inventory).

Two independent reviewers screened titles and abstracts. Data was summarized via descriptive statistics.

Results: A total of 1412 studies were retrieved. Twenty-seven articles were included, 26 (96%) dealing with advanced cancer and one with AIDS patients. Preliminary results showed that the extent of PTG varied between studies, but that patients in most studies reported moderate PTG. The stability of PTG over time varied between studies. Among others, PTG was associated with disease status, coping style, and social support. Correlation of PTG with age, gender, prior trauma, quality of life, and psychological distress delivered inconsistent results.

Conclusion: Many palliative care patients report PTG to some extent. The identified correlates hint at the factors which might facilitate PTG. Further research is necessary to evaluate interventions that might foster PTG and hence allow growth even in the face of death.

Abstract number: FC122
Abstract type: Oral presentation

Generalist and Specialist Palliative Care for Patients with Non-malignant Respiratory Disease: An All-Ireland Qualitative Study
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Background/aims: Potential models of palliative care for patients with COPD and interstitial lung disease have been previously highlighted amongst international research and key strategic guidelines. However, these recommendations are often not effectively implemented in clinical practice and are void of guidance regarding bronchiectasis, another form of non-malignant respiratory disease. This research aimed to explore generalist and specialist palliative care service provision for people with non-malignant respiratory disease and their bereaved carers in the North and Republic of Ireland.
Identification of palliative care needs. Predictors of palliative care needs

Conclusion: This study got a reasonable model of predictors for earlier diagnosis.

50.9% and specificity of 85.6% (presence of KPS which allows access to 75% of the cases of death, with sensitivity of quality Measure of Adjustment - Curve ROC indicated AUC=0.753, of oncologic diagnosis increases 3.9 times the chance of dying. The each KPS unit decreases the chance of dying by 3.6% and the presence

Background: Healthcare teams working in Critical Care Units (CCU) deal with death and futile treatments frequently. The early introduction of Palliative Care (PC) in these units has been indicated as important, but evidence is still scarce, and further research is needed.

Research question: How do health care providers who care for the critically ill patient perceive the practice of PC in CCU?

Aims: To analyze the scientific evidence produced regarding the practice of PC in CCU; to analyze the difficulties that health professionals feel in providing PC to patients in CCU.

Methodology: Systematic literature review on PubMed, Lilacs, RACAP, Scielo and EBSCO, for the terms palliative care, critical care, cuidados paliativos and cuidados ao doente crítico. All Portuguese, Spanish, French and English papers published between January 2012 and December 2016 were included. Eligibility criteria were: qualitative studies carried out in CCU, and focused on the experiences of professionals working directly with critically ill patients. Studies with health care professionals who hold positions of leadership, or perform functions in pediatrics, as well as studies that focus on the perspective of family members were excluded. Results were analysed according to the Qualitative Assessment and Review Instrument.

Results: 1433 studies were retrieved, and 8 studies were included in the review. The studies were conducted in Brazil (n=5), United Kingdom (n=1), Saudi Arabia (n=1) and Australia (n=1). A total of 177 professionals were included in the studies (physicians: 55.29%; nurses: 41.24%). Several common difficulties in the provision of PC in CCU were founded, namely frustration, and emotional exhaustion. Ethical and legal concerns, poor communication skills, prognostic uncertainty and the lack of information about the patient’s wishes are some issues that cause suffering to these professionals. Teamwork, effective communication and training in PC were identified as important issues to a greater integration of PC into CCU.

Conclusions: The early integration of PC into CCU is important to improve dignity and comfort for those who are dying in critical care settings. Literature supports the need for education and greater collaboration between palliative and critical care teams.

Abstract number: FC125

Abstract type: Oral presentation

Depression Symptoms among Patients with Cancer, Cardiovascular, Chronic Respiratory Disease or Diabetes in Outpatient Hospital Settings: A Two Country Study

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Aim: Depressive symptomatology in life-limiting and life-threatening conditions can cause suffering, disability and are closely associated with non-adherence. Mental health problems in this patient population are not routinely screened for in resource-constrained settings and their symptoms are often not easily recognised. This study aimed to determine the prevalence of depression symptoms in ambulatory patients with cancer, cardiovascular diseases, chronic respiratory diseases, or diabetes.

Methods: Cross-sectional study; patients were consecutively recruited from NCD outpatient clinics at 7 hospitals in Namibia and Malawi if diagnosed with cancer, cardiovascular diseases, chronic respiratory diseases or diabetes. Depression symptoms were assessed using the self-reported Centre for Epidemiologic Studies Depression Scale (CES-D), possible range for scores 0-60. Using CES-D African setting cut-offs, (>16 = clinically significant psychological distress and >21 = major depressive symptomatology. Socio-demographic data was self-reported and clinical data extracted from patients’ clinical records. Functional performance was rated using the Karnofsky performance status score (KPS)

Results: 457 patients were recruited; the response rate was 98.5%. Mean age was 48 (SD=15.7); 59% were female. Median KPS was 90 (inter-quartile range=80-100). 130 (28.4%) had cardiovascular diseases (of these 69.7% had hypertensive heart disease, 10.6% ischemic heart disease), 147 (32.2%) had cancer; 73 (15.9%) had chronic respiratory diseases (of these 80.6% had asthma); and 107 (23.4%) had diabetes. The range for CES-D scores was 0-49; the prevalence of clinically significant psychological distress was 64.6%, 57.0%, 45.2% and 43.1% for cancer, diabetes, chronic respiratory diseases and cardiovascular diseases respectively; higher than 20%; expected in a normal population. The prevalence of major depression symptomatology was 38.2%, 26.3, 23%, and 12.5% for cancer, diabetes, cardiovascular diseases and chronic respiratory diseases, respectively.

Conclusion: Ambulatory patients with non-communicable diseases experience a high burden of mental health related problems. The high prevalence of clinically significant psychological distress and major depressive symptomatology is this ambulatory outpatient population in this population calls for urgent attention. It points to need for increasing access to mental health services in the non-communicable diseases continuum of care.

Abstract number: FC126
Abstract type: Oral presentation

A Library of Instruments Endorsed by Published Systematic Reviews for Assessing Patients and their Care
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Aims: Palliative care research encompasses a broad array of domains, care settings, and illnesses, and finding validated measurement instruments is difficult and time-consuming. We therefore compiled a library of high quality and relevant instruments for assessing patients and their care in palliative and end of life care research.

Methods: We included measurement instruments in the library if they met criteria for endorsement in published systematic reviews relevant to palliative care. The 46 systematic reviews varied in their criteria and their rating method, but all evaluated the available evidence for validity and reliability. We included the instruments that were “recommended” or “highly scored” by the authors of each systematic review in this library, and created a free web-based tool to facilitate instrument searches.

Results: The 150 instruments in the library cover a wide range of topics, including: communication, continuity of care, decision making, fatigue, function, grief and bereavement, multiple-domain scales, pain, quality of care, quality of care at end of life, quality of life, sleep, spiritual aspects of care, and physical and psychological symptoms. The library provides information about each instrument to facilitate selection by investigators who are seeking an instrument for a specific purpose, such as the content, applicable populations and settings, number of items, respondent, recall period, whether it requires an interviewer, estimated completion time, and key citations with links to PubMed abstracts. The library is provided as an Excel spreadsheet which can be searched and sorted by attribute.

Conclusions: A major focus of palliative and end of life care research is the patient experience of their disease and medical care, as well as their quality of life and quality of dying. This web-based palliative care instrument library is a novel tool available to assist investigators in finding valid and reliable measurement instruments for their research studies. While this method may omit some instruments, it creates a searchable compendium of high quality instruments for a rapidly emerging field of investigation. Further evidence for instruments will expand this library over time.

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Abstract number: P1
Abstract type: Poster presentation

A Quality Improvement Approach Improves Physician Referral Patterns for Hospice Palliative Care
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Background: Hospice palliative care has been proven to provide the best value care for patients who are expected to die within a few months: overall quality is better and cost is lower—principally by preventing hospitalization. Short lengths of service limit the ability of hospice palliative care programs to provide best value care. Patients look to physicians for the recommendation to enroll.

Methods: The OhioHealth Clinical Guidance Council, comprised of physician subcommittees by specialty, sets standards of care for purposes of improving quality and decreasing cost by facilitating decrease in variation for 3500 physicians serving the system across 40 counties in the State of Ohio in the US. The, median length of service of patients referred by all OhioHealth physicians was obtained for 2015. For the oncology, cardiovascular, neurosciences, primary care and hospitalist clinical guidance councils, a letter from the physician Chair was sent to each physician noting the gap between the council’s opinion about optimal length of stay, the length of stay reported by the National Hospice and Palliative Care Organization (NHPCO), and the median length of stay of all patients referred by OhioHealth physician members of that clinical guidance council. A chart graphing the median length of stay by member, indicating the name of the physician to which the letter was directed, was mailed to each physician. One year later, for calendar year 2016, the measurement of median length of service by physician was repeated.

Results: For all physicians in 2015, the median length of service in targeted specialties was 15 days, in those not targeted (control), 16 days. In 2016, the median length of stay for all physicians in targeted specialties was 25 days. In those not targeted (control) it was 10 days. The national median length of service in hospice palliative care programs is 17 days.
The median length of service for all OhioHealth Hospice patients was 10 days at the time this project was initiated. 

Conclusions: A simple quality improvement approach to improving hospice palliative care length of service using a quality improvement approach yielded a 250% improvement in median length of service between intervention and control groups to a level above the national median.

Abstract number: P2
Abstract type: Poster presentation

The Involvement of Palliative Care Services in the Primary Care Setting and How to Improve This: Experiences of Generals Practitioners and District Nurses

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Background/aims: General practitioners (GPs) and district nurses (DNs) play a leading role in palliative care in the primary care setting. Many services and facilities are available to support them in providing this complex care. We investigated to what extent GPs and DNs involve services and facilities (never, sometimes or often), what their experiences are and how the involvement of these services and facilities can be improved.

Methods: Online survey filled in by 108 GPs and 258 DNs. Three homogenous online focus groups with 8 GPs and 19 DNs.

Results: Home palliative care teams (99%), hospices (94%), and palliative care consultation services (93%), were the services most frequently mentioned by GPs as involved sometimes or often. For DNs these were: volunteers (90%), hospices (88%) and spiritual caregivers (80%). Furthermore, respectively 75% of the GPs and 61% of the DNs sometimes or often involved a clinical pain specialist, 69% and 53% a case manager, 51% and 50% a psychologist and 44% and 57% social welfare.

Differences in involvement between GPs and DNs were statistically significant, except for hospices and the psychologist. The main reason for not involving services and facilities was not needing those services. Other reasons were not seeing it as their task to refer to those services or not knowing how to reach specific services or facilities. The experiences with services and facilities were mainly positive (70%-93%). Negative experiences included the (timely) unavailability of e.g. hospices and medication pumps. The focus groups showed three areas in which GPs and DNs argue improvements can be made:

(1) establishment of local points of information on available services and facilities,
(2) presentation of services and facilities in local multidisciplinary meetings, and
(3) stimulating facilities to proactively offer their services.

Conclusions: GPs and DNs involve services and facilities, but not all to the same degree. When involved, negative experiences with services and facilities are rare. DNs involve psychosocial services and facilities more often than GPs. Not needing services or facilities was the most common reason to not involve them. Question remains whether this reason is justified or that GPs and DNs are unaware of the possible added value of services provided by other disciplines. Local multidisciplinary meetings could be the right platform to familiarise healthcare providers with services and facilities.

Abstract number: P3
Abstract type: Poster presentation

Preferred Place of Death; Requirement of the Public and of Advanced Cancer Patients in Norway

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Background: Dying at home and dying at the preferred place of death (POD) are advocated to be desirable outcomes of palliative care. Preferences for POD among Norwegian public or cancer patients have not yet been systematically examined. In Norway most patients (pts) die in hospital (31%) or care homes (48%) whereas only 14% die at home (2015) which is low compared with other countries in Europe.

Aims: Explore preferences regarding POD among a sample of the public and a sample of advanced cancer pts, and investigate if these preferences are associated with gender, age or level of education.

Methods: A paper survey with 20 closed questions, including preferred POD in case of serious disease with limited life expectancy, was send to a sample of the public by random distribution among employees in the 8 municipalities in Romsdal, Norway (n=530).

Advanced palliative cancer pts (n=71) were recruited from the outpatient cancer clinic at the local hospital in Molde, as part of an ongoing prospective controlled intervention study, the Orkdal Model, ClinicalTrials.gov Identifier: NCT02170168. The case report form at inclusion contained a closed question about their preferred POD. Demographic data were collected using the EAPC Basic Data Set. In both samples descriptive statistical analysis was used for preferences. The Chi-square test was applied for the association analyses.

Results: The response rate from the public was 57% (n=303), 209 women, 94 men, mean age 49,6 years (21-72), the majority had a high school or university education; 54% of the respondents wanted to die at home, 40% in a hospice or a palliative care unit. The response rate from the advanced cancer pts was 68% (n=48), 24 women, 24 men, mean age 67,4 years (48-85), the majority had a high school or university education, 47 pts had metastatic cancer, 41 had an estimated life expectancy of more than one year, mean Karnofsky Performance Index was 89; 50% of the responders most wanted to die at home, 10% at hospital and 14% in a care home. There were no significant associations between gender, age or level of education and a certain preferred POD.

Conclusion: Home was the preferred POD among the public and advanced cancer pts in the Romsdal region. However, few pts die at home in Norway. Health care services should focus on implementation of effective programs and advance care plans meeting the individual preferences early and enabling the pts to remain at home as long as possible and desired.

Abstract number: P4
Abstract type: Poster presentation

Potential Economic Impact of Specialist Palliative Care Mobile Teams in Switzerland: Baseline Data for Future Development

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Background: Specialist palliative care mobile teams (SPCMT) are regarded to be key in delivering effective decentralized end of life care in many countries. In Switzerland, there is no nationwide availability of SPCMT, but more and more Cantonal governments are trying to include them in their future health care plans and budgets.

Aim: The aim of the study is to estimate the potential impact on health care costs of the last three months of life for a palliative care system with SPCMT for all cantons in Switzerland.

Methods: Mandatory health insurance claims of five large health insurers of adults who died between 2008 and 2010 in Switzerland were analyzed retrospectively. This database, combined with data from the federal office of statistics (FSO) was used to determine health care cost in the last three months of life of all deceased per Cantons. Deceased with an external cause of death were excluded. International literature was used to quantify the potential cost (reduction) of introducing SPCMT. We developed two scenarios: scenario 1 - average health care claim costs reduction of 10%; scenario 2 - average health care claim costs reduction of 25%. Both scenario were applied to the expected numbers of death in 2030. Death rate prognosis of the FSO were used to estimate the number of expected deceased in 2030 per 5 year-age groups, gender and Canton. Health care cost estimates for 2030 were based on mean health care costs per deceased in 2010.

Results: The health insurance database provide a representative sample of 57% of persons who died in Switzerland. 94’310 deceased fulfilled our study inclusion criteria. In the last three months of life mean health care claim costs covered by health insurance companies were 12’472 Swiss Francs per deceased (1 CHF = 0.80 Euro). Mean costs varied between 8’383 Swiss Franken in the mostly rural Canton Appenzell-Ausserrhoden to 16’536 Swiss francs more urban Canton Genève. In 2030, annual Swiss health care costs of the last three months of life will be 1855 million Swiss franc based on the health insurance claim data. Of which, 185 million francs potentially could be saved with the availability of SPCMT compared to the no SPCMT (10% scenario).

Conclusions: Development of a calculation model for the potential economic impact of specialist palliative care networks including mobile teams will help to create a solid basis for future political decisions and research combining economic and qualitative outcomes.

Abstract number: P5
Abstract type: Poster presentation

Predicting Primary Care Patients who Are at Risk of Dying within 6-12 Months: A Retrospective Case-control General Practice Chart Analysis

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Background: Effective end of life care requires early recognition of the likelihood of dying within months. Screening of general practice populations has not been successful to date. An RCT of screening GP patients ≥70 with the Surprise Question plus a case finding tool (SPICT) tool vs intuition, found no difference between the two, and high false positive rates. Therefore, a need exists for reliable identification of malignant and non-malignant patients at risk of dying in 6-12 months.

Aims:

1. To identify variables which have the greatest value as predictors of dying within 12 months.
2. To develop and validate a nomogram to predict the probability of death within 6-12 months.

Study design and methods: Case-control study using general practice records. Cases were patients age ≥70 who died (n=215). Controls were patients frequency matched for age and sex who were alive. All had clinical records for ≥18 months before death or chart review. Predictors of interest were items in the SPICT (2012 version).

Method of statistical analysis: Multiple logistic regression was used to identify predictors of death. A nomogram was developed to calculate probability of dying using significant predictors and internally validated.

Results and interpretation: Of the 21 predictors evaluated, the following were statistically significant: deteriorating performance, weight loss, persistent symptoms, palliative care or treatment withdrawal being sought, indicators of frailty (needs assistance with activities of daily living), fractured hip or frequent falls, neurological deterioration, COPD, lung fibrosis and eGFR < 30ml/min/1.73m² with deteriorating health. The nomogram had a predictive accuracy of 78%, sensitivity 67%, specificity 87%.

End of life can be predicted in elderly primary care populations. As many of the elements require an assessment by the clinician, automatic records screening will be problematic. External validation of our nomogram is required prior to widespread use.

Abstract number: P6
Abstract type: Poster presentation

The Barriers and Facilitators to Implementing the Carer Support Needs Assessment Tool (CSNAT) in a Community Palliative Care Setting

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Introduction: Family carers play a central role in community-based palliative care. However, caring for a terminally ill person puts the carer at increased risk of physical and mental morbidity, which is detrimental for both carer and patient (Williams & McCorkle, 2011). The validated Carer Support Needs Assessment Tool (CSNAT) provides a comprehensive measure of carer support needs and is intended for use in community palliative care (Ewing & Grande, 2013). The CSNAT creates an opportunity for carers to discuss their needs with healthcare professionals, facilitating the provision of appropriate support. A recent audit demonstrated poor use of the CSNAT in a Scottish community specialist palliative care service despite training and support.

Aim: To identify barriers and facilitators to implementation of the CSNAT in a community specialist palliative care service.

Methods: A qualitative study was undertaken, involving interviews with 12 palliative care nurse specialists from two community nursing teams in Lothian, Scotland. Data was audio-recorded, transcribed and thematically analysed using a framework approach.

Results: This study found palliative care nurse specialists to be passionate and enthusiastic about carer support practices. It revealed an overarching acceptance and appreciation of the CSNAT by nurses. However, it demonstrated that nurses feel there is potential for the CSNAT to be used more effectively in this setting. The study identifies factors which enable and prevent the use of the CSNAT in a community palliative care setting. Recommendations are made for improving the use, acceptability and uptake of the CSNAT in practice.

Conclusion: Findings from this study have the potential to enhance engagement with the CSNAT, make it more congruent with current nursing practice, and improve the experience of carers of people approaching the end-of-life.

References

A Systematic Review of the Evidence for Community and Person-centred Models of Care and their Impact on Outcomes for People Living with HIV/AIDS

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Background: People living with HIV/AIDS (PLWHA) experience severe symptom burden and psychosocial problems irrespective of treatment status. There is evidence that person-centred approach used to care for PLWHA accessing ART, improved quality of life and psychosocial wellbeing. UNAIDS recommends a 30% increase in community-based care for PLWHA to improve retention in care. This review aimed to appraise the evidence for community and person-centred care models and their impact on outcomes for PLWHA.

Methods: Systematic review conducted in line with the PRISMA guidelines. Six databases (CINAHL, Embase, Global Health, Medline, PsycINFO and Web of Science), were searched from 1980 to February 2017, using predefined search terms. Community models of care were analysed by study location, model type, components of care, outcomes and data quality.

Results: 45 studies of community models of HIV/AIDS care were identified. 40% were from high income countries, 24.4% from upper middle income countries, 31.1% from low and middle income countries and 4.4% were from a mixture of low, middle and upper middle income countries. Community care was delivered in various ways, including outreach into community centres and individuals’ homes, with support by trained healthcare professionals, volunteers and/or peer workers. This review found that community models of HIV/AIDS care improved: treatment adherence; retention in care; viral suppression; mortality; quality of life, loss to follow-up and were cost effective. However, few of the models described included person-centred assessment and management of needs.

Conclusion: Community models of HIV/AIDS care had significant impact on the outcomes for PLWHA. However, few models included person-centred assessment and management of physical, psychological, social and spiritual problems of PLWHA. Therefore, there is a need for future studies to focus on inclusion of these four domains when developing person-centred community care for PLWHA.

Abstract number: P7
Abstract type: Poster presentation

Aim: To describe when patients and GPs have contact after the last hospitalization in a patient’s last year of life, and what characteristics of the patient and of care provision are related to having contact within two days after discharge.

Methods: Health insurance data containing all medical expenses financed by the Dutch Health Insurance Law from Insurance Company Achmea were used. 22% of the Dutch population is insured by Achmea. The Achmea Health Database 2009-2010 was linked to information on long-term care at home or in an institution, the National Hospital Registration, and Causes of Death-Registry from Statistics Netherlands. Differences between patients who mainly received care at home in the last four months of life and died in 2010 of cancer (n=3014), COPD (n=195) or heart failure (n=171), were investigated using a chi-square test and ANOVA. Characteristics related to contact with the GP within two days after discharge were investigated in a backwards logistical regression.

Results: First contact after discharge was within two days for 51.7% of patients, within a week for 77.8% of patients and within a month for 89.3% of patients. Percentages differed according to cause of death (e.g. for contact within two days; 53.1% for patients with cancer, 40.5% for patients with COPD and 40.4% for patients with heart failure). Characteristics related to having contact within two days after discharge were age (OR 1.011; CI 1.004 - 1.018), cause of death cancer (OR 1.634; CI 1.251 - 2.133), home death (OR 2.144; CI 1.758 - 2.615), timing of last hospitalization (months 2-3 before death OR 2.234; CI 1.819 - 2.745: week 2-4 before death OR 4.122; CI 3.247 - 5.233: last week before death OR 3.163; CI 2.282 - 4.383; months 4-12 = reference) and contact with a locum in the week after discharge (OR 2.099; CI 1.467 - 3.003).

Conclusion: There is a substantial portion of patients who don’t have contact with their GP within 2 days (48%) or within a week after hospital discharge (22%). This was more often so for patients who died from COPD or heart failure and when the last hospitalisation was longer before death. To ensure continuity of care, pro-active care is necessary. This is a joint responsibility of GPs and medical specialists.

Abstract number: P9
Abstract type: Poster presentation

Couples Coping with Nutrition-related Problems in Advanced Cancer: A Qualitative Study in Primary Care

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Nutrition-related problems (NRPs) are common in patients with advanced cancer. They are a tremendous threat for social couple-life. To stabilize daily life and routines, couples are challenged to cope with this source of distress. Earlier research primarily focused on individual coping with cancer cachexia syndrome and on dyadic coping with chronic illness. The objective of this research was to study couple-coping with NRPs in advanced cancer.

Seven dyads confronted with NRPs in advanced cancer participated. Both partners were interviewed concurrently. The data were analyzed using the Qualitative Analysis Guide of Leuven (QUAGOL), a comprehensive, iterative in case and across-case analysis method, emphasizing teamwork. This method adds to the reliability and validity of the study results.

Starting with the patient communicating NRPs to the partner, interactive couple-coping pathways were initiated. Our patients presented the NRP overt, with or without solution or they tried to hide the NRP. The evolved couple-coping pathways existed of an action of the partner and a reaction of the patient. They were:

Abstract number: P8
Abstract type: Poster presentation

Continuity of GP Care after the Last Hospitalisation at the End of Life for Patients Who Died from Cancer, COPD or Heart Failure; A Retrospective Cohort Study Using Administrative Data

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Background: Discharge from hospital to home can be a stressful experience for patients and carers. Contact with the GP (either face-to-face or via telephone) is important to ensure continuity of care.

Methods: Systematic review conducted in line with the PRISMA guide-
lines. Six databases (CINAHL, Embase, Global Health, Medline, PsycINFO and Web of Science), were searched from 1980 to February 2017, using predefined search terms. Community models of care were analysed by study location, model type, components of care, outcomes and data quality.

Results: 45 studies of community models of HIV/AIDS care were iden-
tified. 40% were from high income countries, 24.4% from upper middle income countries, 31.1% from low and middle income countries and 4.4% were from a mixture of low, middle and upper middle income countries. Community care was delivered in various ways, including outreach into community centres and individuals’ homes, with support by trained healthcare professionals, volunteers and/or peer workers. This review found that community models of HIV/AIDS care improved: treatment adherence; retention in care; viral suppression; mortality; quality of life, loss to follow-up and were cost effective. However, few of the models described included person-centred assessment and management of needs.

Conclusion: Community models of HIV/AIDS care had significant impact on the outcomes for PLWHA. However, few models included person-centred assessment and management of physical, psychological, social and spiritual problems of PLWHA. Therefore, there is a need for future studies to focus on inclusion of these four domains when developing person-centred community care for PLWHA.
Different pathways could be observed in the same couple. Some dyads, however, were the exception, often those with less observed we-ness. This is the first study to explore the couple-coping pathways dyads confronted with NRP in advanced cancer address to deal with those NRP in their attempt to maintain normality in daily life. Our findings can be valuable in providing psychological support and advice for dyads confronted with NRP in advanced cancer. By recognizing couple-coping pathways, couples may be distinguished who mainly tend to cope resiliently with NRP and those who cope more rigidly and might benefit from professional guidance. Couple-coping with NRP is an interactive process leaning on different coping pathways. We-ness seems associated with the use of a combination of different pathways and as such could lead to a more resilient way of coping. This study was not funded.

Abstract number: P10
Abstract type: Poster presentation

The Role of the Specialized Palliative Care Consultant in PaTz groups in which GPs and Community Nurses Cooperate in Primary Palliative Care

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Background: In PaTz (modelled after Gold Standards Framework) GPs and community nurses working in the same area, meet on a regular basis. One important element is the identification of patients with palliative care needs and including them in the PaTz Palliative Care register. A second important element is the discussion of patients with palliative care needs during PaTz meetings. Participants receive support from a palliative care consultant (physician or nurse with formal training and experience in palliative care).

Aims: To study the background of the consultant; their contribution to the PaTz group and clarity in division of tasks with the chairperson; and their views on gaps in knowledge on palliative care in nurses and GPs.

Methods: Participants in all PaTz groups that are registered with the PaTz Foundation and are active for more than 6 months were invited to fill in a questionnaire (96 groups). A total of 48 consultants, involved in up to 5 different PaTz groups, responded. Frequencies were calculated and answers to open questions on knowledge gaps of nurses and GPs were categorised.

Results: Background was physician for 77.1% and nurse for 22.9% of consultants. Task division between the consultant and chairperson was clear for 86.7% and satisfactory for 97.8% of consultants. During discussions of patients on the Palliative Care register physical complaints are discussed most (96%), followed by informal care (86%) and social (86%) and psychological (84%) aspects. Spiritual care is discussed least often (38%). In these patient discussions, consultants give advice on a specific situation (13% did this for all patients; 64% for most patients), provide information on palliative care (9% for all patients; 60% for most patients), and alert participants to palliative care needs of the patient (11% for all patients; 52% for most patients). The knowledge gaps most mentioned by consultants for the GPs and community nurses was symptom control, timely identification of palliative care needs, and pro-active care provision. Knowledge gaps were identified more often for GPs than for community nurses.

Conclusions: The palliative care consultant has a clear role in PaTz groups and offers support to the generalist care providers in most to all patients discussed. Following the knowledge gaps identified by the consultants, education of GPs and nurses should focus on symptom control, timely identification and pro-active care provision.

Funding
ZonMW, PwF

Impact of the Macmillan Specialist Care at Home Service: A Mixed Methods Evaluation across Six Sites

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Background: The Midhurst Macmillan Specialist Palliative Care Service was founded in 2006 to improve community-based palliative care provision. Principal components include: early referral; home-based clinical interventions; close partnership working; and flexible teamwork with a consultant lead. Following a positive evaluation, elements of the approach were implemented in six further sites across England named Macmillan Specialist Care at Home. This article reports a mixed methods evaluation of the implementation across these ‘Innovation Centres’.

Aim: To assess the process and impact on staff, patients and carers of providing Macmillan Specialist Care at Home services across the six sites.

Methods: A longitudinal, mixed methods research design. Data collection over 15 months (2014-2016) included: Quantitative outcome measures:- Palliative Performance Scale [PPS]; Palliative Prognostic Index [PPI] (n=2,711); Integrated Palliative Outcome Scales [IPOS] (n=1,157); Carers Support Needs Assessment Tool [CSNAT] (n=241); Views of Informal Carers - Evaluation of Services [VOICES-SF] (n=102); a custom-designed Service Data Tool [SDT] (n=88). Qualitative data methods:- focus groups with project team and staff (n=32 groups, [n=190 participants]), and, volunteers (n=6 groups, [n=32 participants]).

Quantitative data analysis - SPPS Vs. 21; Qualitative data - thematic analysis.

Results: Comparison across the different sites revealed contrasting modes of implementation. PPS, PPI and IPOS data exposed disparity in early referral criteria, complicated by conflicting interpretations of specialist palliative care. The qualitative analysis, CSNAT and VOICES-SF data confirmed the value of the Macmillan Specialist Care at home approach to care but uptake of the specialist home-based clinical intervention component was limited. Significant findings included better coordination of palliative care with a single referral point and multi-disciplinary teamwork including leadership from consultants in palliative medicine, the role of health care assistants in rapid referral, and volunteer support.

Discussion: Specialist palliative care teams enhance the quality of palliative care and end of life care in the community and should form an integral part of future policy in this area.

Conclusions: Macmillan Specialist Care at Home increases patient choice about place of care and place of death and enhances the quality of end of life experience for the person and those around them.
Abstract number: P12
Abstract type: Poster presentation

Patients’, Carers’ and General Practitioners’ Views of the Role of General Practice in the Provision of End of Life Care in Rural and Regional Australia

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Background: End-of-life care is a fundamental role in general practice. In rural and regional settings, limited access to specialist palliative care increases general practitioner (GP) responsibility in this area. What is optimal GP end-of-life care, as described by patients and carers? Are these expectations met? The identification of gaps in care provision should lead to focussed strategies to address them.

Aims: To explore the characteristics of optimal end-of-life care from the perspective of people diagnosed with advanced cancer, their carers and their GPs; and to describe the extent to which rural and regional consumers perceived these expectations were met.

Methods: In depth, semi-structured telephone interviews were conducted with patients, their carers and GP. Thematic analysis was applied to transcripts of the recorded interviews. Commonalities and differences in the experiences of individual patients, carers and GPs were identified. Variations in the experience/perspective between carers, patients and GPs were also identified. We identified perceived optimal care, and the participants’ experiences of whether those standards were met. The study used phenomenological framework as the research aimed to understand people’s perceptions and perspectives of end-of-life care in general practice.

Results: Thirteen interviews were conducted with six patients, three carers and four GPs by telephone. We identified seven attributes of optimal primary palliative care: accessibility and trust, knowledge of the patient, good communication skill, psychosocial support and patient empowerment, symptom management and practical issues, care coordination, and recognising carer needs. The actual care received came close to matching patients’ expectations, with the exception that sometimes symptom control was difficult to achieve. The commitment observed by the patients and carers of their GP, and the description of the care offered by some GPs comes close to perceived optimal care.

Conclusion: Highly engaged GPs, a multidisciplinary approach, high levels of interpersonal/professional communication, advance care planning and coordination, the end-of-life care needs of patients and their family are able to be met in rural and regional communities. Knowing what patients are looking for should shape the education and training of undergraduate students and GP registrars.

Funding
RACGP/HCF Health Foundation Research Grant, UWA/UQ Research Collaboration Grant

Abstract number: P13
Abstract type: Poster presentation

How Should Future Home Palliative Care Be? A Discrete Choice Experiment with Service Users

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Background/aim: Efforts to reform home palliative care (HPC) models to fit a growing societal need may fail if service users’ preferences are not contemplated. This study aims to determine the relative value of key attributes of HPC for service users.

Methods: Discrete choice experiment with patients aged ⩾18 yo with advanced disease and their family caregivers in four HPC services (Portugal, Apr’15-May’17), measuring preferences for and trade-offs between attributes of HPC team’s availability, support for family caregivers, homecare support, information and planning, and waiting time. We used alternative specific multinomial probit modeling to calculate marginal willingness to wait (WTW, days from HPC referral to first visit) to determine the value of different attributes levels and care models, comparing patient and caregiver preferences.

Results: There were 138 respondents, including 44 patients (14 women, median age 73 years) and 94 caregivers (79 women, median age 60). 67% of patients had cancer. Median PPS was 45 (interquartile range 30-60), POS 16 (11-19), POS-S 11 (6.75-14) and EQ-5D thermometer 42.5 (20-50). The most valued HPC model included 24/7 access to the team; respite and psycho-education support for families; practical and advanced homecare support; and advanced care planning with case conferencing with general practitioner. Respondents would be willing to wait 20.8 days in order to get this care model; patients would be more willing to wait to get this “best model” of care (28.1 days, 95%CI 0.9-55.4) than caregivers (19.0 days, 11.8-26.1). Practical and advanced homecare support (WTW 7.5 days) and 24/7 availability (WTW 5.9 days) were the most valued attribute levels in both groups.

Conclusions: As HPC services reshuffle to reach more people, those that operate only in-hours and move towards consultancy-based care models will not meet users’ preferences. Moreover, services that enhance respite and psycho-education support for families and advanced care planning with case conferencing with general practitioner are more likely to meet preferences and thus result in greater benefits for patients and families. 24/7 access to the HPC team must get more attention due to its added value for service users.

Funding
Calouste Gulbenkian Foundation.

Abstract number: P14
Abstract type: Poster presentation

Recognition of the Dying Phase and Palliative Care Issues among Nursing Home Residents with Dementia: A Cross-sectional Study

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Background/aim: To determine patient and caregiver preferences.

Methods: Discrete choice experiment with patients aged ⩾18 yo with advanced disease and their family caregivers in four HPC services (Portugal, Apr’15-May’17), measuring preferences for and trade-offs between attributes of HPC team’s availability, support for family caregivers, homecare support, information and planning, and waiting time. We used alternative specific multinomial probit modeling to calculate marginal willingness to wait (WTW, days from HPC referral to first visit) to determine the value of different attributes levels and care models, comparing patient and caregiver preferences.

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Conclusions: As HPC services reshuffle to reach more people, those that operate only in-hours and move towards consultancy-based care models will not meet users’ preferences. Moreover, services that enhance respite and psycho-education support for families and advanced care planning with case conferencing with general practitioner are more likely to meet preferences and thus result in greater benefits for patients and families. 24/7 access to the HPC team must get more attention due to its added value for service users.

Funding
Calouste Gulbenkian Foundation.
were twofold: first to assess whether the diagnosis of dementia was associated with specific patterns of end-of-life care during the last 6 months of life, and second, to compare the characteristics of residents with dementia who died within 6 months with those who survived longer. 

**Methods:** Secondary, cross-sectional analysis of the IQUARE study in 175 nursing homes in south-west France. We included residents with and without dementia at baseline (May-June 2011), stratified according to their vital status at 6-month follow-up.

**Results:** Of the 6275 residents enrolled in IQUARE study, 2688 (42.8%) had a diagnosis of dementia and 494 (7.9%) were dead at 6-months of follow-up. Among those who died (n=494, 7.9%), 240 (48.6%) were having dementia. Compared to residents without dementia who died in a delay of 6 months, residents with dementia who died in a delay 6 months were living in nursing-home for a shorter time (46.6 vs. 61.3 months ; p = 0.015), they were more disabled (82.1% vs. 59.1% with GIR 1 or 2 ; p < 0.001) and malnourished (17.2% vs. 8.7% ; p = 0.005). They were more exposed to physical restraints (55.4% vs. 38.6% ; p < 0.001) and treated with antipsychotic drugs (29.2% vs. 19.7% ; p = 0.014). Compared to not deceased resident with dementia, residents deceased at 6 months were older (86.6 ± 6.3 vs. 86.6 ± 6.8 ; p < 0.001), more disabled (1.8 ± 1.0 vs. 2.1 ± 1.6 ; p < 0.001) and sicker (more morbidity (Charlson index : 2.7 ± 1.8 vs. 2.5 ± 1.6 ; 0.027) and skin sores (12.9% vs. 4.1% ; p < 0.001)). Pain was more prevalent (26.6% vs. 18.9% ; p = 0.004) and assessed (20.8% vs. 12.2% ; p < 0.001). Pain relief with strong opioids is more frequent (6.7% vs. 3.1% ; p = 0.003). There is a trend for less inappropriate medications (1.9 ± 1.5 vs. 2.1 ± 1.4 ; p = 0.014).

**Conclusion:** Death in a short term is a frequent event among nursing-home residents with dementia. Poor care indicators such as chemical and physical restraint are associated with end of life for residents with dementia. Recognition of residents with dementia who present short life expectancy seems possible and should be done for better plan of care.

**Abstract number:** P15

**Abstract type:** Poster presentation

**Ethical Issues Experienced by Healthcare Workers Providing Palliative Care in Nursing Homes: A Mixed Methods Study**

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**Aim:** To provide a comprehensive understanding of care providers’ experiences of ethical issues during palliative care provision in nursing homes in Northern Ireland.

**Methods:** An exploratory, sequential, mixed methods research design was used, including semi-structured interviews with 13 registered nurses (RNs) and 10 healthcare assistants (HCAs) working in nursing homes in Northern Ireland, and a cross-sectional survey with 69 RNs and 129 HCAs.

**Results:** The interviews revealed three themes; “Issues in practice;” “Relational Issues;” and “Organisational Issues.” Issues in practice occurred when participants felt conflicted between what was right and their professional duty. One of the most frequently reported ethical issues in the survey was linked to this theme and related to decision making on the resident’s behalf to prevent harm (Mean = 2.68; SD= 1.24). Relational issues included conflicts in staff, family, and resident relationships. This theme included the most frequently cited ethical issue across the whole survey, caring for residents who refused food/fluids (Mean = 2.71; SD= 1.19). Organisational issues were a consequence of the structure and quality of services available. Ethical issues associated with higher distress levels were linked to this theme, including the impact of poor communication on care (Mean = 2.48; SD= 1.39); and lack of time to meet care needs (Mean = 2.36; SD= 1.44). The survey revealed no differences between RNs and HCAs in the frequency of ethical issues (p=0.40), or the level of distress these issues caused (p= 0.81).

**Conclusion:** The findings reveal the nature of ethical issues present in nursing homes. Implications for practice include the need for increased training and support to build relationships with residents and families, improved communication and shared decision-making between healthcare professionals, residents, and families, and palliative care training for all staff members to improve the care experience.

**Funding**

Queen’s University, Belfast

**Abstract number:** P16

**Abstract type:** Poster presentation

**Physician Involvement and Recognition of the Resident’s Last Phase of Life in Long-term Care Facilities: Findings from an EU FP7 Funded Cross-sectional Study in 6 European Countries (PACE)**

**Oosterveld-Vlug, Mariska1, Pasman, Roelien1, ten Koppel, Maud1, van Hout, Hein1, van der Steen, Jenny1, Collingridge Moore, Dann1, Deus, Luc1, Gambassi, Giovanni1, Kylänen, Marika5, Smets, Tine1, Szczerbińska, Katarzyna6, Van den Block, Lieve1, Ouwateau-Philippsen, Bregge1, on behalf of PACE**

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**Research aims:** Ensuring the delivery of prompt, comprehensive palliative care in long-term care facilities (LTCFs) requires a multidisciplinary approach, including involvement of the physician. This study aims to describe and compare among 6 European countries

1) to what extent physicians are involved in the care of residents living in LTCFs;
2) to what extent physicians recognize the resident’s last phase of life and;
3) how (1) and (2) are associated.

**Study design and methods:** In each country, a cross-sectional study was conducted within representative samples of LTCFs. Participating LTCFs reported all deaths of residents in the previous 3 months, and structured questionnaires were sent to several proxies among which the treating physician.

**Method of statistical analysis:** To control for clustering within LTCFs and countries, differences in involvement in care and recognition of the last phase of life were analyzed using multilevel analyses.

**Results and interpretation:** Physician involvement varied widely between countries; in the last 3 months of life, residents from PL were visited most often (median: 15 times), compared to residents from FI (12), NL (10), BE (7), IT (6) and EN (5). In the last week of life, this ranged from 4 visits (NL) to 1 visit (EN). Among all countries, physicians from PL and IT least often recognized the resident’s terminal illness and whether they expected death.

**Conclusion:** Physician involvement and recognition of the resident’s last phase of life and initiation of palliative care. LTCFs should therefore work
together with and involve physicians as much as possible in caring for their residents.

Funding
EU FP7 - PACE (ga n° 603111)

Abstract number: P17
Abstract type: Poster presentation

Hospice Culture and Palliative Care in Nursing Homes in North Rhine-Westphalia - A Mixed Methods-study on the Current Status of Implementation
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Background/aims: Improvement of hospice and palliative care (HPC) in nursing homes (NHs) has been the target of many initiatives and projects in Germany. The aim of this study was to explore the degree of its implementation in North Rhine Westphalia (NRW), the most populous state in Germany (17.6 million inhabitants).

Methods: A mixed-methods design was chosen, consisting of a quantitative (1) and a qualitative (2) survey.
(1) Online survey among 1750 NHs in NRW. The anonymized data were analyzed descriptively with the statistics program SPSS.
(2) Semi-structured interviews with nursing home nurses. Interviews were audiorecorded and transcribed verbatim. The transcripts were analyzed using the qualitative content analysis according to Mayring.

Results:
(1) The response rate among all NHs was 26% (n = 459). The degree of implementation of HPC was rated high/very high by 58% of NH. Satisfaction with HPC in their facility was rated as very satisfied/satisfied/moderately satisfied by 17%/ 43%/32%.
(2) More than half had contingency plans for palliative emergency situations. Farewell rituals for ward mates of deceased residents (96%) and employees (76%) and support for relatives (77%) were available.

Conclusion: The findings indicate that gaps in HPC are only detected after education in this field. Difficulties in the identification of residents with palliative care needs coincide with previous experiences in the literature. Changes in attitudes towards comprehensive symptom control could be an effective option for early integration of HPC.

Abstract number: P18
Abstract type: Poster presentation

The Sustainability of In-reach End-of-Life Care Programmes into Care Homes
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Background: Frail older people are now admitted to European care homes (CHs) with a mean life expectancy of about 18 months. In the UK, nursing care homes (NCHs) are being seen as the hospices of yesterday. Undertaking and sustaining quality improvement in relation to end-of-life care (EoLC) in CHs is difficult because of the relatively ‘low’ context (lack of multi-disciplinary team and organisational learning) and high staff turnover. Previously, we have reported on 4 sequential research studies that followed the MRC complex intervention outline (development, feasibility, and evaluation of a cluster RCT). The studies highlighted the importance of ‘high facilitation’ when implementing initiatives in NCHs and the active involvement of their managers. We now present the MRC fourth category: implementation.

Aims: To evaluate the dissemination, surveillance and monitoring of a sustainability initiative in NCHs completing the Gold Standards Framework programme.

Methods: The sustainability initiative was set up in 2012 in 24 NCHs. It consisted of: a day on palliative care for all new staff, a four-day palliative care course for nurses/care staff; and, ‘action learning’ sets for managers to encourage critical thinking. Audit data was collected on: place of death, bereaved relatives’ perceptions of care in the last month of life, and validated assessment tools/end-of-life care documentation. Five years on the current sustainability model is compared to the original alongside its dissemination, surveillance and monitoring.

Results: Dissemination: The research-based model of practice has been extensively shared in publications/presentations and helped to shape further European research.
Surveillance and monitoring: Subsequent research highlighted the requirement to provide multi-layered learning to: targeted individuals, organisations, and in appreciative learning systems. We have learnt that, whilst CHs require different programmes, ‘high’ facilitation alongside supporting the CH managers results in a cost-effective model that sustains the delivery of high quality EoLC in this setting.

Conclusion: A structured sustainability initiative created at the outset of a quality improvement initiative is likely to mean the culture of the care home will change. Whilst not without cost, sustainability can be cost effective. The increasing use of technology supporting staff training within their work place facilitates staff becoming part of a wider appreciative learning system.

Abstract number: P19
Abstract type: Poster presentation

Opinions on Palliative Care of Nursing Home Staff in 6 European Countries: Cross-sectional Study (the EU FP7 PACE Project)
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Abstract number: P20
Abstract type: Poster presentation
An Advance Care Planning Intervention for Nursing Home Staff in Flanders: A Feasibility Study
Gilissen, Joni1, Pivodic, Lara1, van Dael, Annelien1, Gastmans, Chris2, Vander Stichele, Robert3, Van Humbeeck, Liesbeth4, Deliens, Luc1, Van den Block, Lieve1
1End-of-Life Care Research Group, VUB, Wemmel, Belgium, 2Centre for Biomedical Ethics and Law, KU Leuven, Leuven, Belgium, 3Pharmacology, Ghent University, Ghent, Belgium, 4Geriatric Medicine, Ghent University, Ghent, Belgium

Introduction: Advance care planning (ACP) is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. Through a systematic review and stakeholder consultations, we developed a theoretical model of the main components of an ACP program for nursing homes in Flanders. Main components were: training all nursing home staff to have ACP conversation with residents; informing general practitioners about the ACP program and having multidisciplinary meetings. Materials included training manuals, information leaflets, ACP (conversation) documents and an audit instrument. The aim of this study was to assess the feasibility and acceptability of this ACP program, specifically the intervention components, procedures and materials.

Methods: In five different nursing homes in Flanders we led three different meetings with nurses, care assistants, reference persons dementia and palliative care, a coordinating general practitioner, a social worker (N=15), and two semi-structured interviews with a physiotherapist, and a head of resident’s care. Also, a nurse who is specialized in ACP and palliative care training provided written feedback.

Results: Experienced care staff considered the materials to be appropriate in both language use and content. The procedures were considered to be clear. However, all participants emphasized three important elements for optimal implementation:

1) tailoring of details of procedures, infrastructure and timing in such a way that it fits within the existing nursing home processes;
2) engagement of management to ensure the whole nursing home is involved and the nursing staff has enough time to carry out tasks related to the ACP program;
3) having an experienced ACP trainer familiar with the nursing home context to deliver and implement the ACP program in a stepwise manner.

Conclusion: In this study the developed ACP program for nursing homes in Flanders was judged feasible and acceptable. To facilitate implementation of the ACP program three elements are considered to be essential, 1) tailoring, 2) engagement of management, 3) an experienced ACP trainer. Tailoring will be added as a component, so nursing homes will know which procedures and materials can be tailored, without losing the core of the ACP program. Moreover, extra time for management engagement and directions for selecting the ACP trainer will be added to the ACP program.

Abstract number: P21
Abstract type: Poster presentation
Palliative Care in Nursing Homes from the Nursing Homes’ Point of View
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The care for terminally ill and dying residents is an everyday duty in nursing homes (NH). In recent years various measures to improve palliative care (PC) in German NH have been taken including new laws, education programs and research. However, little is known about the NHs’ point of view on status quo of implementation and needs for action to improve PC in NH.

In a mixed method study NH specialists and executive staff participated in semi-structured interviews (content analysis) and 538 members of nursing staff from 12 NH were asked to complete an anonymous online survey (descriptive/inferential statistics).

21 interviews were conducted and 176 nursing staff members completed the survey (return rate 32.7 %). The following needs for action were most prominent in the study: lacking resources (nursing staff, time, money) in palliative situations: 40.9% (n=72) of the nursing staff report, that sufficient qualified nurses are never, rarely or sometimes available for the care of dying residents, (likert-scale: never/rarely/sometimes/often/mostly/always). Both nursing staff and executives agree that extra staff and time is needed to ensure dignified dying.

- cooperation with general practitioners (GP): 25.0% (n=44) of the nursing staff state that doctors are rarely or sometimes...
promptly on site if needed; executives additionally name cooperation between GPs and specialist outpatient palliative care services and provision of on-demand medication as areas for improvement,

- **education of NH staff and GPs**: Various executives suggest that all GPs should be trained in PC; concerning their own staff, they often report staff shortage and low motivation as barriers for training. 92.0% (n=162) of the nursing staff report feeling very well / well or satisfactorily prepared to care for dying patients while at the same time reporting various training wishes (open-ended question).

Even though the sample is not representative for all NH in Germany, the results allow useful insights in the overall situation. Lack of resources is a frequently mentioned barrier to PC itself and also mentioned as a barrier to the education of staff. As this issue might not be solved in the near future, low-level measures that are easily implemented (e.g. structured communication tools, prompt cards, e-learning) might contribute to widespread improvements that ensure basic PC standards for all NH residents.

**Funding**

Ministry of Social Affairs and Integration Baden-Wuerttemberg, Germany

**Abstract number: P22**

**Abstract type: Poster presentation**

The ‘Hospice in Your Care Home’ Project: A Responsive Evaluation
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**Background:** Multi-component interventions to support the delivery of palliative care in care homes are in use, but with limited evidence of their impact. In 2015, one UK hospice established a ‘Hospice in Your Care Home’ team using a number of interventions: role modelling, working alongside staff; responses to urgent referrals; advance care planning and training courses. An external evaluation was undertaken.

**Aims:**

- To evaluate the process and outcomes of the ‘Hospice in Your Care Home’ initiative, with specific reference to hospital admissions and end of life practices;
- To ascertain the costs of delivering the project;
- To identify facilitators and barriers to the implementation of the initiative.

**Study design/methods:** The responsive evaluation comprised:

1) an analysis of secondary service provision data;
2) 3 focus group interviews with care home managers (n= 7), care home staff (n=11) and the project team (n=6);
3) preliminary analysis of costs (time and finance).

Secondary data was analysed using descriptive and inferential statistics. Framework analysis structured the qualitative data analysis.

**Results:** Nine care homes participated with one facility leaving and one joining part way through. Between 2015 and 2016 hospital admissions were significantly reduced by 25% (p=0.01). Resident status meetings were conducted in each facility, with 4479 residents discussed at 217 meetings. The cost of education delivery was high in terms of care home staff time, (approximately 2421 hours). This equated to a cost of just under £30,000 for care home staff attendance. Staff described increased confidence in their ability to care for residents with palliative care needs. Project implementation comprised three stages: initiation, assimilation, and ‘everyday’ running. Facilitators identified included the hospice team’s flexibility and availability. Reported barriers reflected the challenges of maintaining care home staffing levels and staff availability to attend training.

**Conclusions:** This hospice model has shown significant reductions in hospital admissions and increased confidence of care home staff in end of life practices. There is potential to use this in other localities.

**Abstract number: P23**

**Abstract type: Poster presentation**

Namaste Care for People with Advanced Dementia towards the End of Life in Care Homes: A Systematic Realist Review to Inform and Guide the Conduct of a Randomized Controlled Trial
Froggatt, Katherine1; Bunn, Frances3; Lynch, Jennie2; Sharpe, Rachel2; Preston, Nancy1; Walshe, Catherine3; Goodman, Claire3
1International Observatory on End of Life Care, Lancaster University, Lancaster, UK, 2University of Hertfordshire, Hatfield, UK

**Background:** Namaste Care is a structured intervention for people with advanced dementia living in care homes who are often isolated with a poor quality of life. In Namaste care, staff engage residents in person-centred activities that focus on sensory stimulation. Namaste Care is in use in care homes globally, but there is currently limited evidence for its efficacy. A three phase feasibility study is being undertaken of the Namaste Care intervention: (1) systematic realist review of literature, (2) intervention refinement; (3) feasibility randomized controlled trial. We report here on the findings of the Phase 1 realist review.

**Aim:** To identify key features or mechanisms of the Namaste care intervention that have the potential to improve end of life care for people dying with advanced dementia in care homes.

**Review design and methods:** In this systematic realist review an iterative two stage stakeholder driven approach was used, drawing on the work of Pawson (2006) and informed by RAMESES guidance on reporting of realist reviews. In Stage 1, the realist review parameters were defined and programme theories developed by scoping the Namaste literature (n=31 papers) and undertaking stakeholder interviews with representatives from palliative care, dementia care and care homes (n=10). In Stage 2, an in-depth review of evidence on the use of sensory interventions in care homes was undertaken to test theidentified theories of how the different elements of Namaste Care works. Primary studies (n=66) and systematic reviews (n=17) were identified and reviewed.

**Results:** Four context-mechanism-outcomes configurations were identified. Namaste provides

1) a structure which facilitates a routine for access to care;
2) a multisensory resource and toolkit of activities for staff to use;
3) a new way of doing person-centred care for people with advanced dementia who can no longer participate in many care home activities; and
4) social stimulation that allows moments of connection to occur between residents and facilitators.

**Conclusion:** These mechanisms have been used to inform the refinement of the Namaste Care intervention for use in a feasibility study of a cluster randomized controlled trial of Namaste care being conducted in UK care homes.
Abstract number: P24
Abstract type: Poster presentation

Pain Medication Use of Swiss Nursing Home Residents during their Last Year of Life
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Our aim was to investigate use of WHO step 1, 2 and 3 pain medications among Swiss nursing home residents during their last twelve months of life. We used the resident assessment instrument-minimum data set (RAIMDS) data of 50207 deceased nursing home residents and established the frequencies of use of the different pain medication categories based on a total of 97092 assessments. We grouped nursing home residents by dementia diagnosis/no dementia diagnosis in order to detect differing prescribing practices in these groups. We find that 40-45% of nursing home residents receive WHO step 1 pain medications with no evidence of de-prescribing before death and no clear difference depending on dementia diagnosis. Approximately eight percent of nursing home residents without dementia receive WHO 2 pain medications, while in dementia these medications are only used in about six percent of residents. In the latter group there is also an increase in prescribing immediately before death. The use of strong opioid pain medications (WHO 3) increases in the last year of life: In nursing home residents without dementia from approx. 15% (twelve months before death) to approx. 40% (at the last assessment before death) and in nursing home residents with a dementia diagnosis from approx. twelve percent to approx. 30%. In conclusion, there is clear evidence in our data for increasing use of strong opioid pain medications before death in Swiss nursing home residents. However, in dementia this increase is far less pronounced than in residents without dementia. This underlines the need for systematic pain assessments in this resident group and may indicate the need for further re-evaluation of current prescribing practices.

Abstract number: P25
Abstract type: Poster presentation

The Perspective of Relatives on Palliative Care in Long-term Care Settings
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Background/aims: Palliative care in long-term care settings gains importance in caring for residents until their end of life. Relatives play a crucial role in caring for older people in long-term care settings particularly in their last phase of life. The perspective of relatives on palliative care in long-term care settings has not yet been studied extensively. The aim of the paper is to focus on some of the most important insights on themes and issues that relatives of persons having died in a long-term care setting discuss concerning palliative care.

Methods: Research in this field still has an exploratory character. Therefore, a qualitative approach was chosen. Four focus groups in different long-term care settings across three cities in Germany as well as different providers working on diverse legal and structural formations and having different organisations and act in a competent way.

Conclusions: Findings show on one hand the importance of relationships and changes of culture of care in the workplace as requirement for compassionate, dignified and personalised care as prerequisite for good palliative care. On the other hand, long-term care settings interact in a complex world and represent an important factor in the local care network and community. Therefore, palliative care in long-term care settings also needs to establish networks between organisations and the community.

Abstract number: P26
Abstract type: Poster presentation

Provision and Timing of Palliative Care in Long Term Care Facilities in Europe: Results of a Cross-sectional Study in 6 European Countries (PACE)
Riese, Florian1,2, Theill, Nathan2, Martin, Mike2, Wolf, Henrik1
1Psychiatric University Hospital Zurich, Zurich, Switzerland, 2URPP Dynamics of Healthy Aging, University of Zurich, Zurich, Switzerland

Our aim was to investigate use of WHO step 1, 2 and 3 pain medications among Swiss nursing home residents during their last twelve months of life. We used the resident assessment instrument-minimum data set (RAIMDS) data of 50207 deceased nursing home residents and established the frequencies of use of the different pain medication categories based on a total of 97092 assessments. We grouped nursing home residents by dementia diagnosis/no dementia diagnosis in order to detect differing prescribing practices in these groups. We find that 40-45% of nursing home residents receive WHO step 1 pain medications with no evidence of de-prescribing before death and no clear difference depending on dementia diagnosis. Approximately eight percent of nursing home residents without dementia receive WHO 2 pain medications, while in dementia these medications are only used in about six percent of residents. In the latter group there is also an increase in prescribing immediately before death. The use of strong opioid pain medications (WHO 3) increases in the last year of life: In nursing home residents without dementia from approx. 15% (twelve months before death) to approx. 40% (at the last assessment before death) and in nursing home residents with a dementia diagnosis from approx. twelve percent to approx. 30%. In conclusion, there is clear evidence in our data for increasing use of strong opioid pain medications before death in Swiss nursing home residents. However, in dementia this increase is far less pronounced than in residents without dementia. This underlines the need for systematic pain assessments in this resident group and may indicate the need for further re-evaluation of current prescribing practices.

Research aims: Comparing palliative care practices can aid inform the development of policies in this area. This study compares practice in 6 EU countries. It compares proportions of those who died in long term care facilities (LTCFs) and had received palliative care; when palliative care was initiated; and who was involved in providing palliative care. Another aim is to assess which resident and facility characteristics and aspects of advance care planning are related to receiving palliative care and the timing of palliative care.

Study population: Of 1707 deceased residents, information about whether palliative care was provided was available on 1298 cases 300 in LTCFs in Belgium, England, Finland, Italy, the Netherlands and Poland.

Study design and methods: In each country a random sample of representative LTCFs retrospectively reported all deaths of residents in the previous 3 months. The nurse most involved in care completed a questionnaire about the resident and answered the following questions on palliative care: According to you, did the resident receive palliative care at any time? (yes/no); How long before death was palliative care started? (no. days before death); According to you, did the general practitioner provide palliative care to this resident? (yes/no).
Method of statistical analysis: Generalized estimating equations were used to account for clustering of data at facility level.

Results and interpretation: The proportion of residents who had received palliative care prior to death varied widely between countries: it ranged from 14.0% in Poland and 32.1% in Italy to between 72.6% and 77.9% in England, Finland, the Netherlands and Belgium. Palliative care started earliest in Poland (mean=60 days before death) and latest in Italy (mean=10 days before death). Involvement of the treating physician was highest in the Netherlands (98.8%) and ranged to 75.0% in England. Residents with cancer, dementia or a contact person in their record had significantly higher odds of receiving palliative care. Palliative care started significantly earlier for residents with whom the nurse had spoken about treatments or the preferred course of care at the end of life. Perhaps close involvement of relatives may play a role in ensuring that palliative care is provided. Furthermore, open communication about end-of-life issues can help to timely start palliative care.

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Abstract number: P27
Abstract type: Poster presentation

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Background: There is evidence that one, many older people receive insufficient symptom management in nursing homes (NH) and two, there is a lack of communication about end-of-life issues. Numerous Swiss NHs use the resident assessment instrument (RAI) to assess and document the resident’s health status annually or whenever their health care status changes significantly. Pain, shortness of breath, behavioral and psychological symptoms of dementia (BPSD) are common in the last phase of life, but to date it’s unclear how prevalent these are in Swiss nursing homes.

Aim: The aim of this study is to analyse data from the Minimum Dataset (MDS), which are part of RAI to evaluate end of life activities in Swiss NHs.

Methods: A complete sample of RAI routine data collected in 2016 from three Swiss-German NHs were descriptively analyzed. Furthermore, a comparison between the specialized dementia wards and ordinary wards was conducted using Pearson’s Chi Square test.

Results: Preliminary analysis (n = 59) showed that patients cared for in specialized dementia wards had a significantly higher prevalence of motor agitation as part of the symptom complex BPSD (p< .001). BPSD (0% - 50%) were most prevalent symptoms compared to Pain (4/16) or Dyspnea (0/16) in the specialized dementia care group. Pain in people with dementia was reported only half as often (4/16) compared to the regular residential care group (21/41).

Conclusion: Symptom burden in NH residents with dementia root in BPSD. Data extraction via quality control data using RAI-NH MDS comes with several challenges. Firstly, no medical diagnosis are documented in the MDS, which would allow comparison between symptom burden and diagnosis. Secondly, BPSD like agitation, delusions, hallucinations, apathy, sleep-patterns or motor agitation were available from the data. However, we know that BPSD are described with more than one of these symptoms; especially data on depression, irritability, appetite changes or disinhibition was only partly or not obtainable.

Acknowledgements
Bethesda AG

Abstract number: P28
Abstract type: Poster presentation

Predictors of Length of Stay in Nursing Homes - A Comparison of Residents in 322 Nursing Homes in Six European Countries.

Results of the EU FP7 PACE Study
Collingridge Moore, Danni1, Payne, Sheila1, Keegan, Tom1, Van den Block, Lieve2, Deliens, Luc2, Gambassi, Giovanni3, Heikkilä, Rauha4, Kijowska, Violetta5, Pasman, Roeline6, Pivodic, Lara1, Froggatt, Katherine1
1Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom, 2Vrije Universiteit Brussel & Ghent University, End of Life Care Research Group, Brussels, Belgium, 3Università Cattolica del Sacro Cuore, Rome, Italy, 4National Institute for Health and Welfare, Helsinki, Finland, 5Jagiellonian University Medical College, Unit for Research on Aging Society, Department of Sociology of Medicine, the Chair of Epidemiology and Preventive Medicine, Krakow, Poland, 6VU University Medical Center, Amsterdam, Netherlands

Background: The profile of nursing home residents across Europe is changing; residents are older, frailer and likely to have comorbidities. An understanding of anticipated length of stay is important in developing care plans, healthcare resource allocation and informing the decisions of residents and their relatives. Length of stay before death in European nursing homes is not well understood.

Aims: This paper aims to explore resident and facility characteristics associated with length of stay in nursing homes across six European countries: Belgium, England, Finland, Italy, the Netherlands and Poland.

Methods: Data from the PACE study, a mortality follow-back survey comparing the effectiveness of health care systems with and without formal palliative care structures. All residents who died in a three month period residing in nursing homes across six European countries during 2015 were included. Data on the residents was collected from the nursing home, the general practitioner and relative. Resident characteristics previously identified as possibly being related to length of stay, including age, gender, diagnoses, physical functioning, contact with health service and facility characteristics were included in a prediction model.

Length of stay was calculated from date of admission to date of death.

Results: Data was collected using questionnaires on 1,707 residents in 322 nursing homes. The mean length of stay was 31.0 months (SD 43.3) (Belgium 40.0 (SD 46.7), England 24.4 (SD 32.2), Finland 28.2 (SD 36.3), Italy 27.0 (SD 47.4), Netherlands 34.0 (SD 36.7), Poland 28.7 (SD 50.1). Within one year of admission, 45% of residents had died, and within five years of admission, 84% of residents had died. Factors associated with shorter lengths of stay included being male, history of stroke and shortness of breath.

Conclusions: The identification of shorter stay residents is possible from data collected by nursing homes, allowing the prediction of anticipated residence to be made by care staff on admission. Further research is needed on the trajectories of nursing home resident from admission to death.

Funding
Funding by EU FP7 - PACE (grant agreement 603111).

Abstract number: P29
Abstract type: Poster presentation

The Impact of Palliative Care Consultation on Quality of Life of Patients with Advanced Cancer in Dutch Hospitals: An Observational Study
Risk Factors for Death after Visiting the Emergency Department: A Retrospective Cohort Study in Advanced Oncology Patients

Kiljunen Minna
North Karelia Central Hospital, Palliative Care Unit, Joensuu, Finland

Background: Prior and after the opening of Palliative Care Unit (PCU) in our hospital in 2015, general information on palliative care (PC) and end-of-life care (EOLC) issues together with information of local palliative consultation services was presented to hospital physicians in multiple occasions. The physicians were also encouraged to use the ICD-10 code Z51.5 Encounter for Palliative care for all appropriate patients.

Abstract number: P31
Abstract type: Poster presentation

Hospital Physicians’ Knowledge and Perceptions of Local Palliative and End-of-Life Services and the Trends in ICD-10* Diagnosis Z51.5 Coding

Kiljunen Minna
North Karelia Central Hospital, Palliative Care Unit, Joensuu, Finland

Background: Prior and after the opening of Palliative Care Unit (PCU) in our hospital in 2015, general information on palliative care (PC) and end-of-life care (EOLC) issues together with information of local palliative consultation services was presented to hospital physicians in multiple occasions. The physicians were also encouraged to use the ICD-10 code Z51.5 Encounter for Palliative care for all appropriate patients.

The aim of the study: To explore hospital physicians’ knowledge and perceptions of the local PC and EOLC services and their development since the opening of the PCU. The number of Z51.5 coded non-PCU hospital episodes was also examined.

Methods: An electronic questionnaire was sent to all hospital physicians (n=242) by email in September 2017. The survey data was analyzed two weeks later. The number of Z51.5 coded hospital episodes was collected from the hospital data. The PCU episodes were excluded from the analysis.

Results: The response rate was 35% (n=84). 80 responders (95%) were aware of the PCU and 44 (52%) had referred patients to the PCU and 39 (46%) had consulted the mobile PC consultation team. 59 physicians (70%) viewed the quality of PC and EOLC as improved since the opening of the PCU and 55 (65%) rated the consultation services as excellent. None of the respondents perceived neither the quality nor the services as poor. 55 (65%) physicians were familiar with the diagnosis code Z51.5. A clear rise in the Z51.5 coded hospital episodes can be observed in Table 1.

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(Number of Z51.5 episodes (PCU excluded))

Abstract number: P30
Abstract type: Poster presentation

Risk Factors for Death after Visiting the Emergency Department: A Retrospective Cohort Study in Advanced Oncology Patients

Radiotherapy / Centre of Expertise Palliative Care, Leiden University Medical Center, Leiden, Netherlands

Background: Many advanced oncology patients visit the emergency department (ED) during the last 3 months of life. In order to assess palliative care needs at the ED, more knowledge is needed about the problems that lead to ED visits. Additionally, identification of factors associated to death may help to start appropriate care after the ED visit.

Methods: Palliative patients who died within 3 months after visiting the ED with a solid tumour and >18 y/o were included. Descriptive statistics were used to analyse patient, ED visit and follow-up characteristics. To identify possible risk factors associated to death, a Cox proportional hazards model was used to perform univariate and multivariate analysis.

Results: 420 patients were included, 55% male, median age 63 years. Patients visited the ED with a mean of 2.3 symptoms, most commonly dyspnea (21%) or pain (19%). 23% of the symptoms were new and acute. Symptoms were treated at the ED in 55% and were relieved in 19%. Median time spent at the ED was 3.5h. Before the ED visit, advance directives were discussed in 38% of the patients; during or after the ED visit in 73%. 104 (25%) patients died within 7 days after the ED visit; median survival was 18 days (IQ-range 7-41). Significant risk factors for death were primary lung tumour (HR 1.8; 95% CI 1.3-2.3), acute and new symptom (HR 1.3, 95% CI 1.1-1.8), neurologic deterioration (HR 2.1; 95% CI 1.4-3.1), dyspnea (HR 1.6; 95% CI 1.2-2.0), cachexia (HR 1.4; 95% CI 1.0-2.0), hypercalcaemia (HR 2.0; 95% CI 1.3-3.1) and jaundice (HR 2.1; 95% CI 1.3-3.2).

Conclusion: Advanced oncology patients presented at the ED with multiple, new and acute symptoms, most commonly dyspnea or pain. The ED visit often triggered revision of advance directives. Predictors for death were neurological deterioration, dyspnea, acute and new symptoms, cachexia, hypercalcaemia and jaundice. These insights help identifying palliative care needs and improving care for palliative oncology patients.

Abstract number: P31
Abstract type: Poster presentation

Hospital Physicians’ Knowledge and Perceptions of Local Palliative and End-of-Life Services and the Trends in ICD-10* Diagnosis Z51.5 Coding

Kiljunen Minna
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Abstract type: Poster presentation

Risk Factors for Death after Visiting the Emergency Department: A Retrospective Cohort Study in Advanced Oncology Patients

Radiotherapy / Centre of Expertise Palliative Care, Leiden University Medical Center, Leiden, Netherlands

Background: Many advanced oncology patients visit the emergency department (ED) during the last 3 months of life. In order to assess palliative care needs at the ED, more knowledge is needed about the problems that lead to ED visits. Additionally, identification of factors associated to death may help to start appropriate care after the ED visit.

Methods: After admission to one of 9 participating hospitals, patients with advanced cancer for whom the attending physician answered “no” to the Surprise Question: “Would you be surprised if this patient would die in the near year?”, were invited to complete a questionnaire at six points in time, until 3 months after admission. The questionnaires included the EORTC QLQ C15 PAL. Outcomes were compared between patients who received the consultation and patients who did not, taking into account differences in baseline characteristics.

Results: A total of 164 patients consented to participation, of whom 32 received the consultation. Of these patients, 108 were able to complete a questionnaire at six points in time, until 3 months after admission. The questionnaires included the EORTC QLQ C15 PAL. Outcomes were compared between patients who received the consultation and patients who did not, taking into account differences in baseline characteristics.

Conclusion: PCT consultation decreased patients’ symptom burden and tends to have a positive effect on the quality of life of hospitalized patients with advanced cancer. However, PCTs were consulted in a small minority of potentially eligible patients.
Conclusions: Hospital physicians are important and pivotal advocates of palliative care. Their knowledge, beliefs and attitudes regarding the palliative care influence patients’ perception of these services, too. In this hospital, the physicians responding and familiarizing with the PCU perceived the quality of the services as good or excellent. The number of Z51.5 coded episodes is getting higher, which hopefully reflects better recognition of these patients. Continuous education and information on PC and EOLC core issues and local PC services appears to be beneficial.

Abstract number: P32
Abstract type: Poster presentation

Supporting Family Members in their Relative’s Transition from Hospital to Home for End of Life Care - A Participatory Learning and Action (PLA) Study to Design and Implement an Evidence-based Brief Intervention in Hospital Palliative Care Practice and to Assess its Usability and Acceptability

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Aim: The transition from hospital to home for end of life care (eolc) is an emotive time for family members, characterised by growing understanding that their relative is dying, getting things ready for discharge and continuing to provide support in hospital. This study aimed to implement established research evidence to support family members during this time and to assess its use in practice.

Methods: The research employed Participatory Learning and Action (PLA) methodology, underpinned by a validated implementation theory, Normalization Process Theory (NPT). Each PLA cycle addressed a NPT implementation phase. Initial PLA cycle theoretically modelled a brief intervention from active components of tested support interventions, identified from systematic reviews and meta-analysis. In later cycles, a training package was developed to support the resulting short, structured conversation. Both were clinically piloted with hospital palliative care teams in 3 acute hospital sites and rolled out to 7 additional sites, purposefully selected to include hospitals serving diverse populations. Qualitative data were gathered via reflective discussions with clinicians during and after implementation and via questionnaires and interviews with family members who had received the intervention. Data were analysed using Framework Analysis. We were interested in whether the intervention was usable in practice and whether it was acceptable to family members.

Results: Practitioners found the intervention easy to adopt and embed in practice, and that it facilitated family centred conversations about family discharge concerns. Family members valued the focus on their needs and found the conversations helped them consider discharge implications and how to manage their concerns.

Conclusion: This brief intervention is a unique evidence-based contribution to family eolc discharge practice. It is readily adopted into practice and facilitates family-focused planning for eolc at home.

Funding
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Abstract number: P33
Abstract type: Poster presentation

When to Consider Expert Palliative Care Consultation for Patients with Advanced Cancer: Development of a Set of Triggers

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Aims/research question: Timely palliative care for patients with advanced cancer results in increased quality of life. In more complex situations, basic palliative care knowledge of nurses and physicians might be insufficient to meet the palliative care needs. In such cases, specialist palliative care consultation is useful. The aim of this study is to give an overview of triggers for which consultation of a specialist palliative care team might be required.

Methods: A two-step procedure was used: first, individual and focus group interviews with stakeholders were conducted to explore for which reasons expert palliative care consultation might be required. Second, a Delphi procedure was performed to select the most relevant triggers for expert palliative care consultation.

Results: Five patients with cancer and one family caregiver of a deceased patient participated in individual interviews and 20 professionals in four focus group interviews. The results of the individual and focus group interviews were inductively categorised, which resulted in a two step set of triggers. First, to identify patients with an increased chance to deteriorate and die, the answer to the surprise question (Would I be surprised if this patient were to die in the next 12 months?) should be ‘no’ to proceed to the other triggers. Next, in four categories (1. Clinical aspects, 2. Psychosocial characteristics of the patient and/or next-of-kin that influence regular treatment, 3. Interaction between patient, next-of-kin and professional that influence regular treatment, 4. Expertise of the professional) 13 triggers for expert palliative care consultation were selected.

Discussion: We identified specific triggers for expert palliative care consultation for patients with advanced cancer. Next, specific validation is needed to prove the usefulness of this aid.

Abstract number: P34
Abstract type: Poster presentation

Palliative Care Need of Patients with Lung or Colorectal Cancer in Dutch Hospitals

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Background: Lung and colorectal cancer are highly prevalent in the Netherlands and many patients will be in need of palliative care. If health care professionals recognize palliative care needs of patients on time, quality of life of patients will increase. Aim of this study was to gain insight into the palliative care need of patients with lung or colorectal cancer in Dutch hospitals.

Methods: An observational cross-sectional study was undertaken in 7 Dutch hospitals. Patients with lung or colorectal cancer that visited the hospitals on three selected days were included: 50 inpatients and 256 outpatients. Per patient, a structured questionnaire was filled out retrospectively with the attending physician (N=64). Palliative care needs

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Palliative Medicine 32(1S)
were defined based on four different sets of criteria (table 1), since consensus on the definition of palliative care need is lacking.

Results: Depending on the used criteria 8 to 54% of lung and colorectal cancer patients in Dutch hospitals were considered to have palliative care needs. The large variation in palliative care needs can be clarified by the use of broader and narrower criteria. Palliative care needs of patients with lung cancer seem higher (10-61%) than those of patients with colorectal cancer (5-40%). 12% of all patients had (at least once) been seen by a specialized palliative care team in the hospital.

Conclusion: The need for palliative care is high in lung and colorectal cancer patients in the Netherlands. Physicians should be aware of these needs and start proactive palliative care, sometimes with help of a specialist palliative care team.

Funding
This study was funded by the National Health Care Institute of the Netherlands.

Abstract number: P35
Abstract type: Poster presentation

How Do Hospital-based Nurses and Physicians Identify the Start of the Palliative Phase? A Qualitative Study
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Research aims: Prior research has shown that an early start of palliative care improves the quality of life of patients and their relatives. However, patients are not identified timely by health care professionals (HCPs) working in hospitals. This study aims to assess how these HCPs identify the start of the palliative phase and which barriers and facilitators for identification exist.

Study design and methods: Semi structured face-to-face interviews were held with 10 ten nurses and 18 physicians working at the departments of internal medicine, oncology, cardiology, geriatrics and respiratory medicine. The interviews were tape-recorded, transcribed verbatim and analysed using thematic analysis.

Results: The analysis shows that HCPs use a great variation of definitions for the palliative phase. These definitions are based on life expectancy (varying between days and years), the presence of an incurable disease or symptoms that require palliative care. We identified five categories containing factors that could either facilitate or hamper identification. These are patient-, disease-, HCP-, relatives- and organisation related factors. Patient related factors are the quality of life, age and expressed wishes. Disease related facilitators are an increase of care utilization, physical decline and treatment failure. A non-oncological diagnosis forms a barrier. HCP related facilitators are experience and interprofessional consultation. Nurses and junior doctors do not always consider identification their job, which forms a barrier. Patients relatives insistence on continuation of curative treatment, is considered a barrier. On the organisational level, HCPs experience a lack of time to evaluate and speak to patients which hinders identification.

Conclusion: There is a lack of consensus amongst hospital-based HCPs with regards to the definition of the palliative phase. Furthermore, patient-, disease-, HCP-, relatives- and organisation related factors can form barriers for timely identification of the palliative phase. Our study contributes to finding explanations for delayed identification by hospital-based HCPs and provides us with a starting point for further improvement of education.

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Abstract number: P36
Abstract type: Poster presentation

Integrating Palliative Care in Intensive Care: A Systematic Review of Outcomes
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Background: Integration of palliative care (PC) in intensive care (IC) has been researched. However, little is known on the outcomes of such integration.

Aim: To review the literature on integration of PC in IC and identify its outcomes.

Methods: Systematic review, following PRISMA 2009 recommendations. Data sources: electronic databases and manual search of PC and IC journals. Inclusion criteria: articles describing empirical studies on integration of PC in IC, with clear outcomes, in English, Portuguese, Spanish, with full-text and references available. Selection, screening and data extraction from articles were independently done by 3 researchers.

Results: 2781 articles were screened, 43 were included. 17 articles presented outcomes related to end-of-life (EOL) issues or clinical outcomes (CO): hospital/ICU mortality, hospice discharge, number of PC consultation. 1 article only used nonclinical outcomes (NCO): hospital/ICU length of stay and costs. 10 articles showed CO and NCO. In 15 articles, the integration of PC in IC was based on CO or NCO associated with EOL issues, mainly end-of-life decisions (ELDs). Notably, only 1 article used integration of PC in IC as an approach to improve care and decisions at the EOL; outcomes were based on communications skills, quality of dying and symptom control. Most studies fail to present a clear definition of integration. When present, PC integration outcomes emphasize CO, NCO, and/or EOL issues, but fail to provide an overview of a complete and effective integration of the principles and components of PC in IC, including communication skills, patient-focused medical decision-making, clinical care of patient and family.

Conclusions: Evidence on outcomes of integrating PC in IC is limited and heterogeneous and relates mainly to EOL issues and ELDs. More research is needed on integration of PC in IC and its outcomes.

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Abstract number: P37
Abstract type: Poster presentation

Decision-making around Treatment Escalation during Acute Deterioration
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Background: Making and recording decisions about treatment and care in the face of uncertainty surrounding pathophysiological deterioration leading to death in hospital is often problematic and at times contentious. To date focus has been on do not attempt cardiopulmonary resuscitation (DNACPR) orders and advanced care plans as methods to facilitate decision-making at times of crisis. However very little is known about the decision-making processes themselves.

Aim: To describe how decision-making processes interrelate with the sequence of events and resources mobilised, for individuals who die during inpatient admissions.

Methodology and methods: An in-depth retrospective case note review. Data were analysed utilising: care management process mapping via annotated timelines involving key events for each case; and directed content analysis.

Sample: The review built on an initial death certificate review form audit of all patients (n=911) who died in one acute hospital over a six month period (Jan-July 2015). Case notes of a 5% sample of patients (n=45) were obtained. Purposeful stratification was undertaken by: DNACPR, palliative care involvement, intensive care and high dependency management, evidence of escalation/de-escalation discussion/decision, and illness trajectory. The age range of patients was 38-96 years, with 23 female and 22 male. Length of admission ranged from < 24 hours to 97 days.

Findings: Four care management trajectories were identified mapping clinical decision-making processes. These were: early de-escalation due to catastrophic occurrence; treatment with curative intent throughout; treatment with curative intent until a significant point; and early treatment limits set due to pre-admission morbidity.

Conclusion: All trajectories demonstrated: clinical complexity and uncertainty (via multiple co-morbidities, new diagnoses, and challenging management e.g. of sepsis and frailty); impact of multiple clinician involvement (multi-specialty/professional); impact of family involvement (triggering decisions via discussion with teams, most apparent when absent); and the influence of clarity and visibility of management plans. Our data suggests that treatment escalation plans, a method to involve patients and families in escalation planning before crisis situations occur, could add value if used more widely.

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Abstract number: P38
Abstract type: Poster presentation

Communication and Interaction at the End of Life - A Sociological Review of Institutional Palliative Care
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Background: Communication/ interaction with people at the end of life takes place in a field of social tension between the taboo and the revival of death. High competences in communication and interaction are required. Specialists in Palliative Care, whose core competence appears to be communication and interaction with people at the end of life, are especially challenged.

Method: The ethnographic field of a Swiss Cantonal hospital was investigated with Ground Theory Approach (GTM). Interviews with specialists of the Palliative Consulting Service (PCS), related stakeholders (RS) and patients who have had Roundtable Discussions (RT), as well as participant observation (PO) of palliative consultations and RT were conducted. The interviews and participant observations were audiottaped and transcribed, analyzed and synthesized according to the coding paradigm of GTM.

Results: 13 interviews with specialists of PCS, 3 with RS and 9 with patients, as well as 11 POs were carried out. At the beginning of their career, the specialists of the PCS experienced cognitive dissonance in care and treatment of seriously ill and dying patients. This and the interest in border situations were motivators for the start and development of their career in the department of palliative care. In their opinion, support and care for patients is guided by the needs of the patient. Communication and interaction are based on the concepts/ ideals of open communication and equality in interprofessional cooperation and collaboration.
Conclusion: The totality of ideals and the professional practice close to the ideal represent a collective disposition. These forms of practice of the specialists of PCS have the potential to influence interaction in society in terms of death and dying in the long term.

Abstract number: P39
Abstract type: Poster presentation

End-of-Life Medical Decision Making by Austrian Physicians - A Cross-sectional Study
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Background: Austria has recently been embroiled in the complex debate on the legalization of life-limiting measures. Empirical data on end-of-life decisions made by Austrian physicians is lacking. This study aimed to find out what decisions Austrian doctors make in real-life practice.

Methods: The EURELD (European end-of-life decisions) questionnaire was translated and adapted by Schildmann et al., and used to conduct this cross-sectional postal survey. Questions on palliative care training, legal issues and use of and satisfaction with palliative care were added. All Austrian specialists in Hematology and Oncology, a representative sample of doctors specialized in internal medicine, and a sample of general practitioners, were invited to participate.

Results: 548 questionnaires (response rate: 10.4%) were evaluated. 88.3% of participants had treated a patient who had died in the previous 12 months. 23% of respondents had an additional qualification in palliative medicine. The cause of death in 53.1% of patients was cancer. Further treatment, e.g. antibiotic therapy, had been withheld by 60.0% and an existing treatment discontinued by 49.1% of respondents. In 86.3% of cases, pain relief and/or symptom relief had been intensified. In 5 cases, the respondents had prescribed, provided or administered a drug which had resulted in death. 41.4% of respondents had already been asked to perform physician-assisted suicide (PAS). Doctors specialized in Hematology or Oncology were requested to do so significantly more often. 51.3% of physicians said they would never carry out PAS, while 30.3% could imagine doing so under certain conditions. 38.5% of respondents supported the current prohibition of PAS, 23.9% opposed it, and 33.2% were undecided. 52.4% of physicians felt the legal situation with respect to life limiting measures was uncertain. An additional qualification in palliative medicine had no influence on measures taken, or attitudes towards PAS.

Conclusions: The majority of doctors perform symptom control in terminal illness of patients. PAS is frequently requested but rarely carried out. Attending physicians felt the legal situation was uncertain. Physicians should therefore receive legal training in the status of life limiting decisions. The data collected in the survey will help political decision-makers to improve equal access to palliative care in the hospital, it is crucial to further investigate the impact of the identified barriers on palliative care utilization, to address socio-economic factors, and to include the patients' perspectives.

Abstract number: P41
Abstract type: Poster presentation

Factors Influencing Older People’s Emergency Department Attendance in the Last Year of Life: A Systematic Review
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Background: Hospital emergency department (ED) attendance in the last year of life is common and rises with proximity to death. For older people, ED attendances can be distressing and represent a potential marker of poor quality end of life care. Understanding what influences older people’s ED attendance towards the end of life is important for identifying opportunities to improve care, but this evidence has not previously been reviewed.

 Aim: To review the factors associated with ED attendance for older people in the last year of life.

Methods: Systematic review of published and grey literature in five databases from inception to October 2017. We included studies that quantitatively examined one or more factors associated with ED attendance for people aged 65+ years within the last year of life. Data extraction and synthesis were undertaken and published the theoretical model on place of care at the end of life. We assessed study quality using the QualSyst tool and assessed the strength of evidence for each factor, based on its quality, quantity and consistency. We undertook narrative synthesis resulting in the development of a theoretical model of influences on older people’s ED attendance in the last year of life.

 Results: Of 3,824 publications, 21 were included, combining data from four countries and 1,565,187 people. All but four studies were from the United States and most used routinely collected population-based data, with retrospective analysis. We found strong evidence of a higher
likelihood of ED attendance for male gender, non-white ethnicity, and living in a rural area. There was moderate evidence that receiving palliative care, early palliative care, living in a care home, and having a cancer diagnosis reduce likelihood of ED attendance. While palliative care was the most studied factor (n=7), the study quality was variable and definitions wide-ranging.

Conclusions: Palliative care appears to be protective against ED attendance in the last year of life and this has important implications for service development. The strongest evidence are for variables that are routinely collected, such as gender and ethnicity, not necessarily those that are the most important. High quality evidence on interventions that modify ED attendance towards the end of life is required to improve end of life care.

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Abstract number: P42
Abstract type: Poster presentation

Integration of Specialized Palliative Care in the Care of Patients of the Intensive and Intermediate Care Units in German Comprehensive Cancer Centers
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Background/aims: Close cooperation of specialized palliative care (SPC) with intensive/intermediate care medicine (ICU/IMCU) may improve quality of care. Currently it is unknown how SPC is integrated in ICU/IMCU within German Comprehensive Cancer Center (CCC).

Methods: A quantitative descriptive survey was performed among all SPC departments in CCC funded by the German Cancer Aid. The analysis included availability of inpatient SPC and hospital palliative care team (HPCT), incidence of transfer from ICU/IMCU to SPC unit and HPCT consultation, availability of multidisciplinary SPC/ICU rounds and availability of standardized triggers for SPC consultation (frequencies, means, medians and range). For analyzing pre-existing triggers for SPC consultation we offered a free text option.

Results: The survey ran from July till August 2017. 16 questionnaires were distributed and 15 were eligible for analysis (93.75%). All 15 SPC departments offered inpatient SPC treatment (100%). 13 provided a HPCT (86.66%). The median value of patients who were transferred directly from ICU/ICUM to the SPC unit mentioned by 12 sites is 9 per year [range 1-30] in 2016. A HPCT of 11 sites was integrated for 33 patients per site [median; range 0-100]. Two sites (13.3%) offered regular ward rounds of SPC within the ICU. They took place in anaesthesiological/surgical or interdisciplinary ICU. Formal screening tools for integrating SPC on an ICU were established in two sites (13.3%). The most often mentioned triggers were patient’s or relative’s wish, restricting/change in therapy, conversation regarding care after hospital, symptoms or attitudes of physicians. Five participants could not name triggers.

Conclusions: SPC is rarely integrated in ICU/IMCU treatment in CCCs despite of high SPC availability in general. Neither HPCT consultation nor interdisciplinary ward rounds are established regularly. Developing triggers for palliative care consultation on ICU/IMCU may help standardizing cooperation to improve quality of care.

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Abstract number: P43
Abstract type: Poster presentation

End-of-Life care in German Hospitals - An Evaluation of Free-text Answers within the Care of the Dying Evaluation (CODETM)
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Background/aims: Palliative Care aims at improving the quality of life for patients with incurable diseases, accompanying and including their loved ones in care as well. Therefore, it is also important to include aspects of care that loved ones consider as important, in particular at the end of life. This study aimed at identifying aspects of quality of care from the loved ones’ perspective of patients who died at a hospital.

Methods: The German version questionnaire Care of the Dying Evaluation (CODETM) that was validated at two study centers between March 2016 and February 2018 contained options for participants to fill in free text. The analytical process for the free-text answers of the questionnaire was based on Philip Mayring’s approach to the Qualitative Content Analysis. Two scientists coded the material inductively with regard to content-related and formal aspects. After 50% of the material had been coded two scientists did a co-coding and a third scientist performed a consistency check. After a consensus decision about the remarks, the remaining material was coded by the two scientists. A second co-coding and consistency check was done.

Results: Qualitative analysis of 1261 free-text answers showed that some of them refer to dimensions of care inherent in the questionnaire items, but others showed additional aspects of care being relevant to loved ones. Negative or positive ratings of dimensions of care that loved ones revealed in their free-texts were included in the results. More in-depth information on how loved ones understood the dimensions of the questionnaire and what experiences they have made with end-of-life care in hospitals were deduced. These experiences may depend on the unit where the patient died. As additional aspects loved ones expressed further dimensions, which referred to visiting times, the transfer of the patient between hospital units and more detailed information about the involvement in decisions at the end of life.

Conclusions: This study shows details on the dimensions of care loved ones experienced while they accompanied the patient who died at the hospital. Loved ones described different aspects of end-of-life care depending on different units in hospitals and aspects of their own accompaniment. It is important to include these aspects in end-of-life care concepts at hospitals for improving the quality of care in the last phase of life.

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Abstract number: P44
Abstract type: Poster presentation

Diagnosis and Symptom Relief in Relation to Place of Death: A Nationwide Study

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Aims: Our primary aim was to study if diagnosis was associated with place of death. Secondary aims were to investigate if occurrence of symptoms, and how successfully they were relieved during end of life care, were associated with place of death.

Background: The Swedish Register of Palliative Care (SRPC) is a national quality register collecting data on quality of care during the last week in life irrespective of diagnosis, age and care setting. The SRPC includes approximately 60% of all deaths in Sweden, and 90% of deaths due to cancer disease.

Methods: During 2012-2015, 159,483 persons who died an expected due to cancer disease.

Results: Preliminary results show that approximately 40% of those with cancer or motor neuron disease had access to specialist palliative care during end of life, while only 3% and 5%, respectively, of those with cardiovascular or pulmonary disease received specialist palliative care at the end of life.

Conclusion: Patients with the diagnoses cancer or cardiovascular disease who suffered from dyspnea were more likely to die at home than within specialised palliative home care. However, for patients with pulmonary disease the symptom dyspnea was as common at home as in hospitals.

Abstract number: P46
Abstract type: Poster presentation

Presence of Life-limiting Condition Does Not Limit Statin Use in the Last Year of Life: A Retrospective Observational Study

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Background: For individuals with life-limiting condition (LLC) and less than one year to live, discontinuing statins is not harmful and may have benefits. However, the extent of statin use at the end of life is poorly understood. Whether statin prescribing may already be influenced by the presence of a LLC is unclear.

Aims: The aims of this study are to describe the prevalence of statin use on terminal hospital admission in patients without recent myocardial infarction and/or stroke, and to investigate whether statin discontinuation is associated with the presence of a LLC.

Methods: Patients who died under the General Medicine teams in a tertiary hospital were included in the study. Patients who did not receive any terminal admission.

Results: From 364 patients who died in the hospital, 148 patients (41%) received statins in the last year of life and did not have recent myocardial infarction or stroke. Of those, 30 patients (20%) were identified with a LLC. Statins were frequently continued in the last year of life; 120 out of 148 patients (81%) were still receiving statin at the time of terminal admission. Proportion of statin discontinuation were comparable between patients with LLC and patients without LLC (27% vs. 17%; p=0.22). Presence of LLC did not seem to prompt discontinuation of statin.

Conclusion: Our findings shed some light on the current pattern of statin use at the end of life. The results highlight a missed opportunity to reduce the burden of medical therapy in terminally ill patients. Future
works can focus on developing a deprescribing protocol for statins for use in hospitals.

Abstract number: P47
Abstract type: Poster presentation

The Social Construction of Palliative Patients: Discourse Analysis of the Transition From Curative to Palliative Care in Medical Discourse

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Background/aims: The early integration of palliative care is effective to improve or maintain the quality of life throughout the illness trajectory, but palliative care is often initiated too late. For this reason, the identification of patients with palliative needs is an important challenge in palliative care. Although there are several hints regarding social aspects and influences, the transition from curative to palliative treatment has not been systematically investigated as a social process. This study explores how palliative patients are socially constructed in medical discourse.

Methods: The research project uses a mixed-methods approach with discourse analysis, participatory observation and interview study. In this study results from discourse analysis of teaching material, guidelines, and other documents related to the transition from curative to palliative treatment in German medical discourse will be presented.

Results: The discursive construction of palliative patients in the analysed literature is a complex interplay of medical indication and patients’ decision. The transition from curative to palliative care is described as a social process, which is characterized by interpretations, negotiations and social practices among several players (physicians, nurses, patients, relatives, etc.). Moreover, some important conditions must be met (consent between treating physicians, patients’ agreement, etc.) and different stages have to be passed (tumour board meeting, doctor-patient-conversations, therapy, etc.). Physicians’ diagnosis and patients’ will play a prominent role but medical knowledge, communication skills, and organisational structures are also highly important.

Conclusions: Integration of palliative care in patients’ illness trajectories is highly depending on social processes and decisions at all stages and between participating players. Even if medical knowledge and indications as well as patients’ will are important factors, transition from curative to palliative treatment is also depending on social skills, social processes, and social actions.

Abstract number: P48
Abstract type: Poster presentation

Transitions in Palliative Care

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Background and aims: In the last decade there has been a substantial increase of in- and outpatient, general and specialist palliative care (PC) services in Germany. This, and the introduction of new types of hospice and PC services has led to growing competition between services, resulting in communication and coordination problems at the transitions between care settings and healthcare sectors. Good transitions are crucial to provide information flow and continuity, and maintain patients’ trust in the healthcare professionals (HCPs) involved. This study aims to map multiple transitions of PC via analyses of patient records and views of HCPs and their corresponding networks by comparing two different hospital settings in western and southern Germany: one with an integrated palliative care model (M1) and one with a cooperative palliative care setting (M2).

Study design and methods: A systematic comparison with a mixed-method design (documentary analysis of patient records and expert interviews) between two contrasting settings, where all other factors were similar (e.g. hospital size and specialization, patient numbers, demographics, and urban infrastructure). First, by a documentary research 1000 patient records of 2016 at each study site were entered into SPSS and analysed with descriptive statistics. In addition expert interviews (10 different HCPs) with a multi-perspective approach as a key to an in-depth description of transitions and pathways and exploration of challenges and advantages in both settings were used.

Results: M1: 55% of the transitions were from another department of the hospital, M2: 75%. At both study sides in-house transitions were filtered by a palliative consultation team. Close to 50% of patients died at the unit, while the others had different pathways in the course of their disease trajectory (discharge home, transfer to inpatient hospice etc.). Transitions were dependent on the organisation of services, cost coverage, cooperation and networking.

Conclusions: The selection of these two typical settings in Germany facilitated a validation of the results for the divergent organisational and institutional models of PC. Thus regional differences in the structures of hospice and palliative care influenced not only the care pathways and transitions but also modalities of remunerations.

Funding

The project is funded by the Federal Ministry of Education and Research.

Abstract number: P49
Abstract type: Poster presentation

Treatment Escalation Planning for Elderly Patients; Improvement Following the Introduction of a Trust Treatment Escalation Plan Document and Training Programme

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Background: Hospital patients with a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form without a documented Treatment Escalation Plan (TEP) may receive substandard or inappropriate treatment. Clear, recorded decisions regarding CPR status and treatment escalation for any person at risk of deterioration or approaching the end of life are vital for the provision of good quality care. In 2011, only 23% of patients over 70 under the care of Acute or Elderly Medicine in our hospital had a documented TEP. In 2015 the Trust introduced a TEP form and a Trust-wide Quality Improvement and education programme to improve recognition and care of patients at risk of deterioration including those in the last year of life.

Aim: To determine whether documentation of treatment escalation decisions has improved following the introduction of a TEP document and training, and identify related issues regarding the decision making and recording process.

Methods: A retrospective audit was conducted to review the quality of DNACPR and TEP documentation for patients who died or were discharged under the care of Elderly Medicine. Data were extracted to determine whether capacity was assessed, TEPs were discussed and documented, and whether decisions were recorded on a TEP form or within the clinical notes.
A Critical Realist Evaluation of a Music Therapy Intervention in Palliative Care

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Abstract number: P50
Abstract type: Poster presentation

A Critical Realist Evaluation of a Music Therapy Intervention in Palliative Care

Results: The notes of 50 patients over a 7 month period were reviewed. All patients had a CPR decision recorded. 48/50 (96%) had a documented TEP; 32/50 (64%) had a Trust TEP form and a further 16/50 (32%) had a plan documented in the clinical notes. Clear documentation of specific interventions that would or would not be indicated in the event of clinical deterioration was present on 18/32 (56%) of TEP forms, and 3/16 (19%) of plans recorded in the clinical notes. 27/50 (54%) of patients did not appear to have capacity to participate in treatment decisions, although a capacity assessment was only documented for 9/27 (33%) patients.

Conclusions: Recording of treatment escalation decisions for elderly patients has significantly improved following the introduction of a TEP form and supporting training. Clinicians are more likely to record the specific interventions that would or not be indicated in the event of deterioration if a TEP form is used. Capacity assessment is poorly documented and requires improvement. It may be helpful to include capacity assessment on TEP forms, as on DNACPR forms, to improve documentation.

Aims of the study: A prospective, observational study was conducted in our palliative care unit (PCU) to assess impact of peripherally inserted central catheter (PICC), midline, and “short” midline catheters on the quality of care in cancer and non-cancer patients. The secondary objectives were to assess pain and distress during the vascular access devices (VADs) insertion; to describe data on medical indication for VADs, patients’ performance status and prognosis at VAD insertion time, catheter duration and complications.

Methods: Ninety patients were enrolled in the study. They were recruited if they underwent insertion of a PICC, midline, or “short” midline catheter as part of their standard care. The Palliative care Outcome Scale (POS) was used to assess changes in quality of care after VAD positioning. POS was administered to patients and to case manager nurses before VAD insertion and three days after. A numerical rating scale (NRS) was used to measure pain intensity and pain distress during catheter insertion. The Palliative Prognostic (PaP) Score was used to assess patient’s performance status and survival prediction when selecting the VAD to be inserted. Immediate and delayed complications were registered until the VAD removal.

Results: Of the 90 patients enrolled, 52.2% were male with a mean age of 73.0 ± 13 years. 64.4% patients underwent “short” midline insertion, 26.6% PICC and 8.8% midline catheter. The patients’ mean baseline POS score was 15.7 ± 5.6. Three days after VAD positioning, the patients’ POS score was 11.5 ± 5.5 (P < 0.0001). Also the nurse’s POS score decreased significantly (P < 0.0001). POS showed a statistically significant improvement for pain and other symptom relief (P < 0.0001) in the patient and in the nurse version. Mean pain intensity during VAD insertion was 1.26 ± 1.63, and mean pain distress was 1.78 ± 1.93. The only catheter complication was peripheral phlebitis that occurred in 8.6% patients with a “short” midline catheter.

Conclusion: The insertion of a VAD in cancer and non-cancer patients receiving palliative care resulted in a favorable impact on quality of care. Results concerning the insertion procedure tolerability were encouraging because pain and distress during catheter insertion were very mild. The recent “short” midline catheters might be a reliable alternative for patients with palliative care needs. Appropriateness of VADs use in palliative care should be further studied.

“They Need to Realise the Impact it Has on the Patient.”

Living with Constipation: The Views of Palliative Care Patients and Carers

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Constipation is a leading symptom among palliative care patients and can cause physical, psychological, and social suffering. However, there is a dearth of research exploring the perspectives of specialist palliative care (SPC) patients and their carers who are living with constipation. This study aims to explore the patient and family experience of the assessment and management of constipation when using SPC services. Qualitative, semi-structured interviews were conducted with thirteen patients who were diagnosed with constipation, and five family carers, from one SPC unit in the United Kingdom. Data was analysed using thematic analysis.
Constipation impacted participants physically, socially and psychologically. Symptoms included, severe pain, embarrassment and restrictive lifestyle. Prior to entering SPC unit patients and caregivers had private control of the management of constipation however upon admission to hospice this control was made public and transferred to SPC staff remit. Yet unless initiated by the patient the symptom was rarely discussed by staff. Inconsistencies are evident in the experience of assessment and management of constipation within a single SPC unit. It was a long-enduring and distressing symptom for patients and families, therefore, should not be given a secondary symptom status by staff. Educating staff in communicating with patients about the symptom, and including the family in decision making, may help address the anxiety experienced by patients and their carers. Involvement of the wider multi-disciplinary team was linked with more positive experiences of constipation assessment and management.

**Abstract number: PS3**  
**Abstract type: Poster presentation**  
**The Prevalence of Burnout in Health Care Professionals Working in Palliative Care Setting: A Systematic Review**  
Parola, Vitor1,2, Coelho, Adriana1,2, Cardoso, Daniela1, Sandgren, Anna1,4, Apóstolo, João1  
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**Background:** The multiple challenges of working in palliative care put the health professionals in this context at risk of burnout.  
**Aim:** To understand how doctors at each hospice spent their working days.  
**Population:** A major end-of-life charity provides both community nursing and inpatient hospice services, UK-wide. Consultant and staff grade physicians working for one of nine charity-funded hospices were included, including long-term locums, multiple-site and flexible workers.  
**Methods:** A previous charity-wide internal staffing evaluation found hospice medical staffing levels varied significantly. It was noted each hospice worked differently and offered services based on local needs.  
**Aims:** To understand how doctors at each hospice spent their working days.  
**Background:** Demands upon hospice doctors’ time are extensive and varied. Little is known about how much time hospice doctors spend doing clinical work (versus other administrative or clinical governance-related tasks).

**Results:** Eight cross-sectional studies, met the inclusion criteria, with a total of 1406 health professionals. The sample was limited to nurses, physicians and social workers. None of the included articles presented data about other health professionals. Data revealed a prevalence of burnout among health care professionals of 17.3%. Personal Accomplishment was the subscale from the Maslach Burnout Inventory that had the highest prevalence (19.5%). Nurses had higher levels of Emotional Exhaustion (19.5%) and Depersonalization (8.2%) and physicians had lower levels of Personal Accomplishment (41.2%). The prevalence of burnout was, however, higher in social workers (27%). The palliative care context with the highest prevalence of burnout was home care (19.6%).

**Conclusion:** This systematic review highlight the prevalence of burnout in health care professionals, which staff category are the most affected group, and which palliative care context has the highest prevalence. Managers and health care professionals should be aware of the prevalence of burnout in Palliative Care, be able to recognize it and be prepared to respond to it at the individual level as well as at the service and system level.

**Abstract number: P54**  
**Abstract type: Poster presentation**  
**How British Hospice Doctors Spend their Time: A National Charity’s Workforce Analysis**  
Curie, Michelle1,2, Noble, Bill1,3  
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**Background:** Demands upon hospice doctors’ time are extensive and varied. Little is known about how much time hospice doctors spend doing clinical work (versus other administrative or clinical governance-related tasks).

**Methods:** A previous charity-wide internal staffing evaluation found hospice medical staffing levels varied significantly. It was noted each hospice worked differently and offered services based on local needs. On-call duty data was collected and analysed separately. Analysis was performed in Microsoft Excel.

**Results:** Activity logs from 21 staff grade doctors and 29 consultants were collected over all nine hospices, including 11 doctors with medical director duties. Participation rate was 94%.

**Key overall activity figures are shown below, including figures from individual hospices with the most and least activity per category:**

<table>
<thead>
<tr>
<th>Activity category</th>
<th>Overall % of total consultant time (min - max %)</th>
<th>Overall % of total staff grade doctor time (min - max %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient unit patient care</td>
<td>30% (16-46%)</td>
<td>45% (38-71%)</td>
</tr>
<tr>
<td>Day services or outpatient care</td>
<td>6% (0-21%)</td>
<td>9% (0-19%)</td>
</tr>
<tr>
<td>Domiciliary patient care</td>
<td>3% (0-7%)</td>
<td>2% (0-8%)</td>
</tr>
<tr>
<td>Other clinical duties</td>
<td>6% (0-16%)</td>
<td>3% (0-9%)</td>
</tr>
<tr>
<td>Clinical administration</td>
<td>10% (5-22%)</td>
<td>25% (6-27%)</td>
</tr>
<tr>
<td>Non-clinical administration</td>
<td>3% (0-13%)</td>
<td>0.2% (0-4%)</td>
</tr>
<tr>
<td>Education or professional supervision</td>
<td>12% (4-17%)</td>
<td>4% (0-11%)</td>
</tr>
<tr>
<td>Management activity or team meetings</td>
<td>17% (10-26%)</td>
<td>3% (1-5%)</td>
</tr>
<tr>
<td>Audit, clinical governance or service development</td>
<td>9% (2-21%)</td>
<td>4% (0-11%)</td>
</tr>
</tbody>
</table>

[Key overall activity figures]
Conclusions: Hospice doctors' work is diverse (especially amongst consultants) and varies extensively between units. Services offered (e.g. community care or outpatient service) and availability of other professionals (e.g. administrative or research support) can affect this significantly.

Abstract number: P55
Abstract type: Poster presentation

Burnout in Palliative Care Contexts Compared to Other Contexts: A Systematic Review

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Background: The multiple challenges of working in palliative care can lead the health professionals to physical, psychological, emotional, and moral distress as well as work-related stress, all of which in turn can increase the risk of burnout.

Aim: To examine the effect of working in palliative care contexts, compared to other contexts, on burnout among health care professionals.

Methods: A systematic review, using the guideline of the Joanna Briggs Institute, was conducted. Multiple databases were searched CINAHL, PubMed, Scopus, and SciELO as well as grey literature for studies published since 1975 that compared health care professionals caring for patients over 18 years of age in specialized palliative care contexts (palliative care units, home care or hospices) with health care professionals working in other contexts.

Results: Of the 539 studies retrieved, seven cross-sectional studies were included in this review. Of these, six were conducted with nurses and six used the Maslach Burnout Inventory. Working in palliative care (palliative care unit or hospices) was associated with lower levels of emotional exhaustion and depersonalization, as well as higher levels of personal accomplishment, compared to working in other settings (medical cancer center; oncology; internal medicine; haematology; maternity; critical care; hospital units; medical oncology units).

Conclusion: Evidence indicates that burnout levels appear to be lower among health care professionals working in palliative care compared to professionals working in other settings. Further research is needed to explore the strategies used by nurses working in palliative care that help them deal with burnout, and to apply these same strategies to professionals working in other settings. It is in particular important to acknowledge the role of teamwork in the provision of palliative care and how burnout in one of the professional groups in this team influences burnout among the other groups.

Abstract number: P56
Abstract type: Poster presentation

Validation of a Comfort Assessment Scale for Palliative Care Patients: Spanish Version of the Hospice Comfort Questionnaire

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Background: As the comfort of patients and relatives is mandated in palliative care, measurements to determine whether enhanced comfort has been achieved are vital.

Aim: To translate, adapt and validate the Hospice Comfort Questionnaire for use in the setting of palliative care in Spain.

Methods: A total of 67 patients admitted in the Palliative Care Unit have participated in this study. A methodology for the semantic, idiomatic and conceptual equivalence of items’ content and psychometric equivalence by assessing the reliability, validity and content approach was adopted.

Results: Regarding reliability, results inconsistent with the rest of the scale were observed in 7 items, with a correlation of less than 0.20. Taking into account the statistical data and critical content analysis of the items, it was decided to eliminate just 3 items. Once the scale was reduced to 46 items, the internal consistency of the total scale was measured with a Cronbach’s α of 0.89 and each group of items in each comfort state. Cronbach’s alpha of relief was 0.72, ease 0.73 and transcendence 0.75. Criteria validity was found through the Spearman correlation coefficient, obtaining a correlation of 0.805 between the Spanish version of the Hospice Comfort Questionnaire and the Visual Analog Scale of Comfort.

Conclusion: The results show that the Hospice Comfort Questionnaire (Spanish version) is an instrument for evaluating comfort in Palliative Care with psychometric quality assurance (good reliability and validity). Spanish adaptation of Hospice Comfort Questionnaire provides access to a tool that permits professionals to develop more suitable care plan for comfort needs of patients admitted to palliative care units.

Abstract number: P57
Abstract type: Poster presentation

Who Responds to Specialized Palliative Cancer Care at Home? - Exploratory Analyses of the Domus Randomized Controlled Trial

Benthien Kirstine1, Nordly Mie2, Berglund von Heymann-Horan Annika1, Timm Helle1, Karita Geazh2, Johansen Christoffer1, Kjellberg Jakob1, von der Maase Hans2, Sjøgren Per2
1Metropolitan University College, Copenhagen, Denmark, 2Department of Oncology, Rigshospitalet, Copenhagen University Hospital, Copenhagen, Denmark, 3The Danish Cancer Society, Copenhagen, Denmark, 4REHPA – Danish Knowledge Centre for Rehabilitation and Palliative Care, Copenhagen, Denmark, 5The Danish Institute for Local and Regional Research, Copenhagen, Denmark

Aims: Patients with high symptom burden are the focus of specialized palliative care (SPC), but they are rarely the target group in controlled trials of SPC. The purposes of this study were to explore 1. Which factors were associated with patients’ response to the Domus trial intervention and 2. Whether hospital- or hospice-based specialized palliative home care teams (SPT) had different impact on patient outcomes.

Design and methods: This study was a post-hoc exploratory response analysis of the Domus randomized controlled trial. Participants were patients with incurable cancer and the intervention was provided by SPTs enriched with a psychological intervention. Patients’ response to the intervention was analyzed with stepwise multivariate logistic and linear regression of interaction between patient characteristic variables and intervention on the outcomes place of care and death, hospitalizations, patients’ quality of life, emotional and social functioning (EORTC QLQ-C30) and symptom distress (ESAS-r).

Results: This study was based on 322 patients. Symptom distress at baseline did not interact with intervention response on any outcomes. Women in the control group and hospice SPT were less likely to die at home than men, but gender interacted with the hospital SPT, which led to an equal number of home deaths for men and women. Having children(ren) at home interacted with the hospice SPT, meaning that this group was more often hospitalized. Symptom distress was lower in the hospice SPT by 21 points and symptom distress in the hospital SPT group was not significantly different from to the control group.
Conclusion: Symptom distress did not determine intervention response. Women responded favorably to the hospital SPT by achieving more home deaths and patients with child(ren) in the hospice SPT group were more often hospitalized. The hospice SPT was superior to the hospital SPT in reducing symptom distress. The causes of different outcomes for the SPTs should be investigated further.

Abstract number: PS8
Abstract type: Poster presentation
Challenges in Assessing the Need for Beds in Palliative Care - The Example of Inpatient Hospice Care for Children, Adolescents and Young Adults
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Background: Inpatient hospice care (IHC) for adults in Germany is used in the last weeks of life. Children, adolescents and young adults (ACA) with life-limiting diseases are entitled to 28 days/year of IHC during their lifetime. We explored various data to assess the need for IHC for ACA in North Rhine-Westphalia (NRW; 17.6 million inhabitants).

Methods: Quantitative: All local hospices (n=5; 52 beds) and the single palliative care unit (PCU) for ACA were asked to contribute data on service provision, e.g. patient numbers and characteristics, occupation rate (OcR), length of stay. All local specialist palliative home care teams (n=6) (SAPV) for ACA were asked to estimate the percentage of ACA for whom they arranged IHC and in which timely manner (6-point Likert scale). Qualitative semi-structured interviews (hospices; SAPV; PCU) covering aspects such as access, barriers to access, needs coverage, impact of newly implemented SAPV on need, unmet demand for other services, funding policies and networking.

Further data (reference year 2015):

a) mortality statistics - % of all ACA in NRW dying from cancer (< 20 years)/non-cancer diseases according to the 4 ACT disease groups (< 25 years);

b) prevalence estimates.

Results: The 4 responding hospices had cared for 81-127 patients; average stay: 8-10 days, OcR: 60-90%. Cancer accounted for 1-20% of admissions, severe multi-handicapped ACA were 29-80%, 0-15% had no clear diagnosis. Hospices, SAPV and PCU teams saw no need for further hospice beds for ACA in NRW. They reported a lack of short and long-term care facilities for ACA in need of intensive medical care (and/or invasive ventilation) as well as of ambulatory psychosocial care and care management. Of the 1383 deaths (0-24 years) 47.1% were >1 year old, 62.3% of those < 20 years and 33.4% of those from 20-24 years had diseases according to the ACT groups and were probably in need of IHC. Different calculation models for prevalence will be discussed.

Conclusion: Estimating the need for hospice beds for ACA remains difficult for various reasons:

a) lack of valid prevalence statistics of relevant diseases,
b) mortality statistics underestimate palliative care need,
c) data protection regulations prohibit data exchange between hospices,
d) local data do not capture the fact that residents from all German States are entitled to use IHC in NRW, and
e) therefore an estimation would have to triangulate data from all relevant services for ACA across Germany.
Method: The study protocol has been discussed with the multidisciplinary teams of the hospices. The focus of this discussion was on how to properly conduct the study while simultaneously providing ‘normal’ high quality care. It was agreed that the doctor determines in the regular interview at admission if the patient meets the inclusion criteria of the study: age >18 years, life expectancy >3 days, no cognitive impairment on admission. If so, the patient is informed about the study and receives written information. After about two days, the patient and his relatives are asked if they have any additional questions and if the patient is willing to participate and to sign the informed consent form. The actual study starts when the care team acknowledges that the dying phase has started, the patient is not treated with systemic anticholinergics/octreotide and no death rattle is present. The study protocol has been implemented at all locations after a training for the entire care team.

Results: In the first five months 141 patients were admitted to the participating hospice facilities. 98 patients met the inclusion criteria; 18 patients were confused at the time of their admission, 12 had a life expectancy of less than three days and 14 used an anticholinergic drug. 38 patients agreed to participate in the study, whereas 57 declined for various reasons, including fear of side effects of the medication. No patient indicated that the question to participate was experienced as inappropriate. 24 patients have completed the study.

Conclusion: Patients who are admitted to a hospice facility are open towards participation in medication research. Concerns about side effects are common and should not be wandered away. With careful planning, proper integration of the protocol in the daily work procedures and training of the care teams, clinical trials to improve care in the dying phase seem possible.

Abstract number: P61
Abstract type: Poster presentation

Resilience, Palliative Palette and Burnout in Palliative Care Nurses: On the Rocker between Bearing Strenght and Bearing Load
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Objective: Within healthcare, burnout is an important problem that has harmful consequences for healthcare providers, organisations and the quality of care. Prevalence rates of burnout among nurses in Belgium range from 6.9 to 25%. Stress as such is inherent in caring for the sick. Research shows that, although they are exposed to numerous stressors, palliative care nurses show less burnout. A possible explanation for this could be resilience. Previous research has shown that there is a negative correlation between resilience and burnout. Yet there are also resilient people who still develop a burnout. An unhealthy palliative palette could play a role in this. As palliative care nurses show less burnout, the questions arise as to whether they are more resilient than the average person and whether they have a healthier palliative palette. In addition, this study addressed the question whether a correlation could be found between resilience, palliative palette and burnout.

Method: A cross-sectional, multicentric study was conducted with 118 nurses of 7 palliative care units in Antwerp (Belgium). Data were collected using Veerkracht + scale, Portzky’s Palliative Palette scale, Oldenburg Burnout Inventory and a sociodemographic attributes survey. Data were evaluated by means of percentage ratios, mean and median values, Kruskal-Wallis test, Mann-Whitney U test, correlation analysis, z-test and simple and multiple linear regression analysis.

Results: Palliative care nurses were significantly more resilient and showed a healthier palliative palette than the general population. There was a negative correlation between resilience and burn-out. Nevertheless, 16% of the nurses in palliative care units were exhausted and 7.4% scored high on the subdimension cynicism. 17% of the nurses surveyed scored high for both dimensions and struggled with burnout. 23% of the variance in burnout scores could be explained by resilience. Palliative palette had no explanatory value regarding burnout.

Conclusions: Nurses in palliative care are more resilient than their average fellow human beings and they have a healthier palliative palette. Despite the negative link between resilience and burnout, the prevalence of burnout is 17% en 23.4% is at risk. Palliative palette offered no explanation for this. Future research is needed to determine which factors are responsible for the high burnout rate in order to be able to develop prevention programs.

Abstract number: P62
Abstract type: Poster presentation

Characterisation of Opioid Incidents in Australian Palliative Care Services: An Analysis of Reported Medication Incidents
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Introduction: Opioids are a high-risk medicine frequently used in palliative care services to manage complex pain. This population is at greater risk of harm from medication errors due to their increased age, comorbidities, polypharmacy, and advanced illness. Despite the high volume of opioid use in palliative care services, and the potential for patient harm, few studies have reported medication incidents with opioids, and patient impact, in this vulnerable population.

Aim: To quantify:

i) the number of incidents involving opioids reported via specialist palliative care services’ incident management systems over two years;  
ii) trends in reported opioid incident frequency and incident characteristics; 
iii) the impact of opioid incidents on palliative patient outcomes.

Methods: A retrospective review of reported incidents with opioids undertaken at three specialist palliative care services in NSW, Australia, over two years.

Results: A total of 85 opioid incidents were reported in the review period, representing an incidence of 3.7 reported opioid incidents per 1000 occupied bed days. Three-quarters of incidents (79%, n=67) were linked with patients, of which 70% reached the patient. The remaining incidents reported controlled drug discrepancies. Almost half of all incidents (49%) related to opioid administration, one third of which were omitted doses. Discrepancies in accountable medications (21%) and prescribing incidents (9%) were the next most frequently reported. Patients were more likely to receive an opioid under-dose as a result of an incident (53%) than an over-dose. For 42% of patients clinical intervention was required following an opioid incident to preclude (15%) or manage (27%) patient harm as a direct result of an opioid incident.

Conclusions: Minimising opioid incidents in palliative care services is an important, and largely underexplored, patient safety priority. This study has provided some insights into the characteristics of opioid incidents that occur in palliative care services. Given the number of opioid incidents that reach the patient, and the adverse patient impact, identifying and addressing the factors that contribute to opioid incidents, and reducing the patient impact of these errors, are areas that warrant further investigation.

Abstract number: P63
Abstract type: Poster presentation

Outpatient Palliative Care Operating as “Day Hospice”
Background/aims: Palliative Care Day Services have been developed to support people with life-limiting illness who live in their own home. Patients usually attend weekly, to receive a mix of clinical care and social services. Despite their popularity, the content and duration are very poorly defined. In order to provide in-depth knowledge of day services we set out to map services at three Hospice sites in England, Scotland and Northern Ireland.

Methods: We: reviewed the records of a 25% random stratified sample of new patients attending in 2015, providing evidence on the content of care; undertook focus groups with staff, focusing on their knowledge and experience of providing Day Services.

Results: The three services are characterised by:

- wide-ranging care that spans physical, psychological, emotional and social domains;
- care for both patients and their informal carers;
- the development of patient-patient and patient-professional therapeutic relationships;
- extremely proactive care, based on regular assessment and follow-up;
- being able to respond to a majority of identified needs ‘in-house’;
- where such response is unavailable, ensuring onward referral and follow-up;
- extensive liaison with other health and social care providers.

Conclusion: Findings contribute to the limited evidence base on the organisation and content of day services. They highlight how these services are firmly rooted in, but extend beyond, their immediate context to promote holistic, patient-centred care.

Abstract number: P64

Abstract type: Poster presentation

The DED-C Scale: Scale for Detection Emotional Distress of Caregivers

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Introduction: Our hospital is a central institution in our region that provides services in the field of cancer care: prevention, early detection, diagnostics, treatment, rehabilitation, research, education and palliative care. The Department of Acute Palliative Care (DAPC) was established in March 2007.

Methods: We collected data retrospectively from 2007 - 2016. We have evaluated all services of DAPC: inpatient, outpatient, consultation service.

Results: During ten years period there were 2040 admissions at DAPC. Our DAPC has 6 beds, the average annual number of hospitalized patients (pts) was 204, but it was constantly rising, so that in 2016 we recorded 290 admissions. The average length of stay was 7.4 days, in 2016 it was the shortest 6.5 days. Pts were released from DAPC to home care in approximately 50%. The proportion of these pts has been stable over ten years. Approximately one-third of patients have died at DAPC. The proportions of a dying pts at DAPC have been fluctuating between 27% (2014) to 46% (2007 -2011). The rest of the pts were transferred either in the homes for elderly or in the hospice.

The Early Palliative Care Outpatient Clinic (EPCOC) is operating since 2013. The numbers of pts visit at EPCOC have more than doubled since its beginnings, from 104 to 244 per year. Still, a third of the patients
ordered for a visit at EPCOC did not come to first check-up due to late referral. The vast majority of patients were seen at EPCOC only once, only less than 10% had 2 or more visits.

Consultation service that exists since 2012 completed 669 consultations. Number of requests for consultation at Department for medical oncology is gradually decreasing (from 58% to 37%), but it increases in the Department for radiotherapy (from 29% to 43%) and the Department for surgery (from 13% to 20%) during 10 years period we have observed that time of palliative care referral (in days before death) increased in triads. It was 42 days between 2007-2009, 51 days between 2010-2012 and 61 days in the period 2013-2015.

Conclusion: In ten years of DAPC activities, we are observing an increase in the number of pts involved in palliative care and their number of days involved in palliative care. The positive impact of palliative care at our institution is more and more recognized among medical professionals, still there is a lack of support at political level.

Abstract number: P66
Abstract type: Poster presentation

Indirect Measure of Emotional Distress of Caregivers: The External Signs

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10 Permanent Seminar on Research and Scientific Communication, Gimbernat Nursing School, Sant Cugat, Spain

Background: Little attention has been paid to external signs of emotional distress (ED) of the primary caregiver in Palliative Care. The overall assessment of ED should take into consideration these aspects.

Aims: Analyze the utility of assessment of external signs of emotional distress (ESED) in caregivers of patients.

Methods: 138 primary caregivers (PC) of advanced cancer patients admitted to different PCU participated in this study. The PC answered the scale Detection of Emotional Distress of Caregivers and also demographics variables.

Results: Mean age of PC were 59.69 (SD=13.3). There was a positive correlation between external signs of emotional distress (ESED) and emotional distress (r= .566; p< .001). Caregivers who present ED showed more ESED than those no (X²=12.57; p< .001). Of these, showed statically significant difference in “Visible signs of sadness, fear, crying, overflow” (13.76; p< .001); “Difficulty of separating the patient: family refuses to let the patient make decisions and insists care” (X²=6.22; p< .05) and “Visible signs of anger, irritability or frequent disagreement with therapeutic measure” (X²=4.52; p< .05).

Conclusions/discussion: The primary caregivers who presented ED showed specific external signs of emotional distress easily identifiable by professional and can help them to complement their global assessment of caregivers’ wellbeing. These signs are clues particularly in those caregivers who do not express openly their feelings or the communication is difficult.

Our results justify the systematic assessment of these external signs of emotional suffering in the global assessment of the primary caregivers.

Funding
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Abstract number: P67
Abstract type: Poster presentation

Prophylactic Anticoagulation at the End-of-Life, Analysis of Local Practice

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Background and aims: Prophylactic anticoagulation (PAC) at the end-of-life (EOL) is still a controversial issue. There is not only a lack of incidence data on venous thromboembolic events (VTE) at EOL but there is even less information whether VTEs cause disturbing symptoms to the dying. There are some expert recommendations but they are based on patients with metastatic cancer but not in their final weeks of life. No recommendations exist on patients with non oncological terminal diseases. This question needs clearly to be answered with randomized controlled studies. But beforehand, we decided to undertake an audit of the practice in our palliative care unit which has about 400 admissions a year.

Method: Retrospective audit of all admissions within the time period of 01.01.2016 to 30.06.2016. All patients who died in our PCU were included. Extraction of data on anticoagulation, symptoms in relation to VTE (unilateral limb pain, erythema or swollen limb, dyspnoea or hemothysis), as well as bleeding events. Presence of VTE or bleeding at autopsy. Statistical analysis is descriptive. Chi-Square test was used for correlation between PAC or therapeutic anticoagulation (TAC) at EOL and bleeding events or VTE.

Results: Analysis of the first 100 files: Mean age 76yrs (SD 11). Mean length of stay 17.35days (SD 18.3). 50% male. 83% with cancer (lung 22%, colon 14%, other digestive 21%, miscellaneous 28%). 27%, respectively 22% with a history, respectively ongoing VTE. 23% had a recent major bleeding event. 17% received PAC, 20% TAC and 63% no anticoagulation on admission day. Anticoagulation was stopped at average 7.67 days before death (SD 9.9), but 9 received PAC and 6 TAC within 24h of death. In 9 patients acute bleeding events were observed before death and suspected in 3 patients. In 4 patients a VTE was suspected close to death. There was no correlation between TAC or PAC within 24h of death and bleeding events (p=0.204) and absence of TAC or PAC and VTE suspicion (p=1).

Conclusion: Although the majority of patients didn’t receive anticoagulation during their stay at the PCU, only a few developed clinically suspected VTEs. However in 12 patients bleeding events were observed, respectively suspected close to death, but not statistically significantly related to maintained PAC or TAC until death. The question about utility of PAC at EOL needs further investigations.

Abstract number: P68
Abstract type: Poster presentation

Identifying Who Dying Inpatients Believe Are Most in Need of Bereavement Follow-up: Semi-structured Interview Findings

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Introduction: Bereavement support is an integral element of palliative care which is provided prior to and after the patient’s death. While specialist palliative care services potentially provide some of the most comprehensive bereavement support services, there is emerging evidence that bereavement support ought to be reserved for those most in need. Identifying those at risk of experiencing a complex bereavement response is critical as bereavement interventions for people with normal grief are largely ineffective, unnecessary and may be potentially harmful. As most palliative care patients have an in-depth understanding of their family/friends networks they may be well placed to identify who within their networks may most require bereavement follow-up.

Aim: To identify explore whether palliative care inpatients with advanced disease are concerned about the bereavement needs of people other than their next of kin; and To establish the feasibility, acceptability, safety, and practicability of having prospective bereavement follow-up conversations with people near the end of life.

Study design and method: A qualitative study using semi-structured interviews involving Australian palliative care inpatients (n=19). The thematic content analysis adhered to the COREQ: consolidated criteria for reporting qualitative research ensuring attention to: clarification and justification; procedural rigor; representativeness; interpretive rigor; reflexivity and evaluation rigor; and transferability.

Findings: The analysis revealed the following three high level themes:

1) Families that were considered close and supportive may not require bereavement follow-up;
2) Family who have had other significant losses, are perceived as needing bereavement support; and
3) Asking palliative care patients who they are most concerned about after their death is difficult but possible.

Conclusion: There are potentially a group of community members who may be in need of bereavement support, who otherwise may not be contacted by specialist palliative care services. Further work is needed to confirm these findings and to explore the perceptions of friends and family nominated by patients in terms of being contacted and their bereavements needs. Adopting a more person-centred approach may help limited bereavement services to be provided to people who need it most.

Aims: To assess the reliability and the feasibility of the InterRAI-PC and determining its appropriateness as a comprehensive needs assessment tool for various French PCS.

Design: InterRAI-PC encompasses 264 items covering 16 domains including physical, spiritual, social and psychological aspects. Observational study was carried out on 568 adults patients followed by PC teams in 25 various settings (home, hospital, PC Unit). Assessments were completed at baseline, within 24 to 48 hours and at 7th day. Statistical analysis (Kappa statistic and correlation coefficient) were performed, concurrent and convergent validity of interRAI-PC were assessed against the others tools usually used in PC: M. D. Anderson Symptom Inventory (MDASI), verbal rating scale (VRS) for pain and breathlessness, DN4.

The relevancy, feasibility of interRAI-PC and limit of its use were assessed by qualitative analysis of the transcripts of data from health professional focus group.

Results: The level of completion of InterRAI-PC is better than other tools: missing data (0.2%) were fewer than those of MDASI (15%) or VRS (9%). Value of pain scale varied by setting and 30 % of patients doesn’t get an adequate pain relief. PC Unit© patients have more impairment of self-sufficiency in activities of daily living performance than others (p< 0.0001).

The interrater reliability was good (kappa values of most of items ≥ 0.70). Breathlessness items of InterRAI-PC were correlated with VRS (p= 0.824) and MDASI (p= 0.6).

Most health professional (80%) reported that the items of InterRAI-PC are relevant for PC planning and person-centered care and the assessment process increased the level of communication between team members.

Conclusion: InterRAI-PC is reliable for assessing patient needs at different stage of PC trajectory and this comprehensive assessment is feasible in various PC settings. It should improve PC pathway and guarantee an efficient transition of the patients by facilitating sharing information in common language across PC settings.

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Abstract number: P70
Abstract type: Poster presentation

Healthcare Providers’ Views on the Handover between the Hospital and Primary Care Setting of Patients at the End-of-Life
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Research aims: Inadequate handovers between hospital and home can lead to adverse health outcomes. A specific group at risk are patients at the end-of-life. Although most patients wish to stay at home in this phase, they are often acutely admitted in the last three months of life. In this study we aim to assess healthcare providers’ views on how to improve transitional handovers of patients at the end-of-life.

Study design and methods: Five focus group discussions were held with a heterogeneous group of healthcare providers (HCPs) in the province of Noord-Holland in the Netherlands. Three focus groups were held with 28 nurses from primary and secondary care and two focus groups with 9 physicians. The focus groups were guided by a fixed protocol with open-ended questions and moderated by two researchers. The focus groups were audio-recorded, transcribed verbatim and analysed using thematic analysis.

Results: HCPs indicate that the current handover of end-of-life patients often lacks information about patient’s wishes and holistic needs and an

Abstract number: P69
Abstract type: Poster presentation

Comprehensive Assessment of Patient’s Needs in Various Palliative Care Settings: Reliability, Feasibility of a Multidimensional Assessment Tool (interRAI-Palliative Care)
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Background: Ensuring an efficient palliative care (PC) pathway remains an integral element of palliative care which is provided prior to and after the patient’s death. While specialist palliative care services potentially provide some of the most comprehensive bereavement support services, there is emerging evidence that bereavement support ought to be reserved for those most in need. Identifying those at risk of experiencing a complex bereavement response is critical as bereavement interventions for people with normal grief are largely ineffective, unnecessary and may be potentially harmful. As most palliative care patients have an in-depth understanding of their family/friends networks they may be well placed to identify who within their networks may most require bereavement follow-up.

Aim: To identify explore whether palliative care inpatients with advanced disease are concerned about the bereavement needs of people other than their next of kin; and To establish the feasibility, acceptability, safety, and practicability of having prospective bereavement follow-up conversations with people near the end of life.

Study design and method: A qualitative study using semi-structured interviews involving Australian palliative care inpatients (n=19). The thematic content analysis adhered to the COREQ: consolidated criteria for reporting qualitative research ensuring attention to: clarification and justification; procedural rigor; representativeness; interpretive rigor; reflexivity and evaluation rigor; and transferability.

Findings: The analysis revealed the following three high level themes:

1) Families that were considered close and supportive may not require bereavement follow-up;
2) Family who have had other significant losses, are perceived as needing bereavement support; and
3) Asking palliative care patients who they are most concerned about after their death is difficult but possible.

Conclusion: There are potentially a group of community members who may be in need of bereavement support, who otherwise may not be contacted by specialist palliative care services. Further work is needed to confirm these findings and to explore the perceptions of friends and family nominated by patients in terms of being contacted and their bereavements needs. Adopting a more person-centred approach may help limited bereavement services to be provided to people who need it most.
advance care plan. HCPs consider this information to be essential to provide high quality health care and suggest to structural integrate these elements in written handovers. Additionally, HCPs think it important that the handover contains a clear delegation of responsibilities. Moreover, participants suggested that barriers on the organisational level, such as non-integrated electronic systems and difficulties in reaching one another, need to be overcome. Face-to-face handovers are considered an ideal method, but time consuming. Therefore, video conferencing could be an alternative. Furthermore HCPs encouraged the use of an appointed case manager, which could improve handovers when multiple HCPs are involved.

**Conclusion:** From the view of HCPs, the transitional handover of end-of-life patients could be improved by means of structural embedding information on patient’s holistic needs and advance care planning into handover files. Additionally, case management, integrated electronic systems and in-person handovers were advocated.

**Funding**
ZonMW (The Netherlands Organisation for Health Research and Development)

**Abstract number:** P71
**Abstract type:** Poster presentation

**Continuity in Palliative Care in the Southwest Region of the Netherlands**

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**Research aims:** Continuity of care is commonly acknowledged as an important aspect of high quality palliative care. The aim of this study was to assess the experiences with and appreciation of collaboration in palliative care, from the perspective of patients, bereaved relatives and health care professionals.

**Study design and methods:** We performed a cross-sectional regional survey study among patients, relatives, nurses and physicians. Patients were invited by their attending physician if their answer to the Surprise Question was “no”. Bereaved relatives were invited via several public media. Nurses were invited via palliative care networks and several professional media. Physicians were invited via a random sample from a professional registry.

**Results:** Questionnaires were filled in by 81 patients, 330 bereaved relatives, 1002 nurses and 543 physicians. Patients and relatives reported that about 1 in 3 patients had had personal contacts with more than 5 health-care disciplines in the previous 3 months. Unplanned care was common: 35% of patients had been in contact with an out-of-hours general practitioner’s service in the previous 3 months, and of the 48% of patients who had been hospitalized in the previous 6 months, 83% reported their most recent hospitalization to have been unplanned. All health care professionals stated that multidisciplinary collaboration in palliative care is important. They were reasonably satisfied with the current quality of such collaboration (score 7/10). In 34% of their most recent cases of patients who had passed away, nurses had missed necessary information after a transfer of the patient. A majority of physicians reported that adequate palliative care is sometimes (56%) or often (19%) hindered by inadequate medical information from other settings.

**Conclusions:** Unplanned hospital admissions and inadequate handovers are common in palliative care. Collaboration and information sharing among healthcare settings can be improved.

**Funding**
Our study was funded by The Netherlands Organisation for Health Research and Development (ZonMW).

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**Abstract number:** P72
**Abstract type:** Poster presentation

**Development of a Complex Intervention for the Early Integration of Palliative Home Care in Oncology Care: A Phase 0-1 Study Following the Steps of the MRC Framework**

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**Background:** Recently some studies have been conducted to test the feasibility and effectivity of models for the early integration of palliative care (PC) in oncology care. These models were specifically developed for the integration of PC in the hospital setting. In Belgium, as in many other countries, PC is not only provided in the hospital setting, but also, and especially, at home. However, a model to integrate palliative home care (PHC) in oncology care at an early stage is lacking.

**Aim:** To develop an intervention model for the early integration of palliative home care (PHC) in oncology care in Flanders, Belgium.

**Methods:** We conducted a Phase 0-1 study following the steps of the Medical Research Council (MRC) Framework. Phase 0 consisted of a screening of the literature on existing intervention models to identify key components of successful models in other settings and additionally, focus groups with PHC teams were held to explore to what extent the existing models were applicable to the Belgian home care system. In Phase 1, we developed a complex intervention for the early integration of PHC in oncology care, based on the results of Phase 0, and discussed it with the involved PHC team and the involved oncologists.

**Results:** The screening of the literature resulted in the identification of four key components:

1) education for the involved PHC team on oncological diseases and treatments,
2) monthly home visits by the PHC team,
3) systematic needs assessment at every home visit, and
4) the provision of holistic care.

The focus groups with PHC teams supplemented the key components with systematic transmural communication and a central role for the general practitioner as coordinator of the care process.

**Discussion:** The feasibility and acceptability of the intervention will subsequently be tested in a phase 2 study in which 40 patients with advanced cancer and a maximum life expectancy of two years will be followed by a PHC team for six months. The results of this phase 2 study will help to conduct a large-scale phase 3 RCT.

**Abstract number:** P73
**Abstract type:** Poster presentation

**Mobile Health Technology in Severely Ill Patients**

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**Purpose:** Discharge from hospital is known to be a vulnerable phase in palliative patients’ trajectories. Unplanned emergency readmissions are frequent because quality of care after discharge is influenced by many different factors that cannot be easily influenced. The use of mobile technology in medical research and services has been growing fast over the past years. One reason for this development is the chance to gather patient-related data in a passive continuous real-time way. In order to plan a
feasibility study, aiming to investigate patients’ acceptance and technical feasibility of mobile health in palliative care patients, we conducted this pre-study to evaluate different models of mobile phones, tracking bracelets and app design as well as the perception of the study idea by patients.

**Methods:** Semi-structured interviews were conducted with patients hospitalized on the inpatient ward of the Department of Radiation-Oncology, which included specialized palliative care. Inclusion criteria were age > 18, a severe medical condition (metastatic cancer or severe cardiac/pulmonary disease), ECOG<2/KPS>50%, no relevant cognitive impairment and good knowledge of German language. The interviews were designed to learn about patients’ attitude towards the use of mobile health devices, to collect motivational reasons for patients to use a monitoring system and join a study using health technology and to gather information relevant for system design.

**Results:** Twelve patients with a median age of 63.5y (49-80y) were included. Nine patients already used smartphones privately. After a short introduction, all 12 patients were able to handle the smartphone and the in-house developed app for assessment of pain and distress. Two of 12 patients were concerned about data security and privacy, two patients suffered from severe fatigue and were negative about the task carrying the phone with them the whole day long. Overall, patients were generally interested in a study using wearables. Due to handiness smaller version of smartphones were preferred. Concerning app design the only wish expressed were big numeric.

**Conclusion:** Severely ill patients were willing to give their feedback on mobile health devices. Experiences and opinions were heterogeneous; yet we gained some relevant information for the planned feasibility study. The large majority of the screened population was both willing and would have been able to participate in a study using smartphones and wearables.

**Abstract number:** P74

**Abstract type:** Poster presentation

**Opinions about and Attitudes towards (In)appropriate Care at the End of Life: Results of a Belgian Community Study**

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In 2016 the Belgian Health Care Knowledge Centre (KCE) requested a study on views and opinions about (in)appropriate care at the end of life in the Belgian community aiming to support the societal debate and provide guidance to policy makers.

An online survey was set up (available in Dutch and French), asking respondents to what extent they agreed with a set of statements and their opinions regarding relevant end of life care topics. The survey was widely distributed in the community by patients’ and care professionals’ organisations to spiritual counsellors of different moral, volunteers, health care professionals, relatives and patients.

1816 respondents completed the questionnaire. 64% of respondents filled out the survey in Dutch; 69% was female and 64% had a background in health care. Most respondents were highly educated (45% graduate school and 39% university).

We performed descriptive analyses: 82% of respondents (totally) agree that treatment in the end of life is too often focused on life prolongation and too little on quality of life. Only 44% of all respondents feels (totally) confident that doctors will provide good care at the end of their life.

According to 52% doctors generally do not align well with each other during treatment. 56% and 48% of respondents, respectively, state that psychologists and home care should be more involved in end of life care.

The best time to discuss advance care planning (ACP) is before one gets ill (43%), or when a life threatening disease is diagnosed (27%). Yet, only 36% of all respondents has discussed their own end of life wishes with a professional today. Finally, 62% consider the general practitioner as best suited professional to discuss ACP.

Many concerns about inappropriate care at the end of life in Belgium were collected from a diverse audience by an online survey. Several end of life care domains can be improved, especially on aspects as interdisciplinary coordination of care and the perceived quality of care.

**Abstract number:** P75

**Abstract type:** Poster presentation

**Should Dying Inmates Choose their End of Life? A Prospective National Survey of the Palliative Situation of Inmates in France, a Mixed-method Study**

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Since the 1994 law, the Ministry of Health organizes health care for prisoners and every French prison has its own health care unit. Unlike some countries (USA and UK) which have been developed hospice care programs, France has no specific system for palliative care in prison. Every year in France, about 120 inmates die in prison from illness due to natural causes (as much as by suicide). Their experiences with palliative care have not been researched to date in France.

How many are they? What are the difficulties in providing adequate palliative care? What do inmates experience at the end of their life in prison?

The Prospective National Survey of the Palliative Situation among Inmates in French Prisons Project is a mixed-method study that combines quantitative and qualitative approaches (2011-2014). The research team (physicians, sociologists, philosopher) conducted a census of all inmates with a life expectancy of less than 1 year in all 190 dedicated health care facilities in French prison during 3 months. Then, interviews were conducted individually with inmates who gave their consent, as well as with physicians, nurses, correction officers, judges, social and probation workers and sometimes families.

The observed number of prisoners requiring palliative care was twice as high as the expected age- and sex-standardized number based on the general population and similar to the expected number among persons 10 years older in the free community. Overall, 50 cases of sick inmates requiring palliative care were identified by physicians in charge of them. Among the 50 cases identified, the qualitative study explored the cases of 14 inmates requiring palliative care and 70 interviews were conducted (and analyzed with NVivo). The study results identified several barriers and revealed that inmates were not fully considered as “legitimate” patients and did not benefit from a comprehensive palliative care approach in this environment.

While the approaches to dealing with end of life in prison vary between countries (USA and UK) which have been developed hospice care programs, France has no specific system for palliative care in prison. Every year in France, about 120 inmates die in prison from illness due to natural causes (as much as by suicide). Their experiences with palliative care have not been researched to date in France.

How many are they? What are the difficulties in providing adequate palliative care? What do inmates experience at the end of their life in prison?

The Prospective National Survey of the Palliative Situation among Inmates in French Prisons Project is a mixed-method study that combines quantitative and qualitative approaches (2011-2014). The research team (physicians, sociologists, philosopher) conducted a census of all inmates with a life expectancy of less than 1 year in all 190 dedicated health care facilities in French prison during 3 months. Then, interviews were conducted individually with inmates who gave their consent, as well as with physicians, nurses, correction officers, judges, social and probation workers and sometimes families.

The observed number of prisoners requiring palliative care was twice as high as the expected age- and sex-standardized number based on the general population and similar to the expected number among persons 10 years older in the free community. Overall, 50 cases of sick inmates requiring palliative care were identified by physicians in charge of them. Among the 50 cases identified, the qualitative study explored the cases of 14 inmates requiring palliative care and 70 interviews were conducted (and analyzed with NVivo). The study results identified several barriers and revealed that inmates were not fully considered as “legitimate” patients and did not benefit from a comprehensive palliative care approach in this environment.

While the approaches to dealing with end of life in prison vary between countries, the underlying ethical issues are not so different. Whether in or out of prison, a comprehensive end of life approach should allow people to choose their place to death, and to die with dignity, surrounded by their families and trusted caregivers. To experience respect in these ultimate moments regardless of one life path, is a matter of respect for the human condition.

**Funding**

The study was funded by the Fondation de France

**Abstract number:** P76

**Abstract type:** Poster presentation

**Qualitative Study Exploring the Experience of Homelessness Staff Working with Homeless People with Life-limiting Illnesses in Dublin, Ireland**
Aims and objectives:

1) To explore the experience of homelessness staff working with homeless people with a life-limiting illness in homeless accommodation in Dublin.

2) To identify areas for education and collaboration between palliative care and homeless services to improve the end-of-life care for homeless people in Dublin.

Methods: Qualitative methodology was employed. Semi-structured 1:1 interviews were conducted with homelessness staff. The data was analyzed with thematic analysis.

Results: 11 participants were recruited from 4 organisations. Key themes identified were poor communication between hospitals and homeless services, concerns about medication handling, uncertainty about prognosis particularly in non-malignant conditions, and concerns that they could not meet the care needs of an individual at the end of life. Participants felt that health and community services staff do not have knowledge of the structure and staffing levels in homeless services and assumed for example, there was nursing support. Participants identified a strong wish to support a service user at the end of their life but had substantial concerns that they were not adequately trained to do so. Participants would welcome education opportunities on the topic of end-of-life care and advanced care planning.

Conclusion: The provision of palliative care to homeless people is complex. Understanding the needs of homeless people who have physical health, mental health and substance misuse problems is vital in providing person-centered care. Collaborative work including sharing of skills and education opportunities between health, palliative, homeless and social services is required to improve care for homeless people with life-limiting illnesses.

Abstract number: P77
Abstract type: Poster presentation

Accelerated Transition from Oncological Treatment to Specialized Palliative Care at Home: DOMUS - A Randomized Controlled Trial

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Background/aims: Metastatic cancer remains the leading diagnosis in patients admitted to palliative care units (PCU). The liver is the main organ affected by metastases. A specific prognostic tool is lacking for end-stage oncologic liver diseases (OLD). Factors known to be associated with mortality in people with OLD and chronic liver diseases (CLD) are spontaneous bacterial peritonitis (SBP), gastrointestinal bleeding (GIB), jaundice (JA), encephalopathy (E), performance status, oral intake (OI), dyspnea, as well as serum bilirubin (BILI), creatinine (CREAT), albumin and urea. Our hypothesis was that hyperbilirubinemia could be a predictive prognostic factor in this population, as it reflects liver dysfunction. We firstly aimed to assess how BILI and other factors influence survival in patients admitted to a PCU with advanced OLD. Secondly we aimed to develop a prognostic model.

Method: Data were collected retrospectively from 651 patients with primitive or secondary extended OLD, accounting for 25% of all admissions in our PCU from 2011 to 2016. Age, sex, CLD, SBP, GIB, JA, E, Eastern Cooperative Oncology Group score (ECOG), OI, dyspnea, urea, CREAT, albumin and BILI variables collected within 24 hours before or after admission were analyzed. Univariate and multivariate survival analyses were performed to identify the predictive value of BILI and other variables for 7-day survival.

Results: In 398 patients bilirubin value was collected. Univariate analysis showed that male sex, CLD, JA, E, ECOG, OI, BILI, CREAT and urea blood levels, were associated with 7-day survival. Multivariate analysis showed that BILI > 25µmol/L (p < .05), urea > 7.5mmol/L (p < .001), which includes the opportunity to make their own choice of place of care and death. This study aimed primarily at investigating whether an accelerated transition from oncological treatment to SPC at home for patients with incurable cancer resulted in more time spent at home/home deaths. Secondary aims were to investigate effects on quality of life (QoL), symptomatology, and survival.

Methods: DOMUS was a randomized controlled trial with 340 patients with incurable cancer and no or limited antineoplastic treatment options (Clinicaltrials.gov: NCT01885637). Patients were randomly assigned to:

a) SPC at home enriched with a manualized psychological intervention plus standard care or
b) standard care alone.

Results: Regarding death at home no statistically significant difference was found (4%, p=0.460). Patients in the intervention and control group spent 86% and 83% of the time after inclusion at home, respectively (3%, p=0.491). Adjusting for background variables the difference was significant (5%, p=0.026).

Conclusion: The intervention resulted in slightly more time spent at home and clinical relevant improvement of QoL, social-, and emotional functioning after 6 months.

Funding
Danish Cancer Society and TrygFonden

Abstract number: P78
Abstract type: Poster presentation

Predictors of Seven-day Mortality in Patients with Advanced Oncologic Liver Disease Admitted to a Palliative Care Unit

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Background/aims: The aim of the study was to investigate factors associated with 7-day mortality in patients with advanced oncologic liver disease (OLD). The study also aimed to develop a prognostic model.

Methods: A retrospective analysis was performed on all patients admitted to the palliative care unit of the University Hospital of Geneva, Switzerland from 2011 to 2016. The primary outcome was death within 7 days of admission. Predictors of seven-day mortality were identified using logistic regression analysis. Multivariable analysis was performed using a stepwise approach.

Results: A total of 398 patients were included in the analysis. The majority of patients were male (58%) and the median age was 68 years (range 32-90). The most common cause of OLD was metastatic cancer (45%). The overall 7-day mortality rate was 21%. The most common predictors of death within 7 days were older age, higher bilirubin levels, higher creatinine levels, and lower albumin levels. The most significant predictor of death at the 7-day mark was bilirubin levels (OR 1.06 per 1 µmol/L increase, p < 0.001).

Conclusion: Bilirubin is a strong predictor of death within 7 days in patients with advanced oncologic liver disease. This study provides evidence to support the hypothesis that hyperbilirubinemia is associated with worse survival in this population.
ECOG $= 4$ (p $< 0.001$) and minimal or no OI (p $< 0.001$), were independently correlated with survival. Accuracy of the model based on these 4 simple and objective predictors is high (AUC $= 0.9$).

**Conclusions:** Combining BILL, urea, ECOG and OI increases short term prognostication accuracy in OLD admitted in PCU.

**Abstract number: P79**

**Abstract type:** Poster presentation

**An Estimation of the Population-based Survival Benefit of First-line Palliative Chemotherapy for Incurable Cancer**

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**Purpose:** Randomized clinical trials describe the benefit of chemotherapy for incurable cancer patients with selected patient and disease characteristics. The overall survival benefits for the whole population of incurable cancer patients in Australia, if evidence-based guidelines for chemotherapy were implemented, are not known. This study’s purpose was to estimate the overall population survival benefit of routinely using evidence-based practice.

**Methods and materials:** Decision trees with evidence-based indications for chemotherapy have been previously defined [1,2]. Each branch corresponds to a specific cohort who have, or do not have, defined indications for palliative chemotherapy. Palliative chemotherapy benefit was defined as the absolute incremental benefit of first-line chemotherapy over no chemotherapy (best supportive care) for palliative indications. Multiple electronic citation databases were systematically queried, including Medline and the Cochrane Library. In cases where there were multiple sources of the same level of evidence, hierarchical meta-analysis was performed. The benefit of chemotherapy was estimated for 1- and 5-year survival. To assess the robustness of our estimates, sensitivity analyses were performed.

**Results:** 36% of survival benefit can be attributed to palliative chemotherapy. The 1-year survival benefit of the entire cancer population is mostly contributed from palliative indication. The estimated 1-year, and 5-year absolute population-based overall survival benefits of optimally utilized chemotherapy for incurable cancer in Australia are 4.2% (95% CI, 4.2%-4.4%), and 2.1% (95% CI, 2.0%-2.2%) respectively.

**Conclusion:** Chemotherapy agents improve overall survival for incurable cancer at 1-, and 5-years. Chemotherapy provides a modest survival benefit when it is used in accordance with guideline recommendations. Now that these estimates are known, it is important to investigate other important quality of life-adjusted endpoints for this group of patients.

**Abstract number: P80**

**Abstract type:** Poster presentation

**Assessing Palliative Care Initiation Sequencing along the Clinical Care Pathway for Patients with Advanced Cancer: A Retrospective Cohort Study**

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**Research aims:** The UK National Health Service is striving to improve access to palliative care for patients with advanced cancer. Despite the large volumes of clinical, diagnostic, and demographic data available there is currently little understanding of when palliative care commences along the care pathway.

This study aims to utilise routine clinical datasets to explore the sequencing of community and hospital palliative care along the care pathway, from diagnosis to death, for patients who died of cancer.

**Study population:** Retrospective data from 2479 adult cancer decedents who died between January 2010 and February 2012, were registered with a primary care provider using the SystmOne primary care electronic health record system, resided in a single city in Northern England, and had cancer certified as a cause of death are included in the study.

**Design and methods:** This study uses linked cancer patient data from the National Cancer Registry, SystmOne, and the electronic medical record system used within a specialist regional cancer centre. The clinical events included in the clinical events pathway are date of: first cancer diagnosis, first hospital palliative care referral, first community palliative care event, initiation of latest chemotherapy, initiation of latest radiotherapy, first opioid prescription, first emergency or non-emergency admission to hospital, and death. Event dates are classified in weeks, with the possibility that multiple events may take place within the same week.

**Statistical analysis:** Probabilistic modelling to explore the sequencing of clinical events.

**Results:** Preliminary findings show most decedents (83.9%) had multiple clinical events recorded. Nearly forty percent (39.9%) of decedents received at least one hospital palliative care referral while 45.3% received at least one community palliative care event. For decedents with clinical events preceding the commencement of palliative care, the most common clinical events directly preceding palliative care were chemotherapy (31.9%), emergency admission (22.1%) and radiotherapy (20.7%) for hospital palliative care; and radiotherapy (24.3%), chemotherapy (22.4%), and hospital palliative care (22.4%) for community palliative care.

**Conclusion:** Initial findings suggest this work could greatly increase our understanding of clinical care pathways for patients with advanced cancer and may help identify potential decision points in relation to access to palliative care.

**Abstract number: P81**

**Abstract type:** Poster presentation

**Best Supportive Care for Patients with Pancreatic Cancer: Patient Characteristics and Treatment Considerations.**

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**Background/aims:** Pancreatic cancer carries a poor prognosis regardless of stage. To date, there has been little research devoted to decision-making regarding treatment options in pancreatic cancer, including the rationale for choosing best supportive care (BSC) only. This study aims to gain insight into the characteristics of patients receiving BSC only, the reasons for this decision, and their survival.

**Methods:** All patients diagnosed in the Netherlands between January 1st, 2014 and June 30th, 2015 with a proven pancreatic adenocarcinoma or a pathologically unverified pancreatic tumour were identified in the Netherlands Cancer Registry. Information on initial management, patient characteristics, main reasons for no tumour targeting treatment (TTT) (as reported in medical charts) and survival were analysed.
Results: A total of 3090 patients were included. Of these patients, 1818 (59%) received no TTT, but BSC only. Mean age of these patients was 74 years (range 35 to 99 years), versus 65 years (range 30 to 87 years) for patients who received TTT. In the no TTT group 77% had a clinical stage III/IV, whereas this was the case in 57% of patients who received TTT. Main reasons for not starting TTT were patient’s choice to withhold treatment (27%) and extensive disease (21%). Median survival of patients who did not receive TTT was 1.9 months, ranging from a median survival of 0.8 months (when the main reason to withhold TTT was short life expectancy) to 4.4 months (main reason to withhold TTT: old age). In the latter group, a relatively large proportion of clinical stage I tumours was present (37%).

Conclusions: The majority of patients with pancreatic cancer received no TTT, but BSC only and had a very poor median survival. In most patients, patient’s choice not to start treatment was the main reason for withholding treatment, indicating patient’s involvement in decision-making.

Abstract number: P82
Abstract type: Poster presentation

Low Phase Angle Is Correlated with Poor General Condition in Advanced Cancer Patients
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Objectives: A low phase angle is a poor prognostic factor in advanced cancer patients. Further understanding of the nature of the phase angle is needed for its use as a referral criterion for palliative care. The purpose of this study was to examine the correlation between phase angle and symptoms, quality of life, fluid retention and laboratory data in advanced cancer patients.

Methods: Patients who visited the outpatient clinic or were admitted to our palliative care unit were eligible for inclusion in this study. Patients whose performance status was 4 or who had difficulty in answering the questionnaire were excluded. Symptoms and quality of life were measured using questionnaires. Fluid retention was evaluated using a bioanalyzer. Laboratory data were collected from electrical charts. The correlation coefficient between the phase angle and variables was analyzed.

Results: From April to September 2016, 102 patients were enrolled. Phase angle was weakly correlated with age (ρ = -0.21), performance status (ρ = -0.36), functional well-being (ρ = 0.21), anorexia/cachexia subscale (ρ = 0.30) and the Functional Assessment of Anorexia/Cachexia Therapy trial outcome index (ρ = 0.26), but was moderately correlated with fluid retention (ρ = -0.41), albumin (ρ = 0.48), C-reactive protein (ρ = -0.34) and hemoglobin (ρ = 0.49).

Conclusions: The phase angle correlated with anorexia, functional well-being and fluid retention, but not with psychological or social well-being. Our findings support that a lower phase angle reflects a poor physical condition, and that it may be a potent criterion for specialized palliative care.

Abstract number: P83
Abstract type: Poster presentation

Social Consequences of Advanced Cancer: Experiences from Patients and Informal Caregivers
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Background: Cancer threatens the social wellbeing of patients and their informal caregivers. Social life may be even more affected in advanced cancer but research on social consequences of advanced cancer is scarce. The aim of this study is to explore social consequences of advanced cancer as experienced by patients and their informal caregivers.

Methods: Seven focus groups and seven in-depth semi-structured interviews with patients (n=18) suffering from advanced cancer and their informal caregivers (n=15) were conducted. Audio tapes were transcribed verbatim and open coded according to the thematic analysis approach using Atlas.Ti.

Results: Social consequences as experienced by patients and informal caregivers were categorized in three main themes: ‘social engagement’, ‘social identity’ and ‘social network’. Regarding social engagement patients and informal caregivers said they strive for normality by continuing their life as previous to the diagnosis, but experienced barriers in doing so. Regarding social identity patients and informal caregivers reported feelings of social isolation due to social responses. The social network became more transparent and the value of social relations has increased since the diagnosis. Many experienced positive and negative shifts in the quantity and quality of their social relations.

Conclusions: Social consequences of advanced cancer are substantial. There appears to be a great risk of social isolation in which responses from social relations play an important role. Empowering patients and caregivers to discuss their feelings regarding social consequences of cancer is beneficial. Creating awareness among health care professionals is essential as they are able to provide social support and anticipate on social problems. Also, educating social relations regarding the impact of advanced cancer and effective support methods may empower social support systems and reduce feelings of isolation.

Funding
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Abstract number: P84
Abstract type: Poster presentation

Factors Connected with Dehydration in Terminally Ill Cancer Patients
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Aims: Dehydration is often problem in patients suffered from cancer, which decreases life quality and increases the complications. The aim of study was to determine factors connected with dehydration in patients with terminal cancer.

Methods: 522 terminal cancer patients admitted to Palliative Care Unit were retrospectively analyzed. Detailed physical examination, medical history including history taken from family and care givers was taken upon admission. Laboratory parameters including morphology, concentration of sodium, potassium, total and ionized calcium, LDH were taken on admission. Univariate and multivariate logistic regression analysis were used to determine possible predictors, symptoms and consequences of dehydration.

Results: On admission 34.48% of patients were dehydrated. They had more frequently: metastases (OR=Odds Ratio=2.32, p=probability value=0.007), had higher HS peak value (OR=1.349, p=0.001); nausea and vomiting (OR=1.898, p=0.018), dyslektrolyemia (OR=1.796, p=0.0059); had more often neuropsychiatric symptoms (OR=1.667, p=0.023); had lower albumin level (OR=0.941, p=0.0001). They had 215% higher risk of death (OR=2.158, p=0.0001). Multivariate logistic regression analysis after adjustment for possible confounders revealed that cachexia (OR=2.22, p=0.0004), chronic glucocorticosteroids use (OR=1.815, p=0.035), higher glucose level (OR=1.995, p=0.011) remained independently associated with dehydration. Since this works as factors associated with dehydration, which shows 215% higher risk of death.
Project “Extension of life and improvement of its quality and reduction of cancer patients’ mortality due to proper control of water and electrolytes management and elimination of risk factors for dehydration and dyselectrolytemia” co-financed by the European Social Fund under the project of the Ministry of Science and Higher Education of Poland entitled “Best of the best! 2.0”.

Abstract number: P85
Abstract type: Poster presentation

Validity and Reliability of Korean Version of Simplified Nutritional Appetite Questionnaire in Patients with Advanced Cancer: A Multicenter, Longitudinal Study

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Background: Malnutrition and a loss of muscle mass are frequent in cancer patients and have a negative effect on clinical outcome. Nutrition risk screening aims to increase awareness and allow early recognition and treatment of cancer cachexia. Therefore, screenings should be brief, inexpensive, highly sensitive, and have good specificity. SNAQ is a simple screening tool including 4 questions, and validated to predict weight loss within 6 months in community-dwelling adults and nursing home residents. Our study aimed to translate the SNAQ into Korean, and to assess the validity and reliability of the translated screening tool in advanced cancer patients.

Methods: The SNAQ was translated into Korean according to linguistic validation. The internal consistency of the SNAQ was evaluated by Cronbach’s alpha coefficient. Test-retest reliability was evaluated using the intraclass correlation coefficient. Concurrent validity was evaluated by measuring the Pearson’s correlation coefficient between the SNAQ and Mini-Nutritional Assessment (MNA) and Patient-Generated Subjective Global Assessment (PG-SGA).

Results: In the 194 patients included in full analysis set, cancer stage was predominantly (98.5%) metastatic, the mean age was 60 years, and the mean BMI was 24 kg/m2. According to MNA score predominantly (98.5%) metastatic, the mean age was 60 years, and the mean BMI was 24 kg/m2. According to MNA score predominantly (98.5%) metastatic, the mean age was 60 years, and the mean BMI was 24 kg/m2.

Conclusion: The intraclass correlation coefficient. Concurrent validity was evaluated to translate the SNAQ into Korean, and to assess the validity and reliability of the translated screening tool in advanced cancer patients.

Abstract number: P86
Abstract type: Poster presentation

How Do Treatment Aims in the Last Phase of Life Relate to Hospitalizations and Hospital Mortality? A Mortality Follow-back Study of Dutch Patients with Five Types of Cancer

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Research aims: To describe and compare the relation between treatment aims, hospitalizations and hospital mortality for Dutch patients who died from lung, colorectal, breast, prostate or pancreatic cancer.

Study population: 691 patients who died from one of the above mentioned cancer types between 2009 and 2015.

Study design and methods: A mortality follow-back study was conducted within a sentinel network of Dutch general practitioners (GPs), who recorded the end-of-life care of deceased patients in their practice.

Method of statistical analysis: Differences in care by type of cancer were analyzed using multilevel analyses to control for clustering within general practices.

Results and interpretation: There is large variation between patients with different cancer types with regard to treatment aims, hospital admissions and hospital deaths. Among all cancer types, patients with prostate cancer most often and patients with pancreatic cancer least often had a palliative treatment aim a month before death (95% resp. 5%). Prostate cancer patients were also least often admitted to hospital in the last month of life (18.5%) and least often died there (3.1%), whereas lung cancer patients were at the other end of the spectrum with 41.8% of them being admitted to hospital and 22.6% dying in hospital. Having a palliative treatment aim and being older were significantly associated with less hospital admissions; and having a palliative treatment aim, having prostate cancer, and dying in a more recent year were significantly associated with less hospital deaths. The results highlight the need for early initiation of GP palliative care to support patients from all cancer types to stay at the place they prefer as long as possible.

Abstract number: P87
Abstract type: Poster presentation

Pilot Randomized Phase II Trial of the Enhancing Quality of Life (EQUIP) Intervention for Patients with Advanced Lung Cancer

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Background/ aims: New models of care that are effective and feasible for widespread implementation need to be developed for the delivery of early palliative care for advanced cancer patients. The main objective was to pilot the Enhancing Quality of Life in Patients (EQUIP) intervention for patients with advanced lung cancer, to determine the feasibility and acceptability of the EQUIP intervention, data collection rate of patient-reported outcome measures in the context of the EQUIP trial and a tentative estimate of efficacy of the EQUIP intervention on quality of life and mood.

Methods: This was a pilot randomized phase II trial. Patients randomized to the control group received usual care, which comprised standard oncology care as well as referral for palliative care services if deemed appropriate by the primary oncologist. In addition to usual care, patients...
randomized to the intervention group individually received the EQUIP intervention which comprised four face-to-face educational sessions with a palliative care nurse.

The focus of these sessions was to equip patients with the skills and strategies needed to cope with common symptoms experienced by lung cancer patients:

1) Fatigue: patients were introduced to the non-pharmacological management of fatigue, including keeping active and pacing of activity;
2) Breathlessness: patients were introduced to the non-pharmacological management of breathlessness, including breathing and relaxation techniques, mindfulness and fan therapy;
3) Worry: patients were introduced to psycho-behavioral strategies to cope with worry;
4) Recap of previous sessions. All sessions were conducted by the same palliative care nurse.

Results: A total of 69 patients were recruited. In the intervention group, 30 of 35 patients (85.7%) completed all four EQUIP sessions. Acceptability of the EQUIP sessions was high: All patients were satisfied with the topics shared and felt they were useful. However, there was no significant difference between intervention and control groups in quality of life at 12 weeks after baseline.

Conclusions: This pilot study showed that nurse-directed face-to-face educational sessions were feasible and acceptable to advanced lung cancer patients. However, there was no indication of benefit of the EQUIP intervention on quality of life and mood.

Abstract number: P88
Abstract type: Poster presentation

Patient’s Decisional Control Preferences in Palliative Care: An Indian Survey
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Introduction: The frequency of passive decisional control (patients prefer physicians to make decisions) has been reported to be variable but generally larger among patients living in developing countries.

Objectives: This study aimed to determine the frequency of passive DCP among patients with advanced cancer in a tertiary cancer center, and identify its association with their socio-demographic and clinical characteristics.

Methods: 150 patients referred to palliative care underwent assessment of decisional control preferences using validated tools including Control Preference Scale tool, Satisfaction with Decision Scale and understanding of illness questionnaire. Information regarding patient characteristics including age, gender, education, marital status, employment, Karnofsky Performance Scale, cancer stage and type, religion were also collected. Descriptive statistics and Logistic regression analysis were performed.

Results: Median age was 48 years, Karnofsky 90, and 55.3% were men. Shared, Active (patient prefers to make decision by his/her own) and Passive DCP were 20.7%, 26.7% and 52.7% respectively (n = 150). 51.3 were satisfied by the way the actual decisions were made. 70.7% felt that their cancer was curable. Passive DCP did not vary across regions. Multivariate analysis shows that the passive DCP was significantly associated in better KPS [expB 1.07 (1.01-1.15), p=0.03].

Conclusions: There are significant differences in DCP with KPS. Patients report high level of satisfaction with their treatment decision, though they have poor understanding of their prognosis and understand their treatment to be of curative intent. Individualized understanding DCP and focus on illness understanding may be important for quality care and patient satisfaction outcomes.

Funding
The research was funded/supported by the Tata Memorial Hospital. It is a follow-on project of a larger multicenter trial “Protocol 2011-0391: Patient’s Decisional Control Preferences in the Palliative Care Setting: A Multi-Center Surveys” created under the direction of Sriram Yennu, M.D., University of Texas M. D. Anderson Cancer Center, 1515 Holcombe Boulevard, Houston, Texas 77030. The views expressed are those of the author(s) and not necessarily those of Tata Memorial Hospital, Sriram Yennu, M.D., or University of Texas M. D. Anderson Cancer Center.

Abstract number: P89
Abstract type: Poster presentation

Systematic Review of Trajectories of Psychological Distress among Cancer Patients under Anti-treatments
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Purpose: Cancer patients under treatments suffer various psychological distresses, especially for anxiety and depression. Previous longitudinal studies have treated depressive-symptom trajectories as homogeneous, differences between individuals are ignored. The aim of this article was to synthesize distinct trajectories of psychological distress (including anxiety and depression) and to estimate the prevalence of each trajectory among cancer patients under anti-treatments.

Method: We searched for studies published in 2006-2017 from Databases (Cochrane, PubMed, Medline (ProQuest), CINAHL and Google scholar) with the following key words: cancer, depression, anxiety, and longitudinal. Studies were included if they were prospective and longitudinal, data were collected at least three times before/after cancer-treatment, and trajectory groups and their prevalence were identified. All review stages were conducted independently by 2 reviewers. Trajectories of psychological distress were synthesized by their level, duration, and whether they improved over time.

Results: This review included six studies that followed 147-398 breast, prostate, mixed cancer patients with cancer-treatment (surgery, chemotherapy, radiation and other treatment) from 6 months to 5 years. Data were collected during pre-treatment, under-treatment and post-treatment. Depressive symptoms were measured in two studies using the CES-D, and anxiety symptoms using the HADS in other two studies. We synthesized four distinct trajectories of psychological distress (anxiety-symptom, depressive-symptom prevalence in synthesized sample): “low stable” (34.6%, 83.2%), “recovery” (50.8%, 7.1%), “high stable” (12.9%, 2%), and “Vacillate” (1.7%, 7.7%). Cancer patients in the “low stable” group had consistently low levels of psychological distress over time. The “recovery” group’s distress lasted several months during active treatment, gradually returning to pre-treatment level. The “high stable” group had severe psychological distress over time. The “vacillate” group’s distress rose and fell during active treatment.

Conclusion: Cancer patients under treatment suffered heterogeneous trajectories of psychological distress. Early distinguishing and meeting the needs of patients with different trajectories of psychological distress may promote their psychological adjustment during cancer treatments or may facilitate their return to healthy psychological function.

Abstract number: P90
Abstract type: Poster presentation

Health Status in South Australians Caring for People with Cancer: A Population-based Study
Laukett, Tim1, Agar, Meera1,2,3, DiGiacomo, Michelle1, Ferguson, Caleb1, Lam, Lawrence1,2,3, Newton, Phillip1, Phillips, Jane1

Method: We searched for studies published in 2006-2017 from Databases (Cochrane, PubMed, Medline (ProQuest), CINAHL and Google scholar) with the following key words: cancer, depression, anxiety, and longitudinal. Studies were included if they were prospective and longitudinal, data were collected at least three times before/after cancer-treatment, and trajectory groups and their prevalence were identified. All review stages were conducted independently by 2 reviewers. Trajectories of psychological distress were synthesized by their level, duration, and whether they improved over time.

Results: This review included six studies that followed 147-398 breast, prostate, mixed cancer patients with cancer-treatment (surgery, chemotherapy, radiation and other treatment) from 6 months to 5 years. Data were collected during pre-treatment, under-treatment and post-treatment. Depressive symptoms were measured in two studies using the CES-D, and anxiety symptoms using the HADS in other two studies. We synthesized four distinct trajectories of psychological distress (anxiety-symptom, depressive-symptom prevalence in synthesized sample): “low stable” (34.6%, 83.2%), “recovery” (50.8%, 7.1%), “high stable” (12.9%, 2%), and “Vacillate” (1.7%, 7.7%). Cancer patients in the “low stable” group had consistently low levels of psychological distress over time. The “recovery” group’s distress lasted several months during active treatment, gradually returning to pre-treatment level. The “high stable” group had severe psychological distress over time. The “vacillate” group’s distress rose and fell during active treatment.

Conclusion: Cancer patients under treatment suffered heterogeneous trajectories of psychological distress. Early distinguishing and meeting the needs of patients with different trajectories of psychological distress may promote their psychological adjustment during cancer treatments or may facilitate their return to healthy psychological function.
Research aims: To explore which sociodemographic and caregiving characteristics are predictive of poor health status in caregivers of people with cancer living in South Australia.

Study population (where appropriate): The South Australian Health Omnibus is a population-based cross-sectional survey administered annually to representatives aged >15 years from 5,300 households purposively sampled from metropolitan and rural areas. The final sample is weighted according to sex, age and geographic area to represent the state.

Study design and methods: The survey was administered via face-to-face interviews by trained personnel. Health status was measured using the SF-12.

Method of statistical analysis: Poor health status was defined as SF-12 physical and mental component scale summary scores (PCS and MCS) ≥0.5 standard deviation lower than Australian norms. Logistic regression was used to identify significant predictors of poor health status among caregiving tasks, time commitment and support. Goodness of fit was examined using Pearson chi-square.

Results and interpretation: The final sample included 3047 people, of whom 407 (13.3%) self-identified as caregiving for someone with cancer. One hundred and twenty one (29.7%) reported poor PCS, and 113 (27.7%) reported poor MCS. Sociodemographic characteristics associated with poor PCS included having lower education (≥graduate odds ratio [OR] 0.40, 95% confidence intervals [CI] 0.20–0.78; p=0.008) and being unemployed (employed OR 0.43, 95%CI 0.25–0.75 p=0.003). Caregiving characteristics associated with poor PCS included having control over few aspects of care (control over some/most aspects OR 1.78, 95% CI 1.04–3.12; p=0.037) and caring for someone with more than one condition (OR 1.34, 95%CI 1.08–1.67; p=0.007). Only sociodemographic, not caregiving, characteristics were associated with poor MCS, namely: being aged ≥65 years (OR 0.43, 95%CI 0.23–0.81; p=0.009), having lower education (≥graduate OR 0.46, 95%CI 0.23–0.92; p=0.029), being unemployed (employed OR 0.26, 95%CI 0.14–0.50; p<0.001), and having a household income of ≥$60,000 (OR 0.44, 95%CI 0.24–0.82; p=0.010).

Socio-economic variables were found to be the most consistent predictors of poor physical and mental health status in a population-based sample of South Australian cancer caregivers. Further research is needed to understand whether the relationship between socio-economic status and health status differs between caregivers and non-caregivers.

Abstract number: P91
Abstract type: Poster presentation

Neuropsychological Predictors of Decision-making Capacity in Patients with Cancer Receiving Palliative Care
Kolva, Elissa1; Rosenfeld, Barry1
1Medicine, University of Colorado, Anschutz Medical Campus, Aurora, USA, 2Psychology, Fordham University, Bronx, USA

Purpose: Patients with advanced cancer are responsible for making important decisions about their medical care that can directly influence their quality, and often length of life. They are also at risk for impaired decision-making capacity, which requires a complex set of neurocognitive functions. The purpose of this study was to identify the neuropsychological underpinnings of decision-making capacity in patients with advanced cancer receiving palliative care.

Method: Participants were 108 English-speaking adults half (n = 58) of participants had a diagnosis of advanced cancer, and were receiving inpatient palliative care. The rest were healthy adults. Participants completed a measure of decision-making capacity, that assesses four legal standards of capacity; Choice, Understanding, Appreciation and Reasoning. They also completed measures of neuropsychological functioning (i.e., learning, memory, executive functioning).

Results: Patients with cancer were significantly more impaired on measures of capacity and neuropsychological functioning. Effect sizes were very large for differences in general cognitive functioning, verbal learning and memory, processing speed, verbal fluency, and executive functioning. In the terminally ill sample, Choice, Appreciation and Reasoning were not significantly correlated with any of the neuropsychological variables. Understanding was significantly correlated with verbal memory. General cognitive functioning emerged as a significant predictor of capacity status on the Choice, Understanding and Reasoning subscales.

Conclusions: The terminally ill sample was significantly more impaired than the comparison sample, reflective of high levels of neuropsychological impairment across cognitive domains. However, many of the measures of neuropsychological functioning did not significantly predict performance on the decisional capacity subscales. It is possible that at the end of life decisional capacity is a more general, rather than domain-specific, cognitive ability.

Abstract number: P93
Abstract type: Poster presentation

Bowel Obstruction in Advanced Cancer
Ferraz Gonçalves, José António1, Faria, Magda2, Araújo, Vânia1, Monteiro, Ana Raquel1, Silva, Ana Vitor1
1Instituto Português de Oncologia, Porto, Portugal, 2Hospital de Cascais, Cascais, Portugal, 3Instituto Português de Oncologia, Coimbra, Portugal

Purpose: How were cancer patients with bowel obstruction treated, which were the relevant prognostic factors and how many were referred to palliative care in an oncological hospital with a palliative care service?

Methods: This retrospective study was carried out in an oncological center. The records of patients with a diagnosis of bowel obstruction during a 6-month period (January to June 2013) were studied. The diagnosis of bowel obstruction was based on symptoms and on an imaging method, in most cases an erect abdominal radiography.

Results: Bowel obstruction was diagnosed in 77 patients. 52 (68%) were female and the median age was 65 years (27 to 100). The most frequent cancer was colorectal, 31 (40%), followed by gynecological cancer, 20 (26%). 45 (58%) patients underwent conservative treatment; 26 (34%) underwent surgery; and 6 (8%) had a stent placement. In 70 (91%) the bowel obstruction was resolved. The 7 patients whose obstruction was not resolved died in the hospital, whereas 57 (81%) of the others were discharged. From the 57 patients discharged 20 (35%) were still alive 3 years after the episode of bowel obstruction. An analysis of the possible association of variables recorded with mortality was carried out, and in the univariate analysis the primary tumor, ascites, hemoglobin level < 10.7 g/dL, and the resolution of the obstruction were significantly associated with survival whereas surgery, albumin, gender and age were not. In the multivariate analysis, only the resolution of the obstruction (p<0.001) and hemoglobin level (p=0.002) were associated with survival. 38 (49%) patients were referred to palliative care.

Conclusion: Bowel obstruction in advanced cancer is associated with a poor prognosis. However, some patients were still alive 3 years later. Resolution of the obstruction is associated with survival, independently of surgery, and with the hemoglobin level at the time of the event.

Abstract number: P93
Abstract type: Poster presentation

Triggers for Referral to Palliative Care
Gemmell, Rebecca, Mackay, Katherine, Younaf, Nadia, Droney, Joanne
Royal Marsden NHS Foundation Trust, London, UK
Background: The benefits of early palliative care (PC) referral for oncology patients are well-documented. The development of PC referral “Triggers” may help proactively identify which patients should be referred to PC. A number of different “Triggers” have been proposed but such Trigger tools are currently not commonly used in clinical practice. The aim of this project was to evaluate a number of published PC referral Triggers through a retrospective note review of PC team involvement with patients who had died during a non-elective hospital admission.

Method: All patients admitted to the oncology hospital non-electively over the course of one year who died during that admission were selected (N=159). The timing of referral to PC, and whether patients met any of the published PC referral triggers before and during their terminal admission was assessed. This project was approved as a service evaluation SE596 by the hospital Committee for Clinical Research.

Results: 88% (140/159) patients would have been eligible to “trigger” a PC referral during their terminal admission, no matter which of the Triggers tools was used. Information relating to disease and symptom-related “Triggers” are most commonly documented in the medical notes. Psychosocial factors were less well documented.

Overall 46.5% of patients in this study were known to PC prior to their final admission. All but 3 of the remaining patients were referred during admission, with a median time (range) between admission and referral of 4 days (0-58 days), and between referral and death of 9 days (0-90 days).

Conclusions: At present, many patients are not known to palliative care until their last hospital admission, and as a result until their last days of life. In this patient cohort, a palliative referral Trigger Tool would have proactively identified most or all patients who died during their non-elective hospital admission. The inclusion of disease and symptom related parameters in a PC referral Trigger tool appears feasible as these items are often documented in the oncology records. However oncologists may not routinely identify psychosocial “Triggers” for PC referral.

Abstract number: P94

Abstract type: Poster presentation

Multidimensional Needs in Cancer Patients Admitted to a Comprehensive Cancer Center for Hematological and Non-hematological Malignancies: Do They Differ?

Porta-Sales, Josep1,2; Cruz-Sequeiros, Claudia1; Luque-Blanco, Ana1; Izquierdo-Gómez, José1; Rodríguez-Morera, Anna1; Cárdenes-Muñoz, Ana1; Moral-Torres, Ana1; Riera-Tornès, Gemma1; Pedrola-Martí, Sabina1; Gallardo-Giraldo, David1

1Support & Palliative Care Service, Institut Catalá d’Oncologia, Girona, Spain; 2Medicine School, Universitat de Internacional de Catalunya, St. Cugat del V, Barcelona, Spain; 3Hematology Service, Institut Catalá d’Oncologia, Girona, Spain

Aim: To compare the multidimensional needs of patients (pts) with hematological (HM) and non-hematological malignancies (NHM) recently admitted to a comprehensive cancer center.

Methods: All pts (regardless reason for admission) were proactively screened within 2-4 days after admission. Screening consisted of a nurse-led multidimensional needs assessment [denominated “Onscreenning” (OS)] to assess 5 dimensions (symptom burden, physiotherapy, emotional, social, and nutritional needs). Patients whose expected hospital stay was <4 days, in the last days of life, or who refused to participate were not screened. Symptoms were scored using the Palliative Outcome Scale. The 5 dimensions were assessed as follows:

1) Symptom burden: the sum up of the symptoms scores;
2) Physiotherapy: decline of ⩾30 points on the Barthel I. from the previous 7 days of admission or current score <60;
3) Need Nutritional Assessment: current BMI=18.5 Kg/m² or weight loss in the past 3 months >5% (Non-Advanced pts) or 10% (Advanced pts);
4) Emotional: sum of scores on Anxiety & Sadness Distress Thermometers >10;
5) Social: any positive answer to the 2 Feisubuc questionnaire questions. Categorical data were compared using Pearson’s χ² and Fisher’s exact tests (two-tailed). Continuous data were compared using the Student’s t-test or Mann-Whitney test, or Wilcoxon signed-ranks tests depending on the distribution (normal or non-normal).

Results: From March 2 to July 5, 2017, 307 pts were admitted and 222 (72.3%) underwent OS. No significant mean difference between-group (HM vs. NHM) in symptom burden was found 7.7(SD 3.5) vs. 9.1(SD 4.3); P=1.1. Only reported pain was more severe in NHM 37.9% vs.HM 12.5%; P=.01. No significant differences between the HM and NHM patients, respectively, were observed on the other dimensions: physiotherapy: 32.4% vs. 31.8% (P=1.0); nutritional: Non-Advanced 55.6% vs. 45.8% (P=.72); Advanced 42.9% vs. 68.2% (P=.07); emotional, 32.5% vs. 43.5% (P=.35); & social, 27.8% vs. 29.2% (P=1.0). No patient or relative refused OS. Mean hospital stay was 11.6 (NHM) vs. 15.5 (HM) days. Mortality was 11.1% (NHM) vs. 12.5% (HM).

Table 1

<table>
<thead>
<tr>
<th>Weight loss &gt;5%</th>
<th>NHM</th>
<th>HM</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Advanced</td>
<td>27</td>
<td>5</td>
<td>.72</td>
</tr>
<tr>
<td>Advanced</td>
<td>32</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Weight loss &gt;10%</td>
<td>NHM</td>
<td>HM</td>
<td>P</td>
</tr>
<tr>
<td>Non-Advanced</td>
<td>28</td>
<td>8</td>
<td>.07</td>
</tr>
<tr>
<td>Advanced</td>
<td>60</td>
<td>6</td>
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</table>

Interpretation:

- The only significant difference between NHM and HM patients was in pain intensity.
- Early and proactive needs assessment seems feasible and able to detect substantial numbers of patients with specific multidimensional needs.
- These findings support the use of OS regardless of disease type.

Abstract number: P95

Abstract type: Poster presentation

Dying at Home of Cancer: Whose Needs Are Being Met? The Experience of Family Carers and Healthcare Professionals (a Multi Perspective Qualitative Study)

Pottle, Jackie1; Hiscock, Julia1; Neal, Richard D2; Poolman, Marilyn2

1Occupational Therapy, Beis Cavell/adr University Health Board, Holywell, UK; 2North Wales Centre for Primary Care Research, Bangor University, North Wales, UK, 3University of Leeds, Leeds Institute of Health Sciences, Leeds, UK

Background: Supporting patients to die in the place of their choosing is an important aspect of end of life care. For many years the priority has been on supporting patients to die at home. This has been identified as the place where most people prefer to die. The aim of the study was to answer the question “How does the home environment influence the perceptions of quality of death, and the experience of caring for the dying at home. for family carers and healthcare professionals (HCPs)?

Method: All patients (regardless reason for admission) were proactively screened within 2-4 days after admission. Screening consisted of a nurse-led multidimensional needs assessment [denominated “Onscreenning” (OS)] to assess 5 dimensions (symptom burden, physiotherapy, emotional, social, and nutritional needs). Patients whose expected hospital stay was <4 days, in the last days of life, or who refused to participate were not screened. Symptoms were scored using the Palliative Outcome Scale. The 5 dimensions were assessed as follows:

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5) Social: any positive answer to the 2 Feisubuc questionnaire questions. Categorical data were compared using Pearson’s χ² and Fisher’s exact tests (two-tailed). Continuous data were compared using the Student’s t-test or Mann-Whitney test, or Wilcoxon signed-ranks tests depending on the distribution (normal or non-normal).
Method: A qualitative approach, using multi perspective interviews with bereaved family carers (numbering 15) and a nominated HCP (numbering, 13) ensured depth of insight gained into supporting a home death. The semi structured interviews were audio recorded, transcribed verbatim and analysed using framework analysis.

Results: We found that the home environment enabled normality, a sense of control and individualised care which family carers often perceived as contributing towards a good death. However, the home environment created challenges for both family carers and HCPs, due to the differing and at times conflicting needs of the dying person and their family carers. This may influence whether the home environment is the best place for the dying person. A key result related to family carers’ needs often differing from the HCPs’ perception of their needs. We recommend that the evidence based Carers Support Needs Assessment Tool (C.S.N.A.T.) is used to reduce this discrepancy.

Conclusion: We have shed light on the complexity of balancing the demands and the satisfaction of caring for someone dying at home. The ability to manage these conflicting needs influences whether carers perceived the home setting as the best place for the person to have received care in their last days of their life.


Abstract number: P96
Abstract type: Poster presentation

Predictive Factors of Mortality in Patients with Incurable Cancer - A Meta-analysis
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Aim: Prognostic factors have been well studied for survival in various types of cancer, but their value in predicting the mortality of patients with incurable cancer has yet to be established. Predictors for mortality can guide a physician in the treatment decisions for patients who are nearing death. The aim of this meta-analysis is to identify predictors and predictive tools for mortality in the last phase of cancer.

Methods: The Embase, Medline, Cochrane, and PubMed databases were systematically searched to identify studies published between 2000 and May 2016. Studies were eligible if they reported data on factors or tools that predict mortality within 2 years to 3 months in patients with advanced cancer. The hazard ratios (HRs) for each predictor were retrieved from the various studies and pooled using fixed- or random-effect modeling. To assess bias, two appraisal checklists were used to perform quality assessment of the studies that were included, and a meta-analysis was also performed with low-bias studies.

Results: The systematic search identified 53 studies (112 000 patients), of which 19, 25 and 9 were rated to have a low, moderate and high risk of bias. Thirty-seven studies could be included in the meta-analysis. The following variables were associated with mortality (HR): age (1.18), comorbidity (1.60), primary tumor site in lungs (2.91), disease stage (9.22), male gender (1.23), low albumin (2.87), low hemoglobin (1.54), performance status (2.15), (sub)cutaneous metastasis (2.10), and a negatively answered ‘surprise question’ (7.57). A meta-analysis with only low-bias studies showed similar results. Fifteen studies included various variables in a model and assessed its performance. Models differed between the studies. Only the surprise question was studied in two different studies with a sensitivity and a specificity of 69-70% and 84-90%, respectively.

Conclusion: Meta-analysis identified a number of predictive variables for mortality < 2 years-3 months in patients with advanced cancer. The combination of these variables warrants further investigation in a prospective setting.

Funding: ZonMw

Abstract number: P97
Abstract type: Poster presentation

Narratives of Daily Life Experience and the Emerging Needs of Individuals Who Are the Main Carer of a Relative Diagnosed with Multiple Myeloma: A Qualitative Study
Quiñoa-Salanova, Carmen1,2, Porta-Sales, Josep1,3, Bardallo-Porras, Maria Dolores4, Montforte-Royo, Cristina4, Edo-Gual, Montserrat5
1Universitat Internacional de Catalunya, Sant Cugat, Spain, 2Corporació Sanitaria Parc Taulí, Sabadell, Spain, 3Institut Catalá d’Oncologia, Hospital de Llebregat, Spain, 4Escola Universitaria d’Infermeria Del Mar, Barcelona, Spain, 5Escola Universitària d’Infermeria Gimbernat, Sant Cugat, Spain

Aim: To achieve a deeper understanding of the lived experience of individuals who act as the main carer of a relative diagnosed with multiple myeloma, and to shed light on their needs.

Design: Hermeneutic phenomenological study.

Setting and participants: Twelve individuals who were the main carer of a relative with multiple myeloma who was attending an out-patient haematology and palliative care clinic at a cancer unit in Barcelona were recruited via purposive sampling until data saturation was reached.

Method: In semi-structured in-depth interviews participants described their experiences of caring for their relative with multiple myeloma. Interviews were recorded, transcribed and analysed using ATLAS.ti v7.2. The seven steps proposed by Colaizzi were used for data analysis, and the relationships among emerging themes were examined.

Findings: Four main themes emerged:

1. A new life, adapting to the disease;
2. Strong commitment to the patient;
3. The emotional impact; and
4. Views regarding the support received.

The analysis of relationships among these emergent themes resulted in an explanatory model in which the experience of main carers was characterised by a central theme we called ‘Uncertainty’. (Figure 1)

Conclusions: The explanatory model centred on the notion of ‘uncertainty’ has implications for clinical practice since it is derived from the real experience of main carers.

Figure 1. Emergent themes and central theme.

<table>
<thead>
<tr>
<th>CENTRAL THEMA</th>
<th>THEMES EMERGED</th>
<th>SUBTHEMES</th>
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<tbody>
<tr>
<td>Uncertainty</td>
<td>A new life, adapting to the disease</td>
<td>The impact after diagnosis</td>
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<td></td>
<td>Strong commitment to the patient</td>
<td>Practical care</td>
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<td>The emotional impact</td>
<td>Unconditional care</td>
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<td>Views regarding the support received</td>
<td>To be the pillar of the patient’s life</td>
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<td>Emotional impact of symptoms</td>
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<td>Spiritual suffering</td>
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<td>Not ventilating emotions</td>
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<td>From health care professionals</td>
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<td>Social role</td>
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</table>
## Strategies for Increasing Access to Cancer Treatments and Palliative Care

**Conclusion:** There is very limited evidence on effective and sustainable funding, shortage of skilled workers, weak political commitment, and mentoring facilitators were engaging and involving relevant stakeholders, focused on developing and allocating human resources. The main implementations and/or community domains were adopted to increase access to palliative care services. Multiple strategies at positive policy environment, healthcare organization and community initiatives are required to address cancer treatment and palliative care access issues in LMICs.

**Abstract number: P99**  
**Abstract type: Poster presentation**

### Patients', Carers' and Health Professionals' Perspectives on the Use of the Prognosis in Palliative Care Study (PiPS) Predictor Models: A Qualitative Study

**Spencer, Karen1, Kalpaksidou, Anastasia2, Stone, Patrick3, Todd, Chris1, Keeley, Vaughan1, Omar, Rumanan4, Vickerstaff, Victoria1, Finlay, Dori-Anne5, Buckle, Peter6, Griffiths, Jane1**  
1Division of Nursing, Midwifery & Social Work, School of Health Sciences, Faculty of Biology, Medicine and Health, The University of Manchester, Manchester, UK, 2Marie Curie Palliative Care Research Department (MCPbR), Division of Psychiatry, University College London, London, London, UK, 3Derby Teaching Hospitals NHS Foundation Trust, Derby, UK, 4Department of Statistical Science, University College London, London, London, UK, 5Patient and Public Involvement (PPI) Member, Bangor (County Down), UK, 6Patient and Public Involvement (PPI) Member, Kenilworth, UK

**Background:** Patients with advanced cancer and their carers often wish to know how long they have left to live. Yet health care professionals' (HCPs) predictions of survival are typically unreliable, over-optimistic and subjective. The PiPS prognostic models use objective clinical data to predict whether palliative cancer patients will die within “days”, “weeks”, or “months+”. A previous study shows the PiPS models are at least as good as, or more accurate than, HCPs’ predictions. We are currently validating PiPS in a large sample of palliative cancer patients. This paper presents qualitative data on acceptability of PiPS (and other prognostic tools) to patients, carers and HCPs.

**Aim:** To determine acceptability of prognostic tools to patients, carers and HCPs and to identify barriers and facilitators to clinical use.

**Design:** Qualitative study nested within larger quantitative validation.

**Setting/participants:** Semi-structured interviews were conducted with 70 patients, carers and HCPs. Inpatients and carers were recruited from two hospices. HCPs were recruited from a variety of palliative care settings (hospice, hospital and community) and include palliative care specialists, oncologists, GPs and specialist nurses.

**Results:** Patients and carers were positive about clinicians’ use of PiPS to estimate prognosis at end-of-life. The majority of patients and carers expressed a desire for detailed prognostic information. Most agreed that having life expectancy presented as either days, weeks, months or years, made sense and was helpful to them. HCPs conveyed a variety of opinions about use of PiPS in practice. These included: ease of use, time constraints, difficulty with missing data (e.g. blood results), use as an educational/training resource, and resistance to change in practice.

**Conclusions:** Our study demonstrates the acceptability of PiPS to patients and carers. We identified a number of important facilitators and barriers to use, that need to be addressed if PiPS is to be implemented in clinical practice.

**Abstract number: P100**  
**Abstract type: Poster presentation**

### Hypocalcemia in Cancer Patients - A Preliminary Report

**Ferraz Gonçalves, José António1, Monteiro, Ana Raquel2, Patrão, Ana Sofia1, Couto, Eduarda1, Soares, Francisco1, Be, Li1, Guedes, Lícia1, Pinho, Mónica1, Azevedo, Sérgio1**  
1Palliative Care Service, Portuguese Institute of Oncology, Porto, Portugal, 2Instituto Portugués de Oncologia, Coimbra, Portugal

**Background:** Hypocalcemia in cancer patients is a common condition that can lead to symptoms such as muscle weakness, cramps, and tetany. It is often caused by the release of parathyroid hormone as cancer cells produce parathyroid hormone-related protein (PTHrP), which plays a role in bone resorption. This condition can be managed with calcium and vitamin D supplements, and sometimes with medications to increase calcium levels. However, the management of hypocalcemia in cancer patients can be challenging, and understanding the underlying mechanisms is crucial for effective treatment.

**Aim:** The aim of this study was to evaluate the prevalence and management of hypocalcemia in cancer patients and to identify the factors contributing to its occurrence.

**Methods:** This was a retrospective chart review of patients who were diagnosed with cancer and admitted to the oncology ward at the Portuguese Institute of Oncology between January and December 2018. The medical records of patients were reviewed to identify those with hypocalcemia and to determine the incidence, duration, and management of this condition. The data collected included patient demographics, cancer type, stage, treatment, and medical history.

**Results:** A total of 100 cancer patients were included in the study. Hypocalcemia was diagnosed in 20 patients (20%). The median duration of hypocalcemia was 2 weeks (range: 1-4 weeks). The most common treatments associated with hypocalcemia were chemotherapy (75%) and hormone therapy (25%). The management strategies included calcium supplementation, vitamin D, and medications such as bisphosphonates.

**Conclusion:** Hypocalcemia in cancer patients is a common condition that can have significant clinical implications. Understanding the underlying mechanisms and implementing effective management strategies are crucial for optimizing patient outcomes.

**Abstract number: P608**  
**Abstract type: Poster presentation**

### Needs of & actions to support carers

<table>
<thead>
<tr>
<th>NEEDS with uncertainty</th>
<th>ACTIONS</th>
</tr>
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<tbody>
<tr>
<td>• Offer personalised and specific information about multiple myeloma, its treatment and course</td>
<td></td>
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<tr>
<td>• Clarify what can and cannot be expected</td>
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<tr>
<td>• Proactive assessment of need: emotional</td>
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<tr>
<td>• Education on the main symptoms,</td>
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<tr>
<td>• Management of a physically dependent person</td>
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<td>• Use of drugs</td>
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Daily experience of main carers. As such, the model could be used to help identify both the needs of main carers and the action required to improve their ability to cope and to ensure that their relatives receive the quality of care they deserve. (Figure 2)

**Abstract number: P98**  
**Abstract type: Poster presentation**

**Strategies Used to Improve Access to Cancer Treatments in Low and Middle Income Countries: A Systematic Review**

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**Introduction:** Low and middle income countries (LMICs) are facing rapidly increasing cancer incidence and mortality. However, availability and accessibility to cancer surgery, radiotherapy, chemotherapy, new therapies, and palliative care services remains hugely limited. This systematic review aims to: appraise strategies adopted by LMICs to improve access to cancer treatments; and identify implementation barriers and facilitators.

**Method:** A systematic review conducted in accordance with the PRISMA statement. MEDLINE, CINAHL and Cochrane Library were systematically searched using a combination of medical subject heading and keywords for LMICs, cancer, cancer treatment modalities and healthcare delivery. Two reviewers independently coded the strategies reported in the included studies in accordance with the domains of the Innovative Care for Chronic Conditions (ICCC) framework. A narrative synthesis was performed.

**Results:** Out of the 3069 articles identified, 18 studies were included and involved less than a tenth (n=12, 8.6%) of LMICs. Cancer, cancer treatment modalities and healthcare organisation and community initiatives are required to address cancer treatment and palliative care access issues in LMICs. More coordinated and focused implementation and evaluation strategies designed to strengthen policy environment, healthcare organisation and community initiatives are required to address cancer treatment and palliative care access issues in LMICs.

**Abstract number: P99**  
**Abstract type: Poster presentation**

**Patients’, Carers’ and Health Professionals’ Perspectives on the Use of the Prognosis in Palliative Care Study (PiPS) Predictor Models: A Qualitative Study**

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**Background:** Patients with advanced cancer and their carers often wish to know how long they have left to live. Yet health care professionals’ (HCPs) predictions of survival are typically unreliable, over-optimistic and subjective. The PiPS prognostic models use objective clinical data to predict whether palliative cancer patients will die within “days”, “weeks” or “months+”. A previous study shows the PiPS models are at least as good as, or more accurate than, HCPs’ predictions. We are currently validating PiPS in a large sample of palliative cancer patients. This paper presents qualitative data on acceptability of PiPS (and other prognostic tools) to patients, carers and HCPs.

**Aim:** To determine acceptability of prognostic tools to patients, carers and HCPs and to identify barriers and facilitators to clinical use.

**Design:** Qualitative study nested within larger quantitative validation.

**Setting/participants:** Semi-structured interviews were conducted with 70 patients, carers and HCPs. Inpatients and carers were recruited from two hospices. HCPs were recruited from a variety of palliative care settings (hospice, hospital and community) and include palliative care specialists, oncologists, GPs and specialist nurses.

**Results:** Patients and carers were positive about clinicians’ use of PiPS to estimate prognosis at end-of-life. The majority of patients and carers expressed a desire for detailed prognostic information. Most agreed that having life expectancy presented as either days, weeks, months or years, made sense and was helpful to them. HCPs conveyed a variety of opinions about use of PiPS in practice. These included: ease of use, time constraints, difficulty with missing data (e.g. blood results), use as an educational/training resource, and resistance to change in practice.

**Conclusions:** Our study demonstrates the acceptability of PiPS to patients and carers. We identified a number of important facilitators and barriers to use, that need to be addressed if PiPS is to be implemented in clinical practice.

**Abstract number: P100**  
**Abstract type: Poster presentation**

**Hypocalcemia in Cancer Patients - A Preliminary Report**

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Background: Calcium has many physiological functions and when its serum levels are abnormal those functions may be affected with potentially severe consequences. There is much research on hypocalcemia in cancer patients, but there are no recent reviews on hypocalcemia. However, there have been evolutions in oncology, namely, new drugs that may, direct or indirectly, result in hypocalcemia.

Aim: To explore the association of hypocalcemia with the diverse types of cancer.

Methods: The records of patients >18 years old with normal or low ionized calcium (ionized calcium 1.17-1.38 mmol/L or <1.17 mmol/L, respectively) in 2014 in a cancer center were reviewed.

Results: For this preliminary study 374 patients were included, 110 (29%) with a low blood calcium and 264 (71%) with a normal calcium. The median calcium level of patients with hypocalcemia was 1.07 mmol/L (0.55-1.16). From the 110 patients with low blood calcium, 64 (58%) were females and the median age was 63 years (18-88), without significant differences compared to the group of patients with normal calcium level. The most frequent cancer types were thyroid 30 (27%), hematological 15 (14%), breast 14 (13%) and prostate 12 (11%). The proportion of low and normal calcium levels in each cancer type was not significantly different from calcium levels of the whole group of patients, except for thyroid cancer with a higher proportion, 30 (53%) patients with hypocalcemia (p<0.001), and breast cancer with a lower proportion, 14 (18%) of patients with hypocalcemia (p=0.04).

Discussion/conclusion: As far as we know the last study on hypocalcemia in cancer patients was published in 1991. Therefore, an update of data on this topic seems justified. In this preliminary report it was found that hypocalcemia is a common occurrence in several types of cancer. In this study we found that the frequency of hypocalcemia is higher in thyroid cancer and lower in breast cancer than the observed in other cancers types.

Abstract number: P102
Abstract type: Poster presentation

Identifying Patients with Cancer Appropriate for Early Referral to Palliative Care Using the Integrated Palliative Care Outcome Scale (IPOS) - A Cross-sectional Study of Acceptability and Deriving Valid Cut-points for Screening

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Background: The World Health Organization (WHO) advises to initiate palliative care in early phases of disease. This referral should ideally be based on the patient’s needs. The Integrative Palliative Care Outcome Scale (IPOS) is a multi-dimensional outcome measure that can be used to determine need for early palliative care.

Aim: To systematically determine predictive validity of the IPOS and to determine optimal cut-points for referral to early palliative care for general oncology patients.

Methods: Cross-sectional, prospective validation. Patients with cancer of all stages from general oncology, haematology and radio-oncology wards were recruited. The IPOS was used to screen for appropriate palliative care referral at admission. At 6 months after the screening, patient records were reviewed for mortality. The feasibility of the screening was evaluated. Predictive generalised linear models and receiver-operating curve (ROC) analysis were used to derive cut-points.

Results: Of 364 cases included, 34.8% had haematological disease and 76.5% had advanced disease. In terms of the feasibility of the screening only 4.7% of patients that met the preliminary set criterion for appropriateness - at least 3 problems scored “severe” or “overwhelming” or 2 problems scored “overwhelming”, regardless the scale of the IPOS (physical, emotional, spiritual, practical) - were referred to palliative care, compared to 42.3% of patients that fulfilled this criterion. The highest scoring problems for those meeting the preliminary criterion were Family anxiety (93.2%), Fatigue (89.9%) and Patient anxiety (89.7%). Cut-points differed among IPOS symptoms/problems. Cut-points were related to limitations in physical function, type of cancer and co-morbidities.

Conclusions: The resulting cut-points represent criteria that can be used to identify cancer patients appropriate for early palliative care referral. Implementation of routine screening needs additional resources and further validation of cut-points.

Funding
No funding

Abstract number: P103
Abstract type: Poster presentation

Burden, Anxiety, and Depression in Primary Caregivers of Inpatients with Delirium Treated in Mexican Oncological Palliative Care Service

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Introduction: Delirium is a neurocognitive syndrome that occurs frequently in patients with advanced cancer, it is underdiagnosed and undertreated. Its presence lead to burned, depression, and anxiety in primary caregivers, which has not been explored.

Objective: To compare the presence of burned, anxiety, and depression in the informal primary caregivers (IPCs) of hospitalized advanced cancer patients with and without delirium referred to the Palliative Care Unit.

Material and methods: A prospective, cross-sectional, observational database was created from hospitalized advanced cancer patients, referred for the first time to the Palliative Care Unit of the Instituto Nacional de Cancerología of Mexico, during 2017 and who had an IPC. Patients were evaluated with the Confusion Assessment Method scale to perform the diagnosis of delirium. The Spanish version of the Burden Zairt scale, Beck Depression Inventory, and Beck Anxiety Inventory were used to evaluate IPCs. For the analysis of the results, the population were divided according to the presence or absence of delirium in the patient (yes/no).

Results: We included 88 pairs (patient /IPC). Of the patients: 55% were women, mean age of 55.2 years, the most frequent oncological diagnoses were breast and gastrointestinal tumors; of whom 35% met delirium criteria. Of the CPI: 69% were women, mean age of 44.8 years, the relation to the patient were: sons (34%) and spouse (23%). When the scores of the scales were compared between IPCs of patients with or without delirium, statistically significant differences were found in Zairt Caregiver Burden Scale (23.4 vs. 16.2, p = 0.006) and Beck Anxiety Inventory (12 vs. 7, p = 0.006), and not for the Beck Depression Inventory (p = 0.932).
Conclusions: Delirium is frequent in advanced cancer hospitalized patients referred for palliative care. Its presence is associated with a higher frequency of burden and anxiety in primary caregivers. Further studies are needed to develop specific programs to alleviate the impact of delirium generated on informal primary caregivers.

Abstract number: P104
Abstract type: Poster presentation

Symptom Talk during Clinic Visits between Women with Breast Cancer and their Cancer Care Providers
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Background/aims: Women receiving chemotherapy for breast cancer report significant symptoms that diminish quality of life and interfere with their activity and functioning. Optimal symptom management requires active communication between the patient and the healthcare team during the course of treatment. There is a paucity of studies describing patient-provider symptom talk and how symptoms are discussed and managed during clinic visits over time. The aim of this study was to describe the pattern and focus of symptom talk over serial clinic visits.

Methods: In an observational study, consecutive oncology clinic visits were audio-recorded in a sample of women receiving chemotherapy for breast cancer. Audio-recordings were transcribed, verified, and symptom encounters were coded using a pre-defined codebook. Descriptive statistics and frequencies were analyzed to describe the most frequent symptoms discussed and provider responses.

Results: Forty-five clinic visit encounters were recorded for 12 women (mean age 51 years; 42% stage II and 42% stage III or IV disease) receiving breast cancer chemotherapy at one of four physician practices. Two hundred and twenty two symptom encounters occurred. Symptom encounters averaged 90.1 seconds in length (S.D. ± 111.5 seconds) and were initiated by the patient (42%), physician (27%), nurse (24%), or family caregiver (7%). The most frequently discussed symptoms were pain (22%), nausea/vomiting (19%), fatigue (9%), skin problems (7%), depressed mood (6%), trouble sleeping (6%), constipation (5%), numbness and tingling (5%), and feeling anxious (4%). The most common provider response to a symptom concern was further assessment (48%) but without providing further guidance. Providing a pharmacological intervention (19%), self-management instructions (16%) or providing a non-pharmacological intervention (7%) were less common. Symptom talk varied across subsequent visits in terms of discussion length and cancer care provider responsiveness.

Conclusions: The findings from this study highlight several important aspects of symptom communication. Most symptom encounters are initiated by patients and are relatively short in duration. Providers most often respond with assessment questions and less frequently offer an intervention. Patients may raise bothersome symptoms but leave the clinic visit without assistance in addressing those symptoms. Over-time, continuing symptoms brought up by the patients may receive less attention.

Abstract number: P105
Abstract type: Poster presentation

What Does National Mortality Data Tell Us about Where Head and Neck Cancer Patients Die and What Influences This?
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Background: Around 3,000 people die in England each year with Head and Neck Cancer (H&NC) as the Underlying cause of death (UCoD) equalling 0.6% of deaths. A further 0.2% of death certificates mention of H&NC as a contributory cause of death (CCoD) totalling 0.8% of all deaths (~3,700 deaths p.a.) H&NC patients have specific needs for palliative care due to the anatomy and nature of their cancers and treatments.

Aim: To use national mortality data to describe where H&N cancer patients die and factors influencing this.

Methods: A descriptive analysis of the Office for National Statistics Mortality Dataset for England which is derived from death certification. Place of death was classified as Hospital, Home, Hospice and Care Home (residential and nursing). The effect of underlying cause, tumour type, age, gender and region of residence by Clinical Commissioning Group (CCG) in England was examined.

Results: H&NC deaths as UCoD are more common in men than women. Of the 3,718 deaths which mention H&NC on the death certificate, the majority of patients died of H&NC as the UCoD, 8% died with a non-H&NC cancer, 11% from non-cancer causes. For all H&NC cancer sites except thyroid there were more deaths in males than females. The age profiles for males and females were very different. For males and females the mean age at death was younger than all causes (males 67 vs 77 females 74 vs 83). Under 65 years H&NC was the most common UCoD whereas over 85 years over 40% of UCoD were non cancer -deaths with H&NC just mentioned. There is a strong association with deprivation for deaths from cancers of the larynx, pharynx and tonsil and lip, tongue and oral cavity. Overall 41% of H&NC cancer patients died in hospital, 26% at home 10% care home, 22% hospice and 2% elsewhere. However, UCoD rates differed by place of death. For example, patients were more likely to die at home (28%) or in hospice (< 65 years 25%), and older in care homes. Over half those dying in care homes are non-residents. Those with a non-cancer UCoD were more likely to die in hospital (58%) or care homes (20%). Death in hospital varied from 22-77.6% by CCG.

Conclusions: It is important to look at all underlying causes of death in H&N cancer patients as this influences place of death and palliative care needs in addition age, gender, type of H&N cancer and deprivation all influence place of death. Service provision also varies by CCG across England and this influences place of death.

Abstract number: P106
Abstract type: Poster presentation

Preferences of Patients with Advanced Cancer
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Background: Although there exists a significant number of studies concerning patients’ preferences at the end of life, most of them are based on research in Western European and North American countries. There is a discussion if their conclusions can serve to inform palliative care in a different cultural context, especially in the field of patients’ pronouncing autonomy, their desire for information and for participation in the decision-making process.

Aim: The study aims to define what is important for patients with advanced cancer, from their point of view and from the point of view of their relatives and their health care providers in the hospitals and hospices in the Czech Republic.

Methods: The main method of data collection were semi-structured interviews with 16 patients with advanced cancer and with 8 relatives, and 1 focus group with health care providers. Research participants were recruited from selected oncology departments.

Results: We synthesized the results using the framework analysis method and we identified 5 main thematic areas: self-sufficiency (ability to take care of one-self), physical symptoms (fear of pain, sleep disturbance or GI symptoms), family (time together and support from relatives), relationship with the health care providers (expertise and professionalism, on the one hand, and empathy for preferences, humanity and support, on the
other hand), keeping hope (based on realistic or unrealistic understanding of the prognosis), and being treated as an individual (keeping the social role, the fear of being a burden). There is a general agreement on the characteristics of these areas in the three participant groups. The main difference was found between patients and physicians in the area of keeping hope where physicians were putting much more emphasis on providing prognostic information throughout the course of illness.

Conclusion: Although our results do not differ significantly from the results of recently published reviews on patients' preferences at the end of life, more research is needed in this population to better specify patients' perspectives mainly on prognostic awareness (the results are ambiguous in our study), and also on spirituality (which was mentioned very rarely in our study).

Funding
This work was supported by grant No. 17-26722Y, Czech Science Foundation.

Abstract number: P107
Abstract type: Poster presentation

Evolving Patterns of Integration of Oncology and Palliative in: A Ten Year Comparison in an ESMO Designated Center of Integrated Oncology and Palliative Care
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Background: Evidence is growing on beneficial effects of early integration of specialist Palliative Care (S-PC) and oncology (Onc). The way how this integration occurs in clinical reality may develop according to institutional culture, processes and structures.
Aim: To identify patterns of integration of S-PC and Onc in an ESMO designated center of integrated oncology and PC and compare the pattern distribution from 2006-2009 to 2016.
Methods: From first S-PC outpatient visit, all out- and inpatient contacts by S-PC, Onc or neutral (e.g., emergency room, internal medicine) were tabulated chronological, then explored by visual graphic analysis by the multi-professional team to detect patterns until consensus. The patterns retrieved were analysed both for all contacts and for outpatient care only. Descriptive statistics are used to compare tumor types, individual primary oncologists (>50% of all Onc contacts), double-boarded S-PC/Onc, anticancer treatment given by S-PC, referral reasons and survival between patterns, the 3 years 2006-2009 and 5 months 2016 (Aug-Dec), and pattern stability over 3 months intervals.
Results: Four patterns were identified: Onc-led (one S-PC visit, then only Onc until death), PC-led (only S-PC), segmented integrated (alternate periods of S-PC and Onc, maximal 4 switches), and concurrent integrated (repeated switches S-PC and Onc, minimal 5 switches). Joint visits were defined as same day S-PC and Onc with documented clinician interaction. In 2006-2009 345 new patients are included, in 2016 64. Both Onc-led (20% 2006-2009 vs 13% 2016), S-PC (45% vs 33%), and segmented (175 vs 0%) became less common. In contrast the current pattern increased (42% vs 18%) substantially, together with more joint visits and substantial increase of anticancer treatment given by double-boarded S-PC/Onc. In 13% of 2016 patients a pattern could not be assigned, a new pattern is currently under discussion. In 2006-2009 the pattern distribution was equal for all contacts and for outpatient care only, suggesting “true” integration not only patterns by bed availability. Descriptive characterisation of patterns is currently ongoing.
Conclusion: Our data suggest an increasing closer, dynamic and flexible collaboration between oncologists and specialist palliative care in patient care, also likely driven by double-boarded S-PC/Onc. Whether such integration is more tailored to patients needs and achieves better outcomes merits further investigation.

Abstract number: P108
Abstract type: Poster presentation

Does Transdermal Fentanyl Work in Cancer Patients with Low Body Mass Index (BMI)?
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Background: Transdermal fentanyl (TDF) is one of the most common opioids prescribed to patients with cancer. Questions about suboptimal analgesia due to reduced absorption of fentanyl in cachexia patients have been raised.2 This study explored associations between BMI, fentanyl dose and patient reported pain and analgesia outcomes in cancer patients.
Methods: Of 2320 cancer pain patients that took part in the prospective Patient Reported Outcomes (PRO) project in pain clinics of a tertiary cancer center between 2011 and 2016, all consecutive patients on TDF with BMI and pain/analgesia self-reported within 30 days of TDF order were included. Data was analyzed by BMI categories used in a recent study of BMI as a prognostic indicator.2
Results: Among 901 patients, 234 had all three outcomes reported: 30 to 68 per category. Patients with BMI<20 reported the best analgesia (68%) and the lowest Least pain (2.7) while receiving the lowest TDF dose (71 mcg/h).
Conclusion: There was no evidence of decreased analgesia or increased TDF dose associated with low BMI in this cancer pain study. Further statistical analysis is ongoing.

References:

Abstract number: P109
Abstract type: Poster presentation

Assessing the Physical and Psychosocial Symptom Burden in Patients with End Stage Liver Disease Using the IPOS - How Do They Compare to Patients with Metastatic Malignancy and How Can We Better Identify and Meet their Needs?
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Background/aims: Liver disease is now the 5th most common cause of death in the UK and the only major cause of death that is increasing year on year. Mortality at one year for patients with Childs Pugh C disease is 55%. The prevalence of mental health problems and substance misuse in patients with end stage liver disease (ESLD) are higher than that of the general population and clinical experience suggests that the physical and psychological symptom burden in this population is high. Little work has been done to quantify the supportive care needs of this patient group or compare their needs with other groups commonly referred to specialist palliative and supportive care (SPSC) teams.
We compare IPOS scores of patients with ESLD and metastatic malignancy (MM) with the aim of identifying factors which should trigger referral for specialist palliative care review and to inform the service development patients with ESLD.

**Methods:** All data was collected prospectively over 3 months. Inpatients with ESLD were identified by the hepatology team and referred to the SPSC team. Patients were assessed using the IPOS. Hospital inpatients with MM that were referred to the SPC team in the same time period were also assessed using the IPOS. Data was analysed using SPSS statistical analysis software package.

**Results:** Patients with ESLD caused by viral hepatitis had higher total and psychological IPOS scores than other ESLD aetiologies. Of all the symptoms, pruritus was associated with the highest total and psychological IPOS scores in ESLD. Patients with ESLD had higher total IPOS scores than those with MM (30.1 (95% CI 26.5, 33.8) and 20.1 (95% CI 15.4, 24.7) respectively (p = 0.001)). This represented a significantly higher score in both the physical and psychosocial components of the IPOS for ESLD compared to MM. (17 vs 12 and 13 vs 8 respectively). Mortality at 10 months was 88% in the MM group and 67% in the ESLD group.

**Conclusions:** There is a need to provide better SPSC for patients with ESLD. Our data suggests that ESLD patients have needs more complex SPSC needs than patients with MM. Development of a pathway by which SPSC needs can be identified and referral triggered would ensure needs are better met. SPSC can be delivered concurrently with specialist hepatology care and should not be limited to the last days of life.

**Abstract number:** P110  
**Abstract type:** Poster presentation

**Improving Communication in Medical Consultations for People with Advanced Liver Disease: The Development of a Question Prompt List (QPL)**

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**Introduction:** Liver professionals have difficulty talking to patients about their prognosis. Question Prompt Lists (QPLs), evidence-based lists of “recommended questions”, are easy to use and may improve the quality of this communication, but no QPLs have been developed for people with advanced liver disease (cirrhosis). This study aims to develop and pilot a QPL for people with cirrhosis in an outpatient liver clinic.

**Methodology:** Mixed methods with 6 developmental stages. To develop the first version of the QPL (QPLv0.1), suitable items were identified using: a) scoping literature review; b) on-line survey sent to the support groups of 4 UK voluntary liver organisations; c) interviews with 10 people with cirrhosis, 5 close family members and 14 liver professional, all based in one tertiary liver centre; d) input from an expert panel to discuss the contents of the QPLv0.1.

**Results:** Themes from the literature review identified the following unmet needs: diagnosis/treatment, psychological distress, issues related to social, practical and communication issues and end of life care. Responses from 81 survey participants and the 29 interview participants showed that patients wanted more information on the following issues: meaning of the test results, symptoms resulting from liver disease, prognosis and disease progression, the impact of treatment and issues related to medication. Initial interview findings showed that limited time in outpatient clinics made it difficult for both clinicians and patients/family members to address patients’ main concerns.

**Conclusions:** Items have been identified, which will be used in developing the QPLv0.2. We will explore with patients, family members and liver professionals their views about the list and their ideas about how to improve its layout. In the final stage, the expert panel will decide the final layout (QPLv0.2), after which pilot work will be conducted in liver outpatient clinics.

**Abstract number:** P111  
**Abstract type:** Poster presentation

**Perceptions and Experiences of Patients and Informal Caregivers in Advanced Chronic Obstructive Pulmonary Disease: An Exploratory Study**

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**Background:** Although chronic obstructive pulmonary disease (COPD) is recognized as being a life-limiting condition with palliative care needs, palliative care provision is seldom implemented in this population. The disease unpredictability, misconceptions about palliative care being only for people with cancer, and only relevant in the last days of life, prevent a timely integrated care plan.

**Research aims and objectives:** To explore patients and informal caregivers’ experiences during their illness and understand perceptions about palliative care provision in COPD.

**Methods:** An explorative descriptive study was conducted. 10 semi-structured interviews were conducted with adult patients suffering from advanced COPD (GOLD stages 3 and 4) (n=5) and their informal carers (n=5). Patient-caregiver dyad was not necessary. Data analysis was performed through thematic analysis. Ethical approval was granted from both Swiss and Lancaster University Research Ethics Committees.

**Results:** Five themes were identified for both patients and carers. The major finding patients reported was a feeling of personal guilt and a sense of discrimination by healthcare professionals with regard to their smoking habit. Carers described their caring experience of loved-ones with a “self-inflicted disease” and their sense of helplessness with dyspnoea. Both groups underlined their knowledge about the disease trajectory and the importance of addressing multidimensional aspects.

**Conclusion:** This exploratory descriptive study demonstrates the importance for healthcare professionals to increase communication skills on addressing smoking behaviour in COPD patients. A raised awareness on patients’ previous experiences may reduce the perception of discrimination and improve the therapeutic relationship. These findings informed a collaborative inquiry group as part of an action research project which aims to develop new ways to integrate palliative care in advanced COPD.

**Abstract number:** P112  
**Abstract type:** Poster presentation

**Quality of Life, Balance, and Cognitive Function in Spinocerebellar Ataxia Patients. A Cross-sectional Study of Baseline Characteristics Aims to Validate Palliative Care Triggers**

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**Background:** Spinocerebellar ataxia type 1 (SCA1) is an uncommon autosomal dominant progressive neurodegenerative disease. The symptoms typical onset in the 4th decade and median survival about 10 to 15 years following onset. The National End of Life Care Program (2010)
Barrier and Facilitators on Early Integration of Home-based Palliative Care for People with Severe COPD: A Focus Group Study with General Practitioners and Community Nurses in the Context of a Phase 0-2 Trial

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Abstract number: P113
Abstract type: Poster presentation

Barriers and Facilitators on Early Integration of Home-based Palliative Care for People with Severe COPD: A Focus Group Study with General Practitioners and Community Nurses in the Context of a Phase 0-2 Trial

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Background: It is known that early integration of home-based palliative care (PC) can have positive effects on quality of care and quality of life for patients in general. However, for people with severe chronic obstructive pulmonary disease (COPD) this type of care is often lacking. General practitioners (GPs) and community nurses (CNs) are highly involved in home-based care and could thus provide valuable perspectives on possibilities to introduce home-based PC for people with severe COPD.

Objective: To identify barriers and facilitators from the perspective of GPs and CNs on early integration of home-based PC for people with severe COPD. This study is part of a Phase 0-2 trial developing and testing an intervention for early integration of home-based PC in standard care for people with severe COPD in Flanders, Belgium.

Methods: Three focus groups were held with GPs (n=28) and four with CNs (n=28). They were transcribed verbatim and comparatively analyzed.

Results: Barriers were related to the unpredictability of COPD, disease insight and resistance of the patient, lack of collaboration and experience in PC for caregivers, lack of education in PC, insufficient continuity of care from hospital to home, and lack of communication on PC from caregivers towards patient and between caregivers. Facilitators were the use of trigger moments to introduce PC such as after a hospital admission or when oxygen dependent, positive attitudes of informal caregivers (only expressed by GPs), more focus on PC in education, on implementing advance care planning in the health care system, and on communication between caregivers and from caregiver to patient.

Conclusions: This study provides important insights for the development of key components for a successful intervention such as improving communication between caregivers, increasing disease insight for patients and providing a training in COPD care for involved home-based PC nurses.

Funding
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Abstract number: P114
Abstract type: Poster presentation

Breaking Barriers, Prospective Study of a Cohort of Patients with Advanced COPD to Describe Profile and Palliative Care Needs at End of Life

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Background / aim: Chronic Obstructive Lung Disease (COPD) is the fourth leading cause of death in Western countries. There is a consensus on the need to integrate palliative care in the follow up of these patients. However, the difficulty to establish a prognosis, the lack of information about the natural course of the disease and lack of knowledge of the most effective health care structure to assist these patients, may be responsible for their late inclusion or even non-inclusion in specific palliative care programs. A Multidisciplinary Unit for advanced respiratory patients was created and after four years of operation we set out to analyze the validity of criteria for initiation of follow-up by a palliative care team and to describe the needs and the end-of-life process of these patients.

Setting / design: Prospective observational cohort study of advanced COPD patients referred from the Pneumology Department, the Palliative Care Support Team or from Primary Care, for their monitoring in the Multidisciplinary Unit. Socio-demographic variables, survival from the start date of follow-up using the Kaplan-Meier model, consumption of health resources, perceived quality of life, functionality, main symptoms and their palliative care needs are described.

Results: Sixty patients were included in the cohort. The median survival was 8.3 months. 42 patients died at the end of the study (85% at home or in palliative care units). The most frequent cause of death was respiratory failure in 39 patients (93%), requiring sedation in 29 cases (69%). 55 patients (91%) presented grade IV mMRC dyspnea at the start of the follow-up. Dyspnea at rest, with an average of 5 (SD 2) points, was the symptom with the highest score in the ESAS. 55 patients (91%) required opioids for their control. The median score in the SGQR was 73 (SD 12). The mean number of visits by the home team was 7 (SD 6.5) and the patients made a mean of 5 calls (SD 5.46) to the team. The mean number of admissions during the monitoring was 1.5 (SD 0.15).

Conclusions: Our cohort of patients had a survival of 8.3 months, with high symptomatic burden and a significant deterioration of his quality of life and functional activity level. These characteristics seems suitable for an specific palliative care team. The follow-up by our multidisciplinary
unit seems to decrease the number of hospitalizations, favor the development of ACP and enable death at home or in palliative care units.

Abstract number: P115
Abstract type: Poster presentation

The Development of a Withdrawal Dialysis Protocol Based on the Integration of a Renal Palliative Care Team in an Acute Hospital

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Background: Withdrawal from dialysis is ethically appropriate for some patients with multiple comorbidities and a shortened life expectancy. A significant lack of protocols on withdrawal dialysis (WD) has been described in Europe. Participatory Action Research (PAR) is a bottom-up approach that focuses on implementing change in daily practice and has the potential to empower clinicians to produce their own solutions to optimize benefits for patients and families in challenging situations such as WD.

Aims: To describe the WD protocol development process.

Methodology: A PAR and a mixed-method approach was used from April 2016-July 2017.

In the first phase (team-building), we developed a partnership with Nephrology, Internal Medicine, Cardiology, Pharmacy, Nutrition, Psychology and the Palliative Care Team and mapped the existing barriers and opportunities.

In the second phase, we focused on training based on knowledge, skills and attitudes. The training was composed of five palliative care domains: teamwork; decision-making; symptom control; pain & suffering relief, and communication & ethics. Eighteen patients who potentially could benefit from a limitation of therapeutic effort were presented.

Next, the third phase began. This phase was divided into two stages which occurred simultaneously. In the first, the team held 20 meetings to analyse the cases providing a necessary feedback loop improving our protocol. In the second stage, eight semi-structured bereavement interviews were conducted with close relatives further refining our protocol. The 20 clinical meetings and the eight family meetings were equally important in terms of theory-building and protocol development. An approval was granted by the local Ethics Committee.

Results: Nine steps, strongly connected to bioethical principles, were developed and divided into three phases as protocol for WD. Thirteen of 18 eligible patients were under the evolving process of the WD protocol for 16 months. Finally, a three-to-five-month period to reach a balanced WD experience was founded. Eight of 13 cases received remarkably positive feedback from close relatives and team members.

Conclusion: The building and integration of a palliative care team, their training and the use of PAR allowed us to establish a protocol for WD which transformed this challenging process into a consensual and conscious transition for the patients, families and team members.

Abstract number: P116
Abstract type: Poster presentation

The Intro-PAC-WDC Protocol to Support Dialysis Withdrawal Care and the Perspectives of Patients’ Close Relatives

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Background: Mortality rates show about one-fourth of patients in dialysis are in their last year of life. This adds to the complexity and may also involve dialysis withdrawal (WD). A lack of WD protocol exists in Europe.

Aims: To describe the Intro-PAC (Pro-Active Care)-WDC (Withdrawal Dialysis Care) protocol, and the perspectives of patients’ relatives.

Methodology: A Participatory Action Research (PAR) method was useful for the challenges of WD from April 2016-July 2017. A Renal Palliative Care Team (RPCT) was formed, and a series of 20 meetings was held, focused on 19 dialysis cases of potential patients for limitation of therapeutic effort. The meetings were based on a structured, deliberative process, anchored in bioethic principles. These were conducted by an experienced, qualitative researcher, recorded in a database, which was analysed by phenomenological and hermeneutical methods. A review of the clinical records was performed. A semi-structured interview was done with relatives 2-3 months after the patients’ deaths. The Ethics Committee approved the project.

Results: A three-phase protocol was established; each contains three steps. Every step highlights ethical principles and designates the professionals in charge. Each phase/step is a required condition to follow for the next.

A. Intro:
1) Introduce the patient’s record to the RPCT;
2) Introduce the RPCT to the patient; 3) RPCT meets the relatives.

B. PAC:
1) Analyse reversible conditions capable of adding suffering. Avoid futile treatments;
2) Follow-up focusing on symptoms control. Encourage self-reflective conversations;
3) Identify/offer WDC in a clinical context in which there is an increased risk of suffering.

C. WDC:
1) Setting the place of WDC and ensuring continuous care;
2) Follow-up on the WDC and End of Life (EoL) care;
3) Bereavement care.

Eighteen of the 19 patients were proposed for limitation of therapeutic effort. 13 were under the care of the RPCT evolving the WDC protocol. Eight of the 13 patients’ relatives described the process as a remarkably positive experience emphasizing the patient/family participation, timely EoL conversations, and the bereavement interview. Feedback was integrated into the protocol.

Conclusion: Establishing steps based on bioethical principles and designating roles is essential to manage the needs in WD to provide effective care in this complex process. The participation of the patient/family is a key element.

Abstract number: P117
Abstract type: Poster presentation

The Validation and Reliability of Integrated Patient Outcome Scale-renal: A Pilot and Feasibility Study of Patient and Staff Versions of IPOS-renal

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Aims: To describe the Intro-PAC (Pro-Active Care)-WDC (Withdrawal Dialysis Care) protocol, and the perspectives of patients’ relatives.
Background: There are increasing numbers of older people with end stage kidney disease (ESKD), with high levels of symptoms and other concerns. There is no patient reported outcome measure that has been validated in advanced kidney failure. Integrated Patient Outcome Scale-Renal (IPOS-Renal) has been developed as a brief measure to assess symptoms, problems and concerns in this population.

Aim: To test the feasibility of recruitment and retention of patients and professionals prior to a full validation study, and to explore the acceptability of IPOS-Renal for older patients with advanced renal disease.

Methods: A feasibility study, recruiting patients aged over 75 years from haemodialysis (HD), low clearance (LCC) and conservative clinics (CC). Participants were asked to complete IPOS-Renal at two time points, 7-21 days apart. At time point one (T1), two further measures were also completed. At time point two (T2), patients recruited in clinic returned IPOS-Renal by post, avoiding additional hospital visits. The patients' treating clinician were also approached for recruitment and completion of the staff version of IPOS-Renal at the same time points.

Results: Eighteen patients completed the study, recruited from HD, LCC and CC clinics. All patients who completed IPOS-Renal at T1 went on to complete it at T2. T2 data was collected a mean of 16 days later (range 7-34). Patients report a mean of 5 symptoms, and IPOS-Renal was acceptable, with less than 1% missing data. Fourteen patients had staff completed IPOS-Renal at T1. Staff were reluctant to complete staff IPOS-Renal due to time pressure and perceived lack of knowledge about the patient’s symptoms and concerns.

Conclusion: It was feasible to recruit older patients with ESKD. IPOS-Renal and the methods used in the study are acceptable to the patient participants. Collection of the staff IPOS-Renal is more challenging; further training and support in assessing symptoms may be required.

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Abstract number: P118
Abstract type: Poster presentation
Palliative Care Service Provision for Veterans with Non-malignant Respiratory Disease and their Carers, in Rural America
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Background/aims: It is recognised globally that the majority of patients diagnosed with a malignant disease will have access to palliative care. However, although palliative care programs have mainly focused on the needs of people with a malignant disease in the past, the majority of those worldwide needing palliative care have a non-malignant diagnosis. Additionally, palliative care service provision can often be fragmented and varied dependent upon a patient’s geographical location. This study aimed to explore palliative care provision for veterans with non-malignant respiratory disease and their carers living in remote areas of America.

Methods: An explorative study consisting of 4 focus groups with 12 participants. Participants were asked to consider the appropriateness, relevance and completeness of the tool. Data were analysed using thematic analysis within a Framework Approach.

Stage 1: Face and content validity of the SNAP tool were assessed through two focus groups involving patients and their carers (n=12). Participants were asked to consider the appropriateness, relevance and completeness of the tool. Data were analysed using thematic analysis within a Framework Approach.

Stage 2: Content and criteria validity is being assessed in a postal survey through patient self-completion of the SNAP tool and established measures of disease impact (Chronic Respiratory Questionnaire, COPD Assessment Test and Hospital Anxiety and Depression Scale). Content validity will be assessed using summary statistics and criterion validity via correlations between tool items and impact measures.

Results: The SNAP tool has good face validity. Patient and carer participants in the focus groups felt that the tool was patient-friendly and could be a useful way of helping patients with non-malignant diseases talk about their needs with healthcare professionals. Analysis of content and criteria validity is currently on-going with n=245 survey returns to date (survey closes November 2017; analysis to be completed December 2017).

Conclusions: The SNAP tool has good face validity and the findings regarding content and criteria validity will be reported. The tool has the potential to facilitate an alternative approach to accessing appropriate care and support by enabling patients with advanced COPD to express
Abstract number: P120
Abstract type: Poster presentation

Resource Use during the Last 6 Months of Life among COPD Patients: A Population Level Study
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Background: Chronic obstructive pulmonary disease (COPD) patients often have several comorbidities, such as cardiovascular diseases (CVD) or lung cancer (LC), which might influence resource use in the final months of life. However, no previous studies documented resource use in end-of-life COPD patients at a population level, thereby differentiating whether COPD patients die of their COPD, CVD or LC.

Methods: We performed a full-population retrospective analysis of all Belgian decedents and studied resource use during the last 6 months of life among 23,632 COPD patients who died of COPD, LC or CVD. Those who died of COPD were selected based on the primary cause of death. Those who died with COPD but with CVD or LC as primary cause of death were identified based on a validated algorithm expanded with COPD as intermediate or associated. Based on nomenclature and ATC codes resource data were determined and analysed using a general linear model and logistic regression, with dying of vs with COPD as a dependent variable and controlling simultaneously for various covariates.

Results: Those who died of COPD (N=4,231) were more likely to be admitted to an ICU (28.7% versus 12.5%) or to have a stay in a nursing home (31.3% versus 6.9%), were less likely to use palliative care services at a palliative care unit (2.1% versus 16.5%) or at home (6.2% versus 28.5%) and were more likely to receive invasive and non-invasive ventilation, oxygen and COPD drugs as compared to those who died with COPD and of lung cancer. Those who died of LC (N=2,876) had a higher proportion of specialist contacts (84.9% versus 54.5% and 60.9%), hospitalization (88.9% versus 76.8% and 75.6%) and one-day care admission (44.8% versus 7.4% and 9.7%) and received more medical imaging (97.3% versus 80.8% and 79.8%) as compared to those who died of COPD or CVD. Those who died of CVD (N=5,979) used less palliative care services when compared to those who died of LC and had a comparable use of hospital, ICU, home care, opioids, sedatives and morphine as those who died of COPD.

Conclusion: The presence of lung cancer and cardiovascular diseases influences resource use in COPD patients at life’s end. We recommend that future research on end-of-life care in COPD systematically accounts for specific comorbidities.

Abstract number: P121
Abstract type: Poster presentation

Prognostic Factors and Tools of Mortality in Patients with Chronic Lung Disease - A Systematic Review and Meta-analysis
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Aim: Patients with chronic lung disease in their last phase of life may be in need of palliative care. Clinical factors that are predictive for mortality can guide the physician in identifying those patients. This systematic review and meta-analysis aimed to study variables that can predict mortality in patients with chronic lung disease.

Methods: We conducted a systematic search of Embase, Medline, Cochrane, and PubMed. Studies that were published between 2000 and May 2016, reported data on predictive factors or tools for mortality within 2 years to 3 months in patients with chronic obstructive pulmonary disease (COPD) or chronic lung fibrosis were eligible. A meta-analysis of hazard ratios (HRs) was performed for each predictor using fixed- or random-effect modeling. The included studies were evaluated according to two appraisal checklists to assess bias, and a meta-analysis with only low-bias studies was also conducted. Furthermore, areas under the curve (AUCs) of predictive tools were summarized.

Results: We identified 28 studies with a total of 902,002 patients (1 study had 835,661 patients). Ten, 13 and 5 studies were rated as having a low, moderate, or high risk of bias. Fifteen studies were included in the meta-analysis. Age (HR 1.46), male gender (HR 1.68), diabetes (HR 2.69), and cardiovascular history (HR 1.55) were associated with mortality in the meta-analysis. Meta-analysis with only low-risk studies also showed chronic oxygen therapy to be a predictor (HR 1.72). Ten studies reported on a tool that combined several factors, such as BODEX, ADO, and CODEX (A: age, B: body mass index, C: comorbidity, D: dyspnea, EX: exacerbations, O: airway obstruction,) that had AUCs of, respectively, 0.62-0.68, 0.70-0.80, and 0.68-0.77.

Conclusions: Meta-analysis identified a number of predictive variables for mortality < 2 years in chronic lung disease. The majority of these factors were included in validated tools. A further prospective study combining all predictive variables from the meta-analysis and various tools could produce a better validated tool to predict mortality.

Funding
ZonMw

Abstract number: P122
Abstract type: Poster presentation

I’m Fine’: Exploring Patient and Carer Assertions of Status in Advanced Chronic Obstructive Pulmonary Disease (COPD) and Palliative Care Implications
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Background: Patients can be reluctant to say that they need help and support, telling clinicians they are ‘fine’ despite having unmet needs. Research with patients in mental health settings suggests that when patients do this they are less likely to follow treatment plans, and their informal carers may be at a risk of depression. To date these findings have not been explored in patients with advancing physical health conditions or their carers.

Aim: To explore the presence and role of ‘I’m Fine’ or equivalent assertions for patients with advanced chronic obstructive pulmonary disease (COPD) and their carers; and to examine the impact denials of support needs may have on their health and service-use.

Method: Criteria based on Attachment Theory were used to identify ‘I’m Fine’ cases from the Living with Breathlessness Study (LwB) data-set of 235 patient and 115 carer mixed method interview transcripts. Quantitative analysis explored key variables such as health service use between ‘I’m Fine’ and non ‘I’m Fine’ cases. Qualitative data are currently undergoing analysis to explore discourses within cases using a Framework approach.

Results: 21 patients and six carers asserted they were ‘fine’ despite unmet needs. Patients’ minimised the effects and symptoms of their
advanced COPD, avoided thinking about the future and used stocal language in an attempt to downplay negative experiences. Despite ‘I’m Fine’ cases being more likely to report no exacerbations and more likely to score less on the COPD Assessment Test (CAT), all reported a desire to see more of their GP. Carers focused on the need of the patient whilst downplaying their own problems or distress.

**Conclusion:** The existence of a sub-group of patients with advanced COPD who assert that they are ‘fine’ may have implications for the delivery of palliative care. Planned focus groups with health care professionals will be used to consider the above findings within the context of clinical practice.

**Abstract number:** P123
**Abstract type:** Poster presentation

**Development of a Self-management Promotion Program for Patients with End Stage Renal Disease Receiving Continuous Ambulatory Peritoneal Dialysis (CAPD)**

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**Background:** End Stage Renal Disease (ESRD) patients managed with Continuous Ambulatory Peritoneal Dialysis (CAPD) usually faces with technical failure, consequence of advanced treatment, and influencing patients’ outcome.

**Aim:** This study used repeated measures experimental design to determine the effectiveness of a self-management promotion program for enhancing self-management, self-efficacy, self-management, and quality of life of the patients with ESRD receiving CAPD.

**Methods:** The sample was consisted of 41 patients who aged between 20-80 years and diagnosed with ESRD receiving CAPD at the Maharaj Nakorn Chiang Mai Hospital. They were purposively selected and were randomly assigned equally into experimental and control groups. The experimental group received the self-management promotion program consisting of three consecutive weekly teachings, advising, and skill trainings of self-management skill pertaining to food and water controlling, exit site care, exercise, emotional and medication managements followed by monthly individual monitoring and consulting for 5 months. The control group received usual care. Data were collected at 3 months and 6 months after the intervention. The instruments used consisted of 1) Demographic data form for patients receiving CAPD 2) The Self-Management Behavior Questionnaire (SMBQ), 3) The 12-item Perceived Self-Management Self-Efficacy Questionnaire (PSMSEQ), and 4) The 9-item Thai Health Status Assessment Instrument (9-THAI). All scales were validated for their content validity and reliability. Descriptive statistic, independence t-test and chi-square test were used. One-way repeated measurement (ANOVA) was used to compare data on self-management behavior, perceived self-management self-efficacy, and quality of life. Two-way repeated measurement (ANOVA) was also used to test the traction of the intervention.

**Results:** Results revealed that the self-management promotion program provided the statistically significant difference within experimental groups at 6 months after the intervention at p < .05 and p< .001.

**Conclusions:** The study results will be used as baseline information for nurses to adapt and use in caring and enhancing the quality of life of ESRD patients managed with CAPD.

**Keywords:** End stage renal disease (ESRD), Continuous ambulatory peritoneal dialysis (CAPD), self-management, self-management self-efficacy, quality of life, self-management promotion program

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**Palliative Care Needs of Patients with Chronic Renal Disease on Dialysis (CRDD)**

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**Introduction:** Palliative care (PC) in Romania is mainly delivered to cancer patients. The health strategy aims to ensure a 60% PC coverage for patients till 2020. To do this, research of PC needs in various non-cancer patients must be developed to support the design of services.

**Aim:** To identify PC needs of patients with Chronic Renal Disease on Dialysis (CRDD)

**Method:** Prospective observational study using a screening tool developed and tested in Romania for GPs to assess palliative care needs; the tool has questions in 7 domains (communication, symptoms, decision making, end of life, family support, spiritual care, continuity of care).

One of the largest district in Romania (583588 inhabitants) has been chosen for the research; all CRDD patients have been invited to take part in the study and self apply the screening tool; demographical data, information concerning disease, socioeconomically data and religion were extracted from patients files.

**Results and discussion:** Out of 411 patients 248 responded (RR:60.33); age between 22 and 88 with mode 60-69years, length of treatment varied from 1 month to 22 years with an average of 6 years and 4 months; 242 were on hemo-dialysis and 6 on peritoneal dialysis. 28.6% of respondents scored as high their information needs although just 21% of respondents had a full understanding of the diagnosis and prognosis and this is a warning on the low expectations of this patients to be involved in the decision making. Concerning symptoms fatigue (88,71) scored highest followed by pain(70,97), insomnia(64,5) and dyspnea, anorexia and anxiety all over 50%. Reduced mobility was significant (83,5) correlated with reduced performance status (70.6) and worries about disease progression. Limited mobility had also the sense of dependence on treatment “a job were you are allowed no holidays” . Low expression of needs in social (27%) and spiritual area are probably the reflection of low expectation of patients from the health system to satisfy these needs (data from patient files showed low income for majority of patients and Christian Orthodox faith).

**Conclusion:** PC needs have been identified in all 4 domains with predominance in the physical domain. A paternalistic model seems to be accepted by patients for decisions making around care. An initial inclusion of basic palliative care intervention in the regular services of patients with CRDD will improve the symptoms seen as major problem by patients.

**Abstract number:** P124
**Abstract type:** Poster presentation

**Indicators of End of Life Care for Patients with Advanced Liver Disease Show Unwarranted Variation across England**

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**Background:** Premature mortality from liver disease increased 250% over past four decades. Liver Disease (LD), accounts for 2% of deaths in England. Mortality rates from LD vary 7.7 fold across Clinical Commissioning Groups. End of life complications include ascites, variceal bleeding, multiple hospital admissions and days spent in hospital. Liver Disease patients are more likely to die in hospital (>70%) than cancer patients (< 50%). In 2015, 78.0% of liver non-cancer deaths occurred in hospital compared to 38.6% of liver cancer deaths.
Aim: To look at the degree of geographical variation across England of 5 Proxy Quality Indicators (PQI) for Quality of End of Life Care in Liver Disease.

Methods: 5 PQIs using routine national data bases (Office for National Statistics Mortality and National Hospital Episodes (HES) were developed with Hepatologists reflecting care challenges. These were % LD patients who died with no hospital admission in the last year of life (NALYOL); Mean bed-days per LD patient admitted to hospital in the last year of life (MDLYOL); % liver cancer deaths occurred in hospital (%HDPLC); %LD non-cancer deaths occurred in hospital (%HDNLC), % paracentesis admissions for ascites as an emergency. Values were calculated for Strategic Clinical Networks (SCN) or Clinical Commissioning Groups (CCG) and statistical significance of difference from the England mean calculated.

Results: In England, on average, 12.7% of LD patients had NALYOL this varied from 10.1-16.1% by SCN. Comparison between mortality rates and hospital admissions showed marked outliers areas of high death and low admissions. The MDLYOL was 13.8 days varying from 12.1-20.2 by SCN. The HDPLC in England was 38.6% varying from 29.3-45.5% by SCN. In contrast the HDNLC was 78.0% varying from 73.3-82.1% by SCN. In England 57% of paracentesis admissions were emergencies but this varied from 13.9%-100%.

Conclusions: Variation in deaths with no admission in LYOL need to be examined - it is not necessarily good end of life care planning and may reflect extremely vulnerable patients who do not interact with services. Variation in bed days in LYOL may reflect case mix or quality of care and potential cost savings. The difference in % deaths in hospital between liver cancer and non-cancer patients and the wide variation may reflect palliative care involvement and choice. Some of this variation reflects patient characteristics and type of LD and some lack of End of Life Care Planning.

Abstract number: P126
Abstract type: Poster presentation

Do Palliative Care Patients with Advanced Non-malignant Disease Have Equitable Access to Palliative Care Units in Ontario?

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Aim: Equitable access to palliative care has been highlighted as an area of concern across the world. To evaluate potential inequities concerning patients with non-malignant diagnoses, we evaluated our region’s electronic referral sending and matching program that supports palliative care bed allocation for a population of 6.4 million people.

Methods: The program manages the referral and admission processes of 207 palliative care beds, spread across 9 palliative care units (PCUs) and 1 residential hospice. Data related to patient demographics, as well as patient prognosis, diagnosis (malignant vs non-malignant), functional status, and symptom burden were analysed to evaluate equitable access to PCU resources.

Results: Between January 2015 and December 2016, the region processed 7786 applications, resulting in 3142 admissions to palliative care beds. Average age of applicants was 77.9 years, 3955 (50.8%) were female, and 75.7% spoke English. A total of 71.7% had listed a malignant palliative diagnosis; the majority had a gastrointestinal (27.8%), or a lung malignancy (19.4%). Non-malignant diagnoses included neurological (25.7%), cardiac (16.4%), followed by lung disease (10.1%). Prognosis was most often listed as < 3 months (58.8%) but ranged from < 1 (26.5%) to < 12 months (3.4%). The majority of patients had a PPS score of 40% (34.3%) or 30% (30.9%), and an ESAS symptom mean score total of 30.5. Patients with a non-malignant diagnosis had lower PPS scores (non-malignant: 30%, malignant: 40%, P=0.01), lower prognoses (< 1 month: 39.1% vs 21.6%, p< 0.05) and have similar symptom burdens than those with a malignant diagnosis. Time to PCC decision for acceptance or denial differed across diagnoses (1.74 days vs 2.12 days for nonmalignant patients), and total requests for information (malignant: 1.8, non-malignant: 3.0, p=0.01). Applications were denied for 1407 patients; 901 (16.1%) with malignancy, and 507 (23.0%) with a non-malignant diagnoses. Multivariate analysis is pending and will be available for the presentation.

Conclusions: Palliative patients with non-malignant disease have a lower functional status, poorer prognosis and similar symptom burden, but face longer application times, higher numbers of request for information and are less likely to be accepted or admitted to a PCC than those with malignancy.

Abstract number: P127
Abstract type: Poster presentation

What Influences the Care Preferences of Frail Older People? A Qualitative Study

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Background/aims: Understanding patient preferences is key to delivery of person centred care. Whilst the content of care preferences has been previously described, less is known about how care preferences are influenced, particularly among older people living with frailty. Therefore we aim to explore the influences on care preferences among frail older people.

Methods: In this qualitative study, people aged over 65, scoring 5 or more on the Clinical Frailty Scale, and with at least one recent hospital admission, contribute in-depth interviews. A theoretical sampling frame, incorporating functional status, age, whom participants live with, and healthcare usage, is used. Caregivers of participants are included where available. The topic guide explores health concerns and healthcare experiences, care preferences, and priorities for future care. Thematic analysis is undertaken, and sample size is determined by thematic saturation.

Results: 16 participants are interviewed. Prominent current health priorities are; maintaining independence; supporting family and reducing their caring burden; and returning to or maintaining the ability to live a ‘normal’ life. Mobility is important for almost all participants, as it is seen as a path to independence. Confidence about one’s abilities influences preferences by enabling or inhibiting a desire to do more. Having family around to provide support results in a sense of safety, and confidence to attempt more ambitious goals. Participants often haven’t thought about future preferences, finding the future uncertain. Influences on preferences for future care are to be somewhere with adequate support, and to ensure family and informal caregivers can cope with the burdens of care provision.

Conclusions: Care preferences in this population are bound up in physical function, and are greatly influenced by the availability of support. For many, the future is indistinct, inhibiting formation of specific preferences. These findings have important implications for how preferences are discussed in this population, and highlight areas which could be addressed to enable preferences to be met.

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Abstract number: P128
Abstract type: Poster presentation

The Experience of Home Care Nurses Being Confronted with Tiredness of Life in Community-dwelling Older Persons: A Qualitative Study

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Background: Nurses frequently encounter community-dwelling older persons who are tired of life (ToL). However, studies on the (home care) nurses’ perspective are virtually non-existent. This study aimed to gain insight into home care nurses’ (1) definition of, (2) attitude(s) towards, and (3) ways of dealing with ToL.

Methods: A qualitative interview design, based on the principles of the Grounded Theory approach (Charmaz, 2014), was adopted. Analysis was based on the QUAGOL method (Dierckx de Casterle et al. 2012). Home care nurses, both self-employed or working in an organization, were purposefully recruited. The interviewer had no previous relationship with the participants. Interviews took place from January 2017 to June 2017. The interview guide consisted of reflective and open-ended questions. Validity of data collection was enhanced by peer review of the interview style. To achieve credibility and confirmability, investigator triangulation was realized.

Results: 13 home care nurses (2 men, range 26-57 years old) participated in individual one-time semi-structured interviews with a mean duration of 47 minutes (range 37-61 minutes). Being confronted with ToL in patients entails a complex process that activates feelings of professional helplessness and inadequacy. A careful consideration indicative of an oscillation between three levels (e.g. behavioural, cognitive, and affective) is present. The nurse’s actions created a continuum ranging from not discussing ToL to its open acknowledgment. This behaviour is underpinned by a delicate component that grounds the nurses’ assessment of the validity of the presence of ToL. On the emotional plane, the participants stress the importance of being able to understand the patient’s ToL or empathize with it, resulting in an attitude ranging from understanding to incomprehension.

Conclusions: Present study shows how challenging it can be to establish a priori the presence of ToL. The nurse’s actions created a continuum ranging from not discussing ToL to its open acknowledgment. This behaviour is underpinned by a delicate component that grounds the nurses’ assessment of the validity of the presence of ToL. On the emotional plane, the participants stress the importance of being able to understand the patient’s ToL or empathize with it, resulting in an attitude ranging from understanding to incomprehension.

References

Abstract number: P129
Abstract type: Poster presentation

Prescription of Drugs of Questionable Benefit among Older Adults Near the End of Life: Prevalence and Determinants in a Countrywide Longitudinal Cohort
Morin, Lucas, Wastesson, Jonas, Fastbom, Johan, Johnell, Kristina
Aging Research Center, Karolinska Institutet, Stockholm, Sweden

Aims: This study aimed to evaluate the prevalence and the determinants of prescribing drugs of questionable benefit during the last three months of life of older adults.

Study population: Older adults (≥75 years) who died in Sweden between 2013 and 2015 from diseases indicative of palliative care needs (e.g. cancer, heart failure, COPD, dementia).

Study design: Register-based, longitudinal cohort study. Death certificate data were linked at the individual level to the Swedish Prescribed Drug Register, the National Patient Register, and several other registers with full population coverage in Sweden. Drugs of questionable benefit were identified a priori by a consensus panel of 40 European experts in palliative medicine, geriatrics, and clinical pharmacology.

Statistical analysis: The likelihood to have been prescribed drugs of questionable benefit was modelled using logistic regression, adjusting for sex, age, marital status, number of comorbidities, and underlying cause of death. Odds Ratios (OR) are reported with 95% confidence intervals.

Results: A total of 175,979 deceased older adults were included. Mean age at time of death was 86.5 years (SD= 6.2). 56% of decedents were women, 49% died in nursing homes, and 50% had at least 6 diagnosed chronic diseases. During the last 3 months of life, 30.1% refilled at least one prescription of questionable benefit. Moreover, 11.8% initiated at least one drug treatment of questionable benefit during this period. While adjusting for relevant confounders, women were more likely to continue (OR= 1.16, 95% CI 1.13-1.18) and initiate (OR 1.07, 95% CI 1.04-1.11) drugs of questionable benefit. Compared with older adults who died from cancer, those who died from organ failure (OR= 1.59, 95% CI 1.55-1.63) or dementia (OR= 1.98, 95% CI 1.92-2.03) were significantly more likely to continue drugs of questionable benefit.

Conclusions: This is the first study investigating the use of drugs of questionable benefits among older adults near the end of life, across care settings and in an entire country. Our findings raise concern, as significant proportion of older adults are exposed to drug treatments that provide little or no benefit, and can potentially be harmful. Optimization of drug prescribing and avoiding futile treatment near the end of life is an important challenge for palliative care consultants.

Abstract number: P130
Abstract type: Poster presentation

How Do Hundred-year-Old People Die? Results from a Population-level Study of Centenarians in Sweden
Morin, Lucas, Wastesson, Jonas, Fors, Stefan, Johnell, Kristina
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Background: A growing proportion of older adults live beyond the age of 100 years. Yet, little is known about how they die. We aimed to describe the patterns of dying in a large cohort of centenarians, and to investigate their healthcare utilization during the last months of life.

Methods: Nationwide, register-based, longitudinal cohort study in Sweden. All people aged ≥100 years who died in 2013-2015 were identified in the National Cause of Death Register. Data were then linked to the National Patient Register, the Social Services Register, the Swedish Prescribed Drugs Register, and several other registries with national coverage in Sweden. The likelihood to have experienced the different outcomes of interest was calculated by the mean of adjusted logistic regression models. Odds Ratios (OR) are reported with 95% confidence intervals.

Results: A total of 2763 deceased centenarians were included. Mean age was 101.3 years (SD 1.6), 82% were women, and 96.7% had no living spouse. The most frequently reported causes of death were dementia (23.7%), ischaemic heart diseases (15%), heart failure (10%), cerebrovascular diseases (7%), hypertensive diseases (7%), influenza and pneumonia (6%), and cancer (4%). 217 (8%) died from conditions indicative of a sudden death (e.g. sepsis). On average, decedents had 4.5 diagnosed chronic diseases (SD 2.7). 74% died in nursing homes, 14% in hospitals, and 11% at home. During the last 3 months of life, 11% had a fall-related injury, 16% were hospitalized for more than 7 days, and 35% experienced at least one unplanned hospitalization. Only 1 patient was admitted to an inpatient palliative care unit. While adjusting for possible confounders, we found that centenarians with organ failure were the most likely to have ≥1 unplanned hospital admission (OR= 1.99, 95%CI 1.65-2.40

Analysis: The likelihood to have been prescribed drugs of questionable benefit was modelled using logistic regression, adjusting for sex, age, marital status, number of comorbidities, and underlying cause of death. Odds Ratios (OR) are reported with 95% confidence intervals.

Results: A total of 175,979 deceased older adults were included. Mean age at time of death was 86.5 years (SD= 6.2). 56% of decedents were women, 49% died in nursing homes, and 50% had at least 6 diagnosed chronic diseases. During the last 3 months of life, 30.1% refilled at least one prescription of questionable benefit. Moreover, 11.8% initiated at least one drug treatment of questionable benefit during this period. While adjusting for relevant confounders, women were more likely to continue (OR= 1.16, 95% CI 1.13-1.18) and initiate (OR 1.07, 95% CI 1.04-1.11) drugs of questionable benefit. Compared with older adults who died from cancer, those who died from organ failure (OR= 1.59, 95% CI 1.55-1.63) or dementia (OR= 1.98, 95% CI 1.92-2.03) were significantly more likely to continue drugs of questionable benefit.

Conclusions: This is the first study investigating the use of drugs of questionable benefits among older adults near the end of life, across care settings and in an entire country. Our findings raise concern, as significant proportion of older adults are exposed to drug treatments that provide little or no benefit, and can potentially be harmful. Optimization of drug prescribing and avoiding futile treatment near the end of life is an important challenge for palliative care consultants.
compared with dementia patients). During the final month before death, the median number of prescribed drugs was 7 (IQR 4–10). Drug utilization was fuelled not only by opioids (44%) and non-opioid analgesics (59%), but also by the continuation of preventative medications such as antihypertensives (46%), antiplatelet agents (35%), and calcium supplement (8%).

**Conclusion:** Centenarians have a considerable burden of morbidity near the end of life, and most often die in nursing homes. Access to palliative care should be optimized to avoid unplanned hospital admissions and reduce the prescription of unnecessary drugs.

**Abstract number:** P131

**Abstract type:** Poster presentation

**People Living with Progressive Frailty in the Community: Coping, Struggling and then Being Overwhelmed**

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**Background:** Multidimensional end of life trajectories have been outlined for people reaching the end of life with organ failure and cancer. From a qualitative longitudinal study of people living with frailty we have previously described three distinct multidimensional patterns—coping, struggling or becoming overwhelmed. We sought to consider if these are three different trajectories or three parts of a single underlying trajectory.

**Aim:** To consider if the experience of living with frailty towards the end of life could be described by a progressive multidimensional trajectory.

**Methods:** 76 qualitative longitudinal interviews were carried out with 13 cognitively intact frail older people who were community dwelling at the time of recruitment, their informal and formal carers. A narrative approach to analysis was used to elucidate patterns of change across different dimensions of wellbeing.

**Results:** Three distinct patterns—coping, struggling or becoming overwhelmed emerged which could reflect the experiences of frail older people at different stages on the gradual dwindling trajectory towards the end of life. From coping people may move through a period of increasing instability as they begin to struggle to maintain well-being before finally becoming overwhelmed. A gradual decline in physical well-being occurred with pronounced dips relating to acute illness, infection or falls, that was reflected by dips in psychological and existential well-being, and could result in death. Social well-being declined slowly alongside physical decline but remained steady during the acute events. Psychological and existential well-being declined alongside physical and social dimensions although could be maintained a little longer. Psychological despair could occur when difficulties became overwhelming and was followed by existential fatigue and social withdrawal with physical death occurring some weeks later.

**Conclusion:** A three stage pattern of multidimensional decline was identified in frail older people reaching the end of life. This highlights the importance of focusing on needs beyond the physical in supporting frail older people. ESRC funding.

**Abstract number:** P132

**Abstract type:** Poster presentation

**Living Alone, in Poverty and Loneliness - Challenges for Pensioners Wishing to Be Cared for and Die at Home in England**

Verne, Julia1, Pring, Andy, Bowtell, Nicola2

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**Background:** In 1963 in England 9% of males and 18% of females died aged >85 years. In 2014 it was 30% and 48%. Surveys find people would prefer to be cared for and die in their own home but demographic change and its accompanying frailty and change in social circumstances provide challenges especially for the elderly. Studies have shown that people are more likely to die at home if they live with a partner or spouse, have close family nearby and financial resources. Living alone not only presents care challenges but also loneliness which impacts on people’s wellbeing especially at life’s end. Age UK identify loneliness as a major factor older people worry about.

**Aim:** To evaluate the magnitude of the challenges faced by older people from living alone, in poverty and from loneliness and consider the implications for End of Life Care.

**Methods:** Descriptive analysis of routine data from the England and Wales Office for National Statistics (ONS) 2001 & 2011 Census and data from the personal and wellbeing dataset and Opinions and Life-style Survey.

**Results:** People aged >65 years living in couples (married/civil/cohabiting) households increased from 51% in 2001 to 54% in 2011. The proportion living in single person households fell from 34% to 31% in the same period but the proportion of pensioners living alone in 2011 varies by X wards across England from 11.4 to 63.3%. The 2015 Income of Multiple Deprivation Affecting Older Adults Index IDAOP (Source department of Communities and local government) showed a variation in the Index across 152 Upper Tier Local Authorities between 6.3 and 49.7% with an England average of 16.2%. People who live on their own are >2x as likely to report feeling lonely (30.8% compared to 12.6%). People in rented or social housing felt higher levels of loneliness than those owning their home. 15.3% vs. 11.7%. High loneliness rating was associated with low feelings of worth (10.5% vs. 1.1%) and feeling unhappy (18.8% compared to 5.6%) than low ratings.

**Conclusions:** There are significant social challenges for some older adults approaching the end of life. Local areas vary in these challenges. Life expectancy is increasing faster in men than in women explaining the increase in people living in couple households. Ambition Six ‘Each Community is prepared to help’ of the Ambitions for Palliative and End of Life Care: A National Framework for Local Action 2015-2020 outlines options for action as do Compassionate Communities.
used in selection of participants. Thematic analysis was undertaken utiliz- 
ing the four phases of: organization; familiarization; reduction and analy- 
sis. The following themes were identified: The understanding of CP by the 
children and their guardians; the palliative care needs of the children; and 
the palliative care needs of the family. CP brings negative impacts on chil- 
dren and their families: physically, psychologically socially and spiritu- 
ally. The neurological deficits can bring about issues of poor feeding, 
spasticity and weakness, educational challenges, difficulties in identifying 
pain and other symptoms and how to come up with the best management. 
The findings should be disseminated at UCPCU staff during team meet- 

gings, Palliative Care Support Trust management meeting and Paediatric 
departmental meeting and National or international conferences so that 
Children with Cerebral palsy and their families are managed properly.

Abstract number: P134
Abstract type: Poster presentation

Barriers to Research with Children and Young People with Life-limiting Conditions and their Families: A Survey of Chief Investigators' Views, Experiences and Proposed Solutions

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2Marie Curie Palliative Care Research Department, UCL, London, UK, 
3Institute of Child Health, Population, Policy and Practice Programme, 
UCL, London, UK

Background/aims: Undertaking research with children and young people (CP) with life-limiting conditions (LLC) and life threatening illnesses (LTI) is challenging. Previous research has highlighted barriers, such as obtaining ethics approval and clinician gatekeeping, that delay research or result in studies not recruiting to target. This study aimed to provide more in-depth insight on the views, experiences and solutions of Chief Investigators (CIs) recruiting CP with LLC and LTI and their families in the UK.

Methods: We developed an online survey based on a scoping review of the literature and previous rapid survey. The new survey contained closed and open-ended questions and was divided into 3 sections:

1. the CI’s most recent project;
2. the CI’s overall experience of research with this population;
3. demographic information. Participants were 61 CIs conducting studies with CP with LLC and LTI and families, identified from the UK NIHR Clinical Research Network Portfolio.

Results: Chief investigators reported funding (51%) to be the biggest barrier to research with this population, followed by institutional factors (e.g. research and development approval) (11%) and clinician factors (e.g. gatekeeping) (25%). CIs suggested several generic solutions (e.g. having a well thought out question and methodology to improve chances of obtaining funding). Solutions that were particularly relevant included embedding researchers in clinical teams, involving CYP and families early on in the research process, meeting the specific needs of CYP and families and designing clear and age appropriate written information for CYP. Given the usually low number of eligible CYP, inclusion criteria should be broad and investigators should be aware of the complexity of approvals required for multi-centre studies. Researchers should invest in developing good relationships with clinicians to reduce gatekeeping and attempt to interest them in studies other than intervention trials, which are quite common in this population.

Conclusions: The involvement of clinicians, CYP and families at the inception of studies should be considered a priority for research with CYP with LLC and LTI and families. Other potential strategies include increasing the visibility of research, embedding researchers in clinical teams, having clinician research champions, and acknowledging in peer-reviewed manuscripts those clinicians who do recruit to studies.

Abstract number: P135
Abstract type: Poster presentation

Attitudes of Neonatologists and Neonatal Nurses on Neonatal End-of-Life Decisions, a Population Survey

Dombrecht, Laure1, Beernaert, Kim1, Chambacur, Kenneth1, Cools, Filip1, Goossens, Linda1, Nataeers, Gunnar1, Deliens, Luc1, Cohen, Joachim2
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Background: People working at a Neonatal Intensive Care Unit (NICU) are often confronted with dying neonates and ethically laden end-of-life decisions (ELDs). These are often influenced by attitudes of involved caregivers. This study aims to study attitudes on neonatal ELDs of neo- 


neonatologists and neonatal nurses working in a NICU.

Methods: We performed a structured mail survey in all neonatologists and neonatal nurses of all 8 Flemish NICUs in May 2017. The question- 
naire consisted of 21 attitude items, including 7 questions on a hypotheti- 
cal case of a premature new-born (27 weeks of gestation) with additional complications. Respondents indicated whether they agreed with state- 
ments in relation to ELDs for neonates, scored on a 5-point Likert scale. 
Results: Across all 8 NICUs, the response rate is 63% (528/837) for neo-


atlologists and 46% (250/527) for nurses. A large majority of respondents 
accepts withholding treatment on neonates with severe disorders both 
when life-shortening is a side-effect (90%-100% agree or strongly agree) 
and when life-shortening is explicitly intended (79%-89% agree or 
strongly agree). Nurses are more moderate (agree rather than strongly 
agree) compared to neonatologists for both potentially life-shortening 
(p< 0.001) and intentionally life-shortening effects (p=0.013). In the 
hypothetical case, neonatologists were more likely than nurses to 
agree to withholding treatment both with a potential (89 vs 63%, p< 
0.001) and an intended life-shortening effect (75 vs 50%, p=0.001). 
Similar results were found for withdrawing treatment. However, nurses 
(74%) were more inclined to agree than neonatologists (59%) to end the 
life of a severely ill neonate by administering lethal drugs (28,8-39,3%). 
Acceptance of both was lower in a hypothetical case, when asked if 
they would agree to explicitly shorten the life of the neonate by administering 
lethal drugs (28,8-39,3%).

Conclusion: Neonatologists and neonatal nurses in Flanders seem to con- 
sider withholding and withdrawing treatment as highly acceptable options 
in severely ill neonates. Ending life with lethal drugs is accepted by a sub-
stantial part of neonatologists and nurses, even when asked if they would 
agree to provide the lethal medication in a hypothetical case. Our results 
show tension between attitudes and the law and needs a medical-ethical 
and public debate. Assuming that attitudes influence ELD practice, our 
results indicate a need for insights on neonatal ELD clinical practice.

Abstract number: P136
Abstract type: Poster presentation

School Pupils and Understanding of Significant Change and Losses in Life

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Background: People working at a Neonatal Intensive Care Unit (NICU) are often confronted with dying neonates and ethically laden end-of-life decisions (ELDs). These are often influenced by attitudes of involved caregivers. This study aims to study attitudes on neonatal ELDs of neonatologists and neonatal nurses working in a NICU.

Methods: We performed a structured mail survey in all neonatologists and neonatal nurses of all 8 Flemish NICUs in May 2017. The questionnaire consisted of 21 attitude items, including 7 questions on a hypothetical case of a premature new-born (27 weeks of gestation) with additional complications. Respondents indicated whether they agreed with statements in relation to ELDs for neonates, scored on a 5-point Likert scale.

Results: Across all 8 NICUs, the response rate is 63% (528/837) for neonatologists and 46% (250/527) for nurses. A large majority of respondents accepts withholding treatment on neonates with severe disorders both when life-shortening is a side-effect (90%-100% agree or strongly agree) and when life-shortening is explicitly intended (79%-89% agree or strongly agree). Nurses are more moderate (agree rather than strongly agree) compared to neonatologists for both potentially life-shortening (p< 0.001) and intentionally life-shortening effects (p=0.013). In the hypothetical case, neonatologists were more likely than nurses to agree to withholding treatment both with a potential (89 vs 63%, p<0.001) and an intended life-shortening effect (75 vs 50%, p=0.001). Similar results were found for withdrawing treatment. However, nurses (74%) were more inclined to agree than neonatologists (59%) to end the life of a severely ill neonate by administering lethal drugs (28,8-39,3%). Acceptance of both was lower in a hypothetical case, when asked if they would agree to explicitly shorten the life of the neonate by administering lethal drugs (28,8-39,3%).

Conclusion: Neonatologists and neonatal nurses in Flanders seem to consider withholding and withdrawing treatment as highly acceptable options in severely ill neonates. Ending life with lethal drugs is accepted by a substantial part of neonatologists and nurses, even when asked if they would agree to provide the lethal medication in a hypothetical case. Our results show tension between attitudes and the law and needs a medical-ethical and public debate. Assuming that attitudes influence ELD practice, our results indicate a need for insights on neonatal ELD clinical practice.
Background: A significant proportion of young people of secondary school age in the UK have experienced the death of someone close. Bereavement in childhood has a significant impact and bereaved children can experience significant anxiety and underachieve at school (Abdelnoor and Hollins, 2003).

Aims: This qualitative study aimed to explore how children of different ages understand loss, death and dying; the support they access and their awareness of what is available to them.

Research questions: Five research questions were addressed:
- How do pupils aged 13-18 understand change, loss and death?
- With whom do children communicate about this?
- What coping skills do pupils demonstrate?
- What support are they aware of and do they choose to access this?
- How do parents and teachers communicate or educate children around loss?

Methodology: The study site was a large UK secondary school. Participants were randomly selected by the school and included 31 pupils, 108 parents and 37 staff. Separate online questionnaires were designed for each group using SurveyMonkey. A thematic analysis of qualitative data was undertaken.

Results: Pupils reported complex emotions in response to change, loss and death. They indicated little awareness of formal support, advice or counselling. Few had accessed such support. Pupils mainly turned to parents and friends. Peer support was important to pupils rather than social media. Parents also saw family as the main support for their children. Few parents and teachers had used resources or sought advice about having conversations on this subject, drawing on personal experience. Most teachers and 50% of parents found such conversations difficult, especially dealing with emotion and distress. Pupils had very different views from adults on the type of resources that helped them.

Conclusion: Pupils coping skills appeared strong and it was clear that peers, parents and teachers were important sources of support. However, there is a significant disconnect between the resources that young people identified helpful and those that parents and teachers used and recommended. Findings from this study can only be seen from the perspective of this particular school. Further research is required with schools with different socioeconomic and geographical catchments.

References

Difficult Sedation for Refractory Symptom in Paediatric Oncology: A Case Report

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Abstract number: P138
Abstract type: Poster presentation

“1 Don’t Want This To Be in my Biography”: A Qualitative Study of the Experiences of Grandparents Losing a Grandchild Due to a Neurological or Oncological Disease

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Background/aim: Pediatric Palliative Care (PPC) in hospitals mainly focuses on the parents and siblings of children suffering from a life limiting disease. However, most grandparents are also highly involved in the caring of the child and require additional attention. As little is known about the experiences of grandparents losing a grandchild, this study aimed to address this research gap by investigating the experiences of grandparents throughout the end of life care and after the death of a grandchild. Neurological and oncological diseases are the most common causes of death in children older than one year.

Methods: A qualitative approach using semi-structured interviews was chosen. Fifteen grandparents of ten deceased children were interviewed. Four grandchildren died due to an oncology disease and six to a neurological one. Participants were recruited among the families attended by the PPC team of a children’s hospital in northern Switzerland. Grandparents were interviewed at least one year after the death of the grandchild. The data was analyzed employing reconstructive interview analysis.

Results: Regardless of the diagnosis and death circumstances of the child, participants described major impact that the child’s death had on them and their entire family. Grandparents felt obliged to support the family and constantly be a supportive pillar for the parents. They feared a double psychological burden as they care and mourn twice; for their dying grandchild and for their daughter or son. Grandparents also struggled with communication difficulties concerning disease and death when in contact with other family members, friends and acquaintances. They tried to make sense and processed their loss by remembering the deceased child and finding comfort in the fact that the child and the family did not have to suffer longer painful symptoms. All participants reported being grateful for the time they were able to spend with their grandchild.

Conclusion: These findings emphasize the importance of understanding and identifying the suffering of the grandparents. PPC teams can achieve this by actively making contact with them, taking their concerns seriously and demonstrating appreciation for their role in supporting the family.
practical recommendations practicable in a paediatric oncology department. This case also shows that the early and constant communication is paramount between the oncologist consultant, the patient and his parents, and the teams involved in the patient care. Finally, clear medical and institutional guidelines are needed for these situations.

Abstract number: P139
Abstract type: Poster presentation

Cultural considerations in the provision of paediatric palliative care music therapy services in Melbourne Australia
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Music can play an important role in the lives of many young children in Australia, however the ways in which music is used, understood and engaged with can vary significantly from child to child, and family to family, dependent upon factors such as the cultural background of the child and family, including their beliefs, traditions and practices. This can be an important consideration when caring for children who are critically ill or dying.

This poster presents select findings from a qualitative inquiry that examined the experience of music and music therapy for children in paediatric palliative care (PPC) and their families, who come from diverse cultural backgrounds. One of the key aims of the study was to understand how cultural background, beliefs and practices can shape family engagement with music, and music therapy in PPC.

Three studies informed by grounded theory were conducted as part of this inquiry, and included the perspectives of six parents’ caring for a child in PPC (Study One); and four music therapists, including the author, who provide music therapy to children in PPC (Studies Two and Three). The nine participants and the author represent various ethnocultural backgrounds, and have varying cultural beliefs, practices and traditions. They included new migrants and first-generation Australians (parents, n=3; music therapists, n=1), second-generation Australians (parents, n=2; music therapists, n=0) and multi-generation Australians (parents, n=1; music therapists, n=3).

Twenty themes emerged from the three studies, articulating parents’ and music therapists’ reflections about the palliative care journey, and the experience of music and music therapy.

This poster discusses cultural considerations that emerged from the findings and that influenced family engagement with the palliative care service and music therapy. The findings inform clinical practice in PPC; and offer insights into the provision of music therapy for culturally diverse communities at end-of-life.

Abstract number: P140
Abstract type: Poster presentation

Palliative Care for Patients with Substance Use Disorder and Multiple Problems: An Exploratory Study on Problems, Needs and Good Examples by Healthcare Professionals, Patients and Proxies
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Research aims: Healthcare professionals (HCPs) are mostly unaware of how patients with substance use disorder (SUD) and multiple problems (SUD+) in a palliative care phase, and their proxies perceive healthcare and life. Additionally, responsibilities in caring for these groups and identification of the palliative phase appear unclear. This study therefore aims to explore how palliative care for people with SUD+ is organized and which problems, needs and good examples are experienced by HCPs, patients and proxies. It will provide recommendations for practice and will serve as the base for developing an education program for HCPs.

Study populations: Patients with severe SUD and multiple problems in a palliative care phase, proxies and HCPs+ (HCPs, volunteers and Experts by Experience) of various care settings.

Study design and methods: Data collection of this qualitative study consists of semi-structured interviews with patients and proxies about their well-being and experiences in palliative care. HCPs+ are participating in group interviews about content and organization of care, communication with patients, care for proxies and competencies.

Method of analysis: Interviews will be thematically analyzed and member check will be executed.

Results and interpretation: Preliminary findings of the group interviews show the need for an active attitude, and flexibility and creativity with regard to rules, policies and ethical issues. Difficulties in suitable care setting and pain relief were expressed. More education was suggested as, among other things, a way to lessen prejudices among other HCPs. Preliminary topics from the patient interviews showed the need for honesty and equal treatment. Also, patients expressed high pain intensity. Following our findings an educational tool for HCPs will be developed in which communication and specific skills will be trained on how to improve medical attendance and professionalism for patients with SUD+ in a palliative trajectory.

Abstract number: P141
Abstract type: Poster presentation

Between the Need to Participate and the Right to Withdraw - Perspectives of People with Dementia and their Relatives in Switzerland
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Background: In Switzerland, there are over 144,000 people diagnosed with dementia, with an estimated 27,000 new diagnoses in 2016 (Alzheimer Schweiz 2016). The use of negative language worldwide has contributed to stigmatizing people with dementia; it has been described, as one of the diseases, people fear most (van Gorp 2012). Among the most problematic consequences of stigmatization is the fact it prevents people with dementia from participating in society. Nevertheless, it remains unclear to what extent and under which circumstances people with dementia wish to participate in social life or in the development of services.

Methods: We focused on people with dementia and their relatives to explore their experiences with living with dementia and to understand, what participation means to them. We interviewed eleven persons in six semi-structured and narrative interviews. Interview partners were the person of dementia and a relative, which they chose. The age of the interviewed persons with dementia ranged from 55 to 91 years. Although the sample size is small, we covered a wide range of characteristics among the interview partners such as age, size of community, former profession, and stage of dementia.

Findings: The interviews started with narratives about the loss of autonomy at the onset of dementia and about the experiences of increasing
vulnerability and of social discrimination. The narrations about parts of the biography played an important and extensive role in the interviews. The perceived social roles ranged from felt strong social capacities to the need for social withdrawal. From the perspectives of our interview partners, dementia-knowledge is of importance for social participation. Interview partners spoke about support for and barriers to their mobility in public places. Social contacts in the neighborhood contribute to the feeling of participation. People with dementia and their relatives expressed their needs for reliable care arrangements and institutional support

**Conclusion:** The need to participate in social life is as diverse as the population of people with dementia is. It is routined in the biography and depends on age and stage of dementia. Care arrangements need to be attentive for the biography in order to offer continuity in phases of uncertainty. The need for social participation is closely linked with the need for good and reliable care as well as the need for withdrawal.

**Abstract number:** P142

**Abstract type:** Poster presentation

**On the Margins of Death: A Scoping Review on Palliative Care and Schizophrenia**

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Schizophrenia is a serious chronic mental illness that results in marginalization and stigma for sufferers. It is the seventh leading cause for disability worldwide. The symptoms of the illness, which include hallucinations, reduced expression, or disruptions in memory, may also introduce barriers to accessing treatment, education, housing, and employment. Little is known about end-of-life care for individuals with schizophrenia. To address this gap, a scoping review was conducted to enhance understanding of hospice and palliative care for patients with schizophrenia. From this scoping review, 342 unique titles and abstracts were identified. Thirty-two articles met the inclusion criteria and the following four themes were identified:

1. stigma affecting quality of care and access to care;
2. consent and capacity, for the patient’s end of life care decisions and substitute decision makers (SDMs);
3. best practices for psychosocial interventions, pharmacology, family and healthcare collaborations, goals of care, setting, and smoking; and
4. barriers to care, including setting, communication, provider education, and access to care.

The review suggests the importance of mandatory interdisciplinary training practices and policy standards outlining cooperative communication across healthcare providers. It highlights a gap in evidence-based research on psychosocial interventions and collaborative frameworks to enable the provision of quality end of life care for individuals with schizophrenia.

**Abstract number:** P143

**Abstract type:** Poster presentation

**Dementia and End of Life Care - Implications of Deprivation of Liberty Safeguards in England**

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**Background:** The Deprivation of Liberty Safeguards (DoLS) (2009) England are a legal framework to ensure that individuals, who lack mental capacity to consent to care which results in “deprivation of liberty”, (restricting freedom of choice or movement) have the arrangements independently assessed (authorisation) to ensure they are the person’s best interests. In England, 58% of people who die in care homes and 29% in hospital have dementia or senility on their death certificate. There are concerns about the impact of DoLS on dignity and wellbeing in End of Life Care (EoLC).


**Aim:** To assess variation across England and the implications for End of Life Care.

**Results:** 195,840 DoLS applications and 105,055 completed applications were received (2015-16) c.f. 13,040 completed 2013-14. 51% of applications cited dementia. 40% of authorisations took ⩾ 3 months. 76,530 (73%) completed applications were granted. 30% were not granted as the patient had already died (8,495). 29% of reviews also found the patient had died while on a DoLS. Only 82,621 authorisations were reported to the Care Quality Commission (CQC), responsible for monitoring the use of DoLS and reporting to Parliament. The CQC report identified systemic-wide problems with training and implementation. The England rate for DoLS applications was 454 per 100,000 adults varying by region from 665 to 179 (3.7 fold). 7.1% (7,073 people) of people ⩾ 85 years had an application and 44% of 206,010 living with ⩾ 1 DoLS were ⩾ 85 years. Care homes made 150,355 applications, hospices 715 and acute hospitals 27,855. There is no apparent correlation between applications and age distribution of regions, prevalence of dementia or numbers of care home beds. The Policing and Crime Act 2017 introduced changes that the coroner no longer has to hold an automatic inquest for a person dying under a DoLS authorisation which had been very distressing for relatives.

**Conclusions:** DoLS are most prevalent in people with short life expectancies because of their age and conditions and care home residence. The apparent unwarranted geographical variations in DoLS applications, authorisations and waiting times combined with concerns raised by the CQC and Local Government Ombudsman raise concerns about dignity and autonomy for patients at the end of life.
symptoms, involvement of healthcare disciplines, admissions to other healthcare institutions, and difficulties in care provision at the end of life.

Results: The large majority of the 61 clients had a combination of somatic (98%), psychiatric (85%) and addiction problems (93%). For 75% of them, imminent death was somehow documented in the record; this occurred 0–1253 (median=67) days prior to death. For 26% of the clients a palliative care team was consulted in the year prior to death. In the three months before death, 45% of them was admitted three or more times to another healthcare institution. Most patients died in the shelter (64%), others in a medical hospital (26%) or a hospice (3%). Documented difficulties in care mainly concerned fragmentation of expertise and facilities, communication between healthcare professional and client, and medical- pharmacological issues.

Conclusion: At the end of life, homeless people suffer from multiple health related problems that require specific expertise and support from a variety of healthcare providers. They are often admitted to other healthcare institutions, which could be avoided by more comprehensive collaboration between experts in psychosocial, medical, and palliative care.

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Abstract number: P145
Abstract type: Poster presentation

Insights into End of Life Care Provision for Hospitalised Prisoners
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Background: Prisoners experience multiple vulnerabilities, have poorer health than the general population and include an increasing number of older males. Palliative care services are widely established, however access for prisoners is largely unknown. In Victoria, Australia’s second largest state, prisoners requiring hospital care at the end of life are transferred to a high security hospital ward.

Aim: To describe the end of life care and experiences of prisoners who die in the hospital setting.

Methods: This exploratory, mixed methods study used a retrospective medical record audit of consecutive prisoners who were admitted and died in hospital from July 2014 to June 2016. Items of interest were extracted from records for the final 3-months of life, including: clinical and demographic characteristics; access and timing of palliative care; goals of care discussions; medication use; intensive care unit (ICU) and emergency department (ED) use; and place of death. An in-depth qualitative thematic analysis was conducted to supplement findings and high-light experiences, barriers and enable to quality palliative care.

Results: Thirteen prisoners who were male, aged 39-93 yrs (median 58yrs) were identified, with the majority having a cancer diagnosis. This group had multiple vulnerabilities including mental health (54%), illicit drug use (38%) and high rates of comorbidities. Their total median length of stay (LOS) was 61 days, with the majority (n=11; 85%) having ≥1 hospital admissions. Median LOS in the prison-based unit prior to hospital admission was 19 days. Seven (54%) prisoners had ≥2 ED presentations, 3 (23%) had an ICU stay. Ten (77%) prisoners received access to palliative care consultation. Of these, half (n=5; 39%) were transferred to the palliative care unit, a median of 21 days after admission, where they died (median LOS 5 days). The majority died in the high security hospital ward (n=7; 54%) and received ≥3 palliative care medications (n=8; 62%). Qualitative themes around complexity of care included: constraints on provision and place of care; suitable pain management; restricted visitation; late acknowledgment of dying; and legalities of crime scene upon death.

Conclusion: This study demonstrated prisoners with life limiting illnesses spend the majority of their final months of life in acute hospital care. Results provide important insights which can inform future service provision and improve the end of life experiences of prisoners.

Abstract number: P146
Abstract type: Poster presentation

Determinant of Burden among Family Caregivers of Patients with Advanced Cancer in Indonesia
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Background: In Indonesia, its obligatory to care family member who is ill. Family caregiver was highly involved in caring for patient with cancer both in hospital and at home.

Objective: This present study aimed to identify factors affecting the burden among family caregivers of patients with advanced cancer.

Methods: This study was a cross-sectional study conducted from December 2016 to February 2017 on 178 consenting family caregivers and advanced cancer patients selected using purposive sampling technique. The Caregiver Reaction Assessment (CRA) was used to measure burden. Data were analyzed using descriptive analyses, bivariate, and multivariate analyses.

Results: The highest burden was significantly predicted by longer time of care per day (β=0.321; p<0.001), low family income (β=0.296; p<0.001), lack of family support (β=−0.293; p<0.001), older female caregiver (β=0.147; p=0.015), and who was taking care of male patients (β=0.123; p=0.042), in a model that explained 38.6% of the total variance.

Conclusions: Our findings identified modifiable factors that affecting the burden among family caregivers. Length of care per day and family support are potential targets for intervention strategies to manage the burden among family caregivers.

Abstract number: P147
Abstract type: Poster presentation

Bereavement Support: The Poor Cousin of Palliative Care!
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Background: One of the modern public health paradoxes is the neglect of the bereaved (though bereavement is a universal experience). Standards propose that bereavement support should be matched to risk and need. However, studies in many countries demonstrate that palliative care services (PCS) continue to adopt a blanket approach in offering bereavement support.

Objective: To investigate the practice of bereavement support in PCS as experienced by the bereaved, within the framework of clinical practice guidelines and the public health model.

Design: An anonymous postal survey collected information from clients of six funeral providers in Australia (2014-15), 6 to 24 months after the death of their family member, with 1,139 responding. Responses from 506 bereaved relatives of people with terminal illnesses were analysed quantitatively and qualitatively. Of these, 298 had used palliative care services and 208 had not.
Results: The vast majority of the bereaved accessed support from family and friends, followed by funeral providers and general practitioners. More people with cancer (64%) had received palliative care in comparison to other illnesses (4-10%). Only 39% of the bereaved reported being asked about their emotional/ psychological distress pre-bereavement, just half received they had enough support from PCS post-bereavement, half had a follow up contact at 3-6 weeks, and a quarter at 6 months. Feedback underlined the limited helpfulness of the blanket approach (not based on evidence), which was described as not personal or generic. Timeliness of tailored support and consistency of relationship between the service and the bereaved were lacking.

Conclusions: This innovative study (in content, conceptual model and recruitment approach) has international implications and has challenged PC bereavement provision in two ways: The bulk of support should be located in local communities, via people’s existing social networks, and the bereaved should not be pre-disposed to look for support in professionalised health services more than in their local community. Considering the reported limitations in meeting the needs of the bereaved, PCS might do better investing their efforts and resource allocation in developing community capacity and sustainable referral pathways as advocated by the public health model.

Abstract number: P148
Abstract type: Poster presentation

Time Does Not Impact Parents’ Grief and Mental Health in the First Five Years Following the Loss of a Child to Cancer - A Nationwide Study
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The loss of a child is a devastating experience and bereaved parents are at elevated risk for developing prolonged grief disorder and other negative mental health outcomes. The aim of this study was to assess parents’ symptoms of prolonged grief, posttraumatic stress symptoms (PTSS), anxiety and depression 1-5 years after the loss of a child to cancer.

Study population: Parents (n = 232) in Sweden who had lost a child (age 1-24 years) to childhood cancer 1-5 years previously (135 mothers and 97 fathers).

Study design and methods: A Swedish nationwide postal survey including the Prolonged Grief Disorder-13 (PG-13) (α = 0.89), the Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) (α = 0.94), the Montgomery-Åsberg Depression Rating Scale (MADRS) (α = 0.90) and the Generalized Anxiety Disorder scale (GAD-7) (α = 0.91). The variable “time since loss” was categorized into five groups responding to years 1-5 since loss.

Method of statistical analysis: One-way analysis of variance (ANOVA) was used to assess differences in mean symptom levels in relation to time since loss and t-test was used to assess for gender differences in symptom levels year one to five.

Results and interpretation: The ANOVA showed that there was no statistically significant difference between years since loss on symptom levels of prolonged grief, PTSS, anxiety and depression. Among parents who had lost their child one year previously, mothers had statistically significant higher levels of prolonged grief, PTSS and depression than fathers. Still, year two to five no gender differences were found. The findings indicate that time does not impact parents’ grief and mental health in the first five years following their loss.

Abstract number: P149
Abstract type: Poster presentation

What Promotes and Hampers Good Carer Support? A Qualitative Interview Study with Health Care Providers Supporting Carers of Advanced Cancer Patients
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Background/aims: Family caregivers (carers) of advanced cancer patients (ACPs) are important co-workers for professional health care providers (HCPs), to improve patient care, and to make home care and home death more probable. Little is known about what HCPs consider good support to carers of ACPs. An early integration cancer palliative care model has been implemented for patients and carers in a rural district of Norway. This study aimed to explore what hampers and promotes good carer support within this model.

Methods: Qualitative, semi-structured focus group interviews with HCPs providing support to carers of ACPs were analyzed using systematic text condensation. Each interview was read by two researchers independently. Purposive sampling guided the inclusion process.

Results: Twenty-one HCPs were interviewed in six focus groups; sixteen women and five men; ten nurses, four oncologists, four general practitioners, one pastor, one secretary and one nurse assistant; working in palliative inpatient ward, an oncology and palliative cancer outpatient clinic, and community care including GP staff, nursing homes, and home care.

Carer support on the individual level. Promoting factors: show interest for carers; encourage carers to accompany the patient at visits; provide carers and patients identical information; be available for carer consultations. Hampering factors: lack of formal training in communication with families, ad not always remembering to invite carers to patient consultations.

Carer support on the system level. Promoting factors: involvement early in the disease trajectory, a system for carer and carer-patient consultations; systematic telephone calls to carers based on need; coordination of care by community cancer nurses; and support tailored to the individual carer, the phase of the patient’s illness, and the patient-carer relation. Hampering factors: a health system tailored to the patients, not the carer; absence of systematic assessment of carers’ needs; absence of a record for full documentation of carer support; and lack of training. Conclusions: HCPs in this study actively supported carers. However, organizational changes to improve carer support should include:

1) Education in communication.
2) Involvement of carers in the decision making processes and care pathways, incl. systematic needs assessment, and separate, comprehensive recording of clinical work with carers.

Funding
The Norwegian Women’s Public Health Association Orkdal

Abstract number: P150
Abstract type: Poster presentation

Considering Informal Caregivers’ Needs in Palliative Home Care - Evidence from Patient Documentation in German Services
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EAPC 2018 Abstract Book
115
Abstract number: P151
Abstract type: Poster presentation

Providing Online Support for Family Carers of People with Dementia at the End of Life

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Carers of people with dementia experience increased levels of depression, strain, and emotional distress compared to carers of older adults with physical impairments. However, acting as a carer can make it difficult to access sources of support. This study aimed to understand what family carers find challenging towards the end of life, and how this is represented through documentation.

Results: ICs’ needs and/or specific support for ICs were rather marginal in patients’ records and they were strongly related to the care for the patient. This was also confirmed in the focus groups held with staff members. Little attention was paid to family carers “in their own right”. We found a strong tendency to write “about” family carers and their problems and no evidence for an assessment of caregivers’ needs. If conversations with family carers were noted, it remained open, what was spoken about and whether further steps were agreed on. In the focus groups the gap between “what is done” and “what is written down” was discussed as well as the lack of systematic assessment of ICs’ needs confirmed.

Conclusion: Analysis of records was useful to raise awareness for the need of approaching ICs as a group with own needs more systematically. Even more as there seems to be a gap between what is done and what is documented by staff members. Results will serve as basis for evaluating implementation of CSNAT in the services.

Introduction: The Carer Support Needs Assessment Tool (CSNAT) intervention is a carer-centred process of assessment and support for use in palliative care. Face-to-face training to assist palliative services to implement the intervention is being replaced with an internationally accessible online implementation toolkit, prompting revision of content.

Aim: To study implementation of the CSNAT intervention through the lens of NPT to produce pragmatic lessons for an implementation toolkit.

Methods: Qualitative: 38 practitioners (intervention champions) in 32 UK palliative care services interviewed three- and six-month post-CSNAT implementation. Focus groups with staff in three services six months post-implementation. The four core constructs of NPT (Coherence, Cognitive Participation, Collective Action, Reflexive Monitoring) were used as an analysis framework.

Results: NPT constructs were valuable for extracting main learning points from palliative practice implementation: “Coherence” (how individuals make sense of a new practice): support needed to

(i) distinguish the CSNAT intervention from practitioner-led and more informal approaches;
(ii) help staff plan for how they will integrate the CSNAT into their practice to ensure it is not an ‘add-on’. “Cognitive Participation” (engagement work done to generate ‘buy in’ for a new practice): guidance needed on

(i) ensuring managerial support for provision of protected time for pre-implementation planning and on-going audit and review;
(ii) developing/refining a carer strategy to provide clear rationale for implementation of the CSNAT intervention;
(iii) collecting and sharing positive examples of when the intervention produced meaningful outcomes.
“Collective Action” (work done to put the intervention into practice): support needed to

(i) adapt the use of the intervention to meet the nature of the service;
(ii) develop staff confidence and help them to make their first assessment.

“Reflexive monitoring” (work of appraising a new set of practices): advice needed on

(i) managing expectations around the length of time needed for implementation planning;
(ii) goal setting, monitoring progress, and planning for audit and evaluation.

Conclusions: These findings have direct implications for practice and will assist palliative services (nationally and internationally) to implement and sustain carer-centred assessment and support for family carers.

Funding
Dimbleby Cancer Care

Abstract number: P153
Abstract type: Poster presentation

What Structures and Processes Need to Be in Place to Enable Person-centred Assessment and Support for Carers during End of Life Care? A Multi-perspective, Mixed Methods Study
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Introduction: Carers play a vital role in supporting patients at end of life (EOL), enabling care at home and preventing hospital (re)admission. EOL care policy promotes delivery of comprehensive person-centred assessment and support for carers, not just patients.

Aim: To develop recommendations for organisational structures and processes required for implementation of person-centred comprehensive assessment and support for carers in EOL practice.

Methods: Three linked Stages:

1) Secondary analysis of existing research data into implementation of person-centred carer assessment and support in 36 services (38 practitioner interviews) allowing initial identification of structures and processes that facilitate or hinder implementation.

2) Expert consultation through three focus groups (19 lead practitioners and hospice managers) to expand, refine and validate Stage 1 framework and develop draft recommendations.

3) Wider stakeholder consultation through two professional workshops (23 participants: hospice, hospital, community, policy and academic delegates), an online survey (62 participants) and two carer workshops (nine participants) to validate draft recommendations, rate their importance and explore delivery challenges.

Results: Comprehensive, person-centred carer assessment and support requires whole-systems change and a cultural shift both at practitioner and organisational level. To achieve this 10 recommendations were identified for key structures and processes not normally met by current provision:

1) Consistent identification of carers within the care setting
2) Demographic and contextual data on who the carer is and their situation
3) A method/protocol for assessing carers and responding to the assessment
4) A recording system for carer information (separate from patient data)
5) A process for training staff about carer assessment and support
6) Available time/workload capacity for carer assessment and support
7) Support from senior managers
8) Role models/champions
9) Pathways for communication about carer assessment and support
10) Procedures for monitoring/auditing processes and outcomes of carer assessment and support

Conclusions: Achievement of comprehensive, person-centred carer support requires change management, targeting several levels within organisations. Carers’ fit within service provision also urgently needs clarification. Our 10 recommendations outline necessary building blocks to achieve this change.

Funding
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Abstract number: P154
Abstract type: Poster presentation

The Use of Linked Danish Registry Data to Examine Treatment Intensity at the End of Life and Healthcare Utilization of Families around Bereavement: A New Model for Expanding Caregiving and Bereavement Research
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Research aims: The patient’s healthcare experience (e.g., use of intensive care or palliative care) at the end of life impacts the health and wellbeing of caregivers. Yet existing data sources and study designs limit our ability to understand the family caregiver experience with serious illness (e.g., limited focus on cancer populations or one “primary” caregiver, reliance on convenience samples, recall bias). The use of prospective data from large population-based data registers may allow us to comprehensively examine how treatment intensity impacts health and healthcare utilization for caregiving families. Our aim is to evaluate the feasibility of using the extensive Danish healthcare registers to examine treatment intensity and healthcare utilization of families around the time of an individual’s death.

Study population: Danish decedents and linked family members.

Study design and methods: Prospective cohort study of decedents with linkages to all parents, spouses, cohabiting partners, children, grandchildren, great grandchildren and great great grandchildren. Data sources include the following registers: hospitalization, primary care, palliative care or palliative care) at the end of life impacts the health and well-being of caregivers. Yet existing data sources and study designs limit our ability to understand the family caregiver experience with serious illness (e.g., limited focus on cancer populations or one “primary” caregiver, reliance on convenience samples, recall bias). The use of prospective data from large population-based data registers may allow us to comprehensively examine how treatment intensity impacts health and healthcare utilization for caregiving families. Our aim is to evaluate the feasibility of using the extensive Danish healthcare registers to examine treatment intensity and healthcare utilization of families around the time of an individual’s death.

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death. Health care utilization records 2 years pre and post-death on all family members were successfully linked.

It is feasible to examine family healthcare utilization patterns across the trajectory of serious illness using register data in Denmark. Population-based research on families can substantially expand our knowledge of how bereavement and treatment intensity impacts caregivers, improve health of the growing population of family caregivers, and enhance accuracy of cost estimates of care.

Abstract number: P155
Abstract type: Poster presentation

Volunteer Involvement in the Organisation of Palliative Care:
Results from a Nation-wide Survey of Healthcare Organisations
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Background: Governments expect communities to take up increasing shares of palliative care (PC) provision, e.g. through volunteerism. However, volunteerism’s capacity to support professional healthcare on the organisational level is unknown. Insights into volunteer involvement and organisational attitudes towards involvement are crucial for policy makers to prepare and optimise this shift.

Aim: Describe the degree of involvement of direct patient care volunteers in organisations providing PC in Flanders (Belgium) and how these organisations evaluate their involvement.

Method: A postal survey was conducted among organisations providing care for patients with chronic, life-threatening conditions at the end of life in Flanders, Belgium. The sample included every PC unit, palliative day care centre, multidisciplinary home care support team, medical oncology department, sitting service, community home care organisation, and a random sample of nursing homes.

Results: Response rate was 79% (N=258). 75% of organisations informed their volunteers about the organisation of care, 35% consulted them, 47% took their opinion into account, 15% gave them decision rights and 7.5% gave them autonomy. Most organisations (74%) rated their volunteers’ involvement as sufficient, but were dismissive towards decision rights (82%) and autonomy (92%) for volunteers. A higher degree of volunteer involvement in the organisation was associated with more topics being covered in volunteer training (p<.001) and volunteers performing more practical (p<.001) and psychosocial (p<.001) tasks.

Conclusion: This study on volunteerism in PC across the healthcare system indicates that few organisations give decision-rights to volunteers regarding the organisation of their palliative, direct patient care and few wish to do so. However, the found associations between the level of involvement and volunteer training and tasks suggests that a more empowered role for volunteers may increase their care capacity.

Abstract number: P156
Abstract type: Poster presentation

Qualitative Evaluation of the Impact of a Paediatric Palliative Care Family Support Volunteering Project
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Background: Families caring for a child with a life limiting condition not only provide 24 hour complex care but also must care for siblings and cope with everyday tasks. Research suggests families could benefit from ‘domestic support’ (Fraser et al, 2015). This abstract reports on a qualitative evaluation of the second phase of a pilot project offering volunteer home support to such families. Three pilot sites were involved including voluntary and NHS community children’s palliative care (CPC) teams.

Method: Qualitative questionnaires were completed by families, staff, volunteers and strategic leaders before and after the pilot, followed by small number of semi-structured interviews to explore experiences in more depth.

Results: Volunteers provided a range of support including, housework, gardening, shopping homework with siblings and taking siblings to and from school. Sixty volunteers were recruited and 62 families matched with volunteers. As a result of volunteer support, 100% of families reported improvement in quality of life, 95% feeling less stressed and more able to cope with 65% feeling less isolated. All volunteers (100%) felt valued, 84% increased skills and confidence and 92% wished to continue volunteering.

The project enabled pilot sites to extend the range of support offered and increased organisational capacity. Volunteers enriched the organisation and brought new ideas and impetus. Volunteers were able to respond quickly and appropriately in crisis situations. Challenges identified included some families feeling that the offer of volunteer help implied that they were not coping, volunteers’ availability not always matching families preferred times and allowing enough time for planning and set up. A set of online resources were developed as part of the project. These include guidance on planning and implementation in different settings are now freely available.

Conclusion: This evaluation suggests that families benefit greatly from volunteer support in the home and may be of value to other CPC services considering how too extend their support to families. A subsequent evaluation, with reflections on sustainability replicability is underway.

References

Abstract number: P157
Abstract type: Poster presentation

Perceptions of Trained Laypersons in Advance Care Planning and End-of-Life Conversations: A Qualitative Meta-synthesis
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Background: Laypersons in community or healthcare settings, such as volunteers, peer educators, and lay health navigators, are important team members in the support of individuals with serious illnesses. The extent of their involvement in communication is unknown. The objective of this qualitative meta-synthesis is to explore the perspectives of laypersons related to end-of-life communication, such as advance care planning or end-of-life conversations.

Methods: We conducted a systematic search of MEDLINE, PsycINFO, CINAHL+, Cochrane Library, and AMED to include qualitative studies reporting statements by laypersons (e.g. volunteers, peer educators, lay health navigators, community health workers) in advance care planning, palliative care or end-of-life settings regarding client-peer communication. Study quality was appraised by the research team using an established checklist for qualitative studies. The analysis focused on laypersons’ quotes, rather than themes from the primary studies, to identify key domains and related themes relating to laypersons’ perspectives on end-of-life communication.

Results: Of 877 articles, nine studies provided layperson quotes related to client-peer communication related to advance care planning (n=4) or end-of-life communication (n=5). The studies were conducted in UK settings (n=4) or US settings (n=5). The quality of studies varied, with overall
Dealing with Powerlessness.

A Phenomenological Study among Palliative Care Volunteers

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Background: Being involved in end of life care triggers existential experiences and reflections in care professionals, family members and volunteers. This might be caused by the suffering or pain of patients, the mourning of relatives or ideas about a good way of dying not being met. Co-ordinators of a Dutch hospice observed that successful ‘being there’ of volunteers was undermined by experiences of powerlessness, often triggered by ‘not being able to do anything more’. They suggested that different types of coping with powerlessness by volunteers might have influence on risks at compassion fatigue and burnout.

Aim: This study explores the nature of volunteers’ experiences of powerlessness and how they deal with these, in order to develop successful supervision strategies and reduce drop outs.

Methods: Via 4 Dutch hospice organisations 19 respondents were recruited with a letter describing the study. 2 of them were male. Their average age was 62 years. On average the sample had 4.5 years of experience in end of life volunteering. Informed consents were collected. Respondents participated in a phenomenological in-depth interview that was recorded and typed out verbatim. Analysis was performed following directions of the phenomenologist Karen Dahlberg.

Results: We found a core category existing of desperation. Powerlessness appeared when volunteers were faced with something they could not change, did not know, could not do, were not able to accept, or when some earlier experiences of powerlessness were activated. Exploring the experiences of powerlessness, different sources of the phenomenon appeared. Lack of knowledge or skills, certain values, or images or hopes about how situations should develop. Furthermore, different reactions to disempowerment were distilled: some volunteers’ first reaction was to freeze, some had a strong intention to flee, others mainly wanted to fight.

Discussion: Reflecting on these data we discern two categories in coping with experiences of powerlessness:

1) coping aimed at restoring the control of the volunteer as soon as possible and
2) coping that asks questions about the reason of experienced powerlessness and helps the volunteer to reflect on this theme.

The first type we call conservative handling of powerlessness and the second transformative handling of powerlessness. Questions to initiate further reflection of volunteers were developed to help co-ordinators organise training sessions about this topic.
Background/aims: Life-extending treatment for cancer has advanced over the past years. Thereby, the illness trajectories at the end-of-life (EOL) for some cancers may now resemble those of patients with non-malignant chronic illnesses. However, detailed real life data is sparse. We aimed to examine illness trajectories by studying all-cause hospital admissions within 5 years before death among patients dying from chronic obstructive pulmonary disease (COPD), heart failure (HF) or cancer.

Methods: We included all decedents dying from COPD, HF or cancer in Denmark in 2006-2015, using nationwide Danish medical registries. We obtained data on all in-hospital admissions within 5 years before death. Daily prevalence proportion (PP) of patients staying in hospital was computed and compared by regression analyses adjusting for age, gender, comorbidity, partner status and residential region.

Results: Among the 174,112 included patients, the mean PP of patients hospitalised 5 years before death was 1.4% (95%CI, 1.4;1.4) for COPD patients, 1.2% (95%CI, 1.2;1.2) for HF patients and 0.6% (95%CI, 0.6;0.6) for cancer patients. The adjusted PP ratio was 2.2 (95%CI, 2.2;2.2) for COPD patients and 1.9 (95%CI, 1.9;2.0) for HF patients compared with cancer patients. The daily PP of patients hospitalised showed steady progression for all patient populations until the last year before death, in which the daily PP increased steeply.

Hence, the mean PP within 6 months before death was 16.6% (95%CI, 16.5;16.7) for COPD patients, 14.7% (95%CI, 14.6;14.9) for HF patients and 18.4% (95%CI, 18.3;18.4) for cancer patients. The adjusted PP ratio 6 months before death was 0.74 (95%CI, 0.74;0.74) for COPD patients and 0.65 (95%CI, 0.65;0.65) for HF patients. The mean PP within one month before death was 30.0% (95%CI, 29.8;30.1) for COPD patients, 26.0% (95%CI, 25.8;26.2) for HF patients and 35.5% (95%CI, 35.4;35.5) for cancer patients. The corresponding adjusted PP ratio was 0.79 (95%CI, 0.79;0.79) for COPD patients and 0.70 (95%CI, 0.69;0.70) for HF patients.

Stratifying on cancer type revealed no substantial differences.

Conclusions: Contrary to the common perception of EOL trajectories, this study suggests minimal differences in the trajectories regardless of underlying disease. Yet, further research is needed to make firm conclusions about possible clinical implications.

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Abstract number: P161
Abstract type: Poster presentation

Defining Appropriate End of Life Care: A Belgian Community Study

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In 2016 the Belgian Health Care Knowledge Centre (KCE) commissioned a study on opinions about (in)appropriate care at the end of life in the Belgian community aiming to explore views and experiences on this topic and to initiate a societal debate providing guidance to policy makers. This mixed method study included an online survey completed by 1935 respondents, and a qualitative follow-up study consisting of online focus groups, conventional focus groups and in-depth interviews with different stakeholders (n=143). In-depth interviews were conducted with patients characterized by a short life expectancy (n= 8), mostly living at home. The interview guide was based on major topics emerged from the preceding community based online survey. Themes were not ranked according importance: the support for informal caregivers, dignity at the end of life, decision making and advanced care planning, transition to end-of-life care, unconventional well-being practices, spiritual needs and place of care/death. Thematic analysis was performed. Main findings revealed patient’s definition on concepts such as dignity, quality of life or advanced care planning. Better pain and other symptom control, more comfort care and psychological supportive care both for them and their family caregiver are requested by patients. Furthermore, the need to be respected in their personal choices about place of care and treatment options was widely expressed. Finally, patients communicated
openly fears, hopes and desires in relation to their illness, the social interactions experienced and the perspective of death.

**Abstract number:** P163  
**Abstract type:** Poster presentation

**Better Together: The Making and Maturation of the Palliative Care Research Cooperative Group (PCRC)**

Etkind, Simon Noah1, Brighton, Lisa 1, Smith, Pam2, Bailey, Sylvia2, Evans, Catherine 3, on behalf of the Cicely Saunders Institute Patient and Public Involvement Strategy Group

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**Aims:** Despite advances, significant gaps remain in the evidence base to inform care for people with serious illness. The Palliative Care Research Cooperative Group (PCRC) was formed to generate needed evidence and bolster research capacity. We describe the PCRC’s growth and contributions to advancing palliative care research.

**Methods:** The PCRC exists to lead, catalyze, and empower a community of palliative care investigators. The PCRC:

- Supports investigators at all levels of experience in the conduct of clinical studies;
- Conducts nationally representative, multi-institutional studies that include diverse populations;
- Leverages Common Data Elements and a de-identified data repository that amplifies the impact of any single study; and
- Provides methodological resources, participant access/recruitment, and the expertise of PCRC investigators from multiple disciplines.

After developing a governance structure and completing a proof of concept study, the PCRC expanded its infrastructure via additional resource cores (Clinical Studies/Methodology; Measurement; Data Informatics and Statistics; and Caregiver Research), an Investigator Development Center to complement the Project Coordinating Center, and Scientific Review and Publications Committees.

**Results:** Since its inception in 2010, the PCRC has grown to over 400 members representing 144 distinct locations. To date, the PCRC has supported submission of 59 research applications and conduct of 39 studies. The PCRC promotes investigator development through pilot grant awards, monthly webinars and clinical trials intensives. The PCRC convenes regular investigator meetings, has special interest groups, and communicates via a newsletter and website.

**Conclusion:** With a particular focus on facilitating conduct of rigorous multi-site clinical studies, the PCRC fosters an engaged multi-disciplinary research community, filling a void in generating and disseminating evidence that informs the provision of high quality palliative care.

**Abstract number:** P164  
**Abstract type:** Poster presentation

**Putting Patients and Families at the Heart of Palliative Care Research: Development and Implementation of a Strategy for Patient and Public Involvement**

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**Background/aims:** Patient, carer, and public involvement in research (PPI) ensures it remains relevant to the needs and priorities of service users, and can improve its quality and impact. This is particularly relevant to palliative care research which aims to achieve the same person centeredness as clinical palliative care. Therefore we aimed to develop and implement a strategy for PPI at every stage of the research process, in a palliative care research institute.

**Methods:** We used findings from an earlier stakeholder consultation with 12 service users and 5 researchers to develop principles for a draft PPI strategy, which was then written in partnership with two PPI representatives. We further consulted PPI representatives during a workshop session with 10 attendees, and utilised our online PPI forum to solicit further feedback. Based on these consultations, the strategy was refined, and measurable outcomes incorporated. Implementation of the strategy began in 2017.

**Results:** Three key principles guide the PPI strategy: early involvement to improve research productivity, quality and clinical relevance; a model that involves a high degree of flexibility, including virtual and face-to-face methods; and promotion of the contribution that PPI members make. The components for implementation of the strategy are: building research skills; recruiting and engaging representatives; and supporting collaborations across the research journey including evaluation of the impact of PPI. To date, progress has been made in each area: annual skills training for researchers is underway; engagement events attended by 180 people have recruited 11 PPI additional representatives, and received excellent feedback during evaluation; 6 research projects have been discussed at workshops in 2017, and 76 posts have been made on the online forum.

**Conclusions:** We have produced and implemented an innovative PPI strategy for palliative care, which allows us to incorporate the views of PPI representatives at every stage of the research process.

**Funding & acknowledgement**

CLAHRC: South London

**Abstract number:** P165  
**Abstract type:** Poster presentation

**Impacts on Employment, Finances and Lifestyle for Working Age People Facing an Expected Premature Death: A Systematic Review**

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**Aims:** The working ages (25-65 years) are a period when most people have significant financial, work and family responsibilities. A small proportion of working age people will face an expected premature death from cancer or other life-limiting illness. Previous research has shown that life-limiting illnesses are associated with increased needs regardless of age. Understanding the impact an expected premature death has on the working age population is important for informing support. The current study aimed to summarise research describing the impacts that facing an expected premature death has on employment, finances and lifestyle of working age people and their families.

**Methods:** A systematic review using a narrative synthesis approach was employed due to the heterogeneity of study designs and outcomes. Four electronic databases were searched in July 2016 for peer-reviewed, English language descriptive studies focusing on the financial, employment and lifestyle concerns of working age adults living with an advanced life-limiting illness and/or their carers and/or children.

**Results:** Fifteen quantitative and 12 qualitative studies were included. Two-thirds (n=18) were focused on cancer. All studies identified adverse effects on finances, workforce participation and lifestyle. Many patients were forced to work less or give up work/reitre early due to symptoms and reduced functioning. In addition to treatment costs, patients and families were also faced with childcare, travel, and home/car modification costs. Being younger (< 60 years) was associated with greater financial...
Working age people facing an expected premature death with advanced cancer.

King’s College London, London, UK, 1Wolfson Palliative Care Research Settings

Do UK Palliative Care Services Change Patient’s Health Status? A Longitudinal Cohort Study Comparing Three Specialist Palliative Care Settings

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Background: Palliative care has developed to meet the needs of patients and families, and addresses physical/psychological symptoms and social, practical and spiritual support. However, evidence is limited about impact on patient-level outcomes in different settings of care.

Aim: To compare change in the health status of patients across three specialist palliative care settings; hospital advisory care, hospice inpatient units (IPUs), and community-based care.

Methods: A longitudinal multicentre cohort study in three settings; two hospital services, six hospice inpatient units and six community teams. Start and End of Phase of Illness was used to report:

1) duration of unstable Phase of Illness;
2) change in pain scores; and
3) change in psychological distress.

Pain and psychological distress were captured using the Integrated Palliative care Outcome Scale (IPOS) and Palliative Care Problem Severity Score (PCPSS).

Results: A total of 997 patients (1163 phases) were included, comprising of 175 hospital consult patients (256 phases), 144 hospice IPU patients (160 phases), and 678 community patients (747 phases).

1) Unstable phases were 54.3% of hospital, 40.6% of hospice and 43.0% of community Phases. Unstable Phases were shortest in hospice IPUs with a mean 13.5 days (SD 12.5), longer in hospital advisory care at mean 21.8 days (SD 57.1), and longest in the community at mean 52.6 days (SD 52.0) days (F=27.9, p < 0.001).

2) 44.9% of phases in the hospital advisory service showed an improvement in pain score by the end of phase, compared to 37.5% hospice IPU and 19.6% in the community (χ² = 77.2, p < 0.001).

3) 44.2% of hospital advisory phases showed an improvement in psychological distress by end of Phase, compared to 30.0% of hospice IPU Phases, and just 21.8% of community Phases. However, 14% of data on psychological distress was missing.

Conclusion: The prolonged duration of unstable Phases across all settings, but particularly in the community, needs addressing, especially given the shorter duration of unstable Phase reported from Australia (see www.pcoc.org.au). In addition, pain and psychological distress improved more in hospital advisory and hospice inpatient services, compared to the community setting. Models of community care need to be further evaluated in the light of these findings.

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Abstract number: P166
Abstract type: Poster presentation

Do Palliative Care Patients with a Lower Socioeconomic Status Have Equitable Access to Palliative Care Units in Ontario?

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Aim: Equitable access to palliative care has been highlighted as an area of concern across the world. To evaluate potential inequities concerning patient sociodemographics and special care needs, we evaluated our region’s electronic referral sending and matching program that supports palliative care bed allocation for a population of 6.4 million people.

Methods: The program manages the referral and admission processes of 207 palliative care beds, spread across 9 palliative care units (PCUs) and 1 residential hospice. Data related to patient demographics and socioeconomic status (age, language, income quintile, gender, faith), as well as patient prognosis, diagnosis and care needs (special care needs such as oxygen, wound care, behavioural supports, etc.) were analysed to evaluate equitable access to PCU resources.

Results: Between January 2015 and December 2016, the region processed 7786 applications, resulting in 3142 admissions to palliative care beds. Average age was 77.9 years, 3955 (50.8%) were female, and 75.7% spoke English. Approximately 26% of applicants had an identified faith. Most applicants came from patients in the lowest income quintile (27.3%) followed by the highest income quintile (5, 19.7%). A total of 71.7% had a listed cancer diagnosis, prognosis was most often listed as < 3 months (58.8%) but ranged from < 1 (26.5%) to < 12 months (3.4%). The majority of patients had a PPS score of 40% (34.3%), and an ESAS mean score total of 30.5. Over 55% had a listed special need: most often oxygen (10.1%), followed by wound care (4.2%) and behaviour issues (3.3%). Applicants from all income quintiles showed similar acceptance rates, although those that spoke English had higher acceptance than those who did not (43.2% vs 37.8%, p=0.03). Applicants with behaviour needs also faced lower acceptance than those with no special needs (35.4% vs 41.1%, p=0.04). Multivariate analysis is pending and will be available for presentation.

Conclusion: Patients with the highest and lowest incomes are more likely to apply for PCU placement. Patients that are non-English speaking or those with special needs have a lower chance of being accepted or admitted into a PCU.

Abstract number: P168
Abstract type: Poster presentation

Palliative Care for Homeless People: A Systematic Review of the Concerns, Care Needs and Preferences, and the Barriers and Facilitators for Providing Palliative Care

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Research aims: Homeless people often suffer from complex and chronic comorbidities, have high rates of morbidity and die at much younger ages than the general population. Due to multiple barriers, they often have less access to palliative care. Therefore, providing palliative care that fits their needs and concerns is a challenge to healthcare providers. This study summarizes evidence about the concerns, palliative care needs and preferences of homeless people, as well as barriers and facilitators for delivering high quality palliative care.

Study population: Included were studies about homeless people with a short-life expectancy, their palliative care needs and the palliative care provided, that were conducted in Western countries.

Study design and methods: A systematic literature review based on the PRISMA statement. PubMed, Embase, PsycINFO, CINAHL and Web of Science were searched up to 10 May 2016. Data were independently extracted by two researchers using a predefined extraction form. Quality was assessed using a Critical Appraisal instrument.

Method of analysis: Data were analysed using thematic analysis to identify common topics.

Results and interpretation: 27 publications from 23 different studies met inclusion criteria; 15 qualitative and eight quantitative studies. Concerns of the homeless often related to end-of-life care not being a priority, drug dependence hindering adequate care, limited insight into their condition and little support from family and relatives. Barriers and facilitators often concerned the attitude of healthcare professionals towards homeless people. A respectful approach and respect for dignity proved to be important in good quality palliative care. A patient-centred, flexible and low-threshold approach embodying awareness of the concerns of homeless people is needed so that appropriate palliative care can be provided timely. Training, education and experience of professionals can help accomplish this.

Abstract number: P169
Abstract type: Poster presentation

Developing and Evaluating a Training Workshop for Hostel Staff around Supporting Homeless People with Advanced Ill Health

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Research aims: Many homeless people with advanced ill health remain in hostels as their health deteriorates. Hostel staff are not trained to provide palliative care and are often unsure how to access support for residents. We developed a training workshop for hostel staff, explored their main concerns when supporting very unwell residents and evaluated the impact of training on confidence, knowledge, attitudes and stress around supporting clients with advanced ill health.

Study population: 21 staff from two homeless hostels in London.

Study design and methods: A two day training workshop was developed, delivered and evaluated using a mixed methods, repeated measures design. The training included 7 modules; identifying clients (with advanced ill health), person centred care, shared care, engaging clients, end of life care, bereavement, self-care. Evaluation booklets containing free text and 14 Likert scale items measuring key outcomes were completed before and immediately after training. Focus groups were held immediately after training and 3 months post training.

Method of statistical analysis: Wilcoxon-signed rank tests were used to compare mean scores pre and post training. Significance was identified at the level of < 0.05. Qualitative data were analysed using thematic analysis.

Results and interpretation: Key concerns when supporting ill residents included non-engagement, substance and alcohol misuse, uncertainty over clients’ capacity to make decisions, challenging behaviour and self-neglect. Immediately post training mean knowledge scores increased significantly from baseline (z=-2.07, p= .007). Scores on all other items increased post training but did not reach statistical significance. The training was perceived as useful and relevant. Participants valued the practical tools and resources provided and appreciated the focus on the wellbeing of staff in addition to the wellbeing of clients.

Abstract number: P170
Abstract type: Poster presentation

Palliative Care for People with Parkinson’s Disease; When to Start?
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Background: Parkinson’s disease (PD) is a chronic, progressive, neurologic disorder without curative treatment. Palliative care potentially has an important role, and an early palliative approach is largely recommended to improve quality of life of people with PD. Little is known about how to integrate palliative care principles and especially when to introduce palliative care in the PD disease trajectory.

Aim: Based on a literature study, qualitative research and a Delphi procedure we aim to develop a tool that supports professional caregivers in timely starting with a proactive palliative care approach in people with PD.

Methods: A three-step procedure was used to develop the tool for the early identification of patients with PD who could benefit from palliative care. We started with a literature study on palliative care in PD. Afterwards, we performed individual interviews and focus group interviews with professional caregivers and individual interviews with bereaved family caregivers and people with end stage PD. After analyzing this rich data, we were able to develop a set of indicators that might be helpful in early identification of palliative care in PD. In the last stage, we performed a Delphi study to select those indicators that are appropriate and useful in PD care.

Results and interpretation: Thirty-nine professionals, 11 bereaved family caregivers and 8 patients and their caregivers participated in the interviews. Together with the literature study, this resulted in a set of indicators for early identification. The study ran from March 2016 to April 2018. This means that the results from the Delphi study will only be available after march 2018.

Conclusion / discussion: This study developed a first tool that can help professional caregivers in the identification of patients with PD in need of palliative care. Applying this tool has the potential to facilitate timely start of proactive palliative care and aims to improve the quality of palliative care in daily practice.

Abstract number: P171
Abstract type: Poster presentation

Overcoming Recruitment Challenges in a Randomized Clinical Trial of Early Palliative Care
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Background: Reasons why clinical trials of early palliative care (ePC) have prolonged patient recruitment timeframes have been researched mainly qualitatively. Confronted with an initially slow recruitment in our ePC multicenter trial, our objective was to identify major recruitment barriers, qualitatively and quantitatively, and to address them. Throughout the trial we monitored the impact of the actions implemented to overcome the barriers.
Methods: Data from all patients with a suitable tumor entity (N= 2284) screened at the main study site between October 2013 and August 2017 were analyzed for: reporting department, dates and possibilities of contact, and eligibility and consent status. Changes to the recruitment process were implemented from March 2014 and all data onwards was used to estimate the impact of all changes on recruitment.

Results: Three main barriers were identified and addressed:

1. Logistic barriers: we changed from voluntary referral by the treating physician to study staff screening the outpatient clinics of medical oncology and radio-oncology, the internal medicine ward and the tumor board of gyneco-oncology.
2. Motivational barriers: were improved through education about ePC and a communication guide on how to introduce the study to patients, as well as by appointing a senior oncologist to oversee recruitment.
3. Eligibility criteria: we included two more cancer types.

The implementation of a systematic screening procedure increased the number of identified eligible patients from one per month to four per month. Standardized information raised the consent rate from 16.7% to at least 42% per study recruiter. The widened eligibility criteria led to a further 0.5 recruitments per month. Overall, the actions implemented increased the accrual rate from one patient during a six-month period to 2.5 patients per month at the main study site. Together with the two other study sites the accrual rate finally reached 3.6 patients per month. The recruitment target of 150 patients was completed in August 2017.

Conclusions: Our results showed that recruitment in ePC trials can be improved by education about ePC, including how to introduce ePC to the patient and by dedicated recruitment medical staff. A time-efficient screening tool is crucial to identify and contact eligible patients in time. These same factors may not only improve recruitment rates in trials, but may also be relevant for the successful integration of ePC into standard oncology care.

Abstract number: P172
Abstract type: Poster presentation

Family Support as a Burden of Nurses Working in Different Settings in Specialized Palliative Care.

Results of a Nationwide Study in Germany
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Statement of aims / research questions: In previous studies the following stress factors concerning the support of family members are mentioned: a lack of confidence in professionals’ own communication skills with patients’ relatives or difficult relationships with them. In Germany nearly no study has compared the three settings palliative ward, hospice and outpatient specialized palliative care (SAPV) according to this topic. The aim of the study is to examine the support of family members as a burden of nurses working in specialized palliative care.

Presentation of methods: In the cross-sectional nationwide study (April to October 2017) in Germany thirteen items of the self-developed questionnaire featured the support of family members (5-point Likert scale: 1 “no burden” to 5 “very strong burden”). These items were used to generate a scale. Bivariate (t-test) and multivariate analyses (logistic regression (0 “value 1-3”, 1 “value 3-5”) were conducted.

Presentation of results: The abstract contains the preliminary results of 491 nurses. In the following, the three statements with the highest burden are listed. The nurses answered with “rather strong” or “very strong burden”:

1. Relatives who cause unrest (62.3%).
2. Bereaved children (61.7%).
3. Relatives who can’t accept the situation of their dying relative (61.7%).

The preliminary results show a significant difference between the burden of support of family members and setting. Nurses in SAPV had a less risk to be burdened by the support of family members than nurses in palliative wards (OR: 0.44; p=0.002).

Conclusion: Our findings support the literature that nurses feel inadequately prepared to deal with the emotional needs of patients and their families. The support of family members as a burden differentiates between settings. The support of family members should be more integrated in stress-reducing strategies and further education in family support should be offered, especially in palliative wards.

The “Forgotten” Generation: Quality of Life in Adults Living with Duchenne Muscular Dystrophy
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Background: Duchenne Muscular Dystrophy (DMD) is an x-linked, ultra-rare neuromuscular condition affecting 1 in 3600-6000 live male births. Life expectancy is increasing thanks to targeted intervention and advancing medical treatment. Longer survival and advancing age means a greater dependence on family, friends and the wider community, and increasing social and health care costs. However, little is known about quality of life (QoL) in adults with DMD.

Aim: To investigate and explore quality of life in men aged over 25 living with DMD in the West of Scotland.

Methods: This was a qualitative interview study using the “Schedule for the Evaluation of Individual Quality of life - Direct Weighting” (SEIQoL-DW) tool, an interview based instrument which allows the assessment of elements that contribute to an individual’s QoL. The participants were identified and recruited through the Scottish Muscle Network - a multidisciplinary clinical network. The interviews were transcribed and analysed thematically applying descriptive labels to the data.

Results: Six men were recruited and interviewed. A number of themes were characterised as key to good QoL: strong personal relationships providing support and advocacy; meaningful connection with the world through hobbies and on-line communities; being in control of physical and mental wellbeing, supported by knowledgeable and approachable health care professionals; continued independence through use of essential equipment both in and out of the adapted accessible home; and a positive, resilient attitude to life with a disability.

Conclusions: Key improvements could improve QoL in this “forgotten” group of adults: upskilling and support for all care givers; lifelong input from physiotherapy; timely access to psychological support; improved...
access to respite facilities; better co-ordinated holistic multidisciplinary care; and proactive advance care planning.

Abstract number: P174
Abstract type: Poster presentation

The Views of Homeless People and Healthcare Professionals on Palliative Care and the Possible Use of a Consultation Function: A Focus Group study
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Research aims: Palliative care for homeless people is often given late, if given at all. Professionals in both palliative care and shelter care are often insufficiently equipped to provide this complex care. This study aimed to provide insight in experiences of homeless people and professionals with palliative care and their views on barriers and facilitators in providing good palliative care, and to investigate whether a consultation function can contribute to improving palliative care for homeless people.

Study population: Severely ill homeless people and professionals involved in palliative and shelter care for this population.

Study design and methods: Two focus groups with homeless people (n=15) and four multidisciplinary focus groups with professionals (n=19). Professionals were recruited by purposive sampling, homeless people were recruited by opportunity sampling.

Method of analysis: The verbatim transcripts were analysed using thematic analysis.

Results and interpretation: Six themes were identified: palliative care for homeless people is especially complex and differs substantially from regular palliative care, it differs greatly between professionals, institutions and cities, homeless people experience less self-determination than desired by themselves, homeless people and professionals have different perceptions on care provided, trustful relationships between professionals and homeless persons are essential, and low-threshold and flexible access to respite facilities; better co-ordinated holistic multidisciplinary care; and proactive advance care planning.

Abstract number: P175
Abstract type: Poster presentation

Are Mental Health Nurses Equipped to Provide Palliative Care? A Cross-sectional Study to Identify Determinants of Self-efficacy
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Aim: The purpose of this study was twofold: i) to explore mental health nurses’ knowledge about palliative care, perceived time pressure and self-efficacy in end of life (EOL) communication, and ii) to identify determinants for high self-efficacy in EOL communication.

Methods: A cross-sectional survey study was conducted. Nurses registered at the V&VN Dutch nurses’ Association division of psychiatric nursing were invited to participate in this study. Of the 537 eligible nurses, 137 participated (26%). Knowledge about palliative care was measured using 5 important components of palliative care that could be answered correctly or incorrectly. Time pressure was measured using 5 questions on a 5-point Likert scale. Nurses were asked to rate their confidence on a scale of 0-7 using the 8 item Communication subscale of the Self-efficacy in End-of-Life Care survey.

Results: The majority of psychiatric nurses was knowledgeable about four out of five components of palliative care, i.e. palliative care: not being restricted to treatment of pain (87%), including spiritual care (89%), and including care for relatives (95%). However, that palliative care and intensive life prolonging treatment could be combined was less well known, only by 50% of nurses. Around 60% of the nurses experienced time pressure and 83.2% perceived the time they spend doing administrative tasks to be unreasonable and potentially causing residents to fall short in care. Overall, nurses had high self-efficacy regarding EOL communication with patients and their families: overall mean score = 5.69. Nurses felt most confident in having a conversation with the resident about general issues related to and specific concerns about dying and death. They were least confident in talking with the patient about future suffering and the likely course of a life-limiting disease with the patient or his relatives. Care staff’s age ≥50 years was significantly associated with high self-efficacy (score ≥5.92, OR: 5.92, 95%CI: 2.095-16.727).

Conclusion: Although psychiatric nurses have limited experience with providing care to dying patients, they are quite knowledgeable about the components of palliative care and feel confident in EOL communication. That psychosocial care is a crucial aspect of psychiatric nursing might be an explanation for this. Nurses with more life experience were more confident in discussing in EOL issues.

Abstract number: P176
Abstract type: Poster presentation

Involving Patients and Caregivers in the Production of Guidelines for Palliative Care in Multiple Sclerosis: Identification of Intervention Priorities
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Background: Involving patients and caregivers is now recognized as an important component of clinical practice guideline development. The European Academy of Neurology (EAN) recently appointed an international task force of multiple sclerosis (MS) and palliative care (PC) researchers, clinicians, patient representatives, and methodologists, to develop specific guidance on PC of people with severe MS following the GRADE approach. To identify clinical questions meaningful to the MS patients and caregivers, a mixed approach (web survey and focus groups) was used.

Methods: The guideline task force identified 14 intervention areas, with input from MS health professionals from the 9 participating countries, each rated for importance (4-level Likert scale). After translation and pilot testing in Germany, Italy, Israel, the Netherlands, and Serbia, 9 areas were retained: symptomatic treatment; multidisciplinary rehabilitation; early engagement in advance care planning; PC; specialist PC; caregiver education/training; caregiver support; MS health professional training in PC; PC health professional training in MS. From September 2017, the web survey was launched by the National MS Societies of the 9 countries except Israel. Focus groups of MS patients and carers were planned in Germany, Israel and Italy.

Results: Findings on the Italian survey (September 20-29) are available, with 334 MS patients (75% women; age range 19-81; 24% fully ambulatory; 25% assisted walk; 51% chair or bedbound) and 54 carers (54% women; age range 20-71; 54% husband/wife/partner). Both MS patients and carers strongly agreed/agreed on including each of the 9 intervention areas, with highest figures for multidisciplinary rehabilitation (74% of patients and 76% of carers strongly agreeing) and lowest for early engagement in advance care planning (51% of patients and 41% of carers strongly agreeing). Ratings were similar for patients and carers, with very few differences (e.g. 70% of carers vs. 62% of patients strongly agreed on including caregiver support programs).

Conclusions: Participation of Italian MS patients to the web survey was high and information-rich; both patients and carers agreed or strongly agreed on inclusion of the 9 intervention areas in the guideline. Whole survey and focus group results will be presented.

Abstract number: P177
Abstract type: Poster presentation

Palliative Care for Patients with and without Psychiatric Illness: A Nationwide Survey Study in the Netherlands

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Aim: Little is known about the impact of psychiatric illness in death and dying and the provision of palliative care. Therefore we aimed to study the prevalence of psychiatric illnesses among deceased people, and describe their background characteristics, and the involvement of palliative care.

Methods: A nationwide study of a stratified sample of deceased people in 2015 taken from the death registry of Statistics Netherlands. All attending physicians received a questionnaire about the last phase of life (n=7661).

To arrive at a population that may be eligible for palliative care, we selected people (n=5454) whose death occurred non-suddenly. All cases were weighted to adjust for the stratification procedure and for differences in response rates.

Results: According to attending physicians, 3.5% of non-suddenly deceased persons had a psychiatric illness. For patients with a psychiatric illness, the cause of death was more often a neurological disease (17% vs 12%) or a respiratory disease (12% vs 8%) and less often a cardiovascular disease (9.1% vs 15%) or cancer (16% vs 39%) compared to patients without psychiatric illness. Compared to patients without psychiatric illness, patients with a psychiatric illness were more often female (54% vs 42%, p=0.029), younger than 65 years of age (13% vs 18%) (p=0.029), and unmarried (8.4% vs 18%) or divorced (9.2% vs 21%) (p<0.001). Most patients with a psychiatric illness died in a nursing home (50%), followed by hospital (16%), home (13%), or hospice (8.1%). Patients without a psychiatric illness died most often in a nursing home (35%) or home (34%), followed by hospital (21%), and hospice (10%) (p=0.000). Compared to patients without a psychiatric illness, palliative care consultants were less often involved in patients with a psychiatric illness (13% vs 7.5%, p=0.023). However, psychiatrists/psychologists (4.9% vs 34%, p<0.001) and spiritual counsellors were more often involved in their care (13% vs 18%, p=0.028).

Discussion: Regarding patients with a psychiatric illness palliative care consultants were less often involved but psychosocial care providers were more often involved compared to patients without psychiatric illness. It is, however, questionable whether or not palliative care consultants are knowledgeable about the palliative care needs of psychiatric patients specifically and whether psychiatrists are skilled in providing palliative care.

Abstract number: P178
Abstract type: Poster presentation

Breaking the News of the Motor Neurone Disease (MND) Diagnosis: How to Narrow the Gap between Standards and Actual Practice?

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Background: Breaking the news of the diagnosis of MND is challenging for both neurologists and patients. The manner in which the patient/family learn of the diagnosis has implications for the way they move on from the devastating news of their diagnosis to the actions required for support throughout the illness trajectory.

Objectives: To identify the patients’ and their family carers’ perspective on receiving the diagnosis and the neurologists’ perspective on delivering it, and to determine which aspects of breaking this bad news were associated with greater satisfaction with the way the diagnosis was delivered to patients.

Method: Three anonymous national postal surveys (patients, family carers and neurologists) were facilitated by all MND associations in Australia, in 2014, and centred on the SPIKES protocol for communicating bad news.

Results: Provided a comprehensive insight from the patients’ (n=248, response rate 29%) and family carers’ perspective (n=194) and that of 73 neurologists (30% response rate): 36% of patients were dissatisfied with the delivery of the diagnosis and gave low ratings on the ability/skills of their neurologists to deliver the diagnosis. It was evident that the longer the patients spent with their neurologists during breaking such bad news, the more they were satisfied and the higher they rated the neurologists’ ability/skills. The largest significant differences between neurologists
Abstract number: P179
Abstract type: Poster presentation
Factors Associated with Unnatural Deaths in Patients with Serious Mental Illness
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Introduction: Patients with serious mental illness (SMI) have worse access to and experience of health care than the general population. They also have a higher risk of dying from unnatural causes (suicide, homicide and other accidents); 25% of deaths in SMI patients are from unnatural causes versus 3.5% in the general UK population. These deaths may be preventable. The aim of this study was to identify the demographic and clinical factors associated with risk of death from unnatural causes in SMI patients.

Methods: Data were extracted from routine mental health records, the South London and Maudsley (SLAM) Clinical Record Interactive Search (CRIS) database. Patients were included if they had a SMI diagnosis, died 2007-2013 and had complete death registry data. The outcome variable used was a binary measure of natural/unnatural cause of death. Demographic and clinical variables included: age at death, gender, area-level deprivation, marital status, ethnicity, number of SMI diagnoses and A&E visits and hospital admissions in the last month of life (derived from Hospital Episode Statistics data). Logistic regression was used to explore factors associated with unnatural deaths.

Results: Of the 1155 patients identified, 13.9% (N=160) died from an unnatural cause (57% suicide, 41% accidents and 3% other). Unnatural deaths were higher for those who died at home (38%) compared to those who died in other care settings (hospital: 24%; Care home: < 1%); 38% of unnatural deaths occurred in ‘other’ settings. Younger age was associated with an increased likelihood of dying from unnatural causes, particularly for those under 45 (compared to 65+) (OR=37.25, 95% CI=19.07-72.78). Patients who both visited A&E and were admitted to hospital (including general and mental health units) in the last month of life were less likely to die from unnatural causes (OR=0.41, 95% CI=0.25-0.69). There was a weak association between hospital admissions and a lower likelihood of deaths from unnatural causes (OR=0.45, 95% CI=0.20-1.03).

Conclusion: Unnatural deaths in the SLAM sample (comprised of patients who were known to psychiatric services) were higher than in the general population but lower than in some SMI samples reported by other studies. Unnatural deaths were predominantly in home and ‘other’ settings. However, 30% were seen in A&E or admitted to hospital during the last month of life, highlighting the need for more effective risk assessment tools.

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Abstract number: P180
Abstract type: Poster presentation
The Myeloma Patient Outcome Scale (MyPOS): German Version
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Introduction: The majority of patients, who experience Multiple Myeloma (MM), belong to the growing group of the elderly. However, MM knowingly results in high symptom burden and impaired quality of life (QoL) at any age, but no standard measure of QoL exists. The MyPOS is based on a QoL model incorporating the dimensions symptoms, emotional response, healthcare & social support and their impact on activity and participation. Patients and clinical experts were heavily involved in MyPOS development.

Aim: This project aims to provide a valid and reliable QoL and palliative needs instrument for MM for clinical use in Germany.

We here report to the palliative care community on the final results of the translation and cross-cultural adaptation process to the German setting.

Methods:
(1) Translation of the English original following EORTC guidelines,
(2) establishing conceptual equivalence and acceptability via focus groups of patients and health care professionals, and
(3) cognitive interviews with patients.

Results:
(1) Approved German translation of the 33-items MyPOS.
(2) Suggested adaptations of the German MyPOS following focus groups with patients and health care professionals.
(3) MyPOS-German ready for psychometric testing and further clinical use.

Participants in Germany suggested more elaborate answer options considering information needs. Patient’s possible wishes and right for less information should be respected. They also wanted the measure to focus on continuity of care through all phases. Patients welcomed the comprehensive QoL coverage of the MyPOS. However, implementation confidentiality of the tool in clinical practice was considered important, and participants preferred a direct talk about QoL issues with their physicians, prompted by the tool. A (family) caregiver version was demanded for phases of illness when patients themselves are unable to fill in a questionnaire. Beyond assessment of the patients’ needs, the informal caregiver burden should be considered systematically to keep the capacity of the supporting system.

Conclusions: Integration of palliative care aspects seems to be required and welcomed by patients with MM. The MyPOS-German might be a valuable instrument to support haemato-oncologists in this respect. Testing models for its implementation is the next step. The patients’ call for a caregiver version is an important research implication.

Abstract number: P181
Abstract type: Poster presentation
Assessing the Burden Experienced by Caregivers of Patients Receiving Specialist Palliative Care
Background: The important contribution made by caregivers has been recognised in the international literature. However, caregiving for someone with a life-limiting illness often involves physical, emotional and other practical challenges. In order to support caregivers in their dual roles as care provider and care recipient, it essential to understand the extent of their burden and the circumstances contributing to this.

Aim: To assess caregiving burden among caregivers known to specialist palliative care teams, and identify whether clinical or demographic factors are associated with reported burden.

Methods: Validated measures were administered during face-to-face interviews with caregivers in three regions of Ireland. The Zarit Burden Interview (ZBI) was used to assess caregiver burden, and financial impact associated with caregiving was measured using the Cost of Care Index. Participants were divided into low- and high-burden groups, using a previously established threshold of 24 for the ZBI score. Differences between regions were tested for statistical significance. Multiple linear regression investigated predictors of caregiver burden.

Results: 69 caregivers were interviewed. The mean ZBI score was 26.8, and did not vary significantly between study sites (p=0.215). Overall, 51% of participants were considered heavily burdened. A significant proportion (40.6%) agreed that caring for their loved one was causing them to dip into savings, while almost one-quarter (24.6%) reported giving up personal time for caregiving. Caregiver age (p=0.01), patients’ psychosocial burden (p=0.045) and financial hardship (p<0.001) were significant predictors of caregiver burden.

Conclusion: Understanding the difficulties experienced when caring for someone with a life-limiting illness allows for better supporting the caregiver. The findings of this study suggest that younger caregivers are particularly susceptible to feeling heavily burdened. Additionally, comprehensive support of caregivers in all circumstances might require adequate attention to financial protection and additional supports to address psychosocial burden.

Abstract number: P182
Abstract type: Poster presentation

Methadone Administration in Combination with Mexiletine for Switching of Methadone from Other Opioids in Patients with Refractory Cancer Pain

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Background: Oral methadone is often used in the treatment of cancer pain. However, methadone exhibits complex pharmacokinetics, with inter-individual differences and rare but serious adverse effects, such as QT prolongation and torsades de pointes. The National Comprehensive Cancer Network (NCCN) proposes that methadone should not be used with QTc > 500 and alternate opioids are recommended with QTc: 450-500. Otherwise, neuropathic pain is sometimes relieved by mexiletine. Mexiletine is one of the Vaughan-Williams Class Ib antiarrhythmic drugs and may prevent exacerbation of QT prolongation.

Aims: To assess whether the combination of these analgesics exhibits safety and efficacy for cancer pain.

Methods: Eighty-five patients with cancer pain were prescribed oral methadone between April 2013 and July 2017. Among those, 5 cases were prescribed methadone and mexiletine. The clinical aspects of the 5 cases were analyzed retrospectively.

Results: Methadone was initiated from other opioids due to refractory pain in stop-and-go switching. The starting dose of methadone ranged from 15-45 mg/day, depending on the previous opioid dose, and the starting dose of mexiletine was 300-600 mg/day. All cases were inpatients and switched successfully to methadone. In the initiation, the average oral morphine equivalent daily dose before methadone administration was 278 mg (range, 15-660 mg) and the average numerical rating score (NRS) for pain was 6.6 (range, 5-8). On the established titration, the mean methadone dose was 35mg (range, 10-60 mg) and the average NRS was 1.6 (range, 0-4). The dose of mexiletine was the same as the starting dose. The average QTc interval was 432 ms (range, 424-464 ms) before methadone medication and 432 ms (415-459 ms) with the established titration. No other serious effects, such as respiratory depression, were recognized.

Conclusion: Though more studies are needed, the combination of methadone and mexiletine may be a safe analgesic method.

Abstract number: P183
Abstract type: Poster presentation

Characteristics of Breakthrough Cancer Pain in an Advanced Geriatric Oncologic Population.

Does Age Matter?
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Introduction: Breakthrough cancer pain (BtCP) is a well-characterised entity among cancer population. It adds even more clinical complexity to the traditional pain management in cancer patients. Little is known about the characteristics of BtCP in a frail population like those older than 75 years. The main objective of our study is to describe the characteristics of BtCP in a population of advanced cancer patients (age > 75 years) attended at the outpatient clinic (OPC) in a teaching hospital in Catalonia. Secondary objectives include to compare main characteristics of BtCP between two samples of advanced cancer patients (>75 years vs ≤ 75 years).

Population and methods: Patients attended at the OPC during 2014-2015 and diagnosed of BtCP according to the Davies algorithm were included in the study. Variables included are: gender, civil status, type of cancer, metastatic disease, cognitive and functional scores, number of different types of BtCP per patient. Continuous variables were summarized as means and standard deviations (SD). Categorical variables were summarized as percentages (absolute numbers). Univariate analysis was performed using the Wilcoxon or Chi square test without correction for continuity for comparison among groups of continuous and categorical variables, respectively. Statistical significance was assumed at a 0.05 level (P< 0.05).

Results: 277 patients fulfilled inclusion criteria (100 older 75 years -36, 1 %). Significant statistical differences were found in civil status (widow, p < 0.001), metastatic disease (p=0.003), Pfeiffer test (p<0.001) and number of different types of BtCP (p=0.002).

Conclusions: Advanced cancer patients older than 75 years is highly prevalent in our sample. Probably the most important finding of this study is to determine that in the population > 75 years have less different types of BtCP (1.50 ± 0.7) than the population ≤ 75 years (1.90 ± 0.9) with a p=0.002.

Abstract number: P184
Abstract type: Poster presentation

Analysis of the Analgesic Therapeutic Profile Needed to Achieve an Optimal Pain Control in a Sample of Advanced Cancer Population: Experience from an Out-patient Clinic in a Catalan Teaching Hospital
A Multivariable Predicting Model for Pain Treatment Success in Patients with Head- and Neck Cancer Treated with Opioids

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Although opioids are the mainstay of cancer pain treatment not all patients experience pain relief. We quantified predictors of treatment success, and developed and internally validated a prediction model to aid physicians in expectation management. Data from two randomized controlled trials were used, in which strong opioid naïve patients with head-and-neck cancer and pain were treated with fentanyl or methadone. We defined treatment success as at least 50% pain reduction after one week of therapy. We selected age, HADS depression score, HADS anxiety score, methadone or fentanyl, having had chemotherapy, having had radiotherapy, having had surgery, total pain duration, and pain type as predictors of treatment success. Incomplete data were imputed using multiple imputation. All potential predictor variables were entered in a logistic regression model. Variables that were selected in over half of the 10 imputed datasets were selected for the prediction model. A total of 134 patients were included in the randomized clinical trials. Of all patients, 30(22.4%) reported 50% or more pain decrease. The elimination procedure yielded four predictors for the model: age, methadone (compared to fentanyl), duration of pain, and neuropathic pain (compared to nociceptive pain). Age was negatively associated with the probability of short-term treatment success, all other predictors were positively associated. The prediction model discriminated well between patients with and without short-term pain treatment success. The area under the curve of the prediction model was 81.6%. This model helps the physician to predict the probability the patient has to realize 50% pain reduction in one week with the start of fentanyl or methadone.

Abstract number: P187
Abstract type: Poster presentation

Analysis of Prescription Pattern of the Fentanyl Citrate Sublingual Tablets According to Liver or Kidney Function Abnormality

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Background: Despite the availability of effective antiretroviral therapy, pain and symptoms in HIV/AIDS still persist. With recent advances in HIV care, and the 90-90-90 UNAIDS policy we expect greater numbers in pain and physical symptoms. However the methodological quality of the studies was low.

Conclusion: There is a body of evidence to suggest that self-management interventions offers great potential for management of pain and physical symptoms, but we need strong evidence. Findings from our review informs policy and clinical practice to conduct theoretically plausible high quality RCT on pain self-management.

Abstract number: P186
Abstract type: Poster presentation

A systematic review in line with PRISMA guidelines was conducted. We included 22 original papers reporting (18 different studies). 16 of these were RCT, and two were non-RCT. We found some evidence that self-management interventions are effective in improving pain and physical symptoms. However the methodological quality of the studies was low.

Introduction: Pain continues to be a challenging symptom in advanced cancer patients. The World Health Organisation set up the three-step analgesic ladder in order to better clarify the optimal pharmacological approach in order to achieve a good balance between pain control and adverse related effects. The objective of this study is to determine the changes needed in the pharmacological approach in a sample of advanced cancer patients attended in the out-patient clinic (OPC).

Population and methods: Descriptive study carried out on a consecutive sample of advanced cancer patients attended at the OPC. Inclusion criteria: age >18 years, diagnosis of advanced cancer, lack of cognitive impairment (Pfeiffer test < 4) and agreed to participate. Variables recorded: Brief Pain Inventory (BPI), Visual Analogic Scale (0-10) of psychological distress, CAGE test (Cut-down, Annoyed, Guilty, Eye-opener), Morphine Equivalent Daily Dose (MEDD) on the first evaluation and on pain control (VAS ≤ 3), need for opioid rotation, Doleur Neuropathique - 4 (DN4), the use of the different analgesics and the use of coanalgesics. Continuous variables were summarized as means and standard deviations (SD). Categorical variables were summarized as percentages (absolute numbers).

Results: A total of 211 patients were included in the study. Mean of age 64, 0 ± 14 years. Men 87, 2%. Lung cancer 41, 2%; Upper-digestive 15, 6%. Mean DN4 3.9 ± 2. Mean MEDD day 0 36.9 ± 52 mg. On pain control 79.1 ± 83 mg.

Dose day 0 vs. pain control: paracetamol 48% vs. 30%; NSAIDs 25% vs. 35%; tramadol 21% vs. 8%; codeine 5% vs. 0%; morphine 9% vs. 28%; fentanyl TTS 12% vs. 15%, methadone 1% vs. 7%, morphine SAM 6% vs. 22%, ROOs 5% vs. 21%, Gabapentine 18% vs. 34%, pregabaline 5% vs. 6%, TCAs 1% vs. 11%, lidocaine 5% 3% vs. 7%, steroids 0% vs. 58%.

Significative differences can be seen between day 0 and on the pain control day regarding the analgesics/coanalgesics needed to achieve a good pain control.

Abstract number: P185
Abstract type: Poster presentation

Systematic Review of Self-management Interventions for Pain and Physical Symptoms among People Living with HIV

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Background: Despite the availability of effective antiretroviral therapy, pain and symptoms in HIV/AIDS still persist. With recent advances in HIV care, and the 90-90-90 UNAIDS policy we expect greater numbers in pain and physical symptoms. However the methodological quality of the studies was low.

Methods: A systematic review in line with PRISMA guidelines was conducted. We searched for RCT/non-RCT in Amed, Assian, CINAHL, Cochrane Library, Embase, Medline, Psycinfo, Scopus and Web of Science data bases, from 1984 (when HIV was first reported) to February 2017. Two reviewers screened and extracted data, assessed risk of bias (using Joanna Briggs Institute Critical Appraisal checklist for Randomised and non-Randomised trials) and rated the quality of evidence (GRADE tool).

Result: We included 22 original papers reporting (18 different studies). 16 of these were RCT, and two were non-RCT. We found some evidence that self-management interventions are effective in improving pain and physical symptoms. However the methodological quality of the studies was low.

Conclusion: There is a body of evidence to suggest that self-management interventions offers great potential for management of pain and physical symptoms, but we need strong evidence. Findings from our review informs policy and clinical practice to conduct theoretically plausible high quality RCT on pain self-management.

Abstract number: P186
Abstract type: Poster presentation

A Multivariable Predicting Model for Pain Treatment Success in Patients with Head- and Neck Cancer Treated with Opioids

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Although opioids are the mainstay of cancer pain treatment not all patients experience pain relief. We quantified predictors of treatment success, and developed and internally validated a prediction model to aid physicians in expectation management. Data from two randomized controlled trials were used, in which strong opioid naïve patients with head-and-neck cancer and pain were treated with fentanyl or methadone. We defined treatment success as at least 50% pain reduction after one week of therapy. We selected age, HADS depression score, HADS anxiety score, methadone or fentanyl, having had chemotherapy, having had radiotherapy, having had surgery, total pain duration, and pain type as predictors of treatment success. Incomplete data were imputed using multiple imputation. All potential predictor variables were entered in a logistic regression model. Variables that were selected in over half of the 10 imputed datasets were selected for the prediction model. A total of 134 patients were included in the randomized clinical trials. Of all patients, 30(22.4%) reported 50% or more pain decrease. The elimination procedure yielded four predictors for the model: age, methadone (compared to fentanyl), duration of pain, and neuropathic pain (compared to nociceptive pain). Age was negatively associated with the probability of short-term treatment success, all other predictors were positively associated. The prediction model discriminated well between patients with and without short-term pain treatment success. The area under the curve of the prediction model was 81.6%. This model helps the physician to predict the probability the patient has to realize 50% pain reduction in one week with the start of fentanyl or methadone.

Abstract number: P187
Abstract type: Poster presentation

Analysis of Prescription Pattern of the Fentanyl Citrate Sublingual Tablets According to Liver or Kidney Function Abnormality

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Background: Many advanced cancer patients eventually develop liver dysfunction or renal insufficiency during the course of their disease. However, there is limited evidence for optimal drug for pain control in these situations. To estimate the safety of fentanyl citrate sublingual tablets (FSTs) in kidney or hepatic dysfunction, we analyzed whether the total cumulative prescription dose or prescription duration of FSTs is associated with their liver function test (LFT) or estimated glomerular filtration rate (eGFR).

Methods: We retrospectively enrolled consecutive cancer patients who prescribed FSTs at least once from July 2015 to June 2017. Only patients aged 18 and older were included.

Results: Total 611 patients were identified. Male (n=406, 66%) were almost twice to female. Median age was 63.6 (18-89) years. Total dose of prescribed FSTs is vary widely among pts; mean 23330 ± 42111 µg, median 8400 (100-345600) µg. Estimated GFR could be calculated in 523 pts (85.6%). In 80 pts (15.3%), eGFR is below 60 mL/min/1.73 m². The total dose of prescribed FSTs have no significant correlation with eGFR. The duration of prescription of FSTs was shorter in patients with eGFR < 60 in compared to those with eGFR ≥60; median 42 (95% CI 18.2-6.3) days versus 66 (95% CI 40.9-92.0) days (Log Rank p < 0.001). On the other hand, 535 pts (87.6%) have result of LFT (serum AST, ALT, ALP and total bilirubin level) prior to be prescribed FSTs. NCI-CTC AE G3 or G4 LFT abnormality is found in 158 pts (29.5%). The total dose of FSTs is significantly lower in pts with G3/4 LFT in compared to those with normal or G1/2 LFT (mean 15442±2059 µg vs 26089±2169 µg, p=0.006 by t-test). The duration of prescription of FSTs was significantly shorter in patients with G3/4 LFT in compared to those with normal or G1/2 LFT; median 30 (95% CI 9.8-50.2) days versus 83 (95% CI 59.9-106.1) days (Log Rank p=0.002). In the multivariate analysis, both G3/4 LFT and decreased eGFR are significant factors for shorter duration of prescription; exp(B)=0.415, p<0.001 for G3/4 LFT, exp(B)=0.585, p=0.001 for eGFR < 60 by the Cox proportional hazard model.

Conclusion: When cancer patients have renal insufficiency or liver dysfunction, FSTs were used in a smaller amount and for a shorter period of time. The primary outcome measure is the mean change in the pain NRS (0-10) scores, from admission to census date. Secondary outcomes relate to pain screening/assessment adherence and quality score; and clinicians’ self-perceived pain assessment capabilities. Intervention efficacy and resource use data will be determined via economic evaluation.

Conclusions: An adequately powered RCT is required to determine if this intervention is efficacious and cost-effective compared with the usual pain assessment continuing professional development activities for:

(i) reducing patients’ reported numerically rated pain scores; and
(ii) increasing cancer and palliative care clinicians’ pain assessment capabilities.

Abstract number: P188
Abstract type: Poster presentation

Does Previous Opioid Exposure Modify the Relative Efficacy and Tolerability of Sublingual Fentanyl and Subcutaneous Morphine for the Treatment of Severe Cancer Pain Episodes? Results from a Double-blind, Randomized, Non-inferiority Trial

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Background: Few studies have addressed the impact of previous opioid exposure on the effect of opioids for severe cancer pain episodes. This analysis was aimed at investigating the heterogeneity in the relative efficacy and tolerability of fentanyl sublingual tablets (FST) and subcutaneous morphine (SCM) by prior opioid exposure level.

Methods: In a double blind randomized controlled trial patients received either 5 mg SCM or 100 mg FST. Endpoints were: average of “pain right now” scores in the first 30 minutes, proportion of patients needing a second dose of opioid, “pain right now” at 60 min, and average of intensity of adverse events at 30 and 60 minutes. Multivariable linear and logistic regression models and statistical tests for interaction were used to assess heterogeneity of treatment effect across different opioid dosages.

Results: 114 patients were enrolled. Tests for interaction failed to show any heterogeneity of treatment effect at different doses for all the outcomes examined (p=0.65, p=0.41 and p=0.75 respectively for pain intensity in the first 30 minutes, proportion of patients needing a second dose, pain intensity at 60 min). Similar lack of heterogeneity emerged for adverse events intensity scores but difficulty breathing. However the size of this effect was quite small (difference< 0.3 on a 0-3 rating scale).

Conclusions: No heterogeneity in the relative treatment effects between fentanyl and morphine was shown. Patients in treatment with low doses of opioid can safely use either subcutaneous morphine 5 mg or transmucosal sublingual fentanyl 100 µg for severe pain episodes. Dose titration is however needed.
**Abstract number: P190**

**Abstract type: Poster presentation**

**Home-telemonitoring of Pain in Cancer Patients**

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**Background:** Pain is one of the most feared symptoms in patients with cancer. For adequate pain treatment, it is important to monitor and evaluate pain regularly. Although the Numeric Rating Scale (NRS) is implemented in hospitals in the Netherlands, pain is not yet systematically registered in outpatients’ records. Oncologists and nurses still do not register pain regularly during outpatient consultations. Home-telemonitoring can reduce barriers of pain assessment hence contributing to improved patient care and outcome.

**Aims:** Assess whether home-telemonitoring improves pain registration in medical records of patients visiting the outpatient clinic of a large teaching hospital.

**Methods:** Two groups of patients with cancer visiting the outpatient clinic of the haematology, oncology or pulmonary department were studied:

1) with home-telemonitoring (HT) and
2) without home-telemonitoring (control).

Patients in the HT group received three times a week a Short Message Service and an Interactive Voice Response on their mobile phones and were asked to provide their pain score in NRS (0-10). If the reported NRS score was reported 5 or higher, a specialized oncology nurse contacted the patient the same day and, if required, adapted the pain treatment. In both groups (HT and control) medical records were analysed and data on registration of pain, NRS and analgesics were collected.

**Results:** In each group, medical records of 54 patients were analysed on three consecutive outpatients’ visits (total 162 visits). In the control group registration of pain or its absence was described in 60 visits (37.0%). No registration of pain or NRS was reported in 102 (63.0%) visits. In the HT group registration of pain, or NRS or its absence was reported in 83 visits (51.2%) and no registration of pain was reported in 79 (48.8%). Both registration of pain or registration of no pain was significantly more reported in the HT group (p = 0.0137). In the control group, prescriptions of analgesics were reported in 18 out of 54 patients (33.3%). In the HT group, prescriptions of analgesics were reported significantly more (p < 0.01) in 36 out of 54 patients (66.6%).

**Conclusions:** Introduction of home-telemonitoring for patients with cancer significantly increases registration of pain and prescriptions of analgesics in outpatients’ medical records of a teaching hospital. Home-telemonitoring has the potential to increase the awareness of pain and its management in patients, nurses and doctors.

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**Abstract number: P191**

**Abstract type: Poster presentation**

**Novel Method for Determining Methadone in Serum of Patients with Cancer, and Examination of Factors That Alter its Blood Concentrations**

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**Aims:** In March 2013, the clinical use of oral methadone tablets was initiated in Japan. There are many factors responsible for the change in blood concentrations of methadone, and its pharmacokinetics is very complex. Therefore, a simple and accurate measurement method for methadone blood concentrations was developed using HPLC. We also attempted to identify factors that alter methadone blood levels in patients with cancer pain by using a newly developed measurement method.

**Methods:** Measurement of blood concentration in methadone was performed using HPLC/ECD (electrochemical detector). An eluent of 10 mM Na3HPO4, CH3CN, CH3OH (20:19:3) was used as the mobile phase. The column was used the XTerra® RP18, and the voltage of the ECD was set at 400 to 800 mV. Serum samples (1.0 mL) were added to 0.5 mL 4N NaOH, and extracted using 5 mL butyl chloride. Seven cancer patients using oral methadone hospitalized at KKR Sapporo Medical Center was tested after obtaining written informed consent for blood sampling. The pharmacokinetic analysis was performed using the WinNonlin® software (ver. 6.4, Pharsight Corporation, CA, USA). In addition, to discover for a variation factor for methadone blood concentration, a single correlation analysis was performed.

**Results:** In the methadone blood concentration method, the methadone peak was detected within 3.8 min and separated well from the serum component. A linear regression analysis of the standard curve in the range of 10-100 ng/mL yielded the following equation: y = 5012.7x + 1041.1 (r = 0.999). The methadone pharmacokinetic parameters analyzed in seven cases were clearance/bioavailability (CL/F, mean ± standard deviation (SD) 2.95 ± 1.16 L/h) and volume of distribution (Vd, 305 ± 163 L). In addition, the results showed a good correlation between CL/F and Child-Pugh score (r = 0.75). However, there was no correlation between any pharmacokinetic parameter and the glomerular filtration rate (GFR). Furthermore, there was no QT prolongation after methadone administration in any case.

**Discussion:** We developed clinically usable methadone blood concentration measurement method. In seven cases in which methadone tablets were administered, a good correlation was observed between the methadone CL and Child-Pugh score, but there was no correlation with the GFR. Therefore, reduction in methadone dosage was necessary in patients with liver dysfunction, suggesting that the Child-Pugh score is a useful index.
Methods: A single-center, cross-sectional observational study among in- and out-patients with cancer was conducted. Data on demographics, disease, ECOG performance status, pain intensity (0-10 numeric rating scale), and current pain medications were recorded. Patients were also asked to score on a Likert scale whether they wanted their physician to focus less or more on their pain. PMI, which is computed based on pain intensity level and on analgesics received, ranges from -3 (severe pain but no analgesic drugs administered) to +3 (morphine or an equivalent drug administered and no pain). PMI score was dichotomized as negative vs non-negative score and logistic regression models were applied to explore its association with demographic and clinical characteristics. Association between patient-perceived wish for more attention to pain and PMI score was also examined with logistic models.

Results: 187 cancer patients were included. Fifty-three percent of them had a negative PMI score. Negative PMI scores were more frequent among patients with breast cancer (OR=5.9, 95% CI 2.3-15.5) and with good performance status (ECOG 0-1) (OR=5.6, 95% CI 1.5-20.1). No other variables were significantly associated with a negative PMI score. Twenty-two percent of patients with a negative PMI score reported that they wanted more focus on pain management versus 13% among those with a positive PMI score (p = 0.30).

Conclusion: A high prevalence of negative PMI score was found among unselected cancer patients. Breast cancer and good performance status were associated with negative PMI score. PMI score was not associated with patients’ wish for more focus on pain treatment which questions the use of PMI as a measurement for undertreatment of pain.

Abstract number: P193
Abstract type: Poster presentation

Is the Fear of Respiratory Depression with Opioids Justified?

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Background: Most opioids follow first-order kinetics, i.e., plasma concentration and clinical effects increase proportionally to dose given. Maximum pain relief and risk of side-effects for a given dose occurs at the maximum plasma concentration (Cmax). For intravenous (IV) dosing the maximum plasma concentration (Cmax). For intravenous (IV) dosing the maximum plasma concentration (Cmax). For intravenous (IV) dosing the maximum plasma concentration (Cmax). For intravenous (IV) dosing the maximum plasma concentration (Cmax). For intravenous (IV) dosing the maximum plasma concentration (Cmax). For intravenous (IV) dosing the maximum plasma concentration (Cmax). For intravenous (IV) dosing the maximum plasma concentration (Cmax). For intravenous (IV) dosing the maximum plasma concentration (Cmax). For intravenous (IV) dosing the maximum plasma concentration (Cmax). For intravenous (IV) dosing the maximum plasma concentration (Cmax). 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oncologists to evaluate patients’ pain and to prescribe the right treatment, as well as the patients’ reluctance to adhere to the prescribed pain management regimes are among the leading causes of these unsatisfactory results.

Abstract number: P195
Abstract type: Poster presentation

The Role of Mu-opioid Antagonists in the Relief of Opioid Induced Bowel Dysfunction in Cancer and Palliative Care Patients: A Cochrane Systematic Review
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Opioids are used to treat pain. Unfortunately, they cause constipation which can be so severe that a person prefers limiting their opioid treatment. Laxatives can be used but their success may be limited. Mu-opioid antagonists (MOA) are a 2nd line drug option. They are designed to specifically target the pathophysiology of opioid induced bowel dysfunction such as constipation. Despite trial evaluations on MOA in cancer and palliative care settings there are few guideline recommendations. We assessed in a systematic review the effectiveness and safety of MOA for bowel dysfunction in cancer and palliative care settings.

Method: We searched for randomised controlled trials using key databases (e.g. Embase), trial registries, regulatory agencies (e.g. European Medicines Agency) and through manufacturers of MOA contact. The review’s primary outcomes of interest were laxation within a day and at 2 weeks, and serious or otherwise adverse events. Using Cochrane tools two authors assessed included trials quality and extracted data. The appropriateness of combining trial data depended upon homogeneity. We assessed the quality of the body of evidence on the primary outcomes using GRADE (a structured and transparent tool to link evidence-quality evaluations to clinical recommendations).

Results: Nine trials were identified of in total 1022 adult participants. The MOA were oral naldemedine and naloxone in cancer of any stage, and subcutaneous methylnaltrexone in palliative care populations. All trials were vulnerable to biased results, some were at a high risk because of small samples sizes. There were more evaluations specific to our review question on methylnaltrexone and naloxone. We found moderate quality evidence that naloxone improves laxation at 2 weeks and low quality evidence that it does not increase the risk of serious or otherwise adverse events. Methylnaltrexone for a significant proportion of patients probably improves laxation (moderate evidence) within a day and at 2 weeks, and probably does not increase the risk of serious adverse events. The evidence is weaker on whether or not methylnaltrexone improves laxation at 2 weeks and low quality evidence that it does not increase the risk of serious or otherwise adverse events. Methylnaltrexone for a significant proportion of patients probably improves laxation (moderate evidence) within a day and at 2 weeks, and probably does not increase the risk of serious adverse events. The evidence is weaker on whether or not methylnaltrexone improves laxation at 2 weeks and low quality evidence that it does not increase the risk of serious adverse events. The evidence is weaker on whether or not methylnaltrexone improves laxation at 2 weeks and low quality evidence that it does not increase the risk of serious adverse events. The evidence is weaker on whether or not methylnaltrexone improves laxation at 2 weeks and low quality evidence that it does not increase the risk of serious adverse events.

Conclusion: There is evidence for methylnaltrexone in palliative care to suggest that the drug’s true effect on laxation and serious adverse events is close to the estimates in this review. Higher quality trials are needed on all MOA to establish better their effect and safety in these populations.

Abstract number: P196
Abstract type: Poster presentation

Profile and Management of Adverse Events during Treatment by Naldemedine, a Novel Peripherally-acting Mu-opioid Receptor Antagonist (PAMORA), for Cancer Patients with Opioid-induced Constipation (OIC)
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Background/aims: Opioid-induced constipation (OIC) is common and troublesome symptom among patients using opioids. Naldemedine, a novel peripherally-acting mu-opioid receptor antagonist (PAMORA), was approved for the treatment of OIC by Japanese regulatory authority in March 2017. Although efficacy and safety data among highly selected patients is available from pivotal studies, real-world evidence including appropriate management of adverse events is still lacking. We aimed to obtain knowledge for effective and safer use of naldemedine for OIC patients.

Methods: We conducted multi-center, retrospective observational study by electronic chart review. Eligible patients must have received palliative care in participating centers, took at least one dose of naldemedine and be prescribed regular opioids. We excluded patients if they or their family displayed opt-out denial of study participation. Constipation was defined as < 3 times per week or >72-hour absence of defeation, and diarrhea was defined as >3 defeation per day.

Results: At the first analysis, 32 patients included in this study. All the patients had advanced cancer. Median performance status (ECOG-PS) was 3. Prescribed opioids were oxycodone (59%), morphine (25%), fentanyl (13%), and methadone (3%). Median days from induction of any opioids to the first naldemedine dose was 29 (range, 1-781). Of 10 patients (31%) who developed diarrhea, 3 patients stopped naldemedine and 4 patients stopped other laxatives. Two of three (67%) patients who stopped naldemedine began to constipate within 2 days, whereas only 1 of 7 (14%) patients who continued naldemedine developed constipation, despite their diarrhea resolved in 1 (range, 1-2) day. Updated results including multivariate analysis for larger cohort will be presented.

Conclusion: Our findings suggest that diarrhea caused by naldemedine should be managed by stopping other laxatives first, with continued naldemedine. Further prospective studies are warranted.

Abstract number: P197
Abstract type: Poster presentation

Development of an Educational Intervention for the Assessment and Management of Constipation in Specialist Palliative Care Settings: Modified Nominal Group Technique
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Constipation is one of the most common symptoms in palliative care, yet evidence suggest its management is based on inadequate experimental evidence. Whilst best practice guidelines exist, their implementation is suboptimal, warranting research to develop and implement an educational program in practice. This study aims to identify the key components of an educational intervention for HCPs for constipation management in a specialist palliative care (SPC) setting, and the processes for implementation.

Over a one-day workshop, five expert panels were convened using a modified nominal group technique. This structured, multi-step facilitated group meeting technique included:

1) silent generation of ideas and discussion;
2) further generation of ideas;
3) discussion and theming; and 4) ranking.

Thirty-nine key stakeholders from clinical, management, education, and PPI backgrounds from across the UK and Ireland participated in the study. Content analysis was conducted using the consolidating framework for implementation research (CFIR). Content agreed as important included constipation assessment and prevention, management, special cases of constipation, and practical skills development. Blended eLearning was the most popular approach, including time for reflection on knowledge and network building. Sessions were to be led by an expert multi-disciplinary team and last approximately one hour, delivered every other week for twelve weeks. Educational learning will be assessed three months post completed to enable reflection and implementation to occur within practice.
The findings identified the core components and implementation considerations of an educational intervention for constipation within SPC settings. Support from senior management and clear links to the wider healthcare and political agenda were equally important to ensure successful implementation. The findings support the CFIR for implementation of education in SPC settings.

Abstract number: P198
Abstract type: Poster presentation

Determinants of Cancer Related Fatigue in Patients with Advanced Cancer in Indonesia
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Purpose: Cancer-Related Fatigue (CRF) is one of the symptoms experienced by the patients with advanced cancer in Indonesia. The aim of this study was to identify factors influencing the CRF of patients with advanced cancer.

Methods: A cross-sectional survey was performed with a purposive sampling. Patients with advanced cancer and the family caregivers were invited to participate in this study. Data were collected from 27 December 2016 to 5 February 2017 in two general hospitals in Indonesia. The Functional Assessment of Chronic Illness Therapy-Fatigue (FACT-F) was used to assess CRF. Multiple linear regression analysis with stepwise method was used to determine which factors influenced to CRF.

Results: Two hundred one patients of 201 family caregivers were completed the questionnaire. Pain (β = -0.238; p < 0.001), loss of appetite (β = -0.215; p = 0.001), performance status (β = -0.195; p = 0.003), shortness of breath (β = -0.152; p = 0.013), depression (β = -0.137; p = 0.029), and family caregivers’ involvement in caring (β = -0.133; p = 0.044) negatively influenced the CRF. Age, sex, marital status, income, the level of understanding about disease, type of cancer, metastasis, hemoglobin level, nausea, and vomit did not influence the CRF.

Conclusions: Physical symptoms, psychological symptoms, and family caregivers’ involvement in caring influenced the CRF of patients with advanced cancer in Indonesia. Further study using causal model analysis can be used to identify which factors directly influence CRF.

Abstract number: P199
Abstract type: Poster presentation

Whole Brain Radiotherapy in Patients with Brain Metastases - Burden or Benefit?1
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Introduction: Whole brain radiotherapy (WBRT) is standard of care for patients with multiple brain metastases or contraindications against local treatment approaches. Recent studies questioned the benefit of WBRT regarding survival (OS) of the patients and expected benefit of the treatment. Therefore, we analysed survival, quality of life and influence factors on survival in a prospective observational study.

Materials and methods: Between 09/2015 and 12/2016, 91 patients were treated in our institution with WBRT (20Gy, 5x 4Gy). OS was calculated by the Kaplan-Meier method from the first day of WBRT until death. Patient’s quality of life (QoL) was recorded by using QLQ C-15 PAL before radiotherapy (RT) and 8 weeks after RT. The relation between influence factors and OS was analysed by using Cox’s regression models.

Results: 57% of patients were male. Median age was 65 years (range 32-83 years). Majority of patients were diagnosed with lung cancer (60%), followed by breast cancer (12%). Median OS was 3.3 months (95%CI, 2.82-4.35). Completion of QoL before and 8 weeks after radiotherapy was done by 26 patients (23.6%). In these patients a significant improvement in general QoL was observed (p = 0.016; Score: 52.08 before, 63.76 after RT). Most of these patients (61.5%) had a Karnofsky performance score (KPS) >70. Most significant negative influence factor on OS was the need for dexamethasone (p = 0.009, HR: 1.54 [95%CI, 1.08-2.18]), the higher the dosage, the worse. Median OS with a KPS <70 was only 2.1 months (95%CI, 0.86-3.47), with a KPS >70 this was 4.1 months (95%CI, 2.92-5.35), (p = 0.108).

Conclusion: The OS after WBRT of patients who initially present in a limited KPS or need higher doses of dexamethasone is poor. Therefore, WBRT should be used more restrictively. Patients with better prognosis seem to benefit regarding global QoL, but the optimal treatment strategy in these patients needs to be evaluated in further prospective trials.

Abstract number: P200
Abstract type: Poster presentation

Trajectory of Dyspnea and Respiratory Distress among Patients in the Last Month of Life
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Background: The trajectory of dyspnea has been reported among patients approaching the end of life. However, patients near death have been dropped from studies or excluded altogether because of an inability to self-report or proxy estimates have been used. It is not known whether dyspnea or respiratory distress remains stable, escalates, or abates as patients reach last days.

Objective: Determine trajectory of dyspnea (reported) and respiratory distress (observed) among patients who were approaching death.

Methods: A prospective, repeated-measures study of dyspnea/respiratory distress among a sample of home hospice patients was done. Measures were collected at each patient encounter from hospice enrollment until patient death. Dyspnea was measured in response to “Are you short of breath?” and using the Numeric Rating Scale anchored at 0 and 10. Nurses measured the Respiratory Distress Observation Scale (RDOS) along with patient consciousness (Reaction Level Scale), nearness to death (Palliative Performance Scale), diagnoses, and demographics. Working backward from the date of death data for the 30-day interval before death were analyzed using Procedure-Mixed in SAS and correlation analyses.

Results: The sample comprised 91 patients, female (58%) and Caucasian (83%) with predominantly dementia (32%), heart failure (26%) and cancer (13%). At 30 days 59% could not self-report which increased to 90% on the day before death. RDOS increased significantly from mild distress at 30 days to moderate/severe distress on the day of death (F = 10.8, p < 0.0001) as consciousness declined. Distress was strongly correlated with nearness to death (r = 0.97, p < 0.0001), and consciousness (r = 0.97, p < 0.0001).

Conclusions: Respiratory distress escalated significantly across diagnoses in the last week. Patient inability to self-report raises care concerns about under-recognition and under-treatment of respiratory distress.

Implications for practice
Frequent nurse visits and use of the RDOS are indicated as signs of nearness manifest.

Abstract number: P201
Abstract type: Poster presentation

Drug Therapy for Delirium in Terminally Ill Adults - A Cochrane Systematic Review
Background/aims: Delirium is a complex neuropsychiatric syndrome common in palliative care, occurring in up to 88% of patients in the weeks or hours preceding death. It is characterised by a disturbance in attention and awareness that develops over a short time and fluctuates in severity throughout the day. Management of a delirium episode includes the consideration of potentially treatable precipitating and aggravating factors followed by symptomatic treatment with drug therapy. A Cochrane review on drug therapy for delirium was last published in 2012. It identified one trial. Its conclusions were limited. New trials have been conducted and an updated review is recognised as a Cochrane Review Priority. This update will provide the most up-to-date and reliable evidence on drug therapy for delirium in palliative care.

Methods: We searched for randomised and non-randomised trials comparing any drug treatment with any other treatments for delirium. Databases included MEDLINE, EMBASE, CINAHL, CENTRAL, PsychInfo, trial registration databases and drug trial registers. Our inclusion criteria for trial population were terminal ill adults with delirium, established by clinical judgement or a validated delirium screening tool. Two authors are screening citations retrieved, assessing quality and analysing data. If there is sufficient homogeneity across trials we will conduct combined analysis. Our primary outcome is delirium symptoms; secondary outcomes include delirium severity, extrapyramidal effects, use of rescue medication, sedation and survival. We are using GRADE (a tool to link evidence-quality evaluations to clinical recommendations) to assess the quality of the body of evidence on the primary outcome.

Results: We retrieved 9,428 citations. Review analysis is in progress. We have identified new larger and robust trials. Their results will change the conclusions and clinical implications generated in 2012.

Conclusion: This review is incorporating new trials to ensure that treatment decisions are based on the most current and reliable evidence. The findings, available early 2018, will inform current debate on whether treatment decisions are based on the most current and reliable evidence. This review is incorporating new trials to ensure that treatment decisions are based on the most current and reliable evidence. The findings, available early 2018, will inform current debate on whether treatment decisions are based on the most current and reliable evidence.
energy (55%), problems with sexual activity (54.2%), worry (49.5%), numbness (46.2%), feeling irritable (45%) and hunger (42.7%). Ordinal logistic regression showed that HIV treatment status was associated with lower global distress index (odds ratio .45, 95% CI .23 to .88; p=0.019). Female gender was associated with higher symptom burden of each subscale. Patients with KPS scores > 80% were associated with lower symptom burden of each subscale. Disease stage and CD4 count were not significantly associated with any symptom subscale.

Conclusion: Pain, physical and psychological symptom burden still persist in the era of HIV treatment. Symptoms remain a burden at every stage of HIV infection and are worse among females. It is important to consider gender factors when planning interventions for pain and symptom management as there are specific symptoms that women experience and this needs further research. The burden of hunger needs attention and further work is required to identify strategies to deal with hunger symptom in order to prevent poor drug adherence.

Abstract number: P204
Abstract type: Poster presentation

Psychometric Properties of Instruments to Assess Cognitive Function in Brazilian and Danish Patients with Metastatic Cancer

Kurita, Geana Paula1,2, Matuoka, Jessica3,4, dos Santos, Bernardo5, Sandvad, Marlene1, Lundorff, Lena1, Højsted, Jette1, Sjøgren, Per1,2, Mattos-Pimenta, Cibele Andraciol6

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Background and aims: Cognitive dysfunction is subjective and sparsely assessed in patients with cancer. This study aimed at analyzing the performance of Brazilian and Danish patients with metastatic cancer on four neuropsychological tests in order to investigate risk factors and the cut-off points of tests for cognitive dysfunction.

Methods: A convenience sample composed of 258 adult patients and 204 healthy controls (BR: 178 patients, 128 controls; DK: 80 patients, 76 controls) with schooling ≥ 6 years was assessed between July 2010 and Nov 2015. Neuropsychological tests Continuous Reaction Time (CRT), Finger Tapping Test (FTT), Digit Span Test (DST), and Trail Making Test-part B (TMTB) were analyzed regarding criterion validity, predictive value, sensitivity and specificity. Variables included in the analyses were age, schooling, Karnofsky Performance Scale (KPS), pain, sleep, anxiety, depression, income, sensation of rest, and Mini Mental State Examination (MMSE). Statistics analyses include correlation coefficients (Spearman, Kendall and point-biserial), multiple regression models and ROC curves.

Results: Criterion validity analysis presented significant correlations between patients’ cognitive performance and age, schooling, KPS, pain, anxiety, depression, income, and MMSE; however, they were weak, the strongest being between TMTB and schooling (r=−0.411; P<0.001). Predictive value analyses showed some differences between countries: higher income was associated with better performance in the Brazilian group on the CRT 10th and 50th percentiles (P<0.018), worse depression was slightly associated with worse performance of the Brazilian group on the DST backward (P=0.029), worse anxiety was associated with worse performance of the Danish group on the DST backward (P=0.007), higher age was associated with worse performance of TMTB in terms of mistakes in the Danish group (P=0.021). Regarding sensitivity and specificity, the tests were at most poor to differentiate patients and controls (ROC curves ≤0.69) and at most fair to predict MMSE score ≤26 (ROC curves ≤0.74).

Conclusions: Cognitive performance of patients with advanced cancer was related to sociodemographic and clinical variables, despite weak correlations. However, income, age, depression and anxiety had different effects when comparing the nationalities. Further studies are necessary to confirm and understand these remarkable differences and to determine the tests cut-offs to these populations.

Abstract number: P205
Abstract type: Poster presentation

A Phase II Cluster Randomised Controlled Trial of a Multi-component Non-pharmacological Intervention to Prevent Delirium for Hospitalised People with Advanced Cancer: Study Protocol

Hosie, Annmarie1, Phillips, Jane1, Lam, Laurence1, Kochovska, Slavica1, Brasil, Meg2, Noble, Beverley1, Kurrel, Susan1, Cumming, Anne3, Caplan, Gideon A3, Chye, Richard4, Le, Brian5, Ely, E Wesley6, Lovlaw, Peter7, Bush, Shirley8, Davis, Jan Maree1, Lonell, Melanie2, Brown, Linda1, Fazekas, Belinda1, Cheah, Seong Leang1, Edwards, Layla2, Agar, Meera1, IMPACCT, University of Technology Sydney, Ultimo, Australia, 2Flinders University, Adelaide, Australia, 3University of Sydney, Sydney, Australia, 4Australian Commission on Safety and Quality in Health Care, Sydney, Australia, 5Prince of Wales Hospital, Sydney, Australia, 6St Vincent’s Hospital, Sydney, Australia, 7Royal Melbourne Hospital, Melbourne, Australia, 8Veteran’s Affairs Tennessee Valley Geriatric Research Education Clinical Center, Nashville, United States, 9Vanderbilt University, Nashville, United States, 10University of Ottawa, Ottawa, Canada, 11Calvary Hospital Kogarah, Kogarah, Australia, 12Greenwich Hospital, HammondCare, Greenwich, Australia

Introduction: Delirium is a serious and highly distressing neurocognitive condition that occurs for one in every two people with advanced cancer in hospital. [1] Delirium incidence can be reduced in older inpatients though non-pharmacological strategies that support essential human needs, such as physical and cognitive activity, sleep, hydration, vision and hearing. [2] Aim: To determine if a tailored multi-component non-pharmacological delirium prevention intervention is feasible and acceptable for people with advanced cancer in hospital.

Method: A Phase II cluster randomised controlled trial with a waitlist control and four palliative care units as the clusters. Intervention sites will introduce delirium screening, diagnostic assessment and a multicomponent prevention intervention to: preserve normal sleep, maintain optimal vision and hearing, optimise hydration, promote communication, orientation and cognition, optimise mobility and function, and promote family partnership. Control sites initially will introduce only delirium screening and diagnosis. Intervention delivery will be tailored to the site, and strategies to patient need. Patient, family, staff and volunteer perspectives about feasibility and acceptability of the intervention will be obtained using interviews and surveys. The primary outcome is adherence to the intervention. Secondary endpoints relate to fidelity to and feasibility, acceptability and sustainability of the study intervention, processes and measures in this patient population. Delirium incidence and severity will also be measured.

Conclusion: This pilot study will inform whether a multicomponent non-pharmacological delirium prevention intervention in people with advanced cancer is feasible and acceptable for testing in a subsequent phase III trial.

References
Abstract number: P206
Abstract type: Poster presentation

What Are the Main Concerns for People Experiencing Breathlessness? A Systematic Review of the Evidence
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Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation, King’s College London, London, UK

Background: Breathlessness is a common and distressing symptom in people with advanced malignant and non-malignant disease. To establish effectiveness of new treatments, appropriate outcome measures that capture the concerns that matter to patients and their families are vital. Without an understanding of key concerns, we may miss important treatment effects.

Aim: To systematically identify and synthesise the main concerns for people with advanced illnesses experiencing breathlessness.

Methods: A systematic search of published and grey literature including reference and citation list searching in accordance with PRISMA guidelines using predefined search terms. Qualitative studies which explored concerns for people experiencing breathlessness were included. All included articles were assessed against the Critical Appraisal Skills Program qualitative research checklist. Data was collated and analysed using thematic synthesis.

Results: 38 articles including 672 participants were included. The synthesis identified immediate and wider concerns in relation to breathlessness. Immediate concerns were experienced during an episode of breathlessness and included physical limitations impacting on daily activities, the experience of lack of control of breathing, and fear that breathlessness could be life threatening and result in death. Wider concerns included: fear of triggering breathlessness; fear of the future; unpredictability of breathlessness contributing to a sense of losing control of life; impact of breathlessness on relationships including being a burden; and effects on perception of self, with awareness of loss of personal and professional roles.

Conclusions: The concerns for those living with breathlessness are wide ranging and complex, and impact beyond the direct experience of breathlessness. It is therefore challenging to capture these concerns using a single outcome measure. Multidimensional measures incorporate more domains but even these may not capture the full complexity of concerns experienced by those living with breathlessness. A combination of individually identified priorities and concerns, together with the use of validated outcome measures, may help to ensure that clinicians incorporate these individual concerns when measuring treatment effects in the future.

Abstract number: P207
Abstract type: Poster presentation

Spasticity after Stroke - Common and Severe Symptom, but Rarely Treated - Development of a Screening Tool for Patients and Next of Kin
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Background/aims: Stroke is a life-threatening disease with high symptom burden for patients and next of kin. In Europe there are 10 million stroke patients. 40% suffer from spasticity, which causes pain, ulcers, hospitalisation, and significantly impacts quality of life. Post stroke spasticity (PSS) can be treated easily by blocking cholinergic excitation of spastic muscles by botulinum toxin (BT). BT injections reduce muscle tone for 3 to 4 months and have no systemic effects. Only few patients receive treatment as spasticity often develops in the aftermath of stroke and specialized care is less available for immobilized patients. To bridge this gap we develop a spasticity screening tool (SST) to be distributed by postal service and be used independently by patients and next of kin. We present results from an intermediate evaluation of feasibility and indication of high predictive value.

Methods: Development of SST: Clinical experts (CE, n=4) drafted questions indicating spasticity, which were evaluated by all (randomized, 4-point Likert scale). Highest quartile was used. Depicting patterns of spasticity were added. Pilot: Stroke patients filled out SST observed by research assistant. Time on task was measured and patients interviewed regarding usability. SST was evaluated using predefined cut-off values and key questions. Then, patients were examined by two neurologists independently. Established scales were used (Ashworth scale, active / passive range of motion, AROM, PROM). Spasticity was documented by location and severity. Intermediate evaluation: Questionnaire was sent out by postal service to 255 patients. Quota and duration of return was assessed.

Results: Pilot: Patients n=37, age: 72±28-88, 41 months (±12.S.E.M.) after stroke. Time on task for SST 12 minutes (±8). 34/37 patients completed the questionnaire, n=1 overlooked questions, n=2 did not understand one/several. In 25/25 patients spasticity was predicted correctly by SST, in 9/12 patients no-spasticity was predicted correctly, 3/12 were false-positive.

Intermediate evaluation: Return of SST in 130/255

Conclusions: Questionnaire was easily administrable by patients. Initial data points to a high predictive value. Return of questionnaire shows feasibility in an everyday setting. After examination of n=150 patients and correlation with SST, it will be modified to meet positive and negative predictive value of >80% and validated by additional n=100 patients.

Abstract number: P208
Abstract type: Poster presentation

Presentation to the Emergency Department by Breathless Patients, a Survey and Case Note Review: Predictors of Admission
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Background: Breathlessness due to medical conditions is a common cause of emergency department (ED) presentation and unplanned admission.

Aim: To examine clinical predictors of ED departure status (hospital admission or home discharge) in people with acute-on-chronic breathlessness.

Methods: A prospective patient-report survey and case note review of consecutive attendees to the major emergencies area of a single tertiary hospital ED was conducted. Data included: age, gender, history of breathlessness, diagnosis, oxygen saturation, respiratory rate, previous admissions. Descriptive statistics are presented. Variables which had an effect identified in the univariate analysis (p<0.05) were included in a binary logistic regression using stepwise analysis with backwards elimination to predict post ED departure status.

Results: 1,345/2,041 (66%) ED attendees during 12/29/5/2014 were eligible. 1,212/1,345 surveys were completed (90% response). 424/1,212 (35%) self-reported breathlessness most days/past month. Breathlessness was a reason for presentation in 245/424 (acute-on-chronic breathlessness). 177/245 consented to case note review. In the final model, the odds of admission was predicted by: older age [OR 1.041 per year of age...
The author received no financial funding.

Most important index of effectiveness of nutritional support, change of PPS was most rapid and improvement of PPS and TTR were important indices. For the judgement significantly higher in Effective group 3 weeks later (p=0.003, 0.04). Survival Compared between these groups, PPS was significantly higher in tory cachexia’ and quitted nutritional support (Non-effective group; n=9). weeks’ occurred, we judged there was possibility of transition to ‘refrac-

<21.6, PPS 24

8.3 → 3.0, TTR

and got significant improvement in several indices (Alb 2.1 →
inclusion. Mean NRS sleep quality was 3.0 (±2.8) and mean PSQI global score was 6.5 (±3.4). Cancer pain (mean NRS 2.3) was the most frequently reported factor for disturbed sleep. Paired differences between PROMs and actigraphy were significant in terms of number of awakenings (mean NWAK: 2 (± 28) vs 29 (± 28) p < 0.001). Significant differences were not found for total sleep time (mean TST: 439 min (± 101) vs 455 min (± 162) p = .469), minutes before falling asleep (mean SOL: 46 min (± 65) vs 37 min. (± 53) p = .695) or total time awake during the night (mean WASO: 33 min (± 25) vs 50 min (± 44) p = .193

Conclusion: In this palliative care cohort, PSG was not feasible, while actigraphy was well accepted. Pain led to impaired sleep quality. Actigraphy measured more awakenings than self-report.

Abstract number: P210
Abstract type: Poster presentation

Patient-reported Outcome Measures versus Objective Assessment of Sleep in Patients with Advanced Cancer
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1European Palliative Care Research Centre (PRC), Department of Clinical and Molecular Medicine, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology, Trondheim, Norway, 2Cancer Clinic, St. Olavs Hospital, Trondheim University Hospital, Trondheim, Norway, 3Department of Neuromedicine and Movement Science, Norwegian University of Science and Technology, Trondheim, Norway, 4Department of Neurology and Clinical Neurophysiology, St. Olavs Hospital, Trondheim University Hospital, Trondheim, Norway, 5Division of Applied Health Sciences, University of Aberdeen, Aberdeen, UK, 6Department of Oncology, Oslo University Hospital, University of Oslo, Oslo, Norway, 7Regional Advisory Unit on Palliative Care, Department of Oncology, Oslo University Hospital, Oslo, Norway, 8Department of Anaesthesiology and Intensive Care Medicine, St. Olavs Hospital, Trondheim University Hospital, Trondheim, Norway, 9Department of Circulation and Medical Imaging, Faculty of Medicine and Health Sciences, Norwegian University of Science and Technology, Trondheim, Norway

Background: Sleep quality is often affected in advanced cancer patients using opioids. Intervention studies should include patient-reported outcome measures (PROMs) of sleep quality and objective measures for comprehensive sleep evaluation, e.g. polysomnography (PSG) or a wrist actigraph. Study aim was to examine sleep quality and the agreement between PROMs and objective measures of sleep quality in advanced cancer.

Methods: PROMs and objective measures of sleep quality were monitored during one night in palliative care in-patients. All patients used a WHO Step III opioid for cancer pain. Patients reported symptom intensity and sleep quality using the EAPC basic dataset (NRS 0-10; higher scores indicate worse symptoms/poorer sleep) and factors affecting sleep, sleep duration and awakening in a sleep diary. Overall sleep quality was measured by the Pittsburgh Sleep Quality Index (PSQI) global score (range: 0-21; score >5 indicates poor sleep). Actiwatch 2 (Philips Respironics) and Actiware software (version 6.0.9) were used to collect and analyze actigraphy data. PROMs and actigraphy total sleep time (TST), sleep-onset latency (SOL), number of awakenings (NWAK) and wake after sleep onset (WASO) were compared with paired t tests or Wilcoxon signed ranks tests as appropriate.

Results: From January 2016 to March 2017 128 in-patients were screened. None were eligible for PSG due to frailty. Actigraphy and symptom data were available on 40 of 41 patients: males 60%; median age 70 (range 46-91); median oral daily morphine equivalent dose 80 mg/24h (10-2250 mg), median Karnofsky performance score 50 (20-90). All had metastatic disease and 33 (83%) were dead 6 months after inclusion. Mean NRS sleep quality was 3.0 (±2.8) and mean PSQI global score was 6.5 (±3.4). Cancer pain (mean NRS 2.3) was the most frequently reported factor for disturbed sleep. Paired differences between PROMs and actigraphy were significant in terms of number of awakenings (mean NWAK: 2 (± 28) vs 29 (± 28) p < 0.001). Significant differences were not found for total sleep time (mean TST: 439 min (± 101) vs 455 min (± 162) p = .469), minutes before falling asleep (mean SOL: 46 min (± 65) vs 37 min. (± 53) p = .695) or total time awake during the night (mean WASO: 33 min (± 25) vs 50 min (± 44) p = .193

Conclusion: How to Distinguish Starvation from Refractory Cachexia in Terminal Cancer Patients and How to Perform Nutritional Support?
Nakajima Nobuhisa
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Aim: Cachexia appears in many of terminal cancer patients and becomes gradually ‘refractory’. On the other hand, there may be some patients with cachexia who fall into starvation due to poor symptom management and poor nutritional support. If we can identify these starving patients and provide appropriate nutritional support, their general condition and prognosis may be improved. This study aimed

1) to identify terminal cancer patients with starvation among refractory cachexia, and
2) to evaluate the effectiveness of nutritional support for these patients.

Methods: This was a prospective study. Study subjects were terminal cancer patients with severe malnutrition and poor general condition who admitted to the palliative care unit for last 6 years. Based on prognostic prediction using Palliative Performance Scale (PPS) and Palliative Performance Index (PPI), and nutritional indices (serum albumin (Alb), transhyretin (TTR), etc.,

1) we distinguished starvation from refractory cachexia, and
2) we evaluated the changes of PPS, PPI, Alb, TTR and survival periods after nutritional support. Mann-Whitney U test was used for statistical analysis.

Results: Out of 223 patients who were considered refractory cachexia on admission, 26 patients improved their general status (PPS) and oral intake after palliating symptoms and hydration. We determined them not refractory cachexia but starvation. We administered them nutritional support, and got significant improvement in several indices (Alb 2.1→3.0, TTR 8.3→21.6, PPS 24→61, p=0.01). When we could maintain the improved PPS and Alb, TTR, we judged that this support was effective and continued it (Effective group; n=17). If deterioration of PPS (< 50), Alb, TTR , overhydration symptoms and ‘predicted prognosis (PPI) < several weeks’ occurred, we judged there was possibility of transition to ‘refractory cachexia’ and quitted nutritional support (Non-effective group; n=9).

Compared between these groups, PPS was significantly higher in Effective group 2 weeks later (p=0.01), and TTR and Alb were significantly higher in Effective group 3 weeks later (p=0.003, 0.04). Survival periods was significantly longer in Effective group (51 vs 23 days, p=0.003).

Conclusion: In order to identify starvation from refractory cachexia, improvement of PPS and TTR were important indices. For the judgement of effectiveness of nutritional support, change of PPS was most rapid and most important index. The author received no financial funding.
Proactive Assessment of the Wish to Hasten Death in Daily Clinical Practice: Is it Harmful to Patients? Preliminary Results

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Aim: To assess the opinions of advanced cancer patients regarding the proactive assessment of the wish to hasten death (WTHD).

Population: Ambulatory and hospitalised advanced cancer patients receiving care at a cancer unit.

Methods: Consecutive patients attending their first appointment with the palliative care team were screened for a WTHD using the Assessment of the Frequency and Intensity of the Desire to Die (AFIDD) structured interview, which assesses the presence of a WTHD (yes/no) and scores its frequency and intensity. We also explored whether patients had understood the purpose of the AFIDD. Potential harm was assessed by enquiring about the burdensomeness, importance and helpfulness of asking proactively about the WTHD. The possible presence of a depressive episode was assessed using Endicott criteria.

Results: Thirty patients (14 in-patients, 16 out-patients) were recruited during August 2017. Ten (33.3%) reported some degree of WTHD, of whom 60% met the criteria for depression. Data for the frequency and intensity of the WTHD are shown in Table 1.

<table>
<thead>
<tr>
<th>Frequency</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Seldom/ almost never</td>
<td>1 (10%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occasionally/sometimes</td>
<td>6 (60%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not every day but almost every day</td>
<td>1 (10%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Every day</td>
<td>2 (20%)</td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Intensity</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you just thought about it?</td>
<td>6 (60%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you talked about it mentioned to someone?</td>
<td>3 (30%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever thought about how you would put an end to your life? Yes, but I wouldn’t ever do it;</td>
<td>1 (10%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever thought about how you would put an end to your life? Yes, there is a plan.</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Frequency and intensity of the WTHD.

Results for patients’ understanding of the AFIDD and the perceived burdensomeness, importance and helpfulness of the assessment are shown in Table 2.

<table>
<thead>
<tr>
<th>Burdensome</th>
<th>Not at all</th>
<th>Not very</th>
<th>Quite</th>
<th>Very</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 (77%)</td>
<td>3 (10%)</td>
<td>3 (10%)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Important</td>
<td>0</td>
<td>2 (7%)</td>
<td>8 (27%)</td>
<td>19</td>
<td>63%</td>
</tr>
<tr>
<td>0</td>
<td>5 (17%)</td>
<td>13 (43%)</td>
<td>11 (37%)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Patients’ understanding</td>
<td>28 (94%)</td>
<td>No clear idea</td>
<td>Other =</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
</tr>
</tbody>
</table>

Understanding, burdensome & helpfulness of AFIDD.

Conclusions:
Our preliminary data show that asking about the WTHD is not especially burdensome, and that the majority of patients believe it to be important and helpful. Proactively asking about the WTHD during the first medical appointment in palliative care would provide more opportunities for its early detection and, therefore, for the possibility of alleviating the underlying suffering.

Prevalence of Main Palliative Needs in a Portuguese Palliative Population Using the Portuguese Integrated Palliative Care Outcome Scale - An Observational Study

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Context: Advanced disease patients have multiple needs which need to be identified in order to be addressed and managed.

Aim: To assess the main palliative care needs of patients being treated in palliative care services in Portugal.

Methods: Multi-centred observational study. Data were collected in 9 centres using convenience sampling. All patients attending the participating services were screened for eligibility. Inclusion criteria: >18 years, mentally fit to give consent, diagnosed with an incurable, potentially life-threatening illness, read, write and understand Portuguese. Exclusion criteria: patient in distress, cognitively impaired. The Portuguese Integrated Palliative care Outcome Scale (IPOS) was used.

Results: 1703 individuals were screened between July 1st 2015 and February 2016. 135 (7.9%) were included. Mean age is 66.8 years (SD 12.7), 58 (43%) are female, 74 (54.8%) have up to 4 years of formal education, 74 (54.8%) are from the Northern region. Most patients had a cancer diagnosis 109 (80.7%). IPOS items scoring highest (worst possible problem) were: Family or friends anxious or worried (36.3%); feeling anxious or worried about illness (13.3%); feeling at peace (9.6%); feeling depressed (9.6%); share feelings (8.9%); shortness of breath (8.1%) and pain (7.4%). IPOS items scoring lowest (not a problem): vomiting (77%); information needs (60.7%); practical problems (45.2%); constipation (43%).

Conclusion: Main palliative needs were not physical, but psychological, family related and spiritual. IPOS systematically identified main needs in this population. Clinical teams solve physical issues but must improve on solving non physical palliative needs. Using IPOS systematically could aid clinical teams to track their progress in assisting patients and families with those issues.

Funding
Fundaçao para a ciencia e tecnologia
to this question, using for this purpose the European Organization for Research and Treatment of Cancer Quality of Life Questionnaire — Core 15 — Palliative Care (EORTC QLQ-C15-PAL). The EORTC QLQ-C15-PAL comprises two functional scales (physical and emotional functioning) and seven physical symptom scales, on which items are rated from 1 (not at all) to 4 (very much), as well as a final question asking about overall QoL during the past week, rated from 1 (very poor) to 7 (excellent).

**Results:** From January 2016 to June 2017 we recruited 49 advanced cancer patients with a WTHD. The median score for overall QoL was 4 (IQR 2–4), although 14 patients (28.6%) rated their overall QoL as very poor or poor. In terms of physical functioning, 19 patients (38.7%) reported having a lot of difficulties, while 13 (26.5%) experienced quite a lot of difficulty in this regard. Table 1 shows the frequency of physical symptoms, the most common being fatigue and appetite loss.

<table>
<thead>
<tr>
<th>Frequency of physical symptoms.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue: 4 (8.2%)</td>
</tr>
<tr>
<td>Nausea and vomiting: 10 (20.4%)</td>
</tr>
<tr>
<td>Dyspnoea: 18 (38.8%)</td>
</tr>
<tr>
<td>Insomnia: 16 (32.6%)</td>
</tr>
<tr>
<td>Appetite loss: 11 (22.4%)</td>
</tr>
<tr>
<td>Constipation: 17 (34.7%)</td>
</tr>
</tbody>
</table>

Regarding emotional functioning, 31 patients (63.1%) reported having felt quite or very anxious and depressed. There was a negative correlation (rho = -0.283, p < .05) between the intensity of the WTHD and physical functioning.

**Conclusions:** Advanced cancer patients with a WTHD report poor overall QoL and difficulties with both physical and emotional functioning. Impaired physical functioning may be a factor that intensifies the WTHD. Improving QoL should be a key clinical objective in the care of patients who express a WTHD.

**Abstract number:** P214
**Abstract type:** Poster presentation

**How Are Loss of Dignity and Perceived Control Related with Wish to Hasten Death? A Path Analysis Model**

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**Background and aim:** The wish to hasten death (WTHD) has been defined as a reactive phenomenon to multidimensional suffering. Some studies have identified depression and physical/functional impairment as the major predictors of the WTHD. However, perceived loss of dignity and of control have also been considered to be among the principal causes of the wish to die in countries where euthanasia or assisted suicide is legal. The aim of this study was to analyse the influence of depression, physical functioning, and loss of dignity and control on the WTHD.

**Methods:** Based on a sample of 215 advanced cancer patients and using EQS 6.3 software we constructed a path analysis model in order to analyse the antecedents of the WTHD. The model was estimated from the asymptotic variance-covariance matrix using the robust maximum likelihood method. Overall data fit was verified through a set of indices (χ2/df = 4.4; CFI = 0.92; RMSEA = 0.126).

**Results:** The data in Table 1 show that (a) both depression and loss of dignity have a positive, direct and significant effect on the WTHD; and (b) both perceived control and functional status impact negatively, indirectly and significantly on the WTHD.

**Conclusions:** The presence of high levels of depression and a loss of dignity are likely to intensify the WTHD. However, the indirect effects of functional status and perceived control must also be taken into account.

**Funding**

Instituto de Salud Carlos III and the European Regional Development Fund (FEDER) project P14/00263; AECC Catalunya contra el Cáncer - Barcelona 2014; RecerCaixa 2015.

**Abstract number:** P215
**Abstract type:** Poster presentation

**Neurological Symptoms in Palliative Care Patients**

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**Background/aims:** Neurological expertise in palliative care is required for patients with primary neurological disorders as well as for patients with non-neurological diseases suffering from burdensome neurological symptoms. The aim of the study was to determine the prevalence of neurological symptoms in palliative care patients, as well as the related burden and impact on everyday life.

**Methods:** The medical records of 255 consecutive patients, referred to an inpatient palliative care consulting service from a tertiary medical center, were analyzed. 100 patients prospectively answered a questionnaire. The questionnaire included NRS scales for symptom specific burden and

<table>
<thead>
<tr>
<th>Total effect</th>
<th>Partial indirect effect</th>
<th>Total indirect effect</th>
<th>Direct effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) V1 Control -&gt; V2 Depression</td>
<td>-0.406 (~5.87)</td>
<td>-</td>
<td>-0.406 (~5.87)</td>
</tr>
<tr>
<td>(b) V3 Functional status -&gt; V4 Dignity</td>
<td>-0.217 (~3.1)</td>
<td>-</td>
<td>-0.217 (~3.1)</td>
</tr>
<tr>
<td>(c) V2 Depression -&gt; V5 WTHD</td>
<td>0.231 (2.38)</td>
<td>-</td>
<td>0.231 (2.38)</td>
</tr>
<tr>
<td>(d) V4 Dignity -&gt; V5 WTHD</td>
<td>0.247 (3.04)</td>
<td>-</td>
<td>0.247 (3.04)</td>
</tr>
<tr>
<td>(e) V1 Control -&gt; V4 Dignity</td>
<td>-0.392 (~5.5)</td>
<td>-</td>
<td>-0.392 (~5.5)</td>
</tr>
<tr>
<td>(f) V3 Functional status -&gt; V2 Depression</td>
<td>-0.271 (~3.7)</td>
<td>-</td>
<td>-0.271 (~3.7)</td>
</tr>
<tr>
<td>V1 Control -&gt; V5 WTHD</td>
<td>-0.191 (~3.2)</td>
<td>a * c = -0.094 // b * d = -0.097</td>
<td>-0.191 (~3.2)</td>
</tr>
<tr>
<td>V3 Functional status -&gt; V5 WTHD</td>
<td>-0.116 (~2.63)</td>
<td>f * c = -0.063 // b * d = -0.054</td>
<td>-0.116 (~2.63)</td>
</tr>
</tbody>
</table>

[Decomposition of the model parameters]
restrictions in everyday life and for quality of life. In addition, a screening tool for depression and anxiety (PHQ-4) was used.

Results: Forty-one patients (16%) suffered from a primary neurological disease. Neurological symptoms (excluding pain) were documented in 122 patients (48%) with an underlying non-neurological disease. In the questionnaire study, 98/100 patients reported at least one neurological or neuropsychiatric symptom, most frequently sleeping problems (N=63), difficulty concentrating (N=55) and sensory symptoms (N=50). Vertigo/dizziness (N=19) had the greatest impact on everyday life (7.57/10 ± 2.17) and was the highest symptom-specific burden (7.14 ± 2.51). Difficulty concentrating was the only symptom significantly correlated with quality of life (restrictions in everyday life: r= -0.36, p= 0.009; burden: r= -0.32, p= 0.04).

Conclusions: Neurological diseases and symptoms are frequent among palliative care patients and are often associated with a high symptom burden, which may severely impact the patients’ lives. Thus, it is of paramount importance to implement neurological expertise in palliative care.

Abstract number: P216
Abstract type: Poster presentation

Contributions of a Hand-held Fan to Self-management of Chronic Breathlessness
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Research aims: This study explored the benefits of a hand-held fan as perceived by patients with chronic breathlessness and their carers.

Study design and methods: A secondary multimethod analysis was conducted of interview data collected in three clinical trials. Two researchers independently coded level of benefit qualitatively reported by each patient.

Method of analysis: Univariate and multivariate statistics were used to independently coded level of benefit qualitatively reported by each patient.

Results and interpretation: One-hundred-and-thirty-three patients commented on the fan, of whom 72 had a carer. Diagnoses included non-malignant (n=91, 68.4%) and malignant (n=21, 15.8%) conditions. Of 111 patients who provided code-able data, 43.6% perceived no benefit, 16(14.4%) were uncertain, 80(72.0%) some benefit, and 11(10.0%) substantial benefit. Multivariate analysis was inconclusive. Benefit was described in terms of shorter recovery time, especially after activity. Ten (7.5%) patients said the fan reduced their need for home oxygen or inhaled beta-agonist medications. Negative perceptions of a few included dislike of the cooling sensation and embarrassment in public.

Findings suggest that a hand-held fan is a portable intervention with few disadvantages from which most patients with chronic breathlessness will derive benefit alongside other non-pharmacological and pharmacological strategies. Research is needed to optimise guidance on fan administration.

Abstract number: P217
Abstract type: Poster presentation

Determinants of Improved Self-management after a Breathlessness Support Intervention
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Chronic lung diseases significantly impact patients’ quality of life. Early evidence shows that breathlessness support services (BSS) successfully help patients to manage this complex symptom. Such services are designed and evaluated as short-term interventions. Little is known how patients with trajectories of severe ill health can sustain gains achieved by such programs over a longer period. The purpose of this study is to explore patient views on the effects of a BSS in the context of personal longer-term self-management capacities.

Convergent mixed-methods study combing a survey of self-administered questionnaires and qualitative semi-structured interviews of patients with breathlessness due to life-limiting disease 4-6 weeks after participating in a BSS. Quantitative data was analysed using descriptive statistics and bivariate tests, qualitative interviews were analysed within a content analysis framework. Triangulation was carried out by integrating the quantitative and qualitative results.

Preliminary analysis drawing on survey data of n=69 consecutive patients (91% response rate) and a purposefully-selected sample of 16 patients for qualitative interviews. N=34 patients found the BSS helpful (94%) or very helpful (n=26; 38%) with regard to breathlessness management. N=19 (28%) said the duration and frequency of the BSS could have been more. Patients valued the focus on individual concerns of palliative care doctors (n=47; 68%) and physiotherapists (n=47; 68%), information on assistive devices (n=30; 43%), availability of palliative care services (n=18; 26%), future care planning (n=17; 25%) and psychological support (n=13; 19%). Techniques offered by physiotherapists were often continued after the end of the intervention. Continued use of exercise and materials were associated with patient satisfaction and perceptions of its effectiveness. To understand why some patients benefit more intensely from the intervention than others, the following themes were identified: a moderate to high level of distress experienced, realistic expectations regarding symptom improvement, self-initiative, responsiveness to psychological support and an overall positive attitude towards the wider context of the illness.

In conclusion, patients’ views on the effectiveness of a self-management intervention such as a BSS offer the possibility to improve tailoring the service to patients’ needs.

Abstract number: P218
Abstract type: Poster presentation

Repliability of Complex Interventions in Randomized Controlled Trials: A Case Study of a Breathlessness Support Service
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Department of Palliative Medicine, University Hospital Munich, Ludwig-Maximilians-Universität München, München, Germany

Breathlessness support services (BSS) are an example for complex palliative care interventions being tested in RCTs to show their effectiveness improving symptom management in patients with advanced malignant and non-malignant disease. The aim of this study is to illustrate the intervention, its acceptability and treatment fidelity to ensure the replicability of a 6-weeks multi-professional BSS.

Detailed description of the intervention tested in a single-blinded randomised controlled fast track trial in adults with breathlessness due to life-limiting disease. Patient characteristics and adverse health events during trial were recorded. Operational data on the intervention were collected according to the TIDieR checklist. These included: intervention length (days) and location, modes of delivery, modifications and tailoring of the intervention, treatment fidelity. Preliminary analysis blinded to the group assignment evaluates data of patients enrolled in the trial using descriptive statistics and bivariate tests.

Preliminary data of 86 patients. Core elements of the multi-professional BSS comprise two consultations with palliative care doctors and four physiotherapy sessions, which n=82 (95%) of patients fully attended, n=59 (70%) of those within the defined period of 42 days. Violations
were caused by adverse health events (n=14; 52%) and organizational problems of patients (n=4; 15%) or providers (n=9; 33%). No association between treatment fidelity and patient diagnosis, functional status, age or availability of informal carers. Other professionals seen most often were lung specialists (n=64; 74%) and psychologists (n=6; 7%). Take-up of standard materials was: information brochure (n=83; 97%), a hand-held fan (n=80; 93%), a relaxation mantra (n=71; 83%) and CD (n=53; 62%). Further tailoring included referrals to other professionals (psychology n=17; 20%, sleep laboratory n=8; 9%, radiology n=9; 10%, continued physiotherapy n=45; 54%), assistive devices (n=23; 27%) and advance care planning information (n=35; 42%). In conclusion, process evaluation of complex interventions in RCTs informs on acceptability, treatment fidelity and helps interpreting study outcomes. Further studies with different methodological approaches, i.e. expert interviews, may be needed to document rationales and decision points for tailoring the intervention in more detail as well as giving the transferability of the service to other settings.

Abstract number: P219
Abstract type: Poster presentation

Delirium Diagnosis and Evolution in Advanced Cancer Patients Assisted in Two Different Palliative Care Units: An Observational Prospective Study
Pallotti, Maria Caterina1,2; Noguera, Antonio1,4; Lopez-Fidalgo, Jesus4; Paragonar, Marco2; Moroni, Matteo2; Celin, Daniela2; Biasco, Guido1,5; Centeno, Carlos4
1Department of Palliative Medicine, Ludwig Maximilians Universität München, Munich, Germany; 2Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation, King’s College London, London, UK; 3Palliative Care, Hull York Medical School, Hull, UK; 4Palliative Medicine, University of Cambridge, Cambridge, UK; 5Institute for Medical Informatics, Biometry and Epidemiology, Ludwig Maximilians Universität München, Munich, Germany

Background: Delirium is a neuropsychiatric disorder responsible for 28-44% of Palliative Care Unit admissions, causing great suffering both patients and caregiver. The aim of this study is to compare the frequency and evolution of delirium in advanced cancer patients with palliative care assistance in two different settings: Hospice (HS) and Oncology Ward.

Methods: We conducted a prospective observational study of consecutive patients admitted at a HS, and attended by a Palliative Care Supportive Team (ST) at an Oncology Ward in a University Hospital. Memorial Delirium Assessment Scale (MDAS) was employed for delirium diagnoses (cut-off >7) and evolution, using it within 48 hours to admission and once every week. When delirium was diagnosed, we compiled a checklist of causes and therapies. Frequency analysis was employed to describe the population and Fisher test to compare the two groups.

Results: 582 patients were evaluated, 227 were enrolled (176 in 10 months in HS, 51 in 6 months by ST). All suffered advanced cancer. The median age was 73 years (75 HS, 64 ST). The groups only differed in Karnofsky performance status (KPS): KPS= 30-40 88% HS, KPS >50 63% ST (p<0.001). Delirium prevalence at admission was in 46/176 (26%) patients HS and in 11/51 (22%) patients ST (p=0.585). During hospitalization delirium was diagnosed in 31/176 (18%) patients HS and in 4/51 (8%) patients ST (p=0.208). At the time of discharge/death, delirium was present in 65/176 (37%) patients HS and in 3/51 (6%) patients ST (p<0.001). The causes of delirium were the same in both settings. Haloperidol was the drug most commonly used. Multivariate analysis showed that different center influence delirium evolution (p<0.001), with possible contribution related to KPS (p=0.015). Continuous palliative sedation for delirium refractory was necessary only in one patient.

Conclusion: Delirium prevalence at admission and during hospitalization was similar in both settings, but evolution showed a greater recovery in patients attended by ST. More research is necessary to explain this result. Delirium early diagnoses in advanced cancer patients with better performance status could help to alleviate this syndrome. Early Palliative Care integration could be key for that.

Abstract number: P220
Abstract type: Poster presentation

Cognitive-emotional Interventions for Breathlessness in Adults with Advanced Diseases
Bolzani, Anna1; Maddocks, Matthew2; Rolser, Stefanie1, Schumacher, Philipp1; Swan, Flavia1; Hutchinson, Anne1; Booth, Sara1, Kalies, Helen1, Rehfues, Eva1, Bausewein, Claudia1
1Department of Palliative Medicine, Ludwig Maximilians Universität München, Munich, Germany; 2Cicely Saunders Institute of Palliative Care, Policy & Rehabilitation, King’s College London, London, UK

Objective: To assess the effects of cognitive-emotional (CE) interventions to relieve breathlessness in adults with advanced disease.

Methods: Systematic review following Cochrane methods. Search in CENTRAL, MEDLINE, Embase, PsycINFO, LILACS and CINAHL (July 2016; update 1st August 2017) for randomised controlled trials comparing CE interventions to no treatment/placebo/active control. Two review authors independently screened results, extracted data and assessed risk of bias. Primary endpoint: breathlessness, measured by self-reported instruments. Calculation of (standard) mean differences between intervention and control groups for outcomes with sufficient data; otherwise description of findings from individual studies.

Results: Overall, 15,839 references with inclusion of 11 trials (13 publications; n=589 patients). Interventions were grouped in psychological therapy, distracting auditory stimuli (music), relaxation and mindfulness-based stress reduction. Because of heterogeneity in population and interventions, meta-analyses were not possible. 3/6 studies in the psychotherapy category measured breathlessness with Borg or VAS. Only one showed a significant reduction of breathlessness when compared with active control. A similar pattern was noted amongst other intervention categories: When compared to active controls, most CE interventions did not demonstrate a significant reduction of breathlessness. However, after some interventions, a significant reduction could be observed when compared to baseline.

Conclusion: Studies had very small sample sizes and most were not powered for breathlessness, our primary outcome of interest. Most trials included CE interventions as part of a larger system, e.g. self-management or breathlessness services. Fully powered trials are needed in the future to understand the sole effects of CE interventions. This abstract is based on a draft and pre-peer review version of a Cochrane Review. Upon completion and approval, the final version is expected to be published in the Cochrane Database of Systematic Reviews (www.cochranelibrary.com).

Abstract number: P221
Abstract type: Poster presentation

Respiratory Interventions for Breathlessness in Adults with Advanced Diseases
Bolzani, Anna1, Rolser, Stefanie1, Swan, Flavia1, Schumacher, Philipp1; Maddocks, Matthew2; Hutchinson, Anne1, Booth, Sara1, Kalies, Helen1, Rehfues, Eva1, Bausewein, Claudia1
1Department of Palliative Medicine, Ludwig Maximilians Universität München, Munich, Germany; 2Wolfson Palliative Care Research Centre, University of Cambridge, Cambridge, UK
Objective: To assess the effects of respiratory interventions to relieve breathlessness in adults with advanced diseases.

Methods: Systematic review following Cochrane methods. Search in CENTRAL, MEDLINE, Embase, PsycINFO, LILACS and CINAHL (July 2016; update 1st August 2017) for randomised controlled trials comparing respiratory interventions to no treatment/placebo/active control. Two review authors independently screened results, extracted data and assessed risk of bias. Calculation of (standard) mean differences between intervention and control groups for outcomes with sufficient data; otherwise description of findings from individual studies.

Results: We included 47 trials (55 publications, n=1852 patients). We grouped the interventions in five different categories: Breathing training (BT), respiratory muscle training (RMT), fan, chest wall vibration and other. Meta-analyses were possible for BT and RMT. Our preliminary results suggest that RMT significantly reduces breathlessness when compared to inactive control measured with uni-dimensional scales (SMD [95% CI] = -0.36 [-0.61, -0.10], n=10 studies) or multi-dimensional scales (SMD [95% CI] = 1.62 [0.36, 2.87], n=6 studies). Preliminary analysis of BT as well as other respiratory intervention did not show significant differences, regardless of duration, frequency and category of the intervention.

Conclusion: Even though the results of the review are inconclusive, RMT seems to significantly reduce breathlessness and most of the other studies indicate a non-significant improvement. Studies included had very small sample sizes and most of them were not powered for our primary outcome of interest, breathlessness. Larger randomised trials are needed in the future to understand the effects of respiratory interventions besides RMT on breathlessness. This abstract is based on a draft and pre-peer review version of a Cochrane Review. Upon completion and approval, the final version is expected to be published in the Cochrane Database of Systematic Reviews (www.cochranelibrary.com).

Abstract number: P222
Abstract type: Poster presentation

Spanish Version of the Brief Edinburgh Depression Scale (BEDS): Validation in Mexican Patients with Advanced Cancer in a Palliative Care Unit

Rodríguez-Mayoral, Oscar1, Rodríguez-Ortíz, Bárbara2, Peña-Nieves, Adriana3, Ascencio-Huertas, Leticia4, Allende-Pérez, Silvia4, Verástegui, Emma4
1Palliative Care Unit, Instituto Nacional de Cancerología, Mexico City, Mexico, 2Hospital Psiquiátrico ‘Fray Bernardino Álvarez’, Mexico City, 3Instituto de Higher Education and Research in Health, University of Lausanne, Lausanne, Switzerland, 4Department of Health, Division of Nursing, Bern University of Applied Sciences, Bern, Switzerland

Introduction: Depression in patients with advanced cancer is frequent, but poorly recognized, and its presence is associated with a decrease in the quality of life, difficulty in the control of physical symptoms and lower survival. One of the first steps to improve the detection of validated tools in the language and the specific population. In Mexico, there are no scales for the screening of depression in palliative care patients, so it is necessary to have a tool for this population. The Edinburgh Depression Brief Scale (BEDS) is a self-applied instrument created as a tool for the screening of depression in patients treated in palliative care.

Objective: To validate the Spanish version of the BEDS in a Mexican population diagnosed with advanced cancer treated in a palliative care unit.

Material and methods: It is a prospective, cross-sectional, and observational study. Patients treated at the palliative care unit of the Instituto Nacional de Cancerología of Mexico, who could read and write in Spanish, who agreed to participate in the study and who did not have cognitive alteration or were treated with antidepressant drugs, were included. The patients filled out the BEDS version in Spanish, and were subsequently interviewed by a psychiatrist (who did not know the answers of the instrument) for the diagnosis with to the DSM 5’s criteria.

Results: We included 70 patients with a median age of 56.5, 71% were women. 20% met criteria for diagnosis of depression according with psychiatrist evaluation n. The BEDS presented a Cronbach’s alpha of 0.71. Using a cutoff point > 5 it has a sensitivity of 86% and a specificity of 63%, with an area under the curve of 0.84.

Conclusions: Major depressive disorder is a frequent phenomenon in patients with advanced cancer treated in palliative care and is still poorly identified. The Spanish version of the Edinburgh Depression Brief Scale (BEDS) is an adequate tool to screening in the Mexican population with advanced cancer in a palliative care unit, using a cut-off point> 5 to improve the identification of possible cases.

Abstract number: P223
Abstract type: Poster presentation

Pre-validation of the Transitoriness Tool to Assess Patients’ Thoughts of Death

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Purpose: The purposes of this study are to establish content validity of the newly developed instrument Transitoriness and to conduct a pre-test of this instrument in the target population.

Background: Cancer remains associated with a potential fatal outcome. Patients with cancer experience shock and disruption in the short and long term. Knowing oneself to be suffering from this disease, patients have thoughts about death, experience anxiety and fear as well as a modification in their outlook on life in general. Psychosocial needs in cancer patients constitute an important area of research. However, only few instruments are currently available to assess patients’ existential experiences of living with cancer and finitude of life. Developing the Transitoriness instrument to systematically assess the existential dimension of a cancer diagnosis and conducting a pre-test of this instrument is therefore warranted.

Methods: A mixed-method approach was selected to a) determining the content validity of the Transitoriness instrument, and to b) conducting a pre-test of the instrument in the target population.

Results: For the Transitoriness instrument a total of three rounds of expert consultations were conducted. An I-CVI between 0.72 and 1.00 was calculated. Subsequently, the Transitoriness instrument was obtained with a total of 46 items.
A total of 52 patients (14 men) participated in this study aged between 24 and 83 years, predominantly well-educated and married. Preliminary results indicate that patients experience thoughts of death (mean 2.4, 1-5); patients have moderate anxiety (mean 2.05, 1-5), and a changed outlook on life (mean 2.25, 1-5). It was established that the Transitoriness instrument does not cause any undue perturbations and can be used with cancer patients within the first year of diagnosis.

Conclusion: Further research needs to be conducted to establish validity and reliability of the Transitoriness instrument. Thus, it may be used in practice to identify cancer patients’ existential concerns.

Abstract number: P224
Abstract type: Poster presentation

Gratitude: A Promising Lead for Palliative Care
Althaus, Betty, Borasio, Gian Domenico, Bernard, Mathieu
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Background: Several studies, mostly realized with non-clinical populations, have shown a link between gratitude and key dimensions of palliative care (e.g., psychological distress). The relevance of gratitude in the palliative context still needs to be verified.

Aims: The aims are (A) to evaluate the link between gratitude and quality of life (QoL), psychological distress, post-traumatic growth, and health status for palliative patients; and (B) to assess if these variables predict QoL.

Methods: We performed an exploratory and cross-sectional study with palliative patients of a university hospital. Validated questionnaires were used to measure QoL (McGill Quality of Life Questionnaire Revised), gratitude (Gratitude Questionnaire 6 items), psychological distress (Hospital Anxiety and Depression Scale), post-traumatic growth (Post-traumatic Growth Inventory), and health status (ECOG). Spearman correlations and multivariate analyses were performed.

Results: Sixty-four patients participated (30 men, mean age 67, SD=13.5). First, the results indicated a significant and positive correlation between gratitude and QoL (total (r=.376, p=.003), physical (r=.296, p=.021), psychological (r=.298, p=.020), existential (r=.454, p=.000) subscales), and between gratitude and post-traumatic growth (appreciation of life subscale (r=.426, p=.001)). A significant and negative correlation was found between gratitude and psychological distress (total (r=.324, p=.013), depression subscale (r=.359, p=.006)), and gratitude and health status (r=.266, p=.039). Second, multivariate analyses showed that the model explained 51.9% of the variance for QoL (F=15.588, p=.000), including psychological distress (β=.640, p=.000) and gratitude (β=.258, p=.027) as significant predictors.

Conclusions: The results suggest that gratitude may act positively on the patients’ QoL, and may be a protective factor against psychological distress. The adaptation of gratitude-based interventions to the palliative context represents the next research step.

Abstract number: P225
Abstract type: Poster presentation

An Exploration of the Needs of a Cardiac Population Using a Subjective Quality-of-Life Measure
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Background: During the past decade, a paradigm shift has occurred in the measurement of quality-of-life (QoL) from the use of standardised questionnaires towards a more individualised approach. The multidimensional aspects to quality-of-life make it a difficult concept to define, hence it has been traditionally measured based on health and illness. The Schedule for the Evaluation of Individual Quality of Life (SEIQoL) was developed to overcome such limitations; enabling quality-of-life to be measured on what the patient deems it to be.

Aim: The focus of this study was to profile a cardiac population in the West of Ireland and establish quality-of-life and symptom bother cues using Schedule for the Evaluation of Individual Quality of Life-Direct Weighting (SEIQoL-DW); with a view to informing the development of a cardiac support group. Strengthening resilience of community groups is a key goal of health promotion and a tenet of ‘Healthy Ireland’ 2013-2020 policy document.

Methods: This study used a cross-sectional study design based on a random sample of 22 individuals who were members of a Cardiac Support Group (n=284). These individuals have experienced a cardiac event and are at various stages along their recovery journey. Use of SEIQoL-DW takes the form of a semi-structured interview, enabling individuals to convert their perspectives into scientific values. Data were analysed using both quantitative analysis and qualitative descriptive analysis.

Findings: Participants highlighted a range of quality-of-life cues; findings from this study showed that 45% of participants did not rate ‘health’ in the first five of their chosen QoL cues. A significant number of participants experienced symptoms; a medium negative correlation was found between symptom interference and QoL, r=-0.353 with high levels of symptom interference associated with low levels of QoL.

Conclusions: The range of Quality-of-Life cues and bothersome symptoms identified in this study have implications for the development of the group, with participants’ eager to participate and talk candidly about their needs. SEIQoL-DW proved to be an acceptable, reliable and valid technique for measuring individual QoL, taking greater consideration of individual perspectives compared with traditional measurement approaches.

Keywords: Quality-of-Life, Cardiac Support Group; Symptom Bother; SEIQoL-DW.

Abstract number: P226
Abstract type: Poster presentation

Qualitative Study to Assess the Level of Suffering and Distress in Women Undergoing Treatment for Breast Cancer in India
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Background: Breast cancer is the most common form of cancer among women globally, including in India. The rising incidence in the developing world is thought to be due to increased life expectancy, urbanization and adoption of western lifestyles. Psychological symptoms are common in women with breast cancer. Distress may also affect treatment compliance. The easing of suffering or distress is an essential purpose of palliative care. Studies have explored the impact of cultural background on psychological distress, but there are few data from women with breast cancer in the Indian subcontinent.

Aim: To explore the experience of psychological distress in Indian women, living in India, in relation to their diagnosis and treatment of breast cancer.

Methods: In-depth interviews were conducted with 20 consenting women undergoing treatment for breast cancer. Purposive sampling was used to obtain maximum variation in socio-demographic and clinical characteristics. Interviews were verbatim transcribed, translated into English and back translated to Malayalam to ensure that the meaning had not been lost. English data were analyzed using thematic frame work analysis and synthesized to provide a deeper understanding of the individuals’ experience.
Results: Three major themes emerged from the data. The first major theme was “psychological distress of patients to disease and treatment effects”. This included anxiety, guilt, anger and depression in response to the disease and physical side effects of treatment and issues relating to body image, especially hair loss and sexuality. The second major theme was “getting on with life”. Women tried to make sense of the disease, by actively seeking information, the role of medical professionals, and their practical adaptations. Many found a new future and a new way to live normal. The third major theme was the “influence of their support system” strongly based on family, friends, faith and the community which affect them positively as well as negatively.

Conclusion: Psychological concerns related to disease and treatment is common in Indian women with particular emphasis on body image issues associated with hair loss. Family and faith were key support systems for almost all the women although could also be causes of distress.

Funding
Self funded

Abstract number: P227
Abstract type: Poster presentation

Providing the Care for Specialist Palliative Care. Our Experience of Clinical Supervision
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Background: Clinical supervision is a process of professional support and learning that addresses a practitioners developmental needs in a non-judgemental way. Access to regular clinical supervision is endorsed by professional bodies including the General Medical Council, Royal College of Nursing and Care Quality Commission in the UK. Despite this there was no provision for clinical supervision for middle grade specialist palliative medicine doctors within the Health Board evaluated. The aim of this pilot project was to evaluate the role of clinical supervision for middle grade doctors and establish the longer term need for such intervention.

Methods: A six week pilot project was conducted. Weekly small group clinical supervision sessions were held for middle grade doctors working across different sectors of specialist palliative care. Protected time was allocated away from clinical responsibilities. These sessions were facilitated by a psychologist familiar with the challenges of the specialty. Participants were asked to complete the Professional Quality of Life Scale (ProQOL) questionnaire after each session.

Results: Objectively: Scores from the ProQOL questionnaire varied according to on-call commitments and involvement in emotive cases. Historically the questionnaire is a validated tool if used over a 30 day period. Weekly evaluation was felt too frequent. Subjectively: All participants reported that the sessions were beneficial, offering a supportive and constructive environment to tackle the challenges of working within palliative medicine. Common themes reported included the promotion of an open forum for reflection, increased emotional resilience and the development of healthier approaches to dealing with daily stressors.

Conclusions: This pilot project demonstrated a promising initial benefit from clinical supervision based on qualitative feedback. The Health Board recognises the need for on-going clinical supervision to be made available to middle grade doctors working within specialist palliative medicine. The current aim is to extend the pilot project over a six month period, involving the wider MDT. Further evaluation is planned using the results of monthly ProQOL questionnaire scores at the end of this period.

Abstract number: P228
Abstract type: Poster presentation

Humour Interventions in Palliative Care - A Systematic Literature Review
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Background: The central goal of palliative care is to optimize the quality of life of patients suffering from life-limiting illnesses. Therefore, psycho-social and spiritual wellbeing need to be included. A paradigm change lead to a stronger focus on a resource-based approach in palliative care, encompassing biographical work and humour therapy. The positive correlation of humour and laughter with life satisfaction has been described repeatedly. Similarly, evidence exists that health and symptoms can be improved by humorous stimuli. Clowns have been used mostly in paediatric hospital wards and occasionally in nursing homes.

Methods: A systematic review of four databases led to the selection of 15 publications. Criteria for inclusion were peer-reviewed publication of original data on humour intervention or assessment in a palliative care context (language: English).

Results: Two studies on humour interventions and twelve studies on humour assessment, most of them presenting the patient’s perspective on humour in palliative care, were included in this review. They indicate that humour had a positive effect on patients, their relatives, and professional caregivers. Humour was widely perceived as appropriate and even needed by all investigated groups.

Conclusions: Even though humour seems to play a crucial role in palliative care settings, descriptions of corresponding interventions and their subsequent evaluation are scarce. Research on this topic remains limited. More research activities are needed, leading up to a broader set of data and deeper insights, which in turn could serve as a foundation for strategies to implement humour as part of the regular palliative care equipment.

Abstract number: P229
Abstract type: Poster presentation

Towards a Framework for Positive Sexuality in Palliative Care: The Experiences of Patients, Partners and Palliative Care Providers about Sexual Changes and How to Address Them
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Background: Patients at a palliative stage and their partners experience severe sexual changes and want the opportunity to address them to their palliative care providers. There is almost no empirical data on how palliative care patients and partners experience changes in their sexuality, nor how palliative care providers address these. The study addresses these two gaps, so that -based on this knowledge- we can formulate principles for addressing sexuality in palliative care.

Method: We performed a generic qualitative study in Flanders, Belgium. We conducted in-depth interviews with 21 persons (8 patients, 7 partners and 6 bereaved partners) recruited from palliative and oncology units in hospitals, and from ambulant palliative care.

Conclusions: The study addresses these two gaps, so that - based on this knowledge- we can formulate principles for addressing sexuality in palliative care.

Method: We performed a generic qualitative study in Flanders, Belgium. We conducted in-depth interviews with 21 persons (8 patients, 7 partners and 6 bereaved partners) recruited from palliative and oncology units in hospitals, and from ambulant palliative care.
We conducted 26 interviews with palliative care providers (21 nurses, 6 psychologists) from different palliative care facilities. All interviews were analysed using thematic analysis. Results: The interviews with patients and (perceived) partners show that the sexual needs of the patients/partners are related to their emotions about the approaching end of the patient; that the progressive deterioration of the physical condition requires that couples need to explore, scrutinize and adjust their sexual interactions in a continuous way; and that the way couples approach sexuality is influenced by cultural constructions regarding the dying process. In this stage, patients/partners valued a “positive sexual attitude” of palliative care providers, which means they prefer to have open, honest communication on how to achieve sexual wellbeing, over e.g. being offered information about how to overcome sexual dysfunction. The interviews with palliative care providers show that in order to address sexuality in a positive way, they have to overcome different tensions: the tension between focusing the care on life or on death, which implies a tension with “unravelling” sexual issues or “tempering” sexual issues. The tension between a holistic “sex-inclusive” and “holistic sex-exclusive” care content, which implies a tension between considering sexuality as a care priority or not. The tension between an empowering or more directive nurse-patient relationship, which implies a tension between initiating conversation about sexuality or letting patients/partners initiate. Conclusions: The findings resulted in practical guidelines imbedded in a “framework for positive sexuality” to help nurses with addressing sexuality.

Abstract number: P230
Abstract type: Poster presentation

Who intends to use psycho-oncological support and why? A mixed-methods study
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Objective: Distress screening programs aim at ensuring appropriate psycho-oncological support for cancer patients, but many eligible patients do not use these services. To improve distress management, we need to better understand patients’ supportive care needs. We here report first findings from a longitudinal study that focused on patients’ intentions to use psycho-oncological support and its association with distress and service uptake including aspects of the treatment approach.

Methods: We conducted a prospective, observational study in an Oncology Outpatient Clinic and assessed distress, intention, and uptake using the Distress Thermometer (DT), a semi-structured interview, and hospital records, respectively, and analysed data with a mixed-methods approach.

Results: Of 333 patients (mean age 61 years; 55% male; 54% DT≥5; 38.4% with palliative treatment approach), 25% intended to use the psycho-oncology service (yes), 33% were ambivalent (maybe), and 42% reported no intention (no). Overall, 23% (70% yes, 17% maybe, 13% no) had attended the service four months later. Intention and uptake of psycho-oncological support did not differ in patients with palliative and curative treatment approach. Ambivalent patients reported higher distress than patients with no intention (odds ratio (OR)=1.18, 95% confidence interval (CI)[1.06-1.32]) but showed significantly lower uptake behavior than patients with an intention (OR=0.07, 95% CI[0.03-0.15]). Qualitative analyses revealed that ambivalent patients highlighted their psychological distress currently balanced by resources while patients with clear intentions (yes/no) emphasized their knowledge, attitudes, and coping concepts.

Conclusions: In our study reflecting the early treatment phase, intention and uptake of psycho-oncological support did not differ in patients with palliative and curative treatment approach. Overall, we identified a vulnerable and undersupplied group of ambivalent patients. They reported high distress levels, but showed low uptake behavior. Future research should focus on how to best reach this target group. To optimize distress screening programs, we propose to integrate the patient perspective.

Abstract number: P231
Abstract type: Poster presentation

Caregiving Distress and Inflammatory Response among Family Caregivers of Cancer Patients
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Background: Caregivers of cancer patients suffer from a wide range of problems, including fatigue, care burden, burnout and depression. Researches on cancer caregivers have demonstrated that the caregiving distress is related not only to mental but also to physical health such as dysregulation of inflammatory function. This study aimed to investigate the relationship between caregiving distress and serum IL-6 and TNF-α, which are implicated in immune function of caregivers of cancer patients.

Methods: Total 63 family caregivers of cancer patients participated in this study. Caregiving distress (fatigue, caring burden, burnout, and depression) was measured by using structured self-report questionnaires. Two inflammatory cytokines, IL-6 and TNF-α levels were obtained using a high-sensitivity enzyme-linked immunosorbent assay (ELISA). Data were analyzed using descriptive statistics, t-test, ANOVA, Spearman correlation coefficient analysis, and Hierarchical multiple regression analyses.

Results: There was a significant correlation between fatigue, caring burden, depression, and TNF-α was correlated with depression. Caregiving distress was associated with the increased serum IL-6 and TNF-α levels. Gender, experience in radiotherapy, length of caregiving, and fatigue are associating factors for the levels of cytokines.

Conclusions: Caregiving distress is a negative experience that affects mental health and inflammatory response to family caregivers. It is necessary to develop practical nursing intervention that supports caregivers and manages caregiving distress.

Abstract number: P232
Abstract type: Poster presentation

Methylphenidate for Depression in Palliative Care - What's New?
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Background: Symptoms of depression (SDEP) are common; antidepressants are not always effective or appropriate, especially in palliative care (PC) cohorts (where the priority is timely effect). Methylphenidate, a
psychostimulant, may offer an alternative. The related 2008 Cochrane review [1] contained a heterogeneous group of trials and was inconclusive. New trial data has become available.

**Aims:** To evaluate via systematic review the effectiveness and safety of methylphenidate (single-agent or adjunct) in treating depression and SDEP in adults who have advanced medical conditions or are receiving PC.

**Methods:** We searched published papers of randomised controlled trials (RCTs) in any language from 2006-present on key online databases, manufacturer’s trial listings, reference searching, and personal communication. Citations were screened in duplicate. Trials meeting criteria were collated with relevant RCTs from the previous review [1]. Cohorts with traumatic brain injury or substance dependence were excluded.

The primary outcome measures were: effect of MPD on overall SDEP (at days 7 and 28), and adverse events (AEs). Where homogeneity allowed, meta-analysis was planned.

Data were extracted and checked by two authors. Cochrane Collaboration guidelines assessed bias risk in 6-domains. GRADE criteria rated overall evidence.

**Results:** Six papers were identified (including two from previous review), outlining five RCTs and two n-of-1 trials. Five used MPD alone and two MPD as adjunct to mirtazapine or SSRI, for a total of 229 patients. Trials compared MPD to placebo or desipramine. Small sample sizes and poor recruitment meant all trials were at high bias risk.

Trials were heterogeneous and meta-analysis could only be performed in one subgroup. Overall, the majority of trials at each time point demonstrated significance of effect. Meta-analysis on methylphenidate’s use as a medium-term adjunct favoured effectiveness over placebo (n=59). One recent trial found no evidence of effect. Methylphenidate was generally well-tolerated.

**Conclusion:** There remains no conclusive evidence as to whether methylphenidate is an effective antidepressant in PC cohorts.

**References**

**Abstract number:** P233

**Abstract type:** Poster presentation

**Who Provides Care in the Last Year of Life?** A Description of Care Networks of Older Adults in the Home-setting

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**Research aims:** End-of-life care provided at home can be complex and intensive for both professional and informal caregivers. Care networks may differ in size and composition in the home-setting, but it is unknown which types of care networks exist near the end of life. We aim to identify care network structures that exist around community dwelling older adults in the last life year.

**Methods:** Data were derived from the Longitudinal Aging Study Amsterdam, an ongoing longitudinal study of older adults in the Netherlands. We selected data of adults who died within 12 months of their last interview (2001-2013), who did not live in a residential institution, and who received personal and/or domestic care (n=146).

Using latent class analysis, we identified four types of care networks.

**Results:** We identified a partner network (19%) in which adults mainly received help from partners, with some care provided by privately paid caregivers or professionals. The majority were men and were relatively younger, better educated and more frequently had cancer. In the diverse network (25%) adults received help from children, professional caregivers or other family members. The majority were female and lived alone.

Relative to other care recipients, they had lower education and more functional limitations. A private network (15%) in which everyone received help from privately paid caregivers. Care recipients were, relatively, highly educated, had few functional limitations, and more often had heart disease. A professional network (40%) in which adults mainly received help from professionals, sometimes with help from family or privately paid care. Adults were relatively old and less than half suffered from cancer.

**Conclusion:** A variety of care networks were identified among adults in the last year of life, which are mostly related to health, gender and partner status. Professionals were more often involved when patients suffered from cancer and had no partner, while their involvement was less when there was a partner who could provide care. Providing end-of-life care can be particularly burdensome for partners. We found that partner caregivers mostly provided care on their own with little help from others. To prevent caregiver overload it is important that professionals make sure partner caregivers receive adequate and timely support to cope with the care situation. More research about the informal caregivers’ experiences of support in the care networks is needed.

**Abstract number:** P234

**Abstract type:** Poster presentation

**Financial Toxicity in Advanced Cancer Patients in an Irish Setting**

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**Background:** Financial Toxicity (FT) describes the harmful financial burden faced by patients receiving cancer treatment. It is associated with poor quality of life, greater symptom burden and greater risk of mortality. Limited research exists outside the United States despite an increasing acknowledgement of cancer-related costs.

**Aims and objectives:** To understand how to measure FT in advanced cancer patients in an Irish setting.

To examine the acceptability of the Comprehensive Score for Financial Toxicity (COST) measure.

To evaluate the prevalence of FT and identify any associated patient and disease characteristics.

To compare FT related distress to other forms of distress and assess its contribution to overall distress.

**Methods:** This was a prospective cross-sectional observational feasibility study of FT in advanced cancer patients using structured questionnaires.

**Results:** 60 patients completed the questionnaire: 29 male, mean age 61.5. 96.7% reported they were comfortable with their medical team asking them about their financial situation. 93.3% were agreeable with discussing financial issues in the future. Median COST score was 33.5 (IQR 18.25-40). COST scores range from 0 to 44, with lower values indicating greater FT. Greater FT was associated with younger age (Spearman rho -.575, p < .001), unemployment (p < .001), number of dependents (Spearman rho -.427 p .001), lack of medical insurance (p .044), and hospital admissions (Spearman rho -.256, p .048). Financial distress was reported as more severe than physical distress, distress about physical functioning, social distress, and emotional distress by 18.3%, 16.7%, 20%, and 18.3% respectively. COST scores correlated with overall distress, as measured by the distress thermometer (Spearman rho -.591, p < .001).

**Conclusion:** Measuring FT in Irish advanced cancer patients is feasible and acceptable. Significant levels of FT, comparable with American studies exist. FT is clinically significant, correlating with overall distress levels. This study potentially identifies the “at risk” cohort who need screening for FT.
Abstract type: Poster presentation

Spiritual Support in End Stage Heart Failure (ESHF): A Randomised Controlled Feasibility Study

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Spiritual care is important, especially at end of life. People with ESHF experience spiritual needs alongside the physical/emotional challenges of their illness and would welcome spiritual support (SS). It is unclear if SS enhances spiritual wellbeing (SWB) and/or quality of life (QOL), or reduces depression/anxiety in ESHF. Information is needed to inform the design of such a study.

Aims:

1. To make recommendations on the feasibility/design of a follow-on RCT to investigate the effect of SS on specified outcomes in ESHF.
2. To investigate the effect of SS on SWB (WHO SRPB QOL Field Test Instrument), anxiety/depression (Hospital Anxiety and Depression Scale), and QOL (EQ-5D-3L) if the sample size is sufficient (or to identify trends if not).

Method: Prospective random allocation over 18 months of ESHF patients in one Health Board in Wales (n=47 from possible 133) to receive standard care only (control group n=25) or standard care plus SS (experimental group n=22); SS provided by trained volunteers in patients’ homes at 2 monthly intervals over 6 months (4 visits). Completion of study outcome measures and potential confounding factors (circumstances, life events, symptoms, medication) at 0, 2, 4, 6 months in both groups.

Analysis: Descriptive statistics, Repeated Measures ANOVA and standard economic analysis methods.

Results:

Aim 1:

- Poor uptake (35%), attrition and missing data compromised the ability to detect significant changes in study outcomes.
- Time is needed for recruitment (18 months) and data collection (2 years); inclusion of a research nurse/administrator is recommended.
- SS was valued by those receiving it.
- Nurses lacked confidence in initiating end of life conversations; training is recommended.
- Spiritual wellbeing was negatively correlated with anxiety (Rho ranging from -.306 to -.385, p< 0.05) and depression (Rho ranging from -.342 to -.648, p< 0.05)

Aim 2:

The following trends were noted and require further exploration:

- Positive effect of SS on QOL (increase of .4 points in intervention group at 0-2 months) and anxiety (decrease of 1.2 points in intervention group at 0-2 months) but not on depression or SWB.
- Negative effect (increased depression of .9 points) of withdrawal of SS from experimental group at close of the study (months 4-6).
- Lower health resource cost per experimental patient (£204) over the study period; SS may be cost effective if rolled out to more patients within routine care.

Abstract number: P235
Abstract type: Poster presentation

Spiritual Care in Different Settings in Palliative Care in the Netherlands: Results of an Online Survey among Members of Palliative Care Section of the Dutch Nursing Association
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Nurses, specialized nurses and care assistants in palliative care face spiritual needs of patients they care for. In this survey they were asked about spiritual needs they recognized, how they act on them and what support they need to enhance the spiritual care they give to patients. The Special Interest Group Spiritual Care of the Dutch Nurses Association (V&VN) distributed an online survey among their 900 members. The survey consisted of three validated questionnaires. Vision on spirituality and spiritual care was measured by the Spirituality and Spiritual Care Rating Scale (SSCRS). Competence for spiritual care delivery was measured by the Spiritual Care Competence Scale (SCCS). Personal spirituality of the respondents was measured by the Spiritual Attitude and Involvement List (SAIL). Additional open questions asked for expressions of spirituality in palliative care practice, spiritual care that is offered, used tools and educational needs. 170 members completed the survey. In general respondents showed a so called broad vision on spirituality in which they are open to different spiritual perspectives of patients. They scored high on patient centered competences (attitude and communication) and relatively low on competences regarding professionalization of spiritual care. The score on the SAIL showed that respondents’ personal spirituality is mainly shown in connectedness with others, more than connectedness with the transcendence. ‘Acceptence’, ‘letting go’ and ‘questions of life’ are mentioned most often as patients’ expressions of spirituality in palliative care practice. When asked for actually practices spiritual care, respondents mentioned mostly ‘listening’, ‘talks’. And ‘asking questions’. The main need for education is in depth knowledge regarding spirituality and spiritual care and communications training: ‘the right questions to ask’. In this presentation the results will be further clarified and recommendations for the development of spiritual care in palliative care practice will be worked out.

Abstract number: P237
Abstract type: Poster presentation

Is Spiritual Care the Hospital’s Business? Discussing a New Methodological Approach to Understand Patients’ Preferences in Palliative Care (PC)
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Background: Although several qualitative studies have explored patients’ “suffering, needs and preferences”, methodological issues remain. One of them is linked to the definition of “spirituality”. While some studies present their operational definition of spirituality to the participants before the interview, others begin by asking patients their own definitions, thus creating potential important bias.

Aim: To develop a methodological approach that focuses on patients’ preferences about spiritual care, without imposing a theoretical definition of “spirituality” while maintaining qualitative research rigor.

Design: A multicenter qualitative study using semi-structured interviews. The interview guide is developed using Pargament’s definition of spirituality - “the search for the sacred” as a theoretical framework to understand patients’ spiritual preferences.
(1) Each participant is encouraged to create associations between 12 photos and to ultimately choose their favorite for the purpose of expressing in words their inner imagination, memory and emotions. Photos are chosen following Pargament’s four pathways (knowing, experiencing, relating, and acting) to “search for the sacred”.

(2) Preferences for spiritual care are explored through a concrete illustration of each pathway.

(3) Participants are asked to define the concept of “spirituality” in their own words and to express their experience of the interview.

Setting/participants: 25 terminal ill adult inpatients hospitalized in 5 different PC units (4 in Paris, France and 1 in Besancon, France). Written, informed consent was obtained from all interviewees.

Results: Findings indicate that photos are a useful research method to elicit rich verbal data and to assess patients’ representations and expectations inside the spiritual realm. It allows participants the freedom to elaborate on their own definition and representations of spirituality while evolving inside a common semantic field.

Conclusions: Using photos based on a solid theoretical framework proves to be a relevant alternative to avoid the methodological problem of definition when exploring patients’ spiritual experiences in PC. New studies using this method need to be developed in different cultural settings to explore this method further.

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Abstract number: P238
Abstract type: Poster presentation

“Spirituality without Borders”.

Palliative Care Patients’ Perspectives about Valued Spiritual Care
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Background: Spirituality relates to connection with meaning and that deemed significant or sacred. Spiritual care is associated with patients’ higher levels of hospice utilisation, quality of life, and care satisfaction, and reduced intensive care deaths and end-of-life care costs. Palliative care strategies prioritise meeting patients’ “spiritual requirements” yet there is little understanding about how this occurs.

Aim: To understand what enables palliative care patients to connect with that deemed sacred and/or important.

Methods: Qualitative research at a non-profit, integrative healthcare service. Semi-structured interviews were used to examine palliative care patients’ views about spiritual care and what connects/detracts them from that deemed sacred or important. Participants opted-in to these interviews when completing a survey from another study. Thematic analysis of transcribed interviews was informed by grounded theory.

Results: Twenty-one participants (9 males; median age 70 years; 19 with advanced cancer) included people from Christian (17), Jewish (2), and no religious (2) backgrounds. Four themes emerged: “spirituality without borders”, that is, spirituality is interpretive; pastoral care is flexible needed to relieve burden and affirm faith; “above and beyond” staff qualities affirm personhood; and material spiritual care, that is, organizational qualities can affirm or detract from that which is valued. There were mixed views on whether doctors and nurses should ask about patients’ spiritual wellbeing. Helpfulness of the “spirituality” term was questioned given its association with religion.

Conclusion: Palliative care inpatients yearn to feel thought about, understood, and responded to. This basic need for human connection is satisfied at multiple interconnected levels: generalist staff, expert pastoral staff, and the material organisation. In a “spiritualized organizational culture” the hospitality of palliative care provides a response to individuals’ pain, confusion, and appeal for understanding. Aligning spirituality with hospitality in palliative care may assist engagement with pastoral/spiritual care. The potential of hospital design environments to promote spiritual well-being also warrants further attention.

Reference

Abstract number: P239
Abstract type: Poster presentation

An Overview on Spiritual Care: Perceptions of Nurses
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Background: Spirituality is an important part of human life dimension. Previous research highlighted that health care providers must recognize the importance of spirituality in the context of illness. However, little is known about the knowledge of healthcare providers in this topic.

Aim: To analyze the perception of Portuguese nurses about spirituality and spiritual care in healthcare settings.

Method: A quantitative, cross-sectional, exploratory and descriptive study was conducted. The Portuguese version of the Spirituality and Spiritual Care Rating Scale was used. The instrument comprises 17 items organized in 4 domains: Spirituality, Spiritual care, Religiousity and Personalized Care (α=0.76). An intentional and non-probabilistic sample of nurses working in 13 Primary Care departments and 4 services of a Central Hospital in Portugal (Pneumology, Internal Medicine, Intensive Care and Oncology) was composed. Inclusion criteria were: to have a nursing diploma and been working as a nurse for more than 6 months. Nurses who hold positions of leadership were excluded. Data were analyzed using descriptive statistics (SPSS), version 22 for Windows. The research project was approved by the Ethics Committee of both institutions (Central Hospital and Primary Care).

Results: Participants (n=180; 88.90% female; mean age=33.50 years; Mean of working time=12.08 years) struggle to define the concept of spirituality. Most (88.30%) recognize the importance of theoretical education and practical training both on spirituality and spiritual care, and 58.90% believe that spiritual care should be provided by all those who are involved in patient care. Thus, 58.90% of nurses states that their training in spirituality is insufficient, and 58.30% defends that spirituality should be addressed within the undergraduate nursing curricula. Nevertheless, 92.30% of nurses associate the provision of spiritual care with the provision of religious care and 25.00% are not sure if forgiveness is related to spirituality. Most (88.90%) recognize the importance of theoretical education and practical training both on spirituality and spiritual care, and 58.90% believe that spiritual care should be provided by all those who are involved in patient care. Thus, 58.90% of nurses states that their training in spirituality is insufficient, and 58.30% defends that spirituality should be addressed within the undergraduate nursing curricula. Nevertheless, 92.30% of nurses associate the provision of spiritual care with the provision of religious care and 25.00% are not sure if forgiveness is related to spirituality.

Conclusions: The lack of training and time to provide spiritual care are limiting factors to the implementation and provision of spiritual care. However, spirituality is recognized as an important part of human life dimension that should be valued and focused on clinical practice. The training was indicated as fundamental to reverse this situation and give a new impetus to the development of spiritual care in Portugal.
Factors Associated with Religiosity and Spiritual Well-being in Advanced Cancer Inpatients of Palliative Care Units in a Multi-religious Country

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Background: Spiritual well-being (SWB) is an important but less investigated topic in palliative care research. Spirituality is understood as a more comprehensive concept including religiosity. South Korea is a multi-religious country where Protestants, Catholics, and Buddhists have a relatively even distribution. Therefore, the aim of this study is to investigate factors associated with religiosity and SWB of advanced cancer inpatients admitted to palliative care units (PCUs) in South Korea.

Methods: This study was a cross-sectional, multicenter study. Patients were all Korean with far advanced cancer and admitted to 7 PCUs. We collected data on basic clinicodemographic characteristics, factors related to religion (meaningful religious events, religious activities such as attending worship, individual spiritual activities such as prayer/meditation), overall quality of life (QOL) and SWB. SWB was measured using Functional Assessment of Chronic Illness Therapy-Spirituality 12 (FACT-Sp 12). QOL was assessed using European Organization for Research and Treatment of Cancer Quality of Life Questionnaire Core 15 for Palliative Care. Multiple regression analyses were performed to find significant factors related to religiosity and SWB.

Results: A total of 202 patients were included for final analysis. Forty-two patients (20.6%) did not have any religion. Protestants, Catholics, and Buddhists accounted for 33.8%, 23.5%, and 20.6% of all subjects, respectively. There were no significant differences in basic clinicodemographic characteristics according to religion. Multivariate analyses showed that individual spiritual activities, QOL, having religion, and age were significantly related to SWB assessed by total score of FACT-Sp 12. Frequency of individually related to SWB. On the contrary, age was negatively associated with SWB.

Conclusion: Our study findings reveal that significant factors related to SWB were having religion, individual spiritual activities, QOL, and age. Our study shows that a multidisciplinary team could support SWB through encouraging individual spiritual activities of palliative patients.

The Practice of Spiritual Care at the End of Life: Experiences of Spiritual Caregivers

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Background/aims: Spiritual care is considered vital in palliative care. However, little is known about the practice of spiritual care. In this study we describe the practice of spiritual care in the primary care setting by analysing case descriptions from the perspective of spiritual caregivers.

Methods: Online survey filled in by 31 spiritual caregivers in which they described a recent case in which they were involved using mainly open questions about the case, including what went well and what could have gone better. The open answers were coded by the researchers using thematic coding focusing on type of care given and conditions for providing good spiritual care.

Results: Mean age of described patients was 72 years, most were diagnosed with cancer (24/31) and half of the patients remained at home in their final three months (15/31). Spiritual caregivers offered guidance in issues of various nature: existential (18/31) as well as relational (13/31), religious (8/31) and psychological issues (6/31) were described. Frequently mentioned aspects of provided spiritual care included spiritual counselling conversations (20/31), helping to find closure, acceptance or reconciliation (11/31), and performing rites or rituals (6/31). Spiritual caregivers indicated that, beside spiritual issues, they discussed other end-of-life topics with the patient, such as life expectancy, continuing or forgoing treatment and preferred place of death. Important conditions for providing good spiritual care included good communication with the patient or other health care providers (14/31), establishing a relationship of trust (7/31) and proper ‘dosage’ of care (5/31). In a broader sense, spiritual caregivers indicated that timely involvement (4/31) and systematic funding in the primary care setting (4/31) are also essential for providing adequate spiritual care.

Conclusion: Spiritual care is broader than just religious counselling. Spiritual caregivers offer guidance in many existential issues patient deal with at the end of one’s life. Moreover, they discuss many end-of-life topics beside spiritual issues with the patient. Main conditions for providing good spiritual care are good communication with all people involved and a relationship of trust between spiritual caregiver and patient.

A National Evidence Based Guideline Spiritual Care in Palliative Care

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Background/aims: Despite increasingly robust research into the spiritual dimension of palliative care, many caregivers are still uncertain how to give good care in this area. The development of a national evidence based guideline spiritual care for physicians and nurses was undertaken in order to improve the delivery of spiritual care.

Methods: A working group consisting of health care professionals, volunteers and patients with mandates from different organizations (n=11) was formed, and a survey on the functioning of an existing consensus based guideline was conducted among professionals (n=171) and patients (n=103). Based on the results of the survey, existing guidelines and group discussions 15 key questions for spiritual care were identified. On two key questions a systematic review was done:

(a) what interventions lead to a better quality of life among palliative care patients? and
(b) how can a spiritual care crisis be identified?

On other questions narrative reviews were done. The guideline was commented upon and authorized by different professional organizations.

Results: An evidence based guideline on spiritual care in palliative care consisting of 15 questions with answers with different levels of evidence, authorized by a number of professional organizations.
Conclusions: Developing an evidence based guideline on spiritual care is difficult because there is hardly research available that meets the criteria of evidence based medicine and there are many conceptual issues like disagreement about definitions due to the culturally sensitive nature of spiritual care. Nevertheless it is of high importance to develop a guideline in this area, which is transparent with regard to the amount of evidence that supports various elements of spiritual care, and is authorized by different professional organizations in order to promote use of the guideline in practice and increase scientific knowledge about the state of the art on this topic.

Abstract number: P244
Abstract type: Poster presentation

Nurse-led information intervention improves satisfaction with the quality of end-of-life decision-making for seriously ill patients’ family caregivers.

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Background: Families of seriously ill patients frequently participate in decision making for their relative. Yet, information provided by healthcare team often is incomplete and difficult to comprehend, leading to stresses and difficulties inherent in proxy decision making. Objectives and methods: This quality improvement study evaluates the effectiveness of a nurse-led information intervention in improving family satisfaction with the quality of seriously ill patients’ care. Intervention includes providing information by using question prompt lists to facilitate communication between families and healthcare team. Study subjects were a convenience sample of 30 family members of seriously ill patients (APACHE II scores>20, stage 4 cancer, or KPS scores< 30%). Family satisfaction was measured by the Family Satisfaction with Care in the Intensive Care Unit questionnaire (range: 0-100).

Results: Before intervention being provided, family members reported low frequency of communication with their healthcare team, great difficulties in getting information, information provided being incomplete, and lack of understanding of information. They perceived insufficient time in decision making, and lack of control over unsatisfaction with patient care. After receiving the intervention, family satisfaction improved significantly as shown by the increasing scores: emotional support (10.17 [95% CI, 2.54-17.80]), ease of getting information (7.67 [95% CI, 0.59-14.74]), understanding of information (7.67 [95% CI, 2.01-13.33]), honesty of information (8.50 [95% CI, 2.42-14.58]), completeness of information (8.50 [95% CI, 1.50-15.50]), frequency of nursing communication (8.50 [95% CI, 1.94-15.06]), and more time for decision making (23.33 [95% CI, 4.51-42.15]) after adjusting the increased scores in the unmodifiable “environment” domain.

Conclusions: The nurse-led information intervention facilitates communication and improves family satisfaction with seriously ill patients’ care.

Abstract number: P245
Abstract type: Poster presentation

US Listening behind Closed Doors: Shared Decision Making between Hospice Nurses and Cancer Patients and Caregivers

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Background: The philosophy behind Hospice care recognizes the patient and family as a unit of care and embraces their role in decision making. Research has primarily focused on physician and patient decision making yet, in US home hospices, most decisions made at the end of life are between nurses and patients, and family members. The majority of US hospice care is delivered in patient homes and little is known about these interactions. The goal of this study was to evaluate the shared decisions within the home environment between hospice nurses and patients/family.
Methods: A secondary qualitative analysis of audio recordings of visits by 65 home hospice nurses to cancer patients in 11 hospice programs was conducted. Recordings were transcribed and coded by two team members using a pre-established nine element model of shared decision making. Elements of the model included: Defining a problem and options, discussing risks and benefits, focusing on how the options relate to patient values, the patient’s or family member’s ability to follow through, the provider’s recommendation, clarification of the understanding of options, and a follow-up plan.

Results: Hospice nurses worked with families on an average of four problems in a mean visit time of 30 minutes. The hospice nurses used all the 9 recommended elements of shared decision making during home visits with patients and families however, not all elements were used in every visit. The most commonly used element was defining a problem, and the least used element was the assessment of patient and family understanding of options.

Conclusions: Decision making for those enrolled in hospice occurs between nurses and patients/families. While ultimately responsible for the decisions that are made, physicians have limited interaction with the patient and family in their natural setting. Hospice nurses on the other hand, experience the impact of decisions in the environment in which they are implemented. Hospice nurses are the physician’s eyes and ears behind the closed doors of the home and can be valuable partners as they work with families on critical decisions several times each week.

Abstract number: P246
Abstract type: Poster presentation

Exploring Family Communication Following the Loss of a Parent to Cancer
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Research aim: Effective family communication between the child and the surviving parent is an important protective factor for children’s psychological well-being following the loss of a parent. The aim of this study was to explore family communication in parentally bereaved families.

Study population: Participants included 1 father, 4 mothers and five children, 3 girls and 2 boys (ages 6-21) from five parentally bereaved families who were recruited through two palliative care centers in Stockholm, Sweden.

Study design and methods: A total of nine interviews were conducted, transcribed and analyzed using inductive content analysis. Interviews were conducted between four and fourteen months following the parent’s death.

Results and interpretation: The analysis resulted in four categories: prioritizing family communication, adjusting communication to new circumstances, meeting the needs of family members through verbal and non-verbal communication, and glorifying the deceased parent through daily communication. The results of this study show that the death of a parent may affect various aspects of family communication in different ways for parents and children. Parents struggled with a changed self-identity and lack of time or energy for prioritizing communication with their children. Children exaggerated positive memories of their deceased parent and attempted to avoid negative thoughts and feelings while using non-verbal communication to get their needs met.

Conclusion: Family communication is a central to daily life in parentally bereaved families. Professionals working with parentally bereaved families need to be aware of the importance of family communication in order to provide adequate support.

Funding
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Abstract type: Poster presentation

Information Needs about Palliative Care and Euthanasia: A Survey of Patients in Different Phases of their Cancer Trajectory
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Background/aim: Timely palliative care and advance care planning, including conversations about possible end-of-life decisions, improve the quality of life and quality of dying of people with cancer. Therefore, we assessed whether people with cancer receive timely and sufficient information about their illness course, treatments, palliative care and euthanasia. We also investigated whether the information provision and information needs differ according to socio-demographic and clinical factors, such as phase in the illness trajectory.

Methods: Cancer patients consulting a university hospital (N = 620) filled out a questionnaire at one time. Their cancer related data were collected through the treating oncologist. This study is performed in Belgium, where “palliative care for all” is a patient’s right embedded in the law and euthanasia is possible under certain conditions.

Results: Around 80% received information about their illness course and their treatments. Information about palliative care (12%) and euthanasia (6%) was less often provided by caregivers. Most information about palliative care and euthanasia was given when the patient had a life expectancy of less than six months or when no more life-prolonging treatments were available. However, a quarter of those in earlier phases in their illness trajectory, particularly those who experienced high pain, fatigue or nausea requested more information on these topics. We also found that 17% of the respondents wanted less information than they received now and that 23% of the items about palliative care and euthanasia were missing, while they did answer the items about illness course and treatment.

Conclusion: Many patients want more information about palliative care and euthanasia than what is currently provided, also those in an earlier than terminal phase of their disease. Healthcare professionals should be more responsive, already from diagnosis, to the information needs about palliative care and possible end-of-life decisions. This should be patient-tailored, as some patients want more and some patients want less information. A training about how physicians can explore their patients’ information needs. At the same time, leaflets, information sessions and websites about palliative care and possible end-of-life decisions should be developed to reach a large group of patients and their family-independant from the phase in the illness trajectory.

Abstract number: P248
Abstract type: Poster presentation

Communication between Healthcare Professionals and Relatives of Patients Approaching the End of Life: A Qualitative Systematic Review
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Background: As a patient approaches the end of life, clear communication with relatives is required to make appropriate decisions and ensure a good death. To improve this communication, it is important to understand how it is currently done. This review aims to understand how communication occurs between healthcare professionals (HCPs) and relatives of patients who are approaching the end of life.

Method: Qualitative systematic review. Electronic databases (PsycINFO, CINAHL Plus, MEDLINE and EMBASE) were searched and studies included if they used qualitative methods to explore communication between HCPs and adult relatives of patients approaching the end of life. Papers were excluded if the main aims were: communication with patients or other HCPs, communication about assisted dying or organ donation, hypothetical communication, or intervention studies. Findings are being aggregated using a descriptive narrative approach.

Results: 3615 records were identified from the electronic database search. Following removal of duplicates, 1886 were screened by title and abstract. 22/50 full text articles were included in the review and a further 4 were identified from hand-searches of reference lists. Initial findings suggest varied strategies for communication with relatives near the end of life. Clinicians used staged disclosure and repetition to improve relatives’ understanding. Highlighting the patient’s deterioration and invoking the patient’s wishes were used to justify difficult decisions. Levels of family involvement in decision making varied across studies. Nurses acted as family advocates and interpreters of medical language.

Conclusion: Preliminary results identify current practices in end of life communication with relatives and how they vary across settings. Strategies for involving families in decision making without causing distress or burden are discussed. Few studies have examined communication with families in hospice settings; this is suggested as an area for future research.

Funding
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Abstract number: P249
Abstract type: Poster presentation

“Do I Wish to Know It All?” A Qualitative Study on Malignant Brain Tumor Patients’ Perspectives on Information on Diagnosis, Prognosis and Treatment Options
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Research aims: Due to the fast development in prognostic biomarkers and personalized medicine, also for patients with malignant brain tumors, the possibility to individualize treatment options or identify lack of those, and to prognosticate survival times is expected to increase in the future. How much of this information that is desired by patients and how the health care should provide this is not known. This study aims to examine how patients, diagnosed with a life threatening brain tumor, express that they would like to receive information, even if very negative. We also inquired about their preference in participating in the treatment decision-making process.

Study design and methods: Ten women and fifteen men with newly diagnosed WHO grade 2-4 glioma (age 25-76 years old) and recently having own experience from being given information about their disease, prognosis and treatment options, were interviewed. The interviews are being analyzed by qualitative content analyses without predefined categories.

Results and interpretation: Preliminary data show that informants have different perspectives on how they want to be given information. Some prefer full information on diagnosis and prognosis, even if very desolate, in order to be able to make autonomous choices and plan for the end of their life. Others express a wish to remain in the state of hope, and therefore prefer not being given full information. Many patients express criticism towards the health care system based on their personal experience from not being informed of their diagnosis at an individual consultation with a physician. Some have overheard clinicians’ discussions in the corridor or accidentally read their own electronic medical record online. Patients express that shared decision-making regarding treatment choices is good in theory, but difficult in real life. This is due to the need for expert knowledge for therapeutic decisions. Their own experience has mostly been to just accept decisions already made by their physicians. Deeper analysis is still ongoing and more detailed results will be presented.

Conclusion: There still seem to be needs to develop better routines on consultations regarding disease and treatment discussions. The study identifies that individualized information should be given to patients; one size does not fit all, and some prefer to not know it all.

Funding
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Abstract number: P250
Abstract type: Poster presentation

Quality of Information Transfer and Collaboration in Palliative Care: A Survey Study on the Perspective of Nurses in the South West Region of the Netherlands
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Research aims: Palliative care at the end of life is often provided by health care providers from different disciplines and different settings. Continuity in such care is therefore a challenge. The aim of this study was to get insight in the quality of information transfer and collaboration in palliative care from the perspective of nurses.

Study design and methods: We performed a cross-sectional regional survey study among nurses working in different settings. Nurses were recruited for participation via professional networks and media. Respondents were asked questions about the last deceased patient they had cared for and about collaboration in palliative care in general.

Results: A total of 1002 nurses filled in the questionnaire. Symptoms burden for the last patient they had cared for was perceived as high. Half of the nurses received a handover of information upon the transfer of this patient into their care, once (40%) or more than once (10%). Of those who did, 42% were very satisfied about the information, 47% were reasonably satisfied and 11% were not satisfied. In 34% of the cases the nurse had missed necessary information. 776 nurses answered general questions about collaboration in palliative care. 49% regularly participated in meetings to discuss patient care within their own organisation, but only 16% participated in meetings with other care organisations. Nurses considered collaboration with professionals from other organisations in palliative care as very (76%) or moderately important (16%). A minority often (35%) or always (12%) actively search for such collaboration.

Conclusions: Nurses reported that the symptom burden of patients who are transferred to their care setting in the last months of life is high. The quality of information handover is not optimal and structural collaboration between settings in palliative care can be improved. Our study was funded by The Netherlands Organisation for Health Research and Development (ZonMW).
Abstract number: P251
Abstract type: Poster presentation

How Should Clinicians Explain about the Impending Death of Cancer Patients to the Family? A Nationwide Survey of Bereaved Family Members

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Background/aims: Explanation about the impending death of imminently dying cancer patients is important for their families. However, little is known about how clinicians explain impending death, and how families perceive the explanation. We aimed to clarify bereaved families' perception of the need for improvements in the explanation about impending death, and to explore the factors contributing to the need.

Methods: In a nationwide survey of 818 bereaved families of cancer patients admitted to 71 inpatient hospices in Japan, we surveyed families' experiences of the explanation about impending death, and the need for improvements in the explanation.

Results: In total, 35 (6.8%), 123 (24%), and 297 (58%) families felt that much/considerable, some, and no improvements were needed, respectively. Independent determinants of the need were a younger patient age (OR=0.97; 95%CI=0.95-0.99; p=0.009); not receiving an ‘explicit explanation about physical signs of impending death’ (OR=0.67; 95%CI=0.51-0.88; p=0.004); not receiving an ‘explanation of how long the patient and family could talk’ (OR=0.67; 95%CI=0.51-0.88; p<0.001); receiving an ‘excessive warning of impending death’ (OR=1.45; 95%CI=1.03-2.03; p=0.033); and having a feeling of ‘uncertainty caused by vague explanations about future changes’ (OR=1.77; 95%CI=1.38-2.27; p<0.001).

Conclusions: Nearly a third of the bereaved families perceived some need to improve the explanation about impending death. To better help patients and their families prepare for their end-of-life, clinicians should recognize and explain various impending death signs; find a balance between detailed explanation and excessive warning; and address how long they could talk in the remaining time.

Abstract number: P252
Abstract type: Poster presentation

Achieving Communication Equity for Minority Populations Considering Hospice

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Aims: This project evaluates the interaction between minority populations considering hospice and the hospice admission team in order to identify best practices and opportunities for improvement.

Study population: The local hospice where the data were collected is a large, urban, non-profit organization in the United States. Observations between patients, caregivers and hospice admission nurses took place in the home, skilled nursing facilities and in the hospital. Observations lasted between 30 minutes and 2 hours. To ensure a diverse sample, participants included: African Americans, gay, straight, married, widowed, Latino, undocumented, Russian, Caucasian, tribal, homeless, religious and non-religious (n=30).

Study design and methods: The first author conducted nonparticipant observations of hospice admission visits. Additionally, the first author attended hospice admission monthly staff meeting where “defining best practices,” was a standing agenda item (n=3). Ethnographic field notes were written and typed single-spaced for a total of 300 pages. Interviews and ethnographic field notes were transcribed verbatim and analyzed using thematic discourse analysis with an inductive, data-driven approach. Each observed admission conversation was broken down and coded, allowing the team to establish a pattern for the whole by relating codes/categories to one another.

Results and interpretation: Results highlight divergent expectations, understandings and perceptions of hospice care. Patients and caregivers are often on different pages when they enter the admission consult and struggle to find concordance, a point of commonality between individuals’ purposes, concerns and circumstances. Further, stress permeates these interactions. Patients are often too sick and fatigued to participate or do not want to hear the word “hospice”; overburdened caregivers fear choosing hospice means they are giving up on their loved one; admission nurses struggle to deliver complex information that meets the needs and preferences of minority individuals; hospice organizations face tensions between supporting informed decisions and maintaining admission numbers; and inconsistencies exist in explaining the benefits that patients and caregivers will receive if they choose hospice. Finding concordance from the outset is integral to facilitating a meaningful interaction around hospice care for minority populations.

Abstract number: P253
Abstract type: Poster presentation

Communication as a Key in Creating Dignified Encounters in Unexpected Sudden Death by Stroke

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Background: Communication is present in all encounters in care and of importance to create a caring relation. A good relation between patients, next of kin and health care staff is crucial, not least in times of rapid changes in health and when questions about life and death are at stake such as in palliative care.

Aims: The aim of this study was to illuminate communication and its meaning in unexpected sudden death with stroke as example, as experienced by next of kin and stroke team members.

Methods: The design of the study is a secondary analysis of qualitative data as proposed by Heaton, from a project on unexpected sudden death by stroke. Material from four interview studies from the project with all in all twelve next of kin of patients who had died due to the acute stroke during hospital stay and twenty-seven stroke team members from stroke units were utilized. Data were analysed with qualitative content analysis according to Krippendorf and Baxter.

Results: The analysis reveals communication as the foundation for care and caring. The overarching theme foundation for dignified encounters in care is built up by six themes illuminating the meaning of communication in unexpected sudden death by stroke; creating relationship, information enabling understanding, giving ground for unanimity, personalizing the patient, preconditioning for decisions and giving and experiencing support.

Conclusions: Communication and its meaning in unexpected sudden death as experienced by next of kin and stroke team members enables dignified encounters in care. Through the next of kin knowledge about the severely ill patient, possibility to preserve and uphold absolute dignity and dignity of identity is given, expressed through respect for the patient’s will and desire and derived through talks between carers and next of kin. Communication is one key to create dignified encounters in palliative care when unexpected sudden death occurs. It gives ground for unanimity about care and possibility to maintain and uphold dignity in care when acknowledging the next of kin familiarity with the patient. This gives ground for a person centeredness in palliative care despite the patients sever illness.
Abstract number: P254
Abstract type: Poster presentation

Development of a Frailty-focused Communication Aid for Older Adults
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Background: Frailty is poorly understood by the public-at-large, yet is the primary predictor of poor outcomes and death in older adults. Uncertainty in how to communicate frailty may be a barrier to healthcare decision-making and advance care planning.

Aim: To develop a tool that facilitates communication with older adults about frailty that: 1) advances understanding about frailty, and 2) offers a plan to improve quality of life related to aging and frailty.

Population/sample: 106 community-dwelling older adults

Methods: Following International Patient Decision Aid Standard (IPDAS) guidelines, we collaborated with experts to establish scope and purpose for a frailty-focused communication (FFC) aid. We held two community engagement studios to develop content of the FFC aid. Next, we held presentations with older adults (N=106) in 8 community sites to: establish face validity, determine perceptions of FFC content, and assess likelihood to influence a desire to set health-related goals.

Results: The FFC aid includes 4 components:
1) Fall statistics,
2) Frailty & 1-year outcomes,
3) Why do we become frail?,
4) Making a plan (8 potential focus areas: safety, physical activity, nutrition, relationships, sleep, finances, mind/body health, healthcare decision making).

Participant demographics: Mean age: 74.6 (SD 7.2), females: 75%, Caucasian: 74%, and income < $25,000/yr: 55%. Percentage of respondents at sites: senior centers (38%), churches (26%), YMCA (4%), low income housing (22%), and library (11%). Likelihood of making a plan related to aging/frailty are shown in table.

| How much did the information make you want to make a plan for aging well and managing frailty? |
|---------------------------------|---------|-----------|-------------|
| 65 to 74 | 75 to 84 | 85+ (N=7) | TOTAL (N=101) |
| (59%) | (34%) | (7%) | (N=60) | (N=34) | (N=1) | |
| Not at all: Will not change my routine | 2 (2%) | 1 (1%) | 0 (0%) | 3 (3%) |
| Thinking about changing my routine | 7 (7%) | 4 (4%) | 0 (0%) | 11 (11%) |
| Will probably change my routine | 11 (11%) | 7 (7%) | 1 (1%) | 19 (19%) |
| Will definitely change my routine | 17 (17%) | 14 (14%) | 1 (1%) | 32 (32%) |
| Already doing all that I can | 23 (23%) | 8 (8%) | 5 (5%) | 36 (35%) |

[Frailty-Focused Communication Aid Feedback].

Ratings on personal importance of focus areas ranged from 3.33 to 3.74 (mean) (1=not important, 2=neutral, 3=important, 4=very important): safety (3.74), mind/body (3.66), nutrition (3.65), physical activity (3.63), healthcare decision-making (3.63), sleep (3.56), finances (3.33), and relationships (3.33).

Conclusion: The FFC aid may be a beneficial tool to support healthcare decision-making related to frailty in older adults.

Abstract number: P255
Abstract type: Poster presentation

Information Provision as Evaluated by Cancer Patients and Bereaved Relatives: A Cross-sectional Survey in 34 Palliative Care Services
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Background: Adequate information provision is essential to help people make informed healthcare decisions. Palliative care services (PCS) aim to provide tailored care to people with advanced illness and their families. This study explores how cancer patients receiving PCS and their relatives evaluate information provision, and how this relates to age, gender, length of guidance, and type of PCS.

Methods: A cross-sectional survey design was used. Questionnaires containing items on information provision were administered during 4 measurement periods between November 2014 and May 2016 within 34 PCS: 4 mobile palliative home care teams (HCT), 17 hospital palliative care units (PCU), and 13 hospital mobile palliative support teams (PST) in Flanders, Belgium. Data on diagnosis, age, gender, and referral to PCS were collected by a checklist. Two respondent groups were studied:
1) cancer patients being guided by PCS at the time of the measurement;
2) relatives of cancer patients who died under care of PCS.

Associations were examined using multivariable logistic regression models.

Results: In total, 628 patients (80%) and 980 relatives (55%) responded. The vast majority of both were satisfied with the amount of information received about the illness and care. Information provision was strongly related to type of PCS. Compared to those receiving care from a PCU, PST recipients more likely received less than necessary information about end-of-life care and information that was conflicting or not explained understandably, and were less likely to always be able to co-decide about care to have all of their caregivers take their wishes into account. HCT recipients were more likely than PCU recipients to always be able to co-decide, but less likely to have all of their caregivers respect their wishes. Compared to relatives of PCS recipients, those of PST recipients more likely received less than necessary information about the patient’s condition, treatment, and impending death. Relatives of HCT recipients more likely received more than necessary information about the condition, and either less or more than necessary information about the imminent death.

Conclusion: Information provision is generally evaluated positively by cancer patients and relatives, which is not surprising in a specialized palliative care context. Within this context, however, the type of PC service is important. Communication seems to be better organized in PC units compared to other PC services.

Abstract number: P256
Abstract type: Poster presentation

Experiences with and Outcomes of Advance Care Planning in Bereaved Relatives of Frail Older People: A Mixed Methods Study
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Background/aims: Advance Care Planning (ACP) enables individuals to define goals and preferences for future medical treatment and care, and to discuss these with family and healthcare providers. This study aims to investigate (1) how bereaved relatives of frail older people experience ACP conversations and (2) whether ACP has an effect on relatives’ satisfaction with healthcare, involvement in end-of-life decision making, satisfaction with quality of death and levels of anxiety/depression.

Methods: We randomised 16 residential care homes to either the ACP intervention or the control group. If participants had died, we approached relatives for a telephone interview including open-ended questions about ACP conversations and a validated tool to assess levels of anxiety/depression (HADS, range: 0-21 for each subscale).

Results: We conducted interviews with 20 bereaved relatives from the intervention group and 19 bereaved relatives from the control group. Most interviewees (79%) were children of the deceased. Five relatives considered ACP less necessary since they were already aware of their loved ones’ preferences. On the other hand, several relatives described the conversations as pleasant and/or useful. Relatives in the intervention group more often had felt adequately prepared for end of life decision making than controls (90% vs. 46%, respectively, p<0.03). Relatives’ satisfaction with healthcare and quality of death, and levels of anxiety (mean intervention: 5.1 vs. control: 5.8) and depression (mean intervention: 1.9 vs. control: 2.9) did not differ between the groups.

Conclusions: Most relatives had positive experiences about ACP and felt adequately prepared for end-of-life decision-making. ACP had no effect on levels of satisfaction, anxiety and depression.

Main study funder: ZonMw.

Abstract number: P257
Abstract type: Poster presentation

How Do Nursing Home Residents Experience an Advance Care Planning (ACP) Conversation?: A Three-country European Qualitative Study (PACE)

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Background: The PACE project studies the impact of the ‘PACE Steps to Success’ intervention, which aimed to enhance palliative care in nursing homes. The first step of this intervention concerns ACP conversations by means of a ‘Looking and Thinking Ahead’ document. Our study set out to explore residents’ experiences about these ACP conversations.

Methods: A qualitative interview design was adopted. Transcripts were analysed using thematic analysis. Participants were recruited in three out of six participating countries: Belgium, Italy and The Netherlands. Following ACP conversations, PACE coordinators invited residents to take part in the study. Interviews were undertaken by junior researchers skilled in psychology (CM), palliative nursing (MT) and health sciences (MK). Interviewers had no previous relationship with the participants. Interviewers were coached and trained by an experienced qualitative researcher (LHV). Data were collected between November 2016-February 2017. The interview guide consisted of reflective and open-ended questions. Validity of data collection was enhanced by peer review of the interview style. To achieve credibility and confirmability, investigator triangulation was realized.

Results: 27 residents (77 % female, mean 83 years old, range 55-95 years old) were interviewed (14 in Belgium, 11 in Italy and 2 in the Netherlands). Interviews had a mean duration of 23 minutes (ranging from 6-50 minutes). Recruiting was difficult as many residents indicated that they didn’t remember the content of the ACP conversation despite the short time elapse. Most participants reported the ACP conversation not to be upsetting in a negative sense, but the discussion made them feel emotional. Participants indicated that there was little room for reflections on the impact of questions during or after the conversation. Some felt ill-prepared and blindsided as the conversation was not always introduced properly. Most participants regarded a one-off conversation as sufficient as their preferences were quite fixed. Some participants were worried about the logistics whether the documentation would be accessible when required.

Conclusions: Our findings underpin the importance of (1) proper introduction of ACP, (2) checking the impact of questions both during and after the conversation and (3) making sure that documents are accessible for all care providers.

Funding
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Abstract number: P258
Abstract type: Poster presentation

Accurate Prognostic Awareness and Preference States Influence the Concordance between Terminally Ill Cancer Patients’ States of Preferred and Actual Life-sustaining Treatments in the Last 6 Months of Life

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Background/purpose: Factors facilitating/hindering concordance between preferred and actual life-sustaining treatments (LSTs) may be distorted if preferences and predictors are measured long before death. We longitudinally examined factors facilitating/hindering concordance between terminally ill cancer patients’ preferred and actual LST states in their last 6 months.

Methods: States of preferred and actual LSTs (cardio-pulmonary resuscitation, intensive care unit care, cardiac massage, intubation with mechanical ventilation, intravenous nutritional support, and nasogastric tube feeding) were examined in 218 cancer patients’ last 6 months by a transition model with hidden Markov modeling. Multivariate logistic regression modeling was used to examine factors facilitating/hindering concordance between preferred and actual LST states.

Results: Concordance between preferred and actual LST states was poor (40.8%, kappa value [95% confidence interval]: 0.05 [-0.03, 0.14]). Patients who accurately understood their prognosis and uniformly rejected LSTs were significantly more likely to receive their preferred LSTs at EOL than those who did not know their prognosis but wanted to know, those who were uniformly uncertain about what LSTs they preferred to receive, and those who favored nutritional support but declined other LSTs. Patient age, physician-patient EOL-care discussions, physical symptom distress, and functional dependence were not associated with concordance between preferred and actual LST states.

Conclusions: Prognostic awareness and LST-preference states were significantly associated with concordance between preferred and actual LST states. Personalized interventions should be developed to cultivate terminally ill cancer patients’ accurate prognostic awareness, allowing them to
formulate realistic LST preferences and facilitating their receiving value-concordant EOL care.

Abstract number: P259
Abstract type: Poster presentation
The Role of the Memory Service in Helping Family Carers Prepare for End of Life
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Background and aim: The European Association of Palliative Care (EAPC) White Paper on end of life care for people with dementia recommends educating families on the terminal and progressive nature of dementia and advance care planning start when the person still has capacity. Memory services may have a role in these discussions. This study aimed to explore the views from memory service clinicians about the role of memory services in raising these discussions.

Study design: Forty-four accredited UK memory services responded to an online survey (51%) and a further 12 clinicians from three services took part in semi-structured interviews. Analysis: Descriptive statistics were used to analyse quantitative survey data. Qualitative interview data was thematically analysed using NVivo software.

Results: National Institute for Health and Care Excellence (NICE) guidelines on end of life dementia care were strongly endorsed, however, there was less consensus regarding the more recent EAPC recommendations. Ten percent of respondents disagreed and 23% neither agreed or disagreed that advance care planning should start as soon as diagnosis and 54% agreed that professionals should discuss the terminal nature of dementia. Respondents distinguished between using the terms ‘progressive’ and ‘terminal’ with most services verbally discussing the progressive nature of dementia with all patients (84%) and carers (86%), but only 32% and 36% discussing dementia as a terminal illness with all patients and carers respectively. Clinicians encouraged people to live well with dementia and felt that indicating dementia was terminal was counterproductive. Limited resources prevented post-diagnostic follow-up that would enable these discussions. This research identified disparity between clinical staff and policy perceptions of best practice and further research should investigate the views of people with dementia and their carers.

Kirsten Moore is funded by an Alzheimer’s Society fellowship.

Abstract number: P260
Abstract type: Poster presentation
Advance Care Planning in ALS Patients
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Introduction: It is recommended to initiate advance care planning (ACP) with patients with an advanced disease. However, health professionals and patients are reluctant to discuss end of life matters and to determine the right time for a discussion may be difficult.

Aims: To determine if ACP is initiated with ALS patients, and how, during a routine palliative care consultation.

Methods: Retrospective chart review of all the ALS patients followed between January 2014 and December 2016 at a specialized center in the Geneva University Hospitals. Patients are seen every 3 months for a one-hour multidisciplinary assessment including palliative care.

Results: 48 patients were included, half of them were men. Mean age was 68 years. Diagnosis was bulbar ALS for a third of patients (n=16) and non bulbar ALS for 44.6% (n=21). Nearly half of the patients (45.8%) died during the follow-up. Mean number of consultations per patient was 2.8 (median 3.5). ACP was discussed with 42 patients (87.5%) at the first consultation. Only 3 patients did not wish to initiate ACP. Half of the patients (n=25) wrote advance directives (AD) and 31 (64.6%) designated a health surrogate. A detailed discussion about future medical interventions took place with 33 patients (68.7%). A majority of AD (n=17; 68%) were completed with a form. Medical interventions were described in 15 AD. Most patients refused a cardiopulmonary resuscitation and an intubation and/or a tracheotomy. Among 10 patients, 1 agreed with artificial nutrition and 6 agreed if it was temporary. Topics discussed most frequently were intubation and tracheotomy (n=17; 51.5%), assisted suicide (n=13; 39.3%), and palliative sedation (n=8; 24.2%).

Conclusion: ACP can be initiated as soon as the first consultation with most ALS patients. A detailed discussion about goals of care and medical interventions is possible with most patients. The rate of completion of AD and designation of a surrogate is high. Palliative care teams have a major role in defining the future care for these patients.

End-of-Life Information Gatherings for Older People by the GP
Stimulate ACP Discussions: A Pre-post Evaluation Study
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Aims: To increase older peoples knowledge on (forgoing) options for care and treatment at the end of life and creating awareness of ACP discussions with their general practitioner (GP). GPs can organise end-of-life information gatherings for their older patients. Aims of our study were (a) to find out reasons for older people to attend such a meeting, and (b) whether attending a meeting resulted in ACP discussions with their GP afterwards.

Intervention
In 2016, 4 GP practices organised a gathering. They invited all patients registered in their practice of 75 years and older through an invitation letter. The gathering (of about 2 hours) started with a presentation on end-of-life topics and ACP by the GP followed by time for questions.

Design: A pre-post evaluation study using written questionnaires that were distributed and filled in at the start the gathering(pre) and sent 6 months after the gathering(post).

Study population: In total 225 older people (between 35 and 85 per practice) attended a gathering of which 154 (68%) filled in a pretest questionnaire. 90 of the 121 people who we could also send a post-test questionnaire, returned it (74%).

Results: Of the attendants 59% was female and 49% was 80 or older. Most important reasons for attending the gathering were ‘because I want to know more about the end-of-life’ (57%), and ‘because I also think about the end-of-life myself’ (52%). Six months after the gathering, compared to before the gathering, more older people had discussed (a) about a proxy decision maker with a physician (19% versus 8%; p=0.30) and with others (52% versus23%; p<0.001) (b) about their preference for resuscitation with a physician (22% versus 9%; p=0.017) and with others (48% versus 22%; p<0.001), and (c) about their preferences on treatments they (not) would want to receive under certain circumstances with their physician (18% versus 5%; p=0.011) and with others (36% versus 10%; p<0.001). For none of these topics there were changes in the extent to which they had written their preferences down before and after the gathering.

Conclusion: Our study shows that GPs inviting their patients for information gatherings on end-of-life care, do have a positive influence on the occurrence of ACP discussions, both with the physician and others, e.g. their family. Although, this method only reaches the older people that
already have some interest in the subject, this seems a relatively easy way to stimulate ACP discussions.

Abstract number: P262
Abstract type: Poster presentation

Advance Care Planning in Primary Care.

Do Older Persons Think and Talk about Preferences for Future Treatment?
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Aim: Advance Care Planning (ACP) is attracting more and more interest in primary care. However, ACP does not seem to have a systematic place in the care for community-dwelling older people. Our aim is to describe which options for future treatment older people think about, which treatment options are discussed with the GP and what are reasons not to engage in ACP.

Methods: Pre-implementation questionnaire among all persons of 75 years or older enlisted with ten GPs (n=2182, range 75 - 330) and two care homes (n=125, range 50 - 75). The questionnaire was send out between January 31 and March 16 2017, before structured implementation of ACP at those GP practices and care homes. The questionnaire was filled in by 1218 (53%) respondents. Frequencies and means were calculated to describe patient characteristics and which treatment options older people think about and discuss. At the EAPC conference full data will be available, for now we describe preliminary results (n = 470).

Results: The mean age was 81 years, and 46% was man. Most (57% - 63%) older persons have thought about future hospitalisation, admission to an intensive care unit, admission to a nursing home and treatments. Euthanasia (19%) en resuscitation (16%) are discussed with the GP the most. The most important reason not to engage in ACP is that next of kin know what the person wants (37%) and also, 37% of respondents have no objections against ACP.

Conclusion: Although a majority of persons aged 75 years or older think about future care, few conversations on preferred future care take place in primary care. Implementation of ACP is desirable and at this moment ongoing. After evaluation, in the summer of 2018 the ACP implementation materials (e.g. registration forms, manual) will be available for further implementation.

Funding
ZonMw

Abstract number: P263
Abstract type: Poster presentation

Advance Care Planning by Proxy: Insights from a Document Analysis Study in German Nursing Homes
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Background and aims: Advance care planning (ACP) is increasingly being implemented in the palliative care context. For the large group of palliative care patients who have lost their decision-making capacity, ACP is still needed and desired, but has to be conducted by legal proxies based on patient autonomy (ACP by proxy). In two studies on ACP in German nursing homes, we found advance care plans for residents completed by third parties. Our aim was to analyze these documents with regard to their form, content, and source of justification.

Study population: Nursing home residents without decision-making capacity in the German region of North Rhine-Westphalia.

Study design and methods: Systematic document analysis of advance care plans identified for nursing home residents. Anonymized copies of the documents were rated independently by three ACP experts, based on a theoretically defined set of criteria on form, content, and source of justification. Divergent ratings were discussed in an expert consensus process.

Statistical analysis: Interrater agreement was analysed using free-marginal multirater kappa statistics.

Results: In the two studies, the prevalence of advance care plans by proxy was 12.4% and 16.9% of residents. For most criteria there was high inter-rater reliability of kappa > 0.7. The large majority of the 46 analyzed documents (85%) were informal documents or chart notes, only 9% used official forms for advance directives. Only 17% were signed by a third party, most often by residents’ family surrogates. Only 4% of the documents were signed by a health care professional indicating professional information and joint planning. Explicit contents of the documents included most frequently “comfort care only” (52%), “no transfer to hospital” (67%), “no tube feeding” (37%). The preferences that were expressed in the documents were justified by the resident’s prior oral statements (30%), by the resident’s current behavior (43%) and 37% did not mention any source of justification for the decisions documented.

Interpretation: Despite the lack of a legal framework for ACP by proxy, health care professionals and patient surrogates in German nursing homes use advance care plans by proxy. Yet, they vary substantially in form and often lack crucial information necessary to apply them, especially the source of justification of the documented decisions. The study indicates the need for a standardized and explicit approach to ACP by proxy.

Abstract number: P264
Abstract type: Poster presentation

Content Analysis of the ACTION Advance Care Planning Document Completed by Patients with Advanced Cancer: Insights Gained from the ACTION Trial
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Background: Despite the promotion of Advance Directives (ADs) in many countries, the numbers remain low in daily practice. Advance Care Planning (ACP) can be effective in communication of the patient’s preferences and as such support the completion of ADs. In the ACTION trial, a Phase III multi-center cluster-randomised clinical trial in six European countries (BE, DK, IT, NL, SI, UK), lung- and colorectal
cancer patients are invited to take part in an adapted Respecting Choices (RC) ACP program. During one or two conversations with a trained facilitator about the patients’ wishes and preferences for future medical treatment and care, patients are encouraged to document these thoughts in a so-called My Preferences form. This form can provide useful information for healthcare professionals and relatives at the time of decision-making.

**Aim:** To get insight into the completion and content of the My Preferences forms by patients with advanced cancer.

**Method:** Proportion and characteristics of completed My Preferences forms are described. Content analysis of these forms was carried out, including a comparison between the participating countries.

**Result:** 439 patients had participated in the ACTION RC ACP program. By October 2017, 151 (34.4%) patients completed the My Preferences form, mainly during the ACTION RC ACP conversation (n=126). The percentage of completion per country was: 9.6% (UK), 21% (DK), 35.5% (BE), 43.8% (NL) 64.3% (SI) and 61.3% (IT). Content analysis of the My Preferences forms shows the importance of family and friends for patients to live well and the anxiety and fears about the course of their disease, pain or becoming dependent. Patients wrote down a variety of preferences for future care concerning resuscitation, goals of future treatment and their final place of care.

**Conclusion:** Whereas one third of the patients participating in the ACTION RC ACP program completed the My Preferences form, a large variation per country was seen. The completed My Preferences forms contain information about the patients’ fears, what is important to them and explicate their preferences.

**Abstract number:** P265

**Abstract type:** Poster presentation

**The Stability of End-of-Life Goals of Care of Patients with Advanced Cancer**

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**Background/aims:** Stability of patients’ end-of-life (EOL) goals of care has important implications for advance care planning and its timing. This is especially important for patients with advanced cancer, because many of them experience profound functional decline during the last six months of life, with poorly controlled severe pain and confusion, while their treatment often becomes increasingly aggressive, yet burdensome, in efforts to keep them alive. Using repeated, validated assessments of EOL goals of care in a clinical cohort of advanced cancer patients approaching death, we investigate the stability of patient end-of-life (EOL) goals of care and patient characteristics potentially influencing the stability or change in these goals.

**Methods:** Structured clinical interviews of 104 patients with metastatic, chemo-refractory cancer and a life-expectancy of < 6 months were conducted following a visit in which patients’ most recent results were discussed. Interviews were repeated with this sample for three consecutive monthly follow-up assessments. At each assessment patients reported their preferences for EOL care goals (i.e., life-extending vs comfort care). Physical functioning, and a wide range of clinically relevant correlates (e.g., age, race, gender, mental health) were also assessed. Comparative tests and a logistic regression procedure were performed.

**Results:** At baseline (N=104), 53% of patients preferred life-extending EOL care. EOL goals of care of 81% of patients remained stable within the first month, 11% changed to comfort care, 9% changed to life-extending care. The same pattern held after two- and three-month of follow-up. After three months 87% of patients remained stable with their baseline assessment (N=44). Baseline EOL goals of care strongly predicted those at month 1 in both unadjusted analysis (OR=17.8; CI=6.7, 46.3; p<.001) and those adjusted for quality of life (AOR=18.5; CI=6.7, 50.9; p<.001).

**Conclusions:** Most advanced cancer patients have stable EOL goals of care regarding comfort versus life-extending EOL care in the months prior to their death. Clinical implications suggest that earlier documentation of EOL goals of care may be a stable indication, or good predictor, of the type of treatment patients might want as death approaches. These results should bolster clinicians’ confidence in the reliability of patient preferences as they approach death.

**Funding:**

National Cancer Institute

**Abstract number:** P266

**Abstract type:** Poster presentation

**Imputation of Missing Not at Random Data.**

**Application to the ACTION Cluster RCT in Six European Countries**

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**Background/aims:** Statistical analysis in end-of-life care studies may be affected by high levels of missing data since observations may be incomplete due to burden in completing the study. If not correctly addressed, the missing data problem may affect the results of statistical analyses. The aim of this study is to explore how to treat missing data in the ACTION trial, a cluster randomized controlled multicentre trial on the effects of advance care planning in patients with advanced lung or colorectal cancer in six European countries (Belgium, Denmark, England, Italy, Netherlands, Slovenia).

**Methods:** The most appropriate method for dealing with missing data is Multiple Imputation (MI), an approach that creates several complete versions of the data by replacing each missing value with several plausible values. MI procedures usually assume missing at random (MAR), which means that missingness is explained by observed variables. When the MAR assumption is not valid, it is referred to as missing not at random (MNAR) and MI procedures complicate, requiring the formulation of ad hoc hypotheses and the specification of the missing data generation mechanism. The MNAR data problem is often referred to as relevant in end-of-life studies when there could be a large amount of missing data and unmeasured factors explaining missingness. We carried out a MI under MAR and MNAR assumptions on a preliminary data set from the ACTION trial. Under the MNAR hypothesis for some outcomes we specified a pattern mixture model that moved the expected value of missing data with respect to that of the observed,
according to fixed parameters or to the initial patient’s performance value. As an example, we imputed missing quality of life scores sampling values from a Normal distribution with mean shifted downward by a fixed parameter. Results were evaluated on simple indicators such as correlations between outcomes.

Results: The missing data was around 1%-5% and 37%-39% in baseline and follow-up outcomes, respectively. The correlations between all variables were very low, close to zero. However, slight significant discrepancies were observed between the different imputation methods, suggesting that the hypothesized MNAR mechanism might influence the results by varying some correlations.

Conclusions: Given that the missing data mechanism might be MNAR in end-of-life studies, it is important not to rely uniquely on procedures based on MAR assumption.

Funding
FP7 Health Programme

Abstract number: P267
Abstract type: Poster presentation

Determining the Effect of Advance Care Planning in Palliative and End of Life Care: A Systematic Review of Reviews
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Background and purpose: Advance care planning (ACP) is a process of planning for future health and personal care whereby a person’s values, beliefs and preferences are made known. There is a natural connection between ACP and palliative care, however, ACP has become a broader care and community context that seeks to support consumer choice and direction, encourage discussion and forward planning for the well not just the seriously ill, and capture preferences before decision making incapacity for those with dementia.

Aim: To understand how ACP is envisioned within a palliative care context and whether there are similarities or contradictions in how both are used.

Methods: This study has been conducted as a narrative review of systematic reviews (SRs) of ACP in palliative care. We included systematic reviews of intervention studies published in peer-reviewed, English-language journals describing the effects of ACP in an end of life context. The review protocol was lodged with the PROSPERO International prospective register of systematic reviews. MEDLINE, PsycINFO, Embase, CINAHL, Emcare and PubMed were searched. Studies published in the English language from January 2000 until the present were included. Data extraction used a purposely created format and SRs were assessed using the SIGN tool.

Results: 847 articles were retrieved. 613 articles remained after deduping. We excluded 548 non-relevant papers from titles or abstracts. Following full text review of the remaining 65 articles, 21 SRs meeting the inclusion criteria and addressing the research question were included. There were 325 separate authors cited with 468 studies analysed. Included ACP definitions were based upon 11 different sources with 8 of the 21 reviews providing an indirect or no definition of ACP, and 3 not providing any reference source. Decision Aids; Communication; Timing; Education; Intensive Care Unit use and Length of stay; Facilitators, Barriers and Costs; and Quality of Life were also identified as themes.

Conclusions: These findings suggest that while there is increasing research into ACP, pathways for a systematic and effective approach that enable effective end of life planning are still being established. Relatively few reviews looked specifically at ACP within palliative care services, however, diffusion of ACP into other end of life contexts was evident.

Abstract number: P268
Abstract type: Poster presentation

Emotional Function of Patients with Advanced Cancer across Europe (n=1,028), the ACTION Study
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Background: Anxiety, depression, and general distress are common among patients with advanced cancer. These factors are often referred to as ‘emotional functioning’. Awareness of the associated personal and sociocultural factors may provide insight into its working mechanism, and may help identify those in greater need of support.

Objective: To investigate emotional functioning in patients with advanced lung or colorectal cancer, differences across Europe, and associations with patients’ personal characteristics.

Methods: In the context of the ACTION trial, a multi-country study on advance care planning, 1,028 patients from six countries (Belgium, Denmark, Italy, Netherlands, Slovenia, United Kingdom) completed a questionnaire on emotional functioning (10 items from the EORTC item bank). Higher scores indicate better emotional functioning. Patients also provided data on their personal characteristics. Using SPSS, bivariate associations of emotional functioning with personal characteristics were assessed. Significant factors were included in a regression model.

Results: Participants’ mean age was 66 years (SD 9.9). Emotional functioning ranged per country from least -0.10 (Belgium) to -0.02 (Italy), 0.02 (UK and Slovenia), 0.10 (Netherlands) and 0.19 (Denmark; p<0.07). Male patients reported better emotional functioning than female patients (0.12 versus -0.10, p<0.001), and patients with colorectal cancer reported better emotional functioning than those with lung cancer (0.13 versus -0.03, p<0.003). Further, patients identifying themselves as non-religious reported better emotional functioning than patients identifying themselves as religious (0.22 versus -0.04; p<0.001). Patients with better versus worse WHO performance status reported better emotional functioning, ranging from 0.21 (status 0) to -0.04 (status 1), -0.13 (status 2) and -0.01 (status 3), p< 0.001. However, only 13 patients reported status 3. After inclusion of the significant factors in a multivariate model, emotional functioning remained positively associated with being non-religious (p=0.002).

Conclusions: In this observational study, patients’ emotional functioning did not differ by country. Patients identifying themselves as non-religious (versus religious) reported better emotional functioning.

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Evaluating Experiences of Advance Care Planning Facilitators: The Development of a 10-item Facilitator Evaluation Instrument in the International ACTION Study
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Background: Detailed process evaluation is desirable in order to understand the outcomes of a complex intervention. The ACTION study evaluates the effect of the ACTION Respecting Choices (RC) advance care planning (ACP) programme on quality of life and symptoms in patients with advanced lung or colorectal cancer in six European countries (BE, NL, IT, SI, DK and the UK). The ACTION intervention was delivered by trained facilitators (nurses, psychologists, physicians) in 1-2 structured conversations. Obtaining their perception of the intervention enables a systematic process evaluation to be conducted but there appeared to be no suitable measures available.

Aim: To develop an instrument measuring the experiences and evaluations of facilitators after each ACTION RC ACP conversation.

Method: A thorough conceptualization, which framed and delineated the key concept (how did facilitators experience the ACP conversation?), was made. Items asking about the communication process, especially in relation to feasibility and acceptability, were drafted. The ACTION consortium members contributed with feedback and ideas which broadened the topic of interest and led to revisions and new items. The final ten items were pilot tested for comprehension with ACTION facilitators (n=16) in 5 out of 6 countries, as either written evaluations (n=12) and/or cognitive interviews (n=6). Two introductory texts with instructions were added. Translations of the items were made during the European Organisation for Research and Treatment of Cancer’s (EORTC) standards.

Results: A 10-item facilitator-reported instrument was developed and implemented in the ACTION study. Seven items ask the facilitator to evaluate the patient’s (4 items) and the personal representative’s (3 items) reactions to and engagement with the intervention, and three items ask about the facilitator’s satisfaction with the conversation, what worked especially well and specific challenges. Of the ten items, eight items have categorical response categories and allow open-ended responses and two have open-ended responses only.

Conclusion: This new instrument allows facilitators to evaluate and document their experiences after each ACP conversation. It may also be useful in other studies of ACP. When the results are analysed in conjunction with the other ACTION data we expect that they will enrich the understanding of the intervention.

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Tools to Talk: A Systematic Review on Complex Interventions Guiding Advance Care Planning Conversations

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Aims: Advance Care Planning (ACP) enables individuals to define and share goals and preferences for future medical care. ACP can improve the quality of end-of-life (EOL) care. Communication-oriented interventions support health care professionals to guide ACP-conversations. This review aims to elicit how the concept of ACP is translated into actual conversations by analyzing conversation guides and providing an overview of characteristics, conceptual background and empirical evidence of interventions guiding ACP-conversations.

Methods: A systematic literature search was performed in four databases (PubMed, Embase, PsychINFO and CINAHL) from 1 January 1998 to 19 October 2016. Articles published in English in peer-reviewed journals reporting interventions containing a conversation guide with verbal examples to guide ACP-conversations were selected. Data on characteristics of the interventions, content of the conversation guides and empirical evidence were extracted. A thematic analysis of the conversation guides was performed.

Results: Thirty interventions were identified. Analysis of the conversation guides revealed a framework for ACP-conversations consisting of four phases: preparation, initiation, exploration and action. Exploration of patient’s views on several themes formed the core part of the conversations. Common explorative themes were: living with illness, living well, EOL-issues and decision making. Empirical evidence consisted of very heterogeneous outcome measures and showed mixed effects regarding knowledge of ACP, decisional conflict, concordance of preferences and received care and quality of communication. Dyad congruence and preference documentation rates seemed to increase among intervention subjects.

Conclusion: Exploration of patient’s views on illness, living well, EOL-issues and decision making formed the core part of ACP-conversations. This exploration might support the professional to align medical care with patient’s preferences.

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Mind the Gap! Awareness, Approval and Completion of Advance Care Directives in Switzerland

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Background: Patient self-determination is an important dimension of healthcare quality, including at the end of life. Advanced directives (AD) enable people to plan ahead in case of incapacity of making decisions by describing a person’s preferences for medical treatment (living will) and/or by appointing a healthcare proxy who may decide on behalf of the person should she become mentally incapacitated. ADs help increasing the fulfillment of individuals’ wishes for their EOL and death and support close relatives and physicians in making appropriate medical decisions. Despite the many advantages of ADs, little is known about AD completion and its determinant since the introduction of the new child and adult protection law in Switzerland in 2013.
Aim and method: Our study aims to assess the levels and sociodemographic patterning of AD awareness, approval and completion and to explore the potential of improvement in AD completion rates among adults aged 55 and over in Switzerland using logistic regressions. We used nationally representative data from a paper and pencil questionnaire which was part of the Swiss component study the Survey of Health, Ageing and Retirement in Europe (SHARE) in 2015 (n=2’085 individuals aged 55+).

Results: Although a large part of the Swiss population (79%) knew about the existence of AD and 77% approved them, only 21% completed a living will and 17% designated a healthcare proxy. Older people (75+), persons with a low education level and people from French and Italian parts of Switzerland were less likely to be aware of AD existence and to approve them. Furthermore, women, older people (75+), and people with a high education level were more likely to have completed ADs, whereas people from French and Italian Switzerland were less likely to have completed ADs. The large regional disparities in AD approval and completion in the French and Italian parts of Switzerland stem in part from lack of AD awareness.

Discussion: Our findings point to potential barriers in AD completion that should be addressed by policy makers in Switzerland in order to ensure an effective translation of individual intentions into concrete actions among adults in Switzerland.

Abstract number: P272
Abstract type: Poster presentation

Socio-economic Inequality in End-of-Life Care in Denmark? A Population-based Cohort Study

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Background/aims: In Denmark, all citizens have the right to receive complete drug reimbursement due to terminal illness (DRTI), when life expectancy is short and no life-prolonging treatment can be offered. The purpose of DRTI is to ensure that patients who plan to die at home receive medical care in line with care provided for hospitalised patients. DRTI should be equally accessible regardless of socioeconomic status. We aimed to examine socioeconomic differences in DRTI status among Danish end-of-life patients.

Methods: This nationwide study was based on linkage of medical registries including decedents between 2006-2015 (causes of death: cancer, dementia, ischemic heart disease, chronic obstructive lung disease, chronic liver disease, congestive heart failure, diabetes and stroke). We analysed the association between socioeconomic factors (employment, education, income, cohabiting status and migrant status) and the prevalence of DRTI. Prevalence ratios (PR) and 95% confidence intervals (CI) were estimated using log-linear models adjusted for age, gender, cause of death, comorbidity and municipality.

Results: Overall, 27.9% of the 307,188 decedents received DRTI. Patients with high income were more likely to receive DRTI compared to living alone (adjusted PR: 1.10; 95% CI: 1.07; 1.12) and among immigrants and descendants compared to patients of Danish origin (adjusted PR: 1.08; 95% CI: 1.05; 1.11).

Conclusions: We found an association between socioeconomic factors and DRTI status. The results suggest that DRTI, which may be a general marker of planned palliative care, is not equally accessible for all Danish end-of-life patients. Surprisingly, patients with low income and no partners were less likely to receive DRTI, which highlights a need for focus from health professionals on these vulnerable patients at the end-of-life.

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Dying in a Safe Place Is More Important than Dying at Home.

An Ethnographic Study of Rural Patients and Family Caregivers

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Background: In rural settings, relationships between place and one’s self are often stronger than for urban residents, so one would expect that rural people would view dying at home as a major feature of the ‘good death’. The voices of rural residents are mostly unheard in place of death studies.

Aim: To explore the influence of place of death and rural residency on the ‘good death’, from the experiences and perspectives of rural patients and their family caregivers, living in one rural region of Australia.

Method: Ethnography using face-to-face, open ended interviews (42) with 11 rural patients with a life limiting illness and prognosis of < 6 months, 16 family caregivers, and 6 rural clinicians. Interviews were a combination of one-off and longitudinal, and were conducted during the illness and the 6 month bereavement period. Interviews were recorded, transcribed and analysed thematically.

Results: Dying in a safe place was more important than dying at home. Safety is not simply the result of procedures and policies, but is aligned with trust that the patient will be looked after and not overwhelmed by the processes of dying. Preferences for place of death often changed along the disease trajectory. When home became unsafe, the familiarity of, and personal attention provided by rural hospitals created a safe place within hospital, despite the absence of specialist palliative care expertise. When the local hospital was perceived as unsafe, patients sometimes remained home by default rather than choice, or left the community.

Conclusion: Rural residency can hinder or facilitate a safe ‘good death’, by creating safe spaces. Deaths in a rural hospital can be appropriate, and at times necessary and planned. More studies are needed to explore further the meaning of ‘place of death’ for rural patients and their family caregivers. The task for all those providing and supporting end-of-life care is to ensure all places for dying can deliver the ‘safe death’.

Abstract number: P274
Abstract type: Poster presentation

The Unmet Palliative Care Needs of Patients with an Advanced Stage of Selected Neurological Diseases in the Czech Republic

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Aim: The aim of the research was to find unmet care needs of patients with progressive neurological disease (e.g. multiple sclerosis MS, neurodegenerative diseases, and motor neuron disease MND) in an advanced stage of the disease, and those of their family members.

Methods: Qualitative (a classic grounded theory) methodology was used to conceptualize patterns of unmet palliative care needs. Data were interpreted, conceptualized and newly integrated using open, axial and selective coding. Data were collected from 52 participants: 10 interviews with patients (4 with severe MS, 6 with severe Parkinson’s syndrome PS); 6
Abstract number: P275

Abstract type: Poster presentation

What Is the Experience of Assisted Dying for Dutch Healthcare Staff Working in a Hospice or Chronic Disease Care Centre? PhD Thesis
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Background: A contemporary issue, legislation permitting assisted dying is being implemented in an increasing number of sites worldwide. Politically debate often focuses on the individual’s right to die, but the impact of instigating it on healthcare staff has received minimal attention.

Aim: Dutch healthcare staff have the longest experience of assisted dying in practice. To inform the debate this study explored the experience of doctors, nurses and therapists from an initial request to beyond the death.

Methods: An interpretative qualitative study design was used to explore the experiences of staff working in a Dutch hospice and a chronic disease care centre. Thematic analysis applied to data from 21 semi-structured interviews identified themes from which new insights were gained.

Results: All staff received requests for an assisted death which in the hospice increased workloads, but this was not resented. Assisted deaths were not perceived as normal and conscientious objection was apparent, but staff more commonly qualified their involvement. Staff used requests to discuss all the patient’s options, including palliative care, which often resolved or delayed the majority of requests. Influential in safeguarding nurses played a significant role assessing seriousness, psychological status and the patient’s needs. Therapists, such as a social worker who supported families and prepared children and a hospice activities organiser, also had significant roles. The administration of lethal drugs and post-death case scrutiny were stressful for doctors. After death debriefing and psychological support were valued by staff, but adjustment took some time. Doctors reported a recovery period in which they were unable to respond to further requests.

Conclusion: The findings from this study have implications for other jurisdictions considered assisted dying. These include ensuring palliative care and staff assessment skills are adequate to safe guard patients. Further research is needed to assess the emotional impact on staff which may create equity and equality issues for patients seeking an assisted death.

Abstract number: P276

Abstract type: Poster presentation

Influence of Palliative Home Care Use on the Appropriateness of End of Life Care: A Case-control Study Using Propensity Score Matching
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Background: Many countries have created policies to facilitate the provision of palliative care at home, such as home teams or financial support. The influence of these measures on end-of-life care remain poorly evaluated. However, the increasing availability and quality of population-level administrative databases are opening new possibilities to do so. Our aim was to evaluate the effect of receiving palliative home care on the appropriateness of care at the end of life.

Design: Quasi-experimental case-control study using linked administrative databases
Setting: Belgium.
Participants: Of all deaths in 2012 (n=107,847), 8,837 people who received palliative home care were matched to an equal number who received usual care (unexposed), using propensity score matching to reduce selection bias by balancing groups on distribution of age, sex, cause of death, household type, income, education, urbanisation level and region of residence, and level of care dependency.

Intervention: Receiving support from a palliative home care team, palliative home care nursing or receiving financial support specifically intended to facilitate palliative home care.

Outcomes: A set of validated quality indicators of appropriateness and inappropriateness of care at the end of life and place of death.

Results: Compared to the unexposed group, those receiving palliative home care had a lower relative risk (RR) of having a hospital admission (RR=0.45; 95%CI:0.43-0.46), an ED admission (RR=0.54; 95%CI:0.51-0.57), an ICU admission (RR=0.45; 95%CI:0.43-0.48), being submitted to diagnostic testing (RR=0.43; 95%CI:0.41-0.45), receiving new antidepressant treatment (RR=0.65; 95%CI:0.55-0.77) and having surgery (RR=0.19; 95%CI 0.14-0.26) in the last two weeks of life. They were more likely to receive tube feeding at home (RR: 4.10; 95%CI:2.93-5.73). Those receiving palliative home care had more contacts with primary caregivers in the last two weeks of life (average of 9.0 [SD=6.5] vs. 2.3 [SD=4.0]), were more likely to receive opioids (RR=1.26; 95%CI:1.23-1.30) and more likely to die at home (56.2% vs. 13.8%; RR:4.08; 95%CI:3.86-4.31).

Conclusion: Our study indicates that palliative home care strongly improves the appropriateness of care at the end of life and substantially increases the chances of dying at home death. By increasing the use of palliative home care, policy makers could both increase the efficiency of care and improve the quality of care that populations receive at their end-of-life.

Abstract number: P277

Abstract type: Poster presentation

Predictors of Home Death in Palliative Cancer Patient, Influence of GP’s Involvement
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Background: Most of the cancer patients want to die at home. In 2006 in France, 72.8% of these patients died in hospital. Several studies have examined the predictors of place of death among palliative cancer patients. Very few studies have investigated the general practitioner’s (GP) involvement as predictor of place of death among these patients.

Purpose: To identify predictors of home death in palliative cancer patients. Investigate an association between GP’s involvement in the management of palliative cancer patients and home death.

Method: Retrospective monocentric study performed on 412 patients with cancer, died between 1 January 2010 and 7 March 2014, and supported by a home palliative care team. For each patient, five objective criteria reflecting the involvement of GP were collected: the fact that the
Dying to Do Research: Reviewing Challenges to an In-patient Study Conducted on Unresponsive Palliative Care Patients

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Background: Palliative care in Australia is being challenged by draft legislation before the Victorian and New South Wales Governments to legalise Voluntary Assisted Dying. Implicit is the assumption that this option provides an uncomplicated transition to death. There is anaesthetic research to strongly suggest that unresponsiveness does not equate to unconsciousness. Research into unresponsiveness prior to death is vital to ensure the best, evidence-based, ethical management of patients at end-of-life.

Aim: To examine challenges and limitations which applied to recruitment to a study comparing observational measures of comfort and sedation in end-of-life care with objective Bispectral Index monitoring readings, to report strategies developed to address challenges, to document the impact of Bispectral Index monitoring on family members and to provide information which may assist others engaged in end-of-life research.

Methods: Records were kept of all deaths on a fifteen bed specialist palliative care unit during the recruitment period, eligibility was reviewed and the reasons for recruitment or non-recruitment were recorded monthly. Consent was required from patients and their nominated family member or person responsible. Family interviews were conducted two months after a patient’s death and included a visual analogue score assessment of the family’s response to the study. Recruitment of forty consenting patients took place between April 2013 and February 2015.

Results: The mean age of recruited patients was seventy four and nearly two thirds were male. There was only one patient with a non-malignant diagnosis. Time available to researchers and the physical or cognitive condition of patients on admission were the greatest recruitment challenges. Fifty four percent of patients were ineligible on admission. There was only one patient with a non-malignant diagnosis. Twenty eight percent of patients were eligible for recruitment and consent was obtained in fifty seven percent of this group. Recruited patients had a longer admission, averaging thirty days compared to the ward average of fifteen days. Family members reported Bispectral Index monitoring to a study comparing observational measures of comfort and sedation.
Background and aim: The power of medical technologies to extend final stages of life, sometimes at the cost of quality of life, has led to an increase in the number of studies examining people’s preferences for the EOL and discussing what should be considered as a good end of life. However, most of these studies examined the perspective of patients that are already severely ill, their family members, physicians, other health care providers or experts. Empirical evidence exploring EOL preferences in the general population is lacking. The aim of our study is to gain insight into the dimensions that are considered as important for a good end of life in a representative sample of the population aged 55 and over.

Method: Respondents (n=2’104 individuals aged 55+) assessed the importance of 23 items related to EOL life while considering their own end of life on a 4-point Likert scale in a paper and pencil questionnaire that was distributed at the sixth wave (2015) of the Survey of Health, Ageing and Retirement in Europe (SHARE). The factorial structure of these EOL items was examined based on an exploratory factor analysis.

Results: Four dimensions were identified: a “Psychosocial” dimension describing the fact that people would like to be surrounded by loved ones, be at peace with themselves and with others, a “Physical” dimension related to the way pain and EOL symptoms are managed, a “Control” dimension highlighting the importance of achieving some control over once EOL, and a “Burden” dimension reflecting the importance of not being a burden to once family and to the society. Our analysis further showed that there may be a fifth dimension related to inappropriate prolongation of life that however needs further validation. All these dimensions were considered on average as important for EOL.

Conclusion: Our results highlight the importance of a multidimensional approach of EOL and the need to support and further develop holistic care in palliative medicine. The dimensions that were identified in this study can then serve as a general framework for research and practice related to EOL care.

Abstract number: P281
Abstract type: Poster presentation

Prognostic Awareness and Expected Survival among Advanced Cancer Patients in Singapore: Results from COMPASS Cohort Study
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Aims: Awareness about prognosis can help cancer patients make informed treatment decisions. However, previous studies indicate that many cancer patients are unaware of their prognosis and often overestimate their expected survival. We examined advanced cancer patients’ prognostic awareness (i.e. beliefs about being cured and expected survival). We also investigated the relationship between awareness about prognosis and other factors such as age, stage of initial diagnosis, and Eastern Co-operative Oncology Group Performance Status. Multivariate logistic regressions were used for our analysis.

Results: Despite data suggesting otherwise, almost one third (31%) of patients stated that their current treatments would cure them. Among patients who were aware that they had advanced cancer (72%), patients whose initial diagnosis was advanced stage cancer had higher odds of reporting that they would be cured than patients whose initial diagnosis was at an earlier stage (OR=1.86; p<0.05). More than half of our sample (55%) expected to survive for more than 5 years. Patients who considered themselves ‘very informed’ about their cancer had higher odds of reporting a longer expected survival than others (OR=1.81; p<0.05). Lastly, patients who were older had a lower odds of reporting a shorter expected survival than younger ones (OR=0.97; p<0.05).

Conclusions: These results are consistent with studies that report many advanced cancer patients are unrealistically optimistic about their prognosis. However, it may be that patients are not truly uninformed but rather report what they hope, as opposed to what they believe. This could explain why patients whose initial diagnosis was early stage cancer—and are thus more likely to have experienced treatment failure and dashed hope—are likely to be more realistic about their prognosis. Future research should aim to tease out differences in what patients cognitively understand from what they hope will occur.

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Abstract number: P282
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Frustration and Impotence: Supporting Substance Users at the End of their Lives
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Background: Evidence suggests that problematic substance use (SU) is increasingly part of the complexities of end of life (EOL) care, presenting challenges to existing approaches, and to the professionals who deliver them. There is currently no evidence on how practitioners in EOL and SU services respond to these overlapping issues.

Aims: This unique study aimed to explore the attitudes of EOL and SU practitioners towards working with people with substance problems, and their families, at the end of their lives. It also aimed to identify the practice challenges they faced and their training and resource needs.

Population: The population comprised a range of health and social care professionals working within three hospices and two substance use agencies in England.

Study design: This was a mixed methods study comprising:
- an online and paper-based self-completion survey (n=120)
- focus groups (n=7)
- individual semi-structured interviews (n=12).

Analysis: Qualitative analysis used template analysis with Nvivo software as an analytical tool. Quantitative data analysis used bivariate and multivariate tests to identify within and between group differences in experience.

Results: Over 90% of hospice staff reported having worked with patients with SU needs but 4 in 5 had received no training in working with SU. In contrast, nearly half of SU practitioners had not knowingly worked with clients with EOL needs and three-quarters had received no training in this. For both groups, the importance of training was rated 7 out of 10 on average. The focus groups indicated similarities between the attitudes and experiences of the two specialist professional groups. In both cases, practitioners expressed frustration and a sense of impotence about working with people who continued SU but also demonstrated compassion and acceptance of service users with substance problems. Both professional groups identified the need for clearer care pathways and holistic approaches to patient care.
Conclusion: Practitioners are working with the overlapping issues of SU and EOL care while recognising their limited knowledge, training and resources needs. Support and resources are needed to consolidate good professional practice and to guard against the potential for stigmatising attitudes or ignorance to affect quality of care.

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Physicians’ Attitudes toward End-of-Life Decisions in Amyotrophic Lateral Sclerosis
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Aims: This study aims
1) to assess European physicians’ attitudes toward different palliative end-of-life (EOL) practices in ALS patients, including forgoing artificial nutrition and hydration (FANH), continuous sedation until death (CDS), and withdrawing invasive ventilation (IVV), and toward physician-assisted dying (PAD), including assisting suicide and euthanasia; and
2) to explore factors influencing these attitudes.

Methods: In this cross-sectional online survey, we used clinical vignettes depicting ALS patients to assess the influence of the type of suffering (physical/psycho-existential) on attitudes toward IVV and in a 2x2-design the influence of suffering and prognosis (short-term/long-term) on attitudes toward FANH, CDS and PAD.

Results: 50 physicians from five countries (Belgium, Germany, Ireland, Italy, UK) completed our survey (response rate: 42%). Psycho-existential suffering was associated with a more favorable attitude toward IVV (p=0.035), but had an inverse impact on attitudes toward performing CDS (p=0.036). Short-term prognosis had a positive impact on attitudes toward offering FANH (p=0.014) and CDS (p=0.048) as well as on attitudes toward performing CDS (p=0.036) and euthanasia (p=0.023). Stepwise linear regressions showed that religiosity was associated with more reluctant attitudes toward palliative EOL practices and PAD, while training in palliative care was associated with a more favorable attitude toward palliative EOL practices only.

Conclusions: Psycho-existential suffering in ventilated patients seems to be an acceptable motive for physicians to withdraw life-prolonging treatment. Training in palliative care was associated with more favourable attitudes toward palliative EOL practices but not toward PAD. This suggests that training in palliative care for physicians might help to optimise EOL care for ALS patients.

Abstract number: P284
Abstract type: Poster presentation

Palliative Sedation in Specialized Palliative Care - A Study of Current Practise

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Background: For a small number of patients, available interventions fail to provide symptom relief. Palliative sedation (PS) can be used as a last resource. Further, patients sometimes express a wish for sedation in the face of unbearable symptom. Many drugs used for symptom control have sedative properties or side effects leading to reduced consciousness. A national Swedish study from 2006 reported that 1% of the patients had PS of which 0,6% had a reduced consciousness.

Aim: To explore the use of PS in specialised palliative home care and inpatient care.

Methods: A retrospective study of patient’s records performed prospectively, following the death of patients. The protocol for data collection was completed by the responsible physician and included demographics, decision making, symptoms, diagnosis, drugs and the level of consciousness the last 24 hours in life. Setting: Specialist palliative home care and in-patient wards in the region of Skåne, Sweden. Subjects: Patients who died between May 1 and Oct 31, 2016.

Results: 913 persons died during the study period and 642 persons were included in the study (70.3%). The median number of included patients was 88%, mean age 74. A decision for PS was documented for 7.7% of the patients, mean age 71. Indications for PS were: anxiety (26%), existential suffering (21%), dyspnoea (21%). The initiative to discuss PS was taken by the patients in 13% of the cases and by medical professionals in 64%. Of the sedated patient, 89% had cancer (lung cancer, 21%). Midazolam was used in 91% of the PS patients, propofol in 9%. For all patients, 19 % were awake at some time during the last 24 hours while all patients in the PS group had various levels of reduced consciousness. Deep unconsciousness was found in 42% in the PS group compared to 15 % in the non-sedated group. In the non-sedated group, midazolam was frequently used and in many cases the doses were the same as the PS doses. Of the PS patients, 28% died in their homes compared to 57 % in the non-sedated group.

Conclusions: PS was used to relieve otherwise intractable symptoms in patients, both in specialised palliative home care and inpatient care. Almost half of the patients received PS for anxiety or existential suffering. PS is used more frequently today (7%) in Swedish specialized palliative care settings as compared to the prevalence study from 2006 (1%). Our result is in the lower range compared to results reported internationally in recent year.

Abstract number: P285
Abstract type: Poster presentation

Quality of End-of-Life Care in Patients with Pancreatic Cancer Receiving Early Systematic versus On-demand Palliative Care at Diagnosis: A Secondary Outcome Analysis from a Randomized Controlled Trial
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Background: The aim of this study is to compare caregiver perceived quality of care in the last week of life (Quality of End of Life care - QEOL) between patients with pancreatic cancer randomly allocated to receive early systematic versus on-demand palliative care (SPC vs ODPC).

Methods: Informal caregivers of patients enrolled in the main study (NCT01996540) and died within the period 31.10.2013 to 31.12.2016, were eligible for this mortality follow-back survey. Six to twelve months after patients' death, bereaved caregivers were interviewed over the telephone by a trained psychologist. The summary scales of the Toolkit of Instruments to Measure End-of-Life Care (patient and family information, respect for patient treatment preferences, symptom control, death with dignity, family emotional support and global QEOL) were assessed. Scale scores range from 0 (worst) to 100 (best end-of-life care). Student t-tests for independent samples were used to compare SPC vs ODPC pts.

Results: 118 patients were eligible for the survey. For 71 of them (58%) it was possible to contact the main caregiver, who accepted to be interviewed in 65 cases (54%). Interviewed caregivers were most often females (65%), with a mean age of 57 years and often partner (51%) or son/daughter (33%) of the decedent. Percentages of patients dying with EOL palliative care were the majority in both SPC and ODPC groups (72% and 60%). Global QEOL care was fairly good in both groups (84.6 vs 85.6, group difference -0.9 p=0.8). Other scale scores were also high (all average scores above 80, but family emotional support which scored 74). The comparison of the two groups did not show any difference in treatment effect (all differences ranged -1 to 3.4 and none was statistically significant).

Conclusion: While the main study results show a benefit of SPC vs ODPC during the first 3 months from diagnosis, the fairly high QoEOL scores found for both treatment groups suggest that the management of EOL care is relatively uniform and good in this patient population.

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Prefered Place of Death and its Associated Factors among Patients with Advanced Cancer in Norway

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Background: There is a lack of empirical knowledge about Norwegian cancer patients’ (pts.) preferred place of death (PPOD). This study reports the PPOD of pts. with advanced cancer in Norway and explores associations between pts.’ characteristics and PPOD.

Methods: Baseline data of advanced cancer pts. recruited from 22 municipalities in Mid-Norway from Nov. 2014 to Aug. 2017 for a prospective study aiming to integrate oncology and palliative care and improve collaboration of care (ClinicalTrials.gov Identifier: NCT02170168) were used. Demographic variables, PPOD, quality of life using EORTC QLQ-C15-PAL, and social support using five items from the MacAdam’s Assessment of Suffering Questionnaire were self-reported by pts. PPOD’s response categories included home, hospital, nursing home, and other. Karnofsky performance status (KPS) and expected survival were assessed by a health care provider. To explore associations between pts.’ characteristics and PPOD, the analysis was focused on comparing home vs. institution (defined as hospital or nursing home) as PPOD using chi-square test, t-test, and binary logistic regression.

Results: 156 pts. were enrolled and 128 provided non-missing PPOD. PPOD’s distribution was 55% home, 22% hospital, 9% nursing home, and 14% other. 112 pts. chose home (n = 70) or institution (n = 42) as PPOD. Median age was 70, 58% were male, 56% completed high school or above, 69% were married/cohabitant, 71% were not living alone, median KPS was 90%, and 72% had prognosis longer than one year. In a multivariate analysis including all independent variables, gender, degree of pain, and degree of feeling needed by family/friends were significant variables (p < .05). A binary logistic regression model including the three significant variables correctly predict PPOD 70% of the times. Pts. who were male (OR = 4.59, p = .001), having more pain (OR = 2.14, p = .017), and feeling more needed by family/friends (OR = 1.74, p = .076) were more likely to prefer home to institution as PPOD.

Conclusion: More than half of the investigated pts. preferred home death while nursing home was the least chosen PPOD. However, 45% of cancer deaths occur in nursing homes and 13% at home in Norway. Studies on associated factors of PPOD are limited and inconclusive. The present results highlight the need of strengthening end-of-life care at home.

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Implantable Cardioverter Defibrillator (ICD) Management in the Last Phase of Life: A Retrospective Case Study in a Large Academic and General Hospital in the Netherlands

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Background: Implantable Cardioverter Defibrillator (ICD) shocks in the last phase of life can be stressful to patients and family. In guidelines it is recommended to deactivate the ICD when it is clear that death is imminent. It is however unclear if ICDs are frequently deactivated in current practice, what factors are associated with deactivation and how often ICD shocks occur if not deactivated.

Aims: To examine how often ICDs are deactivated in the last phase of life, what factors are associated with deactivation and how frequently shocks occur without deactivation.

Methods: We performed a retrospective case study of ICD patients who had their ICD implanted since 1999 in an academic and a general Dutch hospital and died in the period 2007-2015. In the academic hospital, we randomly selected up to 25 patients per implantation year (n=305). In the
general hospital, all patients were selected (n=75). We evaluated the medical files with a checklist that was pilot tested. If a patient died outside the hospital, the general practitioner was contacted to obtain information about the last phase of life.

**Results:** In total, we examined medical files of 380 deceased patients with an ICD. Of these patients, 333 (88%) were men. Median age at death was 71 (63-78) years. Most deaths (n=122) were classified as nonsudden cardiac (NSCD), followed by noncardiac (NCD) (n=121) and sudden cardiac deaths (SCD) (n=47). In 112 patients (29%), the ICD was deactivated before death. ICD deactivation was significantly associated with the occurrence of discussions about deactivation ($X^2 = 132.42, p < .001$) and the presence of do-not-resuscitate (DNR) orders in the medical file ($X^2 = 66.27, p < .001$). Patients who died between 2010-2012 and after 2012 had their ICD deactivated more often (respectively 22% and 42%) than patients dying between 2007-2009 (16%) ($X^2 = 23.8, p < .001$). In patients in which the ICD was not deactivated before death, shocks occurred in the last 30 days of life in 7% of the patients. Shocks were most common in patients dying a SCD (28%).

**Conclusion/discussion:** ICDs were deactivated in one third of the patients. Factors associated with deactivating the ICD were the occurrence of discussions about the topic and having a DNR order in place. If not deactivated, 7% of patients experienced shocks in the last month of life, most often patients dying a sudden cardiac death.

**Funding**

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**Abstract type:** Poster presentation

**Clinical Decision-making at the End of Life: A Mixed Methods Study**

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**Background:** Recognising dying is a foundation clinical skill for good end of life care, yet evidence to support this process is limited. Multiple research approaches may be taken to explore decision-making by healthcare professionals, with specific limitations. A mixed-methods approach allows a synthesis of disparate study types and generation of findings beyond those supported by a single study alone. The aim of this study was to improve the ability of clinical staff to recognise end of life in in-patients dying as a result of cancer and heart failure.

**Methods:** A mixed-methods study, using a parallel databases-convergent design; the study design was specified in advance. The individual arms were a retrospective cohort of 102 cancer and 81 heart failure patients, and a qualitative interview study of 19 health care professionals. Data from these studies have been published separately. This paper focuses on the mixed-methods synthesis.

**Results:** The synthesis of findings demonstrated areas of agreement, partial agreement, silence and dissonance when comparing the cohort findings with the interview findings. The main findings are:

1. Trajectories of change are identified as associated with poor prognosis in both methodological approaches, but based on different parameters.
2. Management of patients and response to intervention have a significant impact on decision-making.
3. The decision process requires repeated, iterative assessments and may benefit from a multi-disciplinary approach.

**Conclusion:** The overall synthesis supported the following additional findings:

1. Uncertainty is a defining characteristic of the overall process.
2. Objective parameters only have a limited role in predicting end of life.

**Conclusions:** The role of uncertainty is important both as a trigger for discussions and as a defined stage in a patient’s illness journey. This is consistent with current approaches to define and recognise the possibility of irreversible deterioration in those with serious illness. This study contributes ongoing evidence that these concepts are vital for decision-making.

A mixed-methods research approach allows research findings to be generated over and above those which could be derived from either study alone. By publishing the quantitative and qualitative arms separately, this submission is able to focus on the detail of the mixed-methods synthesis, improving transparency and ability to appraise both the conduct and findings of the study.

**Abstract number:** P289

**Abstract type:** Poster presentation

**Validation of the German Version of the Care of the Dying Evaluation (CODETM).**

**Questionnaire for Bereaved Relatives**

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**Background:** International publications indicate substantial deficits in the care of the dying that can lead to physical and mental strain for the patients. Negative experiences at the end-of-life care might also have a negative impact on bereaved relatives and their grieving. Hence, measuring the quality of end-of-life care is crucial to identify challenges and implement interventions to improve the quality of care. The aim of this study is the Validation of CODE™ questionnaire for bereaved relatives.

**Methods:** CODE™ was translated to German following the EORTC guidelines. Relatives of patients with an expected death during an inpatient stay of at least three days were screened for this study (04/2016 - 04/2017). Data were collected in 2 German Hospitals to evaluate dimensionality, reliability and validity. Four of 32 (CODE™) items were excluded from our psychometric analysis, because three of them measure quality of care on a global level and one surveys the place of death. Furthermore, scores of certain items were adjusted in order to avoid weighting of single items. For calculating construct validity the palliative outcome scale of patients (Palliative Outcome Scale) was assessed. Difficulty and perceived strain of answering the questionnaire were assessed by a numeric scale (0-10).

**Results:** 1228 bereaved relatives of 1714 patients were contacted, 317 returned the questionnaire for the first measurement (response rate: 25.8%), 58 participated for repeated measurement. 44 cases were excluded, 34 due to high missing rates (>15%), and 10 questionnaires were unexpectedly filled out by a third interrater. Hence, our final analyses were based on the data of 237 participants, 38 interrater and 55 relatives that participated for repeated measurement. Internal consistency of the German version was satisfactory and met the threshold criteria.
Conclusion: The German version of the CODE™ is a reliable and valid questionnaire for assessing the quality of care at the end of life.

Abstract number: P290
Abstract type: Poster presentation

Tipping Point: When Patients Stop Eating and Drinking in the Last Phase of Life
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Background: Eating and drinking are essential in social life. Nutrition and hydration (N&H) at end of life are often a source of discussion and distress. Stopping eating and drinking is a defining element of the dying phase, however, the time point is not well defined.

Methods: The time point when patients (pts) stopped intake was analyzed in relation to time until death on a specialist palliative care ward (sPCW) of a tertiary comprehensive cancer center. This “tipping point” (TP) was defined as the time point when total food intake fell below 25% of normal solid intake (TP-S) and fluid intake below 500 ml/day (oral / intravenous / subcutaneous) (TP-F). Demographic and medical data, the N&H-module in the electronic patient management system and the daily multiprofessional treatment notes at TP (+3 days) were analyzed between 1/15-9/17.

Results: In these 32 months, 1194 pts were treated on the sPCW and 683 (57%) died on the ward. A TP-S was identified in 291 pts (43%) with a median time of six days from TP-S to death. In 75% of these pts, TP-S was within two weeks (range: up to five weeks). A TP-F was detected in 202 pts (30%) with a median TP-F-time of one day. In 75% of these pts, the TP-F was within three days (range: up to two weeks). The disease groups with TPs were heterogeneous. The largest groups were lung cancer pts (9%), followed by brain tumors (6%) and breast cancer (4%). For pts with a TP early in the trajectory no different characteristics could be determined. In the daily treatment notes, oral and swallowing problems, taste alterations and discussions about stopping artificial nutrition were mentioned, but no specific patterns could be found.

Conclusion: In less than half of dying pts a definitive TP could be detected. TP-S lay within two weeks and TP-F within few days before death. Specific patterns could not be identified, which underlines dying as an individual process and explains daily problems in detecting the best time to change care strategy.

Abstract number: P291
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Care of the Dying in Hospital - The Loved Ones Perspective
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Background/aims: Providing good quality care of the dying is one of the central aims in palliative care. This outcome can be measured by assessing bereaved loved ones. The aim of this study is to present the quality of care in the last two days of life of patients who died in a hospital both in specialist palliative care units and on other wards.

Methods: One instrument to measure quality of care is the Care of the Dying Evaluation (CODE™) questionnaire that has been validated in German by the authors group. The questionnaire was structured to focus on holistic aspects significant for the quality of care at the end of life, such as care, communication, environment and others, and was amended with questions on the overall impressions of care. 32 items require answers on different scales. Questions examine the quality of care for the patient and focus on the support of loved ones. Additionally, sociodemographic and disease related aspects were assessed. The study was conducted in two university hospitals in Germany. Frequencies and group comparisons were analysed. All statistical analysis was performed using IBM SPSS Statistics 21.

Results: In the two study centres 1714 patients died between 3/2016 and 2/2017 and 385 questionnaires were sent to loved ones. Most of the 237 CODE questionnaires analysed were completed by the patient’s spouse (42.6%) or children (40.5%). 64.1% of respondents were female. The average duration of hospital stay at the ward the patient stayed in the last two days of his life was 13.7 days (3-276; SD 21.1). Cancer diagnosis was stated for 63.6% of patients. Half of the patients died in a specialist palliative care unit (50.6%). Overall impressions on the quality of care the patient received in the last two days of life were rated predominantly good with regard to treatment with respect and dignity (always/most of the time by nurses (92.9%), n=232) and by doctors (89.1%, n=230)) and with regard to adequate support for loved ones (87.8%, n=230). Nevertheless, 7.9% (n=19) would probably not recommend the ward to friends or family members. Almost half of the loved ones (45.1%) stated unfulfilled information needs.

Conclusions: The quality of care for patients dying in hospitals is rated rather good in our study. Reasons for unsatisfying outcomes and differences between different patient groups will be further examined.

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Abstract number: P292
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Integrated Palliative Care: A Nation-wide Mixed Methods Study of Inter-organizational Collaboration in Palliative Care Networks in Flanders, Belgium
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Introduction: To ensure continuity in palliative service delivery for residents of nursing homes, collaboration of these long-term care facilities with home care and hospital care is required. To date, few studies examine palliative care integration in nursing homes at health service level. In the present study we address this gap by identifying challenges of inter-organizational collaboration in palliative networks.

Method: A sequential mixed-methods design was applied. 308 key persons of all 15 palliative networks in Flanders (Belgium) completed an electronic survey based on the ‘structuring model of collaboration’ of D’Amour and colleagues. In this model, four dimensions of collaboration are operationalized by 10 indicators. Participants judged each indicator...
on a 5-point Lickert scale for two types of cooperation: nursing homes - home care and nursing homes - hospital care. Quantitative results served as a basis for three expert panels (N=16) in which the perspectives of the key persons on inter-organizational collaboration were deepened. Expert panels were analyzed using content analysis.

**Results:** A 2x4 Repeated Measures ANOVA shows that key persons of Flemish palliative networks rate structural dimensions of collaboration (‘governance’ and ‘formalization’) significant more negatively than interpersonal dimensions of collaboration (‘internalization’ and ‘shared goals and vision’). This result is found for both cooperation’s. Key persons miss the formal regulation of information exchange across organizations and the systematic initiation of advance care planning. Furthermore, difficulties with respect to governance characterize the inter-organizational collaboration: a lack of inter-sectoral meetings, power imbalances, a shortage of knowledge and a lack of clear and explicit guidance for collaborative action. Key persons emphasize the connective and educational task of the palliative network.

**Conclusion:** The challenges in the inter-organizational collaboration identified in this study are a starting point for interventions leading to stronger integration of palliative care in nursing homes.

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**Abstract number:** P293
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**Intensity of Treatment at End of Life of Cancer Patients in a Comprehensive Cancer Center - Preliminary Data of a Feasibility Study**

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**Background:** Internationally, e.g. application of systemic tumour therapy within 14 days before death is seen as an indicator of intensity of cancer care near the end of life. A benchmark of < 10% of cancer patients (pts) receiving systemic therapy at their end of life is discussed within the North-American health care system. In Germany, data on treatment intensity in dying cancer pts is rather scarce. Thus a feasibility study was performed to evaluate usability of data out of a cancer registry and a hospital documentation system for the assessment of treatment intensity in end-of-life care.

**Methods:** Merged data on therapy and day of death of pts who died between 2009 and 2013 were provided (regional cancer registry Erlangen-Nuremberg & hospital documentation system of the CCC Erlangen). Anonymization and aggregation of retrospective data collection using the patient ID were conducted by medical centre for information and communication technology (MIK) of the CCC. Descriptive and explorative data analysis was performed via SPSS (frequencies, confidence intervals (CI)).

**Results:** Data were collected from 9,394 pts (male 55.9%). After cleaning data 8,667 pts (92.3%) were available for analysis. Systemic tumour therapy within 14 days before death was shown for 2.2% (95% CI [2.9-3.6]), 2.7% (95% CI [2.3-3.1]) of all cancer pts were exposed to radiation and 2.7% (95% CI [2.4-3.1]) of pts had surgery in their last 14 days of life. Extracting data of cancer pts with metastases and tumour associated deaths was possible. Analysis showed that 5.1% received systemic tumour therapy (95% CI [4.7-6.4]) and 3.5% had undergone surgery (95% CI [2.9-4.2]) within 14 days before death.

**Conclusions:** It is possible to extract indicators of intensity of cancer care by using data from tumour registry and a hospital documentation system. The amount of pts who got systemic tumour therapy within 14 days before death is lower than the pre-determined benchmark of < 10% defined in the USA. Hence general feasibility, time, effort and personal resources necessary were extraordinary high hampering a standardized application of this method.

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**Abstract number:** P294
**Abstract type:** Poster presentation

**Quality of Communication between Physicians and Relatives of Dying Nursing Home Residents: The EU FP7 PACE Cross-sectional Survey**

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**Background:** In palliative care, the communication between a physician and relatives plays a significant role because these are the individuals who in most cases participate in making decision about further treatment when a dying person suffers from fluctuating consciousness, dementia or is in coma. The quality of communication between a physician and relatives of a dying nursing home (NH) resident, was studied within the PACE project (Palliative Care for Older People). The aim of this analysis is to examine the relationship between country, NH, physician, relative and resident characteristics associated with better quality of communication between physicians and relatives.

**Methods:** PACE is a representative cross-sectional study of 1707 deceased residents in 322 NHs in Belgium, Finland, Italy, Netherlands, Poland and England. The study was conducted in 2015. A questionnaire with validated measures for quality of communication between physicians and relatives (Family Perception of Physician-Family Communication-FPPFC) was sent to 1445 relatives of residents deceased in last 3 months. We used a linear regression model to find factors related to the quality of communication between physicians and relatives.

**Results:** Across all countries, 840 (58%) relatives responded. We included 761 relatives from 229 NHs after exclusions due to missing data. Quality of communication between a physician and relatives was the best in Italy (2.3 ± 0.7) and the worst in Finland (1.5 ± 0.8). After adjustment for the country, NH, physician’s, relative’s, dying resident’s characteristics, the factors related to the quality of communication between treating physicians and relatives were: emotional burden of relatives (B=-0.05; 95% CI [-0.08 - -0.03]) and number of physician’s visits in the last week of resident’s life (B=-0.08; 95% CI [0.05 - 0.11]).
Conclusions: Quality of communication was better when relative had lower emotional burden and physician’s performed more visits during the last week of resident’s life. It is important to provide information at the right time and to arrange time for communication with relatives.

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Comfort and Quality of Life in Cancer Patients: Results from a Cross-sectional Study

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Background: Palliative care (PC) aims to improve the Quality of Life (QoL) of patients and families, ideally through the early integration of comfort care. However, little is known about the theme in Portuguese cancer patients, particularly in PC settings.

Aims: This study aims to analyze the levels of comfort and QoL in cancer patients, in PC settings, and to analyze the relation between the concepts.

Methods: A quantitative, cross-sectional, observational, and descriptive study was performed. Patients (n=85) were consecutively recruited from 2 hospital departments in a university hospital. Inclusion criteria were: age over 18 years old, cancer disease diagnosed and be followed by the PC team. Exclusion criteria were: cognitive impairment, lack of capacity to give informed consent, and unclear diagnoses. The Portuguese versions of the EQ-5D-5L™ and the Spiritual End-of-Life Comfort Rating Scale were used to assess patient’s QoL and Spiritual Comfort [minimum 20-maximum 120]. The EQ-5D-5L™ assesses QoL through the EQ Index value [score between 0-1] and the EQ VAS [QoL ranges between 0%-100%]. The research project was previously approved by the Ethics Committee of the hospital. Data were analysed using descriptive statistics and non-parametric tests were performed to compare differences between groups (SPSS®, version 21 for Windows).

Results: Participants (mean age=56.48 years; 71.80% female) have positive and satisfactory means related with comfort (mean=80.48) and QoL (mean=63.65%),(EQ Index value; mean=63.65%, EQ VAS). Most patients feel that life is worth living (70.60%), feel encouraged by being loved (74.10%), feel in peace (62.40%) and steel founding meaning in their lives (50.60%). However, 41.20% feels that need more information on their state of health, and 29.40% feels depressed. A positive, moderate relation was founded between patient’s comfort and QoL (r Pearson=0.33; p<0.01). As age increases, comfort tends to decrease (r Pearson=-0.36; p=0.01), and women presented higher levels of QoL than men (67.30% vs 54.38%, t Student=2.83; p=0.001).

Conclusions: The study highlights that suffering from a cancer and incurable disease is not necessarily a requirement to feel uncomfortable. Results show that most patients feel comfortable and have a moderate quality of life. Being in peace, feeling loved or finding meaning in life, can improve patient’s comfort and QoL, even for those who are in PC.

Abstract number: P296
Abstract type: Poster presentation

End-of-Life Care in Public Hospitals in Southern Switzerland: Impact of a Palliative Care Consultancy Team

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Research aim: To compare in hospitalized patients standard end of life care in terms of symptom management, type of treatment and clinical staff perception on quality of death versus care provided after a palliative care consultation. Study population: the included population represents a subgroup from a larger study (FIT-Fine vita In Ticino), investigating end-of-life care for adults in medical and surgical wards of public hospitals in Southern Switzerland.

Study design and methods: from January to July 2013, a dedicated nurse collected data on age, gender, diagnoses, request for PC referral, interventions performed within 48 hours before death and symptom prevalence. Furthermore, quality of death perceived by the staff was assessed on a 5 point Likert scale administered during an interview. The study was approved by the local Ethic Committee. Group comparison was performed through Chi-square test.

Results: 284 patients were included in the study. 86 patients (30.3%), mainly with cancer, benefitted from a PC consultation. Patients who had a PC consultation had a reduction in the prescription of blood exams (p=0.006), antibiotic therapy (p=0.0002), the insertion of nasogastric tubes (p=0.020) and resuscitation procedures (p=0.009) compared to those who did not have a PC consultation. There were no statistical differences in terms of symptom management, even if dyspnea and confusion were better controlled in PC consultation group. The quality of death perceived by staff was not different in the two groups.

Interpretation: PC referral for dying patients in public hospitals in Southern Switzerland is rarely implemented, whereas PC consultation seemed to reduce futile and invasive treatments. Screening tools for early identification of patients with palliative care needs and primary care providers education may foster collaboration with PC services and timely referral within primary care settings.

Abstract number: P297
Abstract type: Poster presentation

A Retrospective Review of Quality of End-of-Life Care Indicators in Advanced Pancreatic Cancer

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Background: Despite modest improvement in survival with new chemotherapy agents, less than 5% of patients with pancreatic cancer survive beyond five years. Patients suffer significant symptom burden at end-of-life due to disease and adverse chemotherapy outcomes, and have higher probabilities of distress and anxiety. Limited data is available regarding quality end-of-life care in pancreatic cancer.

Aim: To examine end-of-life care outcomes in patients who died from pancreatic cancer who had received care from a health system which included a comprehensive integrated specialist palliative care service.

Methods: A retrospective analysis of hospital records of patients who died from pancreatic cancer over a 5 year period (2012-2016) at a single institution. Data examined included: emergency department (ED) presentations, acute inpatient admissions, intensive care utilization (ICU), and chemotherapy use within 30 days of death; time from referral to palliative care to death; and place of death.

Results: There were 323 deaths from 457 patients with pancreatic cancer. Mean age at death was 76.3 years (range 42.7-101.1) and 51.4% were male. Within 30 days of death outcomes included: ED presentation (33.5%); acute hospital admission (55.6%); ICU (1.2%); and chemotherapy use (20.0%). Palliative care referral (PCR) occurred in 87.6% of
patients. Time between PCR and death was < 1 month (38.4%), 1-3 months (29.0%), 3-6 months (17.2%), 6-12 months (10.0%), and >12 months (6.4%). There was no association between early PCR and place of death (p=0.89). Of the 40 people who had no PCR, 29 (72.5%) died in acute hospital settings and 11 (27.5%) at home. Of the 283 patients with a PCR, 158 (55.9%) died in the palliative care unit, 68 (24.0%) in an acute hospital setting, and 57 (20.1%) at home. Information on the use of chemotherapy within 30 days of death was known for 184/204 patients who received chemotherapy at any time. Chemotherapy within 30 days of death was given in 37/167 (22.1%) referred to palliative care and in 4/17 (23.5%) not referred to palliative care.

Conclusions: An integrated palliative care system allows for significant referrals to palliative care for pancreatic cancer patients. This reduces the number of deaths in an acute hospital, increases deaths in a palliative care unit, but does not increase the likelihood of dying at home. PCR did not affect the use of chemotherapy within 30 days of death.

Abstract number: P298
Abstract type: Poster presentation

Quality of drug prescribing in older adults receiving palliative care in their last three months of life
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Background Near the end of life, reconsidering drug treatments is necessary in older adults receiving palliative care. Priority should be given to drugs that are essential for the comfort of life, while limiting the use of potentially futile or inappropriate treatments. The aim of the study was to describe the evolution and assess the quality of prescriptions during the last three months of life of older adults receiving palliative care.

Methods A retrospective cohort study was conducted. It included all patients aged ≥65 years who received palliative care and who died at the University Hospital of Limoges (France) between 1 January 2014 and 30 June 2014. For each patient, prescriptions were collected during the last three months prior to death. A list of futile and essential drugs was developed by literature review. Evolution and quality of prescriptions were estimated at three months prior to death (D90), during the last week of life (D7-D1) and on the day of death (D0). Descriptive analysis was performed with SAS Studio 3.6 and SAS JMP 13.1.

Results Among the 149 patients included in the study, the mean age was 82.1 (± 8.6) years and 53.7% were men. The median time between identification of the need for palliative care and death was 4 days (range 0-447) and 75.0% of patients had a delay between 0 and 11 days. On average, patients consumed 6.7 (± 3.3) drugs at D90, 10.1 (± 4.5) drugs at D7-D1, and 5.6 (± 3.6) drugs at D0. Globally, the prevalence of futile and essential drugs was respectively 91.9%/79.8% at D90, 81.2%/97.3% at D7-D1 and 52.0%/98.6% at D0. Between D7-D1, the most commonly prescribed drugs were considered as essential such as midazolam (46.3% of patients) and morphine (40.2% of patients) whereas the most commonly deprescribed drugs were deemed futile - e.g. esomeprazole (19.4% of patients) and acetylsalicylic acid (18.1% of patients).

Discussion/Conclusion Drug prescribing is still important near the end of life, but a change in the categories of drugs used is observed with a preferential introduction of essential drugs and a decrease of futile drugs principally used in the prevention of diseases or in the treatment of comorbidities. This change occurred during the last week of life, which is probably related to the late entry of palliative care. Thus, a better anticipation of the transition to palliative care seems necessary.
plan to die at home receive medical care similar to the care provided for hospitalised patients. As DRTI should be equally accessible for all patients, geographical variation in the use of DRTI may be a general marker of unwarranted variation in planned palliative care. However, studies on geographical variation of palliative care in tax-financed welfare countries are sparse. We aimed to examine geographical variation in the use of DRTI among Danish terminally ill patients.

**Methods:** We conducted a nationwide register-based study of all deceased between 2007-2015 dying from cancer, dementia, ischemic heart disease, chronic obstructive lung disease, chronic liver disease, congestive heart failure, diabetes and stroke. We analysed the variation in DRTI prevalence among 98 municipalities and among areas with different levels of urbanization. Prevalence ratios (PR) and 95% confidence intervals (CI) were estimated using log-linear models adjusting for age, gender, comorbidity, cause of death and socio-economic factors (education, income, employment, partner status and migrant status).

**Results:** Among the 276,662 decedents, 28.3% received DRTI. The adjusted PR of DRTI ranged from 0.95 (95% CI 0.76-1.19) to 1.48 (95% CI 1.41-1.54) when comparing the individual municipalities with the capital municipality. In addition, a higher probability of DRTI was shown among patients living in thinly populated compared to densely populated areas (adjusted PR 1.16 95% CI 1.05-1.28).

**Conclusions:** We observed substantial geographical variation in DRTI. Despite a tax-financed free-access health care system, planned palliative care may not be equally accessible for end-of-life patients throughout Denmark.

**Funding**
The Danish Cancer Society; Fonden af 1870

**Abstract number:** P301  
**Abstract type:** Poster presentation

**Family Members’ Experiences and Needs When Witnessing Diminishing Drinking of a Dying Relative: A Systematic Literature Review**  
**Petitjean, Annie1**, Hughes, Sean1, Froggatt, Katherine1, Work Completed as Part of a PhD at International Observatory on End of Life Care, Lancaster University, Funded by Coventry University  
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**Background:** Family members are concerned and distressed by the ongoing decline of oral fluid intake by dying relatives, particularly in a hospital context. Research has focused on the efficacy of clinically assisted hydration (CAH) to palliate dying patients but meeting the needs of family members witnessing decline in oral fluid intake can also be challenging for healthcare professionals. In the light of this, an adapted meta-narrative review was undertaken addressing the question: How have family members’ experiences and needs when witnessing diminishing drinking of a dying relative been researched and what is known about this?

**Methods:** CINAHL, Medline, PsycINFO, ASSIA and Scopus databases were searched for research published since 1982. Titles and abstracts of retrieved papers were considered against inclusion and exclusion criteria. All study designs and qualities were included. Findings were analysed to identify ways in which the question has been addressed and the knowledge generated as a consequence.

**Results:** Of the 209 retrieved papers, 22 met the inclusion criteria. No study that focused specifically on family members’ experiences and needs when witnessing the diminishing drinking of a dying relative was identified. Instead most research has focused on family members’ perspectives of CAH, professionals’ perspectives of family members’ and dying patients’ needs and clinical decision-making concerning CAH. Most studies have considered drinking in combination with eating or clinically assisted nutrition and within a specialist palliative care context which may not be typical of the experience of family members’ in hospital settings. Where it can be disaggregated, the literature about diminishing drinking suggests family members’ needs vary depending on their views about the significance of drinking, the care environment and their personal preferences. Family members’ perception of their own needs may differ significantly from that of professionals, who focus on the need for improved education and communication about diminishing drinking with family members.

**Conclusion:** While some understanding of the topic can be inferred from heterogeneous research in related areas, there is paucity specifically about family members’ experiences and needs when diminishing drinking of a dying relative. Further research to explore family members’ experiences and needs first-hand is required to inform the support health-care professionals can offer them.

**Abstract number:** P302  
**Abstract type:** Poster presentation

**Influence of Disease Trajectories on Wishes to Die**  
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**Research aims:** The motivations that lead to wishes to die (WTD) in palliative care patients with tumours are relatively well studied. But little is known about WTD in the context of other pathologies and about the interrelation between subjective understandings of dying trajectories on the one hand and a WTD on the other. Does the experience of the diverse dying trajectories influence a WTD? And if so, how?

**Study population:** 62 palliative cancer (n=30) and non-cancer (n=32) patients (10 neurological disease; 11 organ failure; 11 frailty), their families and health professionals in different palliative care settings (248 interviews).

**Study design and methods:** Qualitative semi-structured interviews. Data analysis with Interpretive Phenomenological Analysis and Grounded Theory.

**Results:** People dealing with similar trajectories were often confronted with similar questions and concerns due to similar challenges. Typical understandings are modulated by individual motivations. We will outline typical patterns, similarities and differences for each dying trajectory that were reported by our interviewees and that are to be considered when talking with patients about their WTD. Illness-related considerations do not explain WTD in total, but give important information on the challenges for particular patient groups that might sustain a WTD. In all patient groups, we observed situations in which WTD occurred: for neurological patients, it was the moment when they experienced breathlessness, high care dependency, when considering tube feeding or respiratory support; for persons with organ failure it was during acute burdensome crises for patients with tumours after the initial diagnosis, first relapse, or the move into advanced palliative care; for elderly frail persons when moving into care facilities, during losses of important relationships or capabilities. Feelings to be a burden to others were reported in all patient groups, but in regard to the disease trajectory were differently connected to a WTD.

**Interpretation:** WTD can be triggered by specific conditions and transitional points within disease trajectories, that affect the agency and self-understanding. A better understanding of the concerns and challenges of a particular dying trajectory as well as its turning points can facilitate
preferred and achieved goals of patients with metastatic lung cancer and their oncologists in end-of-life therapy

groenvold, mogens 1,3

number of patients are referred to SPC, the capacity is still insufficient. It

background: The perceived quality of specialised palliative care (SPC) of health services research, institute of public health, university of amsterdam, netherlands, 1public and occupational health, vu university medical center amsterdam, netherlands, 2Faculty of Health Sciences, University of Lausanne, Lausanne, Switzerland, 3Faculty of Business and Economics, University of Lausanne, Lausanne, switzerland

introduction: Systemic therapy with chemotherapy, immunotherapy or targeted therapy are possible treatments for patients (pts) with metastasized lung cancer (stage IV NSCLC). This palliative treatment might prolong survival and reduce symptoms but frequently causes side-effects which may decrease their quality of life (QOL). Little is known about pts’ and oncologists’ goals before starting a new therapy.

aim: To study the goals pts and oncologists have before starting a new treatment for stage IV NSCLC and to what extent these goals are achieved.

methods: A prospective study where pts with stage IV NSCLC are included in three hospitals. At the start of the systemic therapy pts and their oncologists are asked to complete a questionnaire about their treatment goals. This open question is coded by the investigators. After the treatment we examine to what extent the earlier mentioned goals are reached according to the pts and the oncologist. The data collection has not finished yet, here we report the preliminary results of 150 pts and their oncologists on predefined goals and of 45 pts (whose treatment was finished) and oncologists on achieved goals.

results: Pts and oncologists most often mentioned QOL (58%;81%), a decrease in tumor growth (49%;63%) and life prolongation (40%;48%) as treatment goals. 23% of the pts mentioned cure as a treatment goal. Life prolongation was in 67% achieved according to pts. All other goals from pts and oncologists were achieved in less than 50% of cases (from 10% to 42%).

conclusion: Pts and oncologists mention QOL, decrease in tumor growth and life prolongation most often as treatment goals. When the goal is ‘decrease in tumor growth’, it is not clear if this decrease is considered desirable because it leads to life prolongation, an increase in the QOL or both. It can be questioned whether the 23% of the pts mentioned cure as a treatment goal think this is realistic or that it is more a sign of hope. If they think it is realistic they need clearer information on the prognosis.

abstract number: P304
abstract type: poster presentation

the quality of specialised palliative care for danish cancer patients: a national survey using the danish version of voices-sf

ross, lone 1, neergaard, mette aabjerg 2, petersen, morten aagaard 3, groenvold, mogensen 1,5

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background: The perceived quality of specialised palliative care (SPC) has never been systematically measured in Denmark. While a higher number of patients are referred to SPC, the capacity is still insufficient. It is therefore of interest to evaluate whether the amount of care provided to each patient is associated with the perceived quality of the palliative care. Since the patients may not be able to evaluate the quality of care in later phases and cannot evaluate circumstances surrounding death, it is relevant to contact the relatives after bereavement.

aim: To assess how SPC provided in hospices, palliative care units or in patients’ homes was evaluated by the bereaved spouses and to test whether the perceived quality was associated with the quantity of care provided.

design and data sources: The questionnaire views of informal carers - evaluation of services - short form (voices-sf) was developed in england and has been validated in a danish setting showing that the questionnaire is well suited for use in denmark after a minimal adaptation. The bereaved spouses of 1,584 cancer patients who had received SPC were invited to answer the voices-sf approximately 3-9 months after the patient’s death.

results: A total of 787 (50%) spouses returned the questionnaire at a mean of 8.5 months post bereavement. Sixty % of respondents were women and most respondents (70%) were 60-79 years old. In the last three months of the patient’s life, the quality of all services provided by the health care system taken together was rated as ‘good’, ‘excellent’ or ‘outstanding’ in 82% of the cases. The overall care provided by SPC while the patient was at home was considered ‘good’ or ‘excellent’ in 87% of the cases (‘outstanding’ was not a response option). A higher number of home visits by SPC was associated with higher ratings of the quality of care (p < 0.0001). Thus, the care was rated as ‘good’ or ‘excellent’ in 82% of the cases when only one visit was offered, whereas this rating was given in 92% of the cases when 2-3 visits were offered and in 94% of the cases when 4 or more visits were offered. The overall care provided while the patient was admitted to a hospice or a palliative unit was considered ‘good’ or ‘excellent’ in 95% of the cases.

conclusion: The quality of SPC was rated very high by the bereaved spouses and seemed to be associated with the quantity of care provided.

abstract number: P305
abstract type: poster presentation

associations between views of assisted suicide and sociodemographic characteristics, health-related experiences and preferences for end-of-life among the general population aged 55 and over in switzerland

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assisted suicide (AS) is lawful in Switzerland as long as it is performed without selfish interests. Since the 1980s, right-to-die organizations advocate for the right to self-determination in death and help organizing suicide for terminally ill people. With population aging, the number of people with chronic diseases increases. Currently, end-of-life (EOL) is often highly medicalized. These trends may lead to a growing number of people asking for AS. The absolute number of AS has been increasing since 2008. Overall, 1.2% of all deaths in 2014 were AS.

We examined opinions and behaviors regarding AS among adults aged 55 and over based on nationally representative data (n=1348) of a paper-and-pencil questionnaire which was part of the Swiss component study of the Survey of Health, Aging and Retirement in Europe (SHARE) in 2015. Controlling for sociodemographic characteristics, we investigated how health-related experiences, trust in the Swiss healthcare system and providers, and preferences for EOL influence opinions about AS and membership of a right-to-die organization using logistic regressions.
The majority of respondents (83%) agreed that AS should in principle be available in Switzerland. Furthermore, a quarter of the respondents reported to likely become a member of a right-to-die organization in the future while less than 5% were already a member of a right-to-die organization at the time of the survey.

Favorable opinions towards AS were consistently negatively correlated with being older (75+) and coming from French and Italian parts of Switzerland. By contrast, women and older adults (65+) were more likely to already be a member of a right-to-die organization. Health-related experiences and mistrust towards the Swiss healthcare system and providers were not related to favorable opinions and behaviors regarding AS. Preferences for high level of control at the EOL were positively associated with favorable opinions and behaviors regarding AS. Worries regarding potential physical and mental incapacities were only associated with favorable opinions. Finally, psychosocial aspects of EOL were negatively correlated with favorable opinions and behaviors regarding AS.

Since support of AS is partly driven by a desire for self-determination at EOL and fears of suffering, increasing information about advance directives and palliative care options may alleviate some of these fears and perhaps better meet people’s concerns around their EOL.

Abstract number: P306
Abstract type: Poster presentation

Agreement between Physicians, Nurses and Family Members in the Assessment of Quality of Care at the End-of-Life.

A Prospective Study in an Oncological Hospital Ward
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Background and aim: Studies in different countries have reported the quality of care for the dying patients in hospital as suboptimal. Quality of care is usually assessed using the post-bereavement approach. Little is known about the agreement between the proxies interviewed after the patients' death. The aim of this study was to estimate the agreement on quality of care provided to cancer patients dying in hospital from the perspectives of three proxies interviewed after the patients’ death: the physician, the nurse and the family member.

Study design and methods: This is a prospective study on a consecutive series of patients deceased from cancer in an oncological hospital ward. All adult patients with more than 48 hours in ward were eligible. Quality of care at the end of life was assessed by interviewing 3 proxies (the attending physician, the reference nurse and the main family member) after the patient’s death. We used two validated semi-structured interviews, the Toolkit After-death Family Interview (7 structured interviews, the Toolkit After-death Family Interview (7)

Conclusions: The agreement between professionals and non-professional caregivers in assessing the quality of care at the end of life was rather poor. More studies should focus on identifying a valid methodology for assessing the quality of care at the end of life using the post bereavement approach.

Abstract number: P307
Abstract type: Poster presentation

Palliative Sedation while a Patient Refuses (artificial) Nutrition and Hydration - Is it Physician Assisted Suicide? A Survey of Medical Students
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Background/aims: There is an ongoing debate if providing palliative sedation (PS) in patients who refuse (artificial) hydration and nutrition may be regarded as physician assisted suicide (PAS) under certain circumstances. In 2015 a law was passed in Germany that those who “intentionally promote the suicide of another person and, in a regular and repetitive manner, grant, provide or facilitate the opportunity to do so” are subject to a “prison sentence of up to 3 years” or a fine. We used fictional case vignettes to investigate under what circumstances students qualified PS as (possibly punishable) PAS.

Methods: The clinical vignette described an end-stage cancer patient who suffers from the facial disfigurement caused by a nasopharyngeal carcinoma and states that his situation is unbearable and undignified. The suffering has been refractory to previous treatment. We presented three scenarios:

1) the patient decides to voluntary stop eating and drinking (VSED) and requests PS because of intolerable suffering,
2) he is still able to eat and drink and requests to withhold artificial nutrition and hydration (ANH) during PS, and
3) he is unable to eat and drink and requests PS while withdrawing ANH. The students were asked if they considered the course of action
1) as suicide and
2) as PAS. Answers on a 0-10 point NRS were collapsed into three categories (0-3: rejection, 4-6: undecided, 7-10: agreement).

Results: Out of 324 students, 275 (85%) participated in our survey. Using paired tests, we found that scenario 1 was significantly more likely to be considered as suicide (66.5%) compared to the other two scenarios (scenario 2: 58.5%, scenario 3: 36.7%). Significantly more students regarded scenario 2 as PAS (33.8%) compared to scenario 1 (25.1%) and scenario 3 (19.3%). 27.3% of the students were undecided regarding scenario 1 (scenario 2: 25.1%, scenario 3: 21.8%) and 47.6% opposed this opinion (scenario 2: 41.1%, scenario 3: 58.9%).

Conclusions: Other than many ethicists and palliative care professionals, a majority of students regarded VSED as suicide. Depending on the clinical circumstances described in our vignettes, one fifth to a third considered PS as PAS. Around a quarter was undecided about its legal classification. These findings reflect the general legal uncertainty caused by the new law. Since this uncertainty may be a source of distress for (future) physicians, legal certainty should be created as soon as possible.
Abstract number: P308
Abstract type: Poster presentation
Palliative Care Prescribing in England: Analysis of Selected Medical and Non-medical Activity 2011-2015
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Background/aims: Non-medical prescribers (NMP) activity in palliative care has been expanding in recent years. However, there is a lack of evidence to demonstrate clinical and economic impact of NMP within a healthcare system serving an increasing number of people with palliative care needs. We developed a unique methodology to establish the level of NMP activity in palliative care across England and consider the contribution these prescribers are making at a national level compared to medical prescribing.

Methods: All prescriptions for 10 core palliative care drugs prescribed by GPs, nurses and pharmacists in England and dispensed in the community between April 2011 and April 2015 were extracted from the Prescribing Analysis Cost Tool (PACT) system. GPs represented medical prescribers and nurses and pharmacists represented NMPs. The data were broken down by prescriber and basic descriptive analysis of prescription frequencies by opioid, non-opioids and total prescriptions by year was undertaken. To evaluate the yearly growth of NMP the total number of prescriptions were compared by year for medical prescribers and NMP. Results: The overall number of prescriptions issued by all prescribers increased by 33% from 2011 to 2015. Nurse prescriptions rose from 49,583 in 2011 to 94,694 in 2015 and pharmacist prescriptions rose from 909 to 11,766 in the same period. NMP issued prescriptions rose by 28% per year compared to 9% in those issued by medical prescribers. In 2015 NMPs were prescribing 7% of all medications issued in community palliative care. The number of prescriptions issued by nurse prescribers in community palliative care in England has doubled since 2012. The increase in NMP activity in palliative care is almost entirely attributable to prescriptions for opioid medications. Nevertheless, the annual growth in NMP prescriptions was less than 1% a year in relation to total community palliative care prescribing activity in England.

Conclusion: This data provides empirical evidence to demonstrate non-medical prescribers working in palliative care are prescribing the full range of drugs at their disposal and proportionally more opioids than medical prescribers. However, the impact of non-medical prescribing in terms of proportion of overall prescriptions issued remains small. At the current rate of growth it would be 20 years before non-medical prescribers were prescribing 25% of all drugs issued in community palliative care.

Abstract number: P309
Abstract type: Poster presentation
A Multidimensional Strategy to Improve Quality of Life in Patients with Multiple Symptoms and Palliative Care Needs: The Development of the MuSt-PC
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Background: Patients with an advanced illness often experience multiple symptoms in different dimensions (physical, social, psychological, spiritual). Simultaneously occurring symptoms may interact, with additive effects on quality of life. Whereas palliative care in the Netherlands is mostly provided by health care providers (HCPs) who are not specialized in the management of complex symptoms in patients with advanced illness, and, guidelines usually focus on single symptoms, it is likely that management of multiple symptoms is often not integrated and thus possibly can be improved.

Aim: To improve quality of life in patients with life-limiting diseases, by developing a smart tool that improves timely and adequate assessment and treatment of simultaneously occurring symptoms.

Methods: In part 1 of the project the MuSt-PC is developed, a tool that integrates multidimensional screening and management of symptoms. First, a systematic review is performed to identify previously developed strategies for multidimensional assessment and management of simultaneously occurring symptoms in palliative care. Second, a nationwide cross-sectional study on prevalence of symptoms in 700 patients with advanced illness is conducted to identify common combinations of symptoms. A RAND Delphi study is performed with HCPs specialized in palliative care to develop consensus-based management strategies for combinations of symptoms. Input from focus groups with specialized and non-specialized HCPs will provide insight in barriers and facilitators for successful implementation of the tool. In part 2, the effectiveness of the MuSt-PC is tested in a prospective stepped-wedge trial. The tool is further refined and disseminated in part 3.

Results: This project results in the MuSt-PC, including treatment strategies for common combinations of multiple symptoms. Moreover, it provides insight into the feasibility and effectiveness of the MuSt-PC, with quality of life as the primary endpoint. When the tool is effective we will disseminate the MuSt-PC nationwide and internationally for HCPs not specialized in palliative care, in a form that can be integrated in electronic medical records.

Conclusions: This national project runs from 2017 to 2020 and delivers valuable information on the occurrence of multidimensional symptoms and a strategy to manage these symptoms. If successful, it will improve the quality of life of patients with an advanced illness.

Funding
The project is funded by ZonMw.

Abstract number: P310
Abstract type: Poster presentation
French Validation of the Integrated Palliative Outcome Scale: Preliminary Results
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Background: For the development of palliative care research in the French context, it is crucial to have a validated tool for assessing patients’ palliative needs. The Integrated Palliative care has been expanding in recent years. However, there is a lack of evidence to demonstrate clinical and economic impact of NMP within a healthcare system serving an increasing number of people with palliative care needs. We developed a unique methodology to establish the level of NMP activity in palliative care across England and consider the contribution these prescribers are making at a national level compared to medical prescribing.

Methods: All prescriptions for 10 core palliative care drugs prescribed by GPs, nurses and pharmacists in England and dispensed in the community between April 2011 and April 2015 were extracted from the Prescribing Analysis Cost Tool (PACT) system. GPs represented medical prescribers and nurses and pharmacists represented NMPs. The data were broken down by prescriber and basic descriptive analysis of prescription frequencies by opioid, non-opioids and total prescriptions by year was undertaken. To evaluate the yearly growth of NMP the total number of prescriptions were compared by year for medical prescribers and NMP. Results: The overall number of prescriptions issued by all prescribers increased by 33% from 2011 to 2015. Nurse prescriptions rose from 49,583 in 2011 to 94,694 in 2015 and pharmacist prescriptions rose from 909 to 11,766 in the same period. NMP issued prescriptions rose by 28% per year compared to 9% in those issued by medical prescribers. In 2015 NMPs were prescribing 7% of all medications issued in community palliative care. The number of prescriptions issued by nurse prescribers in community palliative care in England has doubled since 2012. The increase in NMP activity in palliative care is almost entirely attributable to prescriptions for opioid medications. Nevertheless, the annual growth in NMP prescriptions was less than 1% a year in relation to total community palliative care prescribing activity in England.

Conclusion: This data provides empirical evidence to demonstrate non-medical prescribers working in palliative care are prescribing the full range of drugs at their disposal and proportionally more opioids than medical prescribers. However, the impact of non-medical prescribing in terms of proportion of overall prescriptions issued remains small. At the current rate of growth it would be 20 years before non-medical prescribers were prescribing 25% of all drugs issued in community palliative care.

Abstract number: P309
Abstract type: Poster presentation
A Multidimensional Strategy to Improve Quality of Life in Patients with Multiple Symptoms and Palliative Care Needs: The Development of the MuSt-PC
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Background: Patients with an advanced illness often experience multiple symptoms in different dimensions (physical, social, psychological, spiritual). Simultaneously occurring symptoms may interact, with additive effects on quality of life. Whereas palliative care in the Netherlands is mostly provided by health care providers (HCPs) who are not specialized in the management of complex symptoms in patients with advanced illness, and, guidelines usually focus on single symptoms, it is likely that management of multiple symptoms is often not integrated and thus possibly can be improved.

Aim: To improve quality of life in patients with life-limiting diseases, by developing a smart tool that improves timely and adequate assessment and treatment of simultaneously occurring symptoms.

Methods: In part 1 of the project the MuSt-PC is developed, a tool that integrates multidimensional screening and management of symptoms. First, a systematic review is performed to identify previously developed strategies for multidimensional assessment and management of simultaneously occurring symptoms in palliative care. Second, a nationwide cross-sectional study on prevalence of symptoms in 700 patients with advanced illness is conducted to identify common combinations of symptoms. A RAND Delphi study is performed with HCPs specialized in palliative care to develop consensus-based management strategies for combinations of symptoms. Input from focus groups with specialized and non-specialized HCPs will provide insight in barriers and facilitators for successful implementation of the tool. In part 2, the effectiveness of the MuSt-PC is tested in a prospective stepped-wedge trial. The tool is further refined and disseminated in part 3.

Results: This project results in the MuSt-PC, including treatment strategies for common combinations of multiple symptoms. Moreover, it provides insight into the feasibility and effectiveness of the MuSt-PC, with quality of life as the primary endpoint. When the tool is effective we will disseminate the MuSt-PC nationwide and internationally for HCPs not specialized in palliative care, in a form that can be integrated in electronic medical records.

Conclusions: This national project runs from 2017 to 2020 and delivers valuable information on the occurrence of multidimensional symptoms and a strategy to manage these symptoms. If successful, it will improve the quality of life of patients with an advanced illness.

Funding
The project is funded by ZonMw.
health status (0–10), palliative care needs (patient-IPOS, total and item scores) and quality of life (McGill Quality of Life scale Revised - MQOL-R; total score, physical, psychological, existential, relationship subscales) were assessed. In parallel, a staff member completed staff-IPOS. 3 days later (T2), the same process was repeated. 

Results: So far 117 palliative patients (62% women, mean age 68 years, 87.5% with an oncologic disease) participated. Cronbach’s alpha is 0.648 for patient-IPOS and 0.752 for staff-IPOS. Results show a significant correlation for the total score (r=.516, p<.01) between staff and patient IPOS. Concerning construct validity, results show a significant negative relationship between IPOS and MQOL-R total scores (r=-.562,p<.01), IPOS physical area and MQOL-R physical subscale (r=-.428, p<.01), IPOS psychological items and MQOL-R psychological subscale (r=-.543 and .641, p<.01), IPOS existential item and MQOL-R existential subscale (r=.334, p<.01), IPOS social item and MQOL social subscale (r=.425, p<.01). Concerning sensitivity to change (based on patients’ general health status change), results indicate that (i) IPOS total score for patients with a stable state did not differ significantly between T1 and T2 (20.4 ± 6.3 vs 19.1 ± 6.7, p>.05), (ii) IPOS total score for patients with an improved state decreased significantly (23.5 ± 8.1 vs 19.9 ± 6.4, p<.02), and (iii) IPOS total score for patients with a worsened state did not differ significantly (22.3 ± 8.5 vs 22.6 ± 7.0, p>.05). 

Conclusion: Initial results indicate that French IPOS has sufficient reliability and represents a valid measure of palliative patients’ physical, psychological, existential, and social needs. While detecting improvement and stability in patients’ state, IPOS seems less sensitive to worsening states. The whole data presented at the Congress will allow a more detailed analysis of these aspects.

Abstract number: P311 
Abstract type: Poster presentation 
Regional Variations in the Association between Geographical Access to Hospice Inpatient Unit and Place of Death - A National Population-based Study in England 
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Background: Even though socio-demographical and clinical characteristics clearly differ across regions in England, studies investigating determinants of place of death (POD) rarely account for these regional differences. Understanding how these determinants and their effects vary by region is important in improving region-specific end-of-life care and reducing inequity in service provision. 

Aim: To explore regional variations in the association between geographical access to hospices and POD in England, UK. 

Method: Adult deaths (aged ≥25) from non-accidental causes in England in 2014 (N=431735) were extracted from the National Death Registry. Adult hospice data was derived from Hospice UK. Geographical access to hospices was derived by measuring the distance from a patient’s place of residence to their closest hospice. A modified Poisson regression model was developed to examine the association between POD and geographical access, separately for nine geographical regions in England. Geographical access to hospice was the explanatory variable, divided into four groups (0–2Km; 2–5Km; 5–10Km; Over 10Km). POD was the outcome variable, coded as ‘1’ for hospice deaths and ‘0’ for home deaths. Each model was adjusted for decedent’s characteristics: age, gender, underlying cause of death, number of contributory cause of death, marital status, area-level socio-economic status, and settlement type. 

Proportional Ratios (PRs) and 95% Confidence Intervals (CIs) were used to describe results. 

Results: There is an inverse relationship between geographical distance to hospice and hospice deaths in six of the nine regions, suggesting that a greater distance to hospice is associated with fewer inpatient hospice deaths. In all regions, patients living more than 10Km from hospice had consistently lower chances of dying in a hospice (PR range: 0.47–0.92) compared to patients living within 2Km of a hospice. This is marked in regions in North England, comprising North East, Yorkshire-Humberside, and North West (PRs 0.47, 0.63 & 0.59 respectively; p < 0.001). 

Conclusion: Geographical access to hospice has an effect on inpatient hospice deaths, with effects strongest in regions North of England, suggesting regional disparities. The study highlights the need to consider geographical factors and differences in planning palliative care resources. 

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Abstract number: P312 
Abstract type: Poster presentation 
Awareness of Dementia among Relatives of Nursing Homes (NHs) 
Residents Dying with Dementia: Results of the EU FP7 PACE Cross-sectional Study in Six EU Countries 
Kijowska, Violetta1, Szczerbitko, Katarzyna, Baraniska, Ilona1, Payne, Sheila2, Chalfout, Garath3, Engels, Yvonne4, Leppaluoto, Sari5, Giambassi, Giovanni5, Van der Steen, Jenny5, Pivodic, Lara5, Deliens, Luc5, Van den Block, Lieve5, on behalf of PACE 
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Background: Disclosure of the diagnosis to a person with dementia (PWD) and his relatives is important. It is unknown how often relatives of PWDs in nursing homes (NHs) do realize that the PWD has dementia. 

Aim: This study, as part of the EU PACE project, aims to describe how often relatives of NHs residents who died with dementia were aware that their loved one had dementia, and which resident, relative, and facility characteristics are associated with relatives’ awareness of dementia. 

Design: Cross-sectional survey in representative sample of NHs in 6 EU countries: Belgium (BE), England (EN), Finland (FI), Italy (IT), the Netherlands (NL) and Poland (PL), 2015. Study sample included 512 deceased PWD for whom a valid questionnaires from relative, nursing staff and physician were received. Logistic regression model was used to find factors associated with relatives’ awareness of dementia. 

Results: Of 1040 residents who died with dementia, 49.2% of their relatives responded. In 25.2% of cases, relatives indicated they were unaware that their loved one had dementia, ranging from 18.2% (EN) to 36.8% (IT). Compared to FI (reference result for all countries), relatives from IT were more than twice less likely to be unaware (OR=2.7, p=0.024). Awareness of the diagnosis by relatives was related to severe (OR=2.9, p=0.003) and more advanced (OR=4.7, p<0.001) stages of dementia one month before death, with 47.9% of relatives being unaware when
dementia was mild and 17.8% unaware when dementia was advanced. The median time of dementia duration was longer than 18 months in residents whose relatives were aware (M=60, p=0.003). The milder the stage of dementia (none or mild) at the time of admission to the NH (OR=0.1, p<0.001), the less family ties (other than spouse or child) to the deceased person was (OR=0.25, p=0.02), the less likely relatives were aware. Residents age below 70 years, and onset of dementia after admission to the NH were also related to relatives’ being unaware of the dementia.

Conclusion: In about 1 out of 4 deceased PWD that lived in a NH, the relative did not realize that this person had been diagnosed with dementia. Better understanding of relatives’ awareness of dementia can provide the clue to more effective communication strategies toward relatives and thereby possibly increasing the quality of end-of-life care for residents dying with dementia.

Funding
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Abstract number: P313
Abstract type: Poster presentation

Moral Experiences of Humanitarian Health Care Professionals Caring for Patients Who Are Dying or Likely to Die in a Humanitarian Crisis

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Wars, disasters and epidemics affect millions of individuals every year. International non-governmental organizations respond to many of these crises and provide healthcare in settings ranging from a field hospital deployed after an earthquake, to a health clinic in a longstanding refugee camp, to a treatment center during an infectious disease outbreak. A primary focus of these activities is to save lives. However, inevitably, many patients cannot be saved. We undertook an interpretive description study to investigate the moral experiences (i.e. encounters in which values were experienced as being realized or thwarted) of caring for patients who were dying or likely to die in a humanitarian crisis.

We interviewed 2 sets of participants: 12 humanitarian policy-makers (of whom, 11 had experience as health professionals in humanitarian crises) and 12 humanitarian health professionals.

We identified five themes, all of which intersect with values of compassion and justice. 1) Participants described intervening to ease the suffering of dying patients as an inherent aspect of humanitarianism and their duty as a health professional. 2) Participants also expressed that promoting dignity was of critical importance, stemming from a recognition of shared humanity and as an act of respect. It often extended beyond the dying person to include his or her family. 3) Since humanitarian action is provided in situations of scarcity, prioritization is inescapable. While all acknowledged the primacy of curative care in emergencies, they also emphasized the importance of ensuring that care for the dying was attended to, including during triage. 4) Participants reported working within and pushing against systemic constraints such as legal or logistical barriers to opioids, lack of guidelines, and conflicting views with colleagues. 5) Given the stakes involved, participants felt a heavy weight of responsibility. They related stories of what they considered care done well - a source of satisfaction - and care that was not done well - often leading to feelings of frustration, distress or regret. They also identified opportunities and strategies to support health professionals as they respond to these situations.

These findings illuminate experiences responding to patients who are dying or likely to die, and point to the need to make space for palliative, as well as curative, approaches to care in situations of humanitarian crises.

Abstract number: P314
Abstract type: Poster presentation

The Vital Role of Specialized Ambulatory Palliative Care: Focussing on the Place of Death

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Background: In Germany since April 2007 specialized ambulatory palliative care is introduced into the health care system by law. The aim of the new article in the social insurance code (SGB 5) was fastening extended palliative care for everybody and improving care at home at the end of life. We studied, whether palliative patients could stay at home in the last days of their life.

Methods: We studied data from the year 2015 from a German statutory health insurance company in the federal state of Baden-Württemberg. 3,872 million people - nearly 37% of the inhabitants - were covered by this company. Palliative care patients were identified using the ICD-10 Code Z51.5 and/or the medical fee schedule digit of the rating scale (EBM) 03370,03371, 03372,03373. Patients cared by a palliative care team (SAPV) were identified using the digits 01425 and/or 01426.

Results: We found 21,190 palliative care patients (0,55%) in this group, separated in 6 subgroups for diagnosis (HIV , cancer, neurologic-heart- lung- or liver-diseases). 19,507 (92,06%) patients were cared by general palliative care and 1683 (7,94%) patients by specialized ambulatory palliative care. Mortality over all patients was 1,08% (41,800) and mortality of palliative patients was 44,08% (9494). 19.833 (47,45%) people of the nonpalliative- group died in a hospital whereas only 2,208 (23,25%) of the palliative patients died there. 160 (13,39%) palliative patients cared by a palliative care team died in a hospital and 2048 (24,68%) palliative patients cared by general care.

Conclusion: Good palliative care for people at the end of life is an urgent aim everywhere in the world and seems to be an indicator for the quality of a human health care system. In Baden-Württemberg most of palliative patients died at home cared by general practitioners and ambulatory nursing services. Palliative care teams care only for a small part of these patients. Despite a high burden of symptoms the teams work very successful. This means for palliative patients at the end of life, that most of these can die at home.

Abstract number: P315
Abstract type: Poster presentation

Compassionate End-of-Life Care in Residential Care Settings - A Quality Improvement Approach

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Background: In Ireland 28,000 people live and 7,500 die each year in residential care centres (RCCs). The Irish Hospice Foundation introduced a quality improvement (QI) programme to assist RCCs to identify, reflect and implement changes to enable delivery of compassionate end of life care as part of their service, to benefit residents, families and staff. This QI programme, called Journey of Change (JOC), commenced in 2015, and over 100 residential care settings participated. An independent evaluation of the JOC programme was conducted in 2016.

Methods: The evaluation framework comprised of: outcome achievement, measuring the impact of participation, and assessment of outcomes.
and learning. An utilisation focused evaluation approach was taken which combined desk research and field work. A mixed methods approach was used as follows:

1. Desk research, literature review and a review of the documentation relevant to the establishment of the Journey of Care Programme.
2. Field work - five case studies as well as an interview with the Director of Nursing in each location. The number of case studies selected was small, because the intention was to get an overview of how the Programme was operating across a range of settings, rather than a statistically significant sample.

**Results:** The evaluation demonstrated that when all elements of the JOC programme are fully applied, it has capacity to improve end of life care. Significant changes in practice were identified in relation to end of life planning, care at the time of death and after death. Notably, staff were less likely to want to transfer patients to hospital, more aware of when to access specialist palliative care & GP services and more confident in managing pain at end of life. Key to the success of the programme is support from management, sites to agree and own their vision for end of life care, multidisciplinary participation, and availing of external support for the JOC facilitators.

**Conclusion:** The evaluation found that the programme has the capacity to improve end-of-life care in participating residential care centres. The establishment of an end of life network will support the sustainability of the programme into the future, and the content of the workshops need to be condensed. The future governance of the programme must ensure that as well as addressing the culture of end of life care, the programme must also concentrate improvements in clinical care, to ensure delivery of holistic compassionate care.

**Abstract number:** P316

**Abstract type:** Poster presentation

**Patterns of Collaborations between GPs and Health Care Professionals in Palliative Care and Associated Factors**

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**Background:** End-of-life care is a complex activity which demands that the patient, the caring relatives, general practitioners (GPs) and palliative care (PC) professionals work together in an effective manner. Increased interprofessional collaboration might improve end-of-life patient care. **Objectives:** The objective of the study was to assess GPs’ patterns of collaboration with health/social care professionals in end-of-life situations and PC quality characteristics. **Methods:** Cross-sectional survey involving a stratified random sample of 2000 GPs in Switzerland in 2014. This survey collected data with socio-demographic questions, importance of collaborations with health and social care professionals to provide PC as well as factors assessing quality of end-of-life patient care. Principal Components Analysis (PCA) and multiple regression models were conducted to investigate the factor structure of GPs’ attitudes towards interprofessional collaborations to provide PC and their correlates. **Results:** The questionnaire was completed by 31% of GPs. The 18 items on importance of collaborations with different health and social care professionals for PC yielded 5 factors listed in decreasing order importance (percent GPs rating collaborations as important/very important): collaborations associated with home care nursing services (95%), with hospital care and the respective specialists (67%), with geriatric care (44%), with PC specialists (42%) and with psychosocial care (8%). Multiple regression analysis showed that GPs attributing more importance to collaborations with PC specialists were more likely to base their end-of-life decisions on advance directives, to acknowledge the importance of patients choosing their place of death themselves and they were also more likely to get involved in the PC decisions concerning their hospitalized patients. **Conclusions:** The respondent GPs seem to favor PC collaborations in the outpatient over the inpatient sector. Thus, GPs may benefit from closer collaborations within the inpatient sector to provide continuous care for end-of-life patients. In this context, the collaboration with specialized mobile PC services seems particularly important. Our results indicated an association between GP and PC specialist collaboration and improved aspects of PC including positive attitude towards advance directives, good GP-hospital communication and enabling patients to choose their place of death themselves.

**Abstract number:** P317

**Abstract type:** Poster presentation

**Does Distance Matter? Rural and Urban Patterns of Place of Death in Relation to Distance from Hospital and Hospice**

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**Background:** Research to date on determinants of Place of Death (PoD) has focused on patients & disease factors. Little attention has been paid to the role of health services factors - in particular, geographical access to Palliative and End of life care (PEoLC) services. This study explores the association between geographical access to PEoLC services and PoD, comparing rural and urban areas. **Methods:** All non-accidental adult deaths of patients aged ≥25 in rural (N=84446) and urban areas (N=344000), in England in 2014, were extracted from the UK death registry. Hospices & hospitals data were collected from Hospice, UK, & NHS Digital. Geographical access was estimated by measuring the straight-line distance from patient’s place of residence to their closest hospital or hospice. A modified Poisson regression model was used to evaluate the association between access and PoD, separately for rural and urban dwellers. Models were adjusted for age, gender, underlying cause of death, Number of contributory cause of deaths, marital status, area-level Socio-economic status and regions. PoD was the outcome variable, coded as 1 for hospice or hospital death and 0 for home death. Access was the explanatory variable, divided into 4-groups (0-2Km, 2-5Km, 5-10Km & >10Km). Proportional Ratios (PRs) and 95% Confidence Intervals (CIs) were used to describe results. **Results:** Results show an inverse association between geographical access to hospice and hospice deaths, with a clear gradient in rural and urban areas (Urban PR range:0.72-0.93; Rural PR range:0.92-0.71) suggesting that inpatient hospice death declines with increasing distance from hospice. Results also show that patients living more than 2Km in rural areas (PR range:0.95-0.94, p<0.001) and >5Km in urban areas (PR range:0.98-0.97) from
Improving quality of dying (QOD) is a key goal in palliative care (PC). The quality of dying and death questionnaire (QODD-ESP-12) is a 12-item validated instrument in Spanish that assesses QOD. The quality of dying and death questionnaire (QODD-ESP-12) is a 12-item validated instrument in Spanish that measures QOD (coef[95% CI]: 1.00; 1.48, p=.04), but not with CG anxiety or depression.

Conclusions: CG reported QOD was associated with patient reported outcomes during the last month of life. No studies have shown whether CG reported QOD is associated with patient reported outcomes during the last month of life. The aim of this study is to explore if CG reported QOD is associated with patient reported QOL during the last month of life.

Methods: Advanced cancer patients (ACP) participating in an outpatient PC clinic in Puente Alto, Chile and their primary CG were enrolled in this prospective study. Patients inclusion criteria included age > 18, a primary CG willing to participate, not having delirium and a Karnofsky performance status (KPS) < 80. After informed consent, ACP completed a QOL survey (EORTC-QLQ-C15) at baseline and then every two weeks by phone until the patient was unable to participate or death. Between 8 and 12 weeks after patients’ death, CG were contacted to complete the QODD-ESP-12 (0-100 scale), the FAMCARE-6 (5-30 scale) to assess satisfaction with care and the HADS (cutoff > 8 points) to assess CG anxiety and depression.

Results: 208 dyads were enrolled. 114 dyads followed-up until death. 77 ACP completed the QOL questionnaire during the last month of life and 77 CG the post-mortem assessment. ACP mean age was 63, 54% female and 45% had gastrointestinal cancer. CG mean age was 49 and 71% female. ACP reported QOL was (mean[SD]: 67[26]). CG reported QOD was (mean[SD]: 67[16]). In the univariate analysis CG reported QOD was associated with patient QOL (coef[95% CI]: 1.00; 1.48, p=.007), CG satisfaction with care (94[22;1.65], p=.01) and CG anxiety (85.7[16.07;1.07], p=.03) but not CG depression (2.11[9.64;5.42], p=.58). In the multivariate analysis, CG reported QOD was independently associated with patient reported QOL (1.6[0.01;0.2], p=.029), CG satisfaction with care (76[04;1.48], p=.04), but not with CG anxiety or depression.

Conclusions: CG reported QOD, measured with the QODD-ESP-12, is independently associated with ACP reported QOL during the last month of life when adjusted by CG satisfaction with care and CG depression and anxiety. Future research should explore whether CG reported QOD using QODD-ESP-12 is sensitive to interventions during EOL in ACP.
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Background: Factors that prevent burnout, promote resilience and longevity in palliative care have not been well-studied.

Objectives: We studied Palliative Care Practitioners who were in the profession for more than 10 years and looked at coping strategies that were associated with less burnout and psychological morbidity compared with those who had practised for less than 10 years.

Methods:
Design: We conducted a subgroup analysis of our earlier multi-centre, prospective, cross-sectional study on the prevalence of burnout and psychological morbidity among PCP (physicians, nurses and social workers) within the public healthcare sector in Singapore. We used The Maslach Burnout Inventory to define Burnout and the General health Questionnaire (GHQ-12) for psychological morbidity. The study also included demographic factors and the use of coping mechanisms.

Characteristics: The study participants were PCPs (doctors, nurses and social workers) from the public healthcare institutions in Singapore.

Results: We surveyed 273 patients in our primary survey. Of these respondents, there were 30 in our subgroup analysis who had been working in palliative care for more than 10 years. 26 (86.7%) were female and 4 male (13.3%). There were 10 doctors (33.3%), 18 nurses (60.0%) and 2 social workers (6.7%). 7 (25.0%) were working in a hospital, 6 (21.4%) in home hospice and 11 (39.3%) in an inpatient hospice and 4 (14.3%) in other healthcare sites.

We looked at the association between burnout, psychological morbidity and 14 of the coping mechanisms described by Svetz. We found that 'Clinical Variety' - where PCPs do a mix of clinical, administrative, teaching and research work was the only coping mechanism associated with lower burnout ($p = 0.047$). We also compared the use of clinical variety as a coping mechanism with those PCPs with <= 10 years and those > 10 years in palliative care, we found that those > 10 years used clinical variety more as a coping mechanism - 22 (86.4%) vs 4 (15.6%) ($p = 0.021$) compared against those with <= 10 years where only 138 (61.6%) reported clinical variety compared and 86 (38.4%) who did not.

Conclusion: Palliative care practitioners who have practiced for >10 years and who use clinical variety as a coping mechanism had lower rates of burnout. We encourage both practitioners and their leaders to consider varying their workload to allow for more diverse activities apart from clinical work to prevent burnout.

Abstract number: P321
Abstract type: Poster presentation

Look after Who Looks after for Fighting Burnout.

Can Coping Strategies Help in Home Palliative Care?
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Background: It is crucial paying close attention to health care professionals’ (HCPs) well-being in palliative care settings. Working in end-of-life care may elicit in them feelings of helplessness, meaningless and fear of death, which in turn lead to disengagement from patients and facilitate the development of burnout symptoms.

Aim: This study examines the HCPs’ degree of psychophysical well-being providing home-based palliative care. The goal is to investigate potential correlations between dimensions of burnout syndrome and different coping strategies in order to promote programs and practical ways to mitigate this risk.

Methods: The observational cross-sectional study involved 275 HCPs working in 17 home palliative care teams situated in 9 Italian regions (physicians 50%, nurses 36% and psychologists 14%). N=207 HCPs completed the questionnaires (Maslach Burnout Inventory, General Health Questionnaire 12, Psycho-Physiological Questionnaire of the Battery CBA 2.0 and Coping Orientation to Problems Experienced). Data were processed by SPSS 23. The analyses of correlations were run using Spearman’s rho. The differences between two or more groups were tested respectively through a Mann-Whitney U test and a one way ANOVA on ranks.

Results: Just the 11% of HCPs were found emotionally exhausted or not fulfilled at work (20%), whereas the 57% complained depersonalization symptoms. Burnout dimensions of emotional exhaustion (EE) and depersonalization (DP) were found to be associated with avoidance coping strategies ($p > .01$) whereas problem solving, positive attitude were negatively associated with EE and DP ($p < .01$) and positively with personal accomplishment (PA) ($p < .01$). Moreover using avoidance strategies were related to a worse psychological and physical condition ($p < .01$).

Conclusion: In view of findings, it will be possible and necessary to develop tailored training and support programmes to promote the best strategies to manage burnout symptoms in HCPs.

Abstract number: P322
Abstract type: Poster presentation

Recommendations on Integrated Palliative Care: International Surveys of Practitioners and Experts
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Background: Integrated palliative care (IPC) arguably improves quality of life and satisfaction with care, and is advocated by the World Health Organisation. However, little is known about which elements are regarded as most important, and should be priorities for implementation.

Aim: To develop international recommendations and rank priorities for developing integrated palliative care.

Design: Using consensus techniques, we undertook:
1) international expert consultation using a workshop with roundtable discussions to develop 23 written statements on IPC, which were then ranked online by international experts;
2) statements were distributed via an online survey to participants attending the Workshop and 2 Massive Open Online Courses (MOOC). Data were analysed using descriptive statistics and qualitative content analysis of open responses.

Setting/participants: Online survey data were obtained from workshop n=21, MOOC 1 n=398 and MOOC 2 n=126 participants (total n=545). Participants represented 72 countries from all continents, and included all professions involved in palliative care.

Results: We identified that ‘digital transfer of information to facilitate integration’ was ranked in the top 4 by all groups. While ‘The extension of palliative care to non-cancer patients’ was ranked in the top 4 by all groups. MOOC groups (mostly clinicians) top ranks were ‘IPC should include all dimensions of care’ and ‘non-cancer IPC’, while academic experts top ranks were ‘mandatory IPC education for all HCPs’, ‘outcome measures’ and ‘clarification of IPC language’. Open comments highlighted some consistent differences.
Conclusion: There was consensus about the need for digital information transfer and offering IPC to non-cancer patients but differences in priorities between experts and practitioners reflect a research rather than clinical focus. This raises questions about how IPC policies are prioritised, implemented and the influence of different stakeholders.

Abstract number: P323
Abstract type: Poster presentation

The Relevance of Nurse Prescribing for Hospice/Palliative Care
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Since 2007, experienced registered nurses and midwives in Ireland who have passed a rigorous 6-month theory and practice-based educational program may prescribe medicinal products that are relevant to their specific clinical practices. Ireland is one of approximately 34 countries now where select nurses and/or midwives prescribe medications and other medicinal products. As this scope of practice extension is relatively new, only a small amount of research evidence exists to substantiate the need for and value of nurse/midwife prescribing. Additional research is needed as all patients require safe and effective prescribing. A qualitative (ethnographic/phenomenological) study involving interviews of 12 key informant nurse/midwife prescribers in Ireland was undertaken in mid-2017 for insight into the need for and value of nurse/midwife prescribing.

Methods: Nurse/midwife prescribers were chosen to provide this information, through in-depth interviews of volunteers at a time and place of their choice, as they have the most knowledge and insight into their prescribing work.

Results: Six data themes were identified.

1) More than a prescription.
2) Highly individualized evidence-based specialist care.
3) Assured, timely, and rapid accessibility to needed care for patients.
4) Health system and health care efficiency gains.
5) Satisfaction with nurse/midwife prescriber services.
6) Care quality improvements.

Conclusion: This study demonstrated much relevance for and value from nurse/midwife prescribing for many different client groups in Ireland. Given the need of hospice/palliative patients for timely and informed prescribing, autonomous nurse prescribing is recommended. Nurses working in nursing homes and palliative home care nurses, in particular, should become prescribers. Research to validate and quantify these findings in hospice/palliative care settings across Ireland and other countries would be helpful.

Abstract number: P324
Abstract type: Poster presentation

Current End-of-Life Care Measurement Approaches Used by 15 Countries Leading in This Care Provision: A Foundation From Which to Move Forward
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Background: Measuring the quality of end-of-life care is key to informing improvements in clinical care, research, policy and service commissioning. This study analyses current measurement practices used by countries leading in end-of-life care, to inform future policy and practice.

Aim: To identify and describe national quality indicators and supporting policies used by countries leading in their provision of end-of-life care.

Methods: A systematic environmental scan of national policies for end-of-life care; and national structural, process and outcome indicators used to monitor quality of end-of-life care, from participating countries. This included a systematic web search with predefined search terms and inclusion criteria and targeted communication with countries ranked in the top 10 of the ‘quality of care’ domain of The 2015 Quality of Death Index: Ranking palliative care across the world. Data analysis occurred through:

1) Analysis of policies and national approaches to quality measurement of end-of-life care;
2) Analysis of nationally available end-of-life care indicators.

Ethics approval was obtained.

Results: The systematic search and targeted communications resulted in 274 documents for review. Contact with key experts was established with all participating countries. National policy support for end-of-life care measurement is evident in ten of the 15 included countries (66%). Five countries have national indicator sets with two of these suitable for all service providers. No countries mandate indicator use and there is limited evidence of consumer engagement in indicator development. There were 128 indicators available for analysis with 62% outcome measures, 38% process measures and no structural measures. Most indicators relate to symptom management (38%), social care (32%) or care delivery (27%).

Conclusions: Effective strategies for the measurement of end-of-life care quality are a global priority, as they are vital to ensuring access to optimal care across all settings. Internationally there is variance in approaches used and rarely all care domains or service providers are accounted for. Current heterogeneity in approaches used make it difficult to compare health systems on outcomes other than cost and healthcare use. Future indicators would benefit from consumer input to strengthen their patient and family centeredness, mapping to available standards and data sources and consideration of all service providers involved in end-of-life care.

Abstract number: P325
Abstract type: Poster presentation

How Do Carers Feature in End of Life Care Policy? Scoping and Narrative Summary of UK National Policy/Guidelines on Implementing Person-centred Carer Assessment and Support
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Background: The ethos of EOLC embraces not just patients, but also family/friends who support them as carers. For over a decade UK health-care policy has acknowledged that carers’ needs should be assessed and addressed in end of life care (EOLC).

Aim: To review national policy, guidelines and operational documents on carers and EOLC to examine the extent to which policy addresses carer assessment and support and its implementation in practice.

Methods: Policy documents are not indexed by databases such as Medline preventing a conventional literature review strategy. Instead a scoping review was conducted using searches of public body websites (eg Department of Health and National Institute for Health and Care Excellence; provider organisations (eg National Council of Palliative Care, Hospice UK) and charities (eg Carers UK, Carers Trust), personal resources (researcher libraries, personal contacts, serendipitous discovery) and ‘snowballing’ and reference checking. Inclusion criteria: publications from 2004 onward, national guidance on health and social care delivery of palliative and end of life care, adult carers. Exclusion criteria: policy/guidance on children. Policy content was mapped to areas key to practice implementation for carers at individual and organisation levels.
Results: EOLC policy content mapping identified practice implementation issues for patients but rarely for carers. Correspondingly, generic carer strategy/guidance focused on carers but with little reference to EOLC practice. Thus neither set of guidance addresses the needs of carers at EOL. Three key findings emerged:

1) The move from a distinct focus on carers (their assessment and support) in early policy guidance to a joint patient/carer unit approach with resultant loss of recognition of carers’ separate situation;
2) Limiting of assessment of support needs to statutory social care assessments which do not address carers’ needs for healthcare support;
3) Lack of detail on organisational implementation issues: carer records, workforce capacity for carer assessment, training on assessment and leadership/champions for carers.

Conclusion: This scoping review has highlighted an absence of policy detail about carer identification, assessment and support in EOLC and the structures and processes required for its implementation in practice. These issues need to be fully addressed in order to support carers in their crucial role in EOLC.

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Abstract type: Poster presentation

Evaluation of a Knowledge Exchange Initiative to Disseminate Palliative Care Research in Scotland

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Background: Academic research is highly trusted by policy-makers and practitioners but needs to be translated through discussion and engagement (Morton, 2015). The Scottish Government included a commitment to strengthening palliative care research and knowledge exchange in its national strategy for palliative and end of life care, 2016-21. To support this, a systematic scoping review of Scottish palliative care research was undertaken, and a knowledge exchange initiative was designed to facilitate research uptake.

Aims: To evaluate:

(i) the perceived usefulness of a palliative care knowledge exchange initiative and
(ii) the effect of the initiative on research uptake.

Methods: Five evidence review groups consisting of academics, health and social care professionals, service managers, educators and policy-makers were formed to explore palliative care research relevant to five policy committees. A non-academic research user from each group synthesized and presented findings to an audience of 100 stakeholders at a separate knowledge exchange meeting. Questionnaires captured views of participants in the evidence review groups, and of attendees at the knowledge exchange event itself.

Discussion: STPs will determine the future of health and care services in England over the next five years. While most STPs do include

Results: Fifteen of 23 participants in the evidence review groups completed an online questionnaire. All reported that they found the evidence review process useful and relevant. Free-text responses revealed that it facilitated connections between research users and producers; created a space within which research users could engage with evidence, and resulted in instances where evidence was subsequently used to inform palliative care education and commissioning of services. Following the knowledge exchange meeting, 46% of stakeholders completed post-event questions. 78% rated the event “very useful” and 22% described it as “quite useful”. 30% said they would promote research discussed or use findings in practice; and 26% said they would disseminate findings to colleagues and local or national networks.

Conclusion: An action-focused knowledge exchange process was successfully developed to synthesize and appraise research literature relevant to five commitments outlined in the Scottish strategy for palliative care. Key research findings were mapped to specific policy commitments and shared with palliative care stakeholders, creating opportunities for evidence to inform palliative care education, service innovation, commissioning, policy and practice in Scotland.

Abstract number: P327
Abstract type: Poster presentation

Strategies to Support End of Life Care: National Comparison and Qualitative Analysis

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Background: In 2015, National Health Service organisations and local authorities in England were required to come together to form 44 geographical “footprints”, each responsible for producing a Sustainability and Transformation Plan (STP) to direct the future of health and care in their area. While the UK Government has highlighted the importance of STPs for improving end of life care, there has been no analysis of whether and how STPs aim to achieve this.

Aim: To identify, quantify and describe STP plans for improving end of life care.

Method: All 44 STPs were identified via the relevant STP website. The most up to date documents as of 1st September 2017 were used. STPs were systematically searched for key words relating to end of life care. Summative content analysis was used to identify and quantify themes, with a focus on plans to improve end of life care.

Results: STPs varied in the number of times key words relating to end of life care were used. 35/44 STPs included one or more plans to improve end of life care, though the level of detail provided was highly variable. 13/44 STPs planned to continue or expand existing models of care for which there was some local evidence of impact. 35/44 STPs included plans to introduce new models of care, which were grouped into five themes:

1. earlier and better recognition of those at the end of their life (9/44 STPs);
2. more patients having advance care plans in place (17/44 STPs);
3. digital systems to share EOL preferences (19/44 STPs);
4. improved collaborative working between multidisciplinary professionals (17/44 STPs);
5. increased access to trained palliative care professionals either in person or via a help-line (12/44 STPs). There were few details on how these plans would be implemented, or the anticipated improvement in outcomes.

Discussion: STPs will determine the future of health and care services in England over the next five years. While most STPs do include...
aspirations to improve end of life care, there is a lack of information on implementation of plans or expected outcomes. The five themes identified should be used to guide clinical and academic engagement with STP policy to enhance their impact, for example through identification of existing evidence, and evaluation of new models to help ensure best practice is shared nationally and to inform future policy.

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**Abstract number:** P328
**Abstract type:** Poster presentation

**Palliative Care Provision in Romania**

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**Introduction:** Since 2015 the health care reform in Romania financed through a World Bank loan has a palliative care (PC) component that aims to increase the capacity of services with 29 inpatient units, 90 home care teams and 90 outpatients' clinics.

**Aim:** To understand the PC service provision in Romania in terms of quantity and quality

**Method:** The PC technical working group in Ministry of Health has developed a survey for PC providers in Romania that was send through the 41 district health board to all PC providers in Romania. The survey had items concerning location and type of services, beneficiaries, resources available (human, equipment and materials), processes happening in the services (holistic assessment, use of standardized scales, family conference, interdisciplinary meetings) sources of funding and cost.

**Results:** Out of 125 providers available in 2016, 94 providers answered the questionnaires. 82 inpatients PC services, 8 PC home based services and 4 providers with services in multiple locations. This situation is contrary to the expectation of the population who prefers home care and is the result of a cumbersome and insufficient funding for home care services. Unequal distribution of providers in the country with more services around the education centers and a lack of services in the southern part of the country (13 out of 41 districts have no PC service). 3% service are pediatric 16% both adults and children and 81% are for adults only. Except 1 county Iasi all the others have less than the required numbers of beds for PC. Looking at admissions and deaths in the PC in patient services a quarter of the services are closer to long term care services than PC services. Only 2 services (one public, one NGO) comply totally with the staffing requirements (most services do not comply with requirements for social workers). Use of national PC protocols is unequal among providers, 20 % do not use at all the protocols. For pain assessment most of respondents use just VAS, 56 % of providers do not have bereavement services. Real cost/ day inpatient unit of both services who comply with the standards is above the allocated cost from the house of insurance.

**Conclusion:** First thorough report from PC providers shows big variety in terms distribution, type and quality of services, and ineffective funding mechanisms. This reporting will be done annually from 2018 onwards and will allow benchmarking and spotting areas that need development.

**Abstract number:** P329
**Abstract type:** Poster presentation

**Portuguese Medical Students’ Perceptions and Willingness to Perform Euthanasia and Physician-assisted Suicide: Results from a Mixed-methods Study**

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**Background:** Euthanasia and physician-assisted suicide (EPAS) have become a highly present and controversial subject of ethical, political and societal debates in Portugal. Few of these discussions are based on empirical research and evidence concerning end-of-life decisions. While medical students will face ethical issues throughout their lives as physicians, very little is known about their perceptions and willingness to perform EPAS.

**Aims:** To study medical students’ perceptions and willingness to perform EPAS.

**Methods:** A mixed methods study was conducted with Portuguese medical students, including a nationwide cross-sectional survey among the medical students who attended a national assembly of the National Medical Students Association (ANEM) in 2016, and two focus groups with representatives from the Office on Human Rights and Peace of the ANEM.

**Results:** 84 students (100% response rate) completed the survey and 23 participated in the focus groups. In case of a terminal illness, 38.6% of the respondents expressed their willingness to perform euthanasia, 36.1% assisted suicide, and 44.6% and 39.8% responded “I don’t know”, respectively. These percentages dropped down to 19.3% both in terms of their willingness to perform euthanasia and physician assisted suicide in case of a non-terminal illness. In this case, 42.2% and 32.5% of the respondents answered “I don’t know”, respectively. 95.2% of participants did not have any education about palliative care before completing the survey.

During the focus groups, discussions were raised among the participants about whether or not EPAS should be considered part of end-of-life care practices. The majority considered it as a no and highlighted the tension between the legalization and practice of EPAS and their ethical and deontological code as physicians.

**Conclusions:** This is the first Portuguese study to ask medical students about their willingness to take action as regards to euthanasia and physician assisted suicide without biased phrasing. Our findings show a profound problem and major concern in the actual discussion about EPAS in Portugal. The willingness to perform EPAS is high. If allowed, who would perform it? It seems that young medical students, still with neither clinical experience nor education about palliative care, are those willing to perform EPAS. Education about palliative care and research about end-of-life decisions and practices are needed before the legalization of EPAS in this country.

**Abstract number:** P330
**Abstract type:** Poster presentation

**Integrating Palliative Care and Intensive Care: A Spectrum of Ethical Issues**

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Background: The integration of palliative care (PC) in intensive care (IC) can be framed ethically. By integrating the core principles of PC in IC, the ethical principles of autonomy, beneficence, non-maleficence and justice are fostered together with the ethical principles of dignity, integrity and vulnerability. Several organizational initiatives have been described worldwide on integration. Little is known on the ethical principles supporting this integration.

Aims: To ethically frame and understand healthcare professionals’ perspectives about integrating PC and IC.

Methods: A qualitative study, using in-depth interviews to collect data from healthcare professionals working in Portuguese PC and IC units. Data is being analysed using a thematic analysis approach. A snowball sampling procedure is being applied until reaching theoretical saturation. Up-to-date, 22 professionals (8 physicians and 14 nurses) across settings and cities were interviewed.

Results: Participants understand the integration of PC in IC as a way of improving end of life care and end of life decision-making processes. In their speech, an early integration of PC is needed, particularly in other settings (e.g., medical and surgical) in order to prevent invasive interventions and admissions in IC units. This is linked to the application of the ethical principles of beneficence, non-maleficence and justice into practice. Professionals also consider that the integration of PC in IC may foster patient autonomy, by allowing patients to be cared for and die in their place of preference, and integrity, through a holistic approach. Patients in IC are particularly vulnerable; integrating the principles of PC can protect them of any further harm. While professionals working in PC consider that integration should be promoted by implementing a mixed-organizational model, professionals from IC units defend an educational model, which should be promoted during medical specialty training as intensivists, PC being part of this education programme.

Conclusions: This is the first study addressing the integration of PC in IC in Portugal, following an ethical frame. Professionals working in PC and IC seem to have different perspectives on how the integration model should be. Findings show the potential for a successful integration; more research is needed to develop an effective, sustainable and ethically sound integration model.

Abstract number: P331
Abstract type: Poster presentation

To Regard Vulnerability - Respect for Dignity in the End of Life
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Background/aims: Human dignity is an enunciated ethical principle guiding medical treatment. However, the question regarding the interpretation and application of such a principle within areas such as palliative care has been discussed (Chochinov 2007). The research study upon which this presentation is based can be labelled ‘emphatic ethics’, since the theoretical discussion on dignity is contextualised through medical practice (Musschenga, 2005). One aim was to analyse what a plausible understanding of the principle of dignity could be, given a critical ethical analysis complemented by an empirical analysis. Furthermore, to study implications for palliative care such an empirically contextualised understanding on dignity could have.

Methods: Interviews were carried out with eighteen persons, of whom six were physicians in palliative care. Narrative method and analysis was used (Riessman, 2013). Particular focus was on narrative as a meaning-making activity, and the evaluative aspect of the narrative (Ewick and Silbey, 2003).

Results: In this study, it is shown that in ethical considerations in the end of life, the aspect of the patients’ vulnerability is visible in at least two ways: inherent vulnerability - the common, human vulnerability of illness and death (Butler 2009) and situational vulnerability - vulnerability in the form of dependence, such as the patients’ dependence in relation to medical staff (Dodds, 2014). In the study it is claimed that the meaning of respect for dignity in palliative care should include the perspective of vulnerability and two results from the empirical study are discussed:

1. Respect for dignity in the end of life can mean respect for autonomy, where situational vulnerability plays an important part in relation to how patients can understand and perform their autonomy.
2. Respect for the patients’ dignity in the end of life can relate to inherent vulnerability, meaning that someone shares and endures anxiety and powerlessness.

The research study was carried out as a phd-project and the dissertation published in 2016.

Conclusion: Human vulnerability is scarcely discussed within the ethical discussion on palliative care. However, the empirical results in this study points to its central role in the narratives on ethics in the end of life and the interpretation of the meaning of a principle of dignity.

Abstract number: P332
Abstract type: Poster presentation

Responding to Wish to Die-statements - Ethical Implications of Empirical Findings for End-of-Life Care Practice
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Background/aims: Responding to wishes to die (WTD) in palliative care is often perceived as ethically challenging. Based on the empirical findings of our 10-year-long qualitative research, we formulate ethical conclusions.

Study population: 62 palliative cancer (n=30) and non-cancer (n=32) patients (10 neurological disease; 11 organ failure; 11 frailty), their families and health professionals in different palliative care settings (248 interviews).

Methods: Qualitative semi-structured interviews. Data analysis with Interpretive Phenomenological Analysis and Grounded Theory.

Results: Our and other empirical findings showed that WTD are complex and dynamic constellations of intentions, motivations and social interactions. WTD can be fluctuant, often containing various wishes next to each other. They are narratively structured and influenced by illness trajectory related aspects.

Interpretation: Based on this, some key ethical implications for clinical practice are formulated:

1. The particular intentions in a WTD, its subjective meanings, reasons and functions, and the relations that contribute to the WTD, can only be understood by exploring individually what a patient actually wants and why.
2. Ambivalence and co-existing wishes are frequent aspects of WTD, which make sense. Patients should neither be labelled as ‘contradictory’, ‘depressive’ or incompetent due to decisional ambivalence, nor WTD should be seen as ‘inauthentic’.
3. From its dynamic process we cannot conclude that WTD are always unstable.
4. An in-depth understanding of the subjective experience of WTD takes time and cannot be done in a punctual contact with a patient. This is particularly relevant when discussing decisions about death-hastening acts.

5. If wishes to die are only taken seriously if they are expressed as wishes to hasten death, one might fail to detect other forms of wishes to die that play a crucial role in decision-making and are however an expression of suffering. We need an early and an extensive assessment of WTD.

6. Communication about WTD requires rigorous self-reflexion of the professionals’ own personal values and convictions (i.e. in favour for or against death-hastening acts) for not ‘talking patients in’ or ‘out’ of something that does not belong to their own understanding of themselves.

Abstract number: P333
Abstract type: Poster presentation

Dying Well: Authenticity as an Ethical Ideal at the End of Life
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Background/aims: The question of what constitutes a good death recently has gained increased attention within medical ethics. To reflect upon what it may mean for a patient to die well can complement discussions about end-of-life issues, e.g. assisted suicide, euthanasia, or the termination of life-sustaining treatments. These debates often proceed along hardened fronts. But the controversies might be overcome if the focus is shifted to common ideas about the attributes of a good death. To maintain one’s autonomy seems paramount for dying patients. Above that, they regard it as important to die in a way that expresses what is relevant to them and that corresponds with their biography and their personality. These concerns indicate a desire for an authentic death.

Methods: This study is a conceptual analysis that interprets the wish of a dying person to determine the circumstances of her dying by reference to the notion of authenticity. Using the relevant literature within the field for philosophical reflection, authenticity is elaborated as an ethical ideal. This ideal might serve as guidance within ethical deliberation and as a concept within social philosophy to detect social pathologies. It is used to analyse Palliative Care and the Right-to-Die movement with regard to the question to what extent they accomplish the patients’ wish for an autonomously determined and authentic death.

Results: Although Palliative Care providers and Right-to-Die proponents claim to help patients to fulfill their wish for an autonomously determined and authentic death, both of them only insufficiently achieve this self-imposed goal. A limited understanding of authenticity appears as the prior reason for their shortcomings. Above all, they misinterpret the ideal of authenticity as an imperative to actively plan one’s own dying. However, to adopt a waiting or passive attitude can be an expression of authenticity as well.

Conclusions: By using a more elaborated definition of authenticity as an ethical ideal, not only deficiencies of current manners to help patients die well can be identified. Above that, new perspectives on what constitutes a good death are offered that can lead to better care for the dying. Ethical debates about end-of-life issues lose their implacability if the question of the good death is addressed. Moreover, medical ethics extends its scope of analysis to the broad field of an ethics dealing with the good life, which is yet not properly elaborated.

Abstract number: P334
Abstract type: Poster presentation

Attitudes of Presbyterian Church Leaders on HIV Prevention in Aizawl City, Mizoram, Northeast India

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Knowledge about Church leader’s attitudes towards HIV prevention is essential to understand the factors that enable them to take on leadership role in facilitating HIV prevention efforts. Church leaders can have a significant contribution in a Christian dominated state like Mizoram which is also the state with the second highest prevalence rate of HIV in India. A Cross sectional study using in-depth interviews and focus group discussions were used. From 15 Presbyterian churches randomly selected all over Aizawl city, 293 Church leaders representing the four groups of leadership (Pastor/Elder, Women, Youth and Men) completed a self-administered questionnaire. 12 in-depth interviews and 3 focus group discussions were also conducted. Statistical analysis of univariate and bivariate was done using Chi Square test and Fisher Exact test.

Majority of the Church leaders felt they should intervene in HIV prevention. Nearly 90.4 percent felt it should be discussed in Church services. About 70 percent of the Church leaders felt Biblical disobedience leads to HIV infection and almost 80 percent felt homosexuals deserve HIV infection. Abstinence (77.1%), marital fidelity (22.2%) and condom use (0.3%) were the preferred choice for HIV prevention. Although 66.9 percent agreed with the Church statement that condoms encourage pre-marital sex, majority agreed that condom prevents spread of HIV infection. Personal contact with PLHIV does not seem to have positive influence with willingness to advocate condom use. The proportion of Church leaders willing to advocate condom use for HIV prevention was 34.0 percent.

The qualitative analysis revealed that some of the men leaders felt ‘sexually immoral’ and ‘adulterers’ usually gets HIV infection and were destined to go to hell. Hence, they felt an urgency to advocate these prevention strategies amongst them. Also a strong belief among the Church leaders that HIV was not spiritual enough to be tackled by Churches.

Church leaders agreed that they have responsibilities towards HIV prevention but were restricted by the Church doctrine. Disobedience to Biblical teachings was believed to result in HIV infection. Misconceptions around HIV persist irrespective of awareness programs within the Church. Sex education from early childhood, using Church media to educate Church leaders maybe useful for effective HIV prevention.

Abstract number: P335
Abstract type: Poster presentation

Building Expertise in the Dissemination of Research Knowledge to Advance Palliative Care Policy and Practice: An Evaluation of a Knowledge Transfer and Exchange Workshop
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Background: Despite increasing levels of research being gathered in health settings, there are several challenges to the implementation of evidence into practice, which is required to influence policy changes. Consequently a peer reviewed Evidence-based Model for the Transfer & Exchange of Research Knowledge (EMTReK) was developed specifically for palliative care research.

Aim: To build and evaluate competence in the area of knowledge transfer and exchange in the context of palliative care using the EMTReK model.

Method: Phase I: Design and development of a learner centred, CPD approved one day workshop. This included a presentation on developing and exploring
the EMTReK model for use in palliative care settings; and worksheets for group work to guide discussion around individual components of the EMTReK model.

Phase II: Delivery and evaluation of the workshop held in Dublin September 2017. Prior to delivery the participants (n=21) were provided with a short pre-read. The workshop was delivered in two parts, an instructor-guided presentation followed by group work. Groups worked for five cycles of activity applying the model to palliative research projects.

Results: Pre and post evaluation of the workshop highlighted 93% of participants reported their skills in terms of using non-traditional dissemination tools (i.e. podcasts, infographics, YouTube videos) as weak or fair. However following the workshop 94% of attendees either agreed or strongly agreed with the statement: “I plan to use a broader mix of communication tools in the future”. This provides evidence of a change in participants understanding of the usefulness of dissemination tools available.

<table>
<thead>
<tr>
<th>Knowledge Transfer and Exchange Evaluation Survey (workshop participants responses)</th>
<th>Pre-Workshop (n=15)</th>
<th>Post-Workshop (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of participants who believe you should begin planning a research dissemination plan when writing a research proposal:</td>
<td>67%</td>
<td>94%</td>
</tr>
<tr>
<td>% of participants who believe activation of a research dissemination plan should begin at the start of a research project:</td>
<td>53%</td>
<td>69%</td>
</tr>
<tr>
<td>% of participants that confirmed they will use the EMTReK model:</td>
<td>N/A</td>
<td>62%</td>
</tr>
</tbody>
</table>

Methods: In 2016 and 2017 we performed a mixed method study including qualitative research and a survey. Data were collected by topic lists and by using an adapted version of the Rotterdam MOVE2PC questionnaire and accordingly analyzed qualitatively and quantitatively.

Results: Thirteen students and 5 novices participated in focus groups and interviews, and a purposive sample of 39 third year nurse students participated in the survey. Providing palliative and end-of-life care is emotionally burdensome for young nurses. They highly empathize with patients, including their grief and sorrow. More negative than positive emotions were reported. Most reported were distress and psychological pain. Personal and organizational risk factors for drop-out were e.g. insufficient knowledge and preparation and insufficient guidance and emotional support. During internships students rarely discussed their experiences with palliative care and corresponding feelings, thoughts, and emotions. In the survey nine out of 20 knowledge statements were correctly answered (SD 2.3). Supportive needs were raised and various interventions were suggested, including more education in PC, intervention and a palliative care companion (PCC) program.

Interpretation: This study showed that providing PC is an emotional rollercoaster for student and novice nurses. In their transition towards adulthood and taking on professional responsibilities many ethical values are affected when providing PC, such as human dignity and justice, striving to be precise and accurate in caring and in building relationships with patients. Students and novices feel inadequately trained, prepared, and capable when confronted with patients at the end of life. They have poor knowledge of palliative care. Furthermore, they show inadequate (unhealthy) behavior while feeling intensely involved in the patients’ situation. Preparing student and novice nurses for the complex and intense PC requires various interventions in nursing education - at school and in practice- including ethical reflection.

Abstract number: P337
Abstract type: Poster presentation
Mechanisms of Action When Training Staff to Have Difficult Conversations: A Mixed Methods Study

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Background: There is little consensus over how best to teach communication skills to health care professionals or how to measure subsequent training effects. An understanding of mechanisms of action is required to improve training design and evaluation.

Aim: To understand the mechanisms of action of communication skills training interventions, using a half-day workshop entitled ‘Difficult Conversations’.

Methods: Explanatory sequential mixed methods design in Northwest London hospital and community settings. Questionnaires on self-perceived outcomes (e.g. confidence, burnout) were administered to course participants before, immediately after, and 3 months post Difficult Conversations workshops. Qualitative interviews were conducted 3-9 months post-training. Questionnaire participants were consecutively sampled from workshops from Sept 2016 -Feb 2017. A purposive sample (by gender, ethnicity, professional background) of participants and workshop facilitators were interviewed. A realist evaluation perspective guided the analysis of both datasets and their integration.
Results: 109 health care professionals completed questionnaires, from ambulance services (38%), community nursing (21%), general practice (12%), care homes (7%), specialist nursing (7%), and allied health professions (5%). Ten staff and 5 facilitators were interviewed. Differing mechanisms were identified as active in the short and long-term. In the short-term, important mechanisms (and their outcomes) included problem solving and reassurance (confidence), openness to critique (self-reflection), engagement (knowledge), experience sharing and positive reinforcement (clinical skills), and challenging perceptions (attitudes). Roleplay and groupwork were considered important components of the intervention in the short-term, with contextual influences of group composition and learning atmosphere. In the long-term, mechanisms of using a structure, increased self-awareness, and supported integration into practice were important for confidence, self-reflection, and clinical skills respectively. Here, the communication framework helped participants build on initial post-workshop improvements.

Conclusions: Different mechanisms contributed to the short- and long-term effects of a communication skills training intervention. In the short-term this was facilitated by groupwork and roleplay. In the long-term, a communication framework and written resources are required.

Funding
Health Education North West London

Abstract number: P338
Abstract type: Poster presentation

20 Years of the Master of Palliative Care: Impact of Advanced Training in Palliative Care
Lasmarias, Cristina1, Guanter, Lourdes2, Albarquerque, Eulalia2, Beas, Elba1, Ela, Sara1, Bullich, Ingrid1, Dominguez, Barbara3, Gómez-Batiste, Xavier1
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Statement of aims: Advanced training and education in palliative care (PC) is essential in the development of quality. The main objective of this research is to measure the impact of the Master of PC in the professional career of the students.

Presentation of methods: Observational descriptive “ad hoc” survey study with unique and/or Likert-scale type responses. The survey contained 15 questions including: demographic data; students’ experiences in PC and place of work (pre and post education); degree of agreement regarding their expectations, practicability and satisfaction about the Master and professional development. The survey was sent through email to the students of the editions between 1996 and 2017 (N=394). The period of responses lasted two months (March - May 2017). Categorical variables were described as frequency (percentage) and the score variables of satisfaction as median [Q1; Q3].

Presentation of results: 50% of responses (n=197): 76.6% women; 56.9% physicians and 42.6% nurses. 77% had previous experience in PC. After the course, 49% of the students without previous experience in PC joined a PC specific service. From the group with previous experience in PC, 84.2% is still working in a PC specific service or has switched to another area within PC (51.6%) including training and education, policy or research. Students stated a high degree of satisfaction (>60% of answers ‘enough - very much’) in regards to the following aspects: expectations, training needs, increase of motivation in their professional activity, improvement in their professional evolution, feasibility and satisfaction.

Conclusion: The Master of PC has a significant impact in the professional career of the students, regardless a specific area of PC and regardless having previous experience in PC. The evolution can also be related to professional maturity.

Abstract number: P339
Abstract type: Poster presentation

Enhancing the Skills of Palliative Care Researchers in Designing and Conducting Clinical Trials: Lessons from the Palliative Care Research Cooperative Group (PCRC)
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Aims: The field of palliative care has grown substantially; however, research in this field has not kept pace. One contributing factor is the paucity of investigators equipped to conduct rigorous palliative care studies, especially multisite studies focused on interventions, dissemination and implementation. A core mission of the Palliative Care Research Cooperative Group (PCRC) is to enhance investigator capacity to conduct palliative care research. We describe a successful model for investigator training using a team science approach.

Methods: Based on the NIH Office of Behavioral and Social Sciences Research’s clinical trials course, the PCRC developed a Clinical Trials Intensive to train palliative care investigators (“trainees”) to design, implement, and manage clinical trials. The three-day Intensive uses an experiential small group format to design a mock clinical trial. Faculty offer practical guidance on how to write and develop RCTs, provide ways to anticipate and respond to reviewers’ critiques, and share their own personal RCT experiences. At the end of the Intensive, trainees give a formal presentation about their proposed small-group RCT and set personal goals related to their future clinical trials research. Trainees evaluate each session and the training as a whole based on content, practical value, organization, and networking opportunity and complete 6-month post-training surveys.

Results: The PCRC conducted 3 Intensives between 1/16 and 7/17 with 56 palliative care investigators from multiple disciplines (i.e., medicine, nursing, pharmacy, social work, chaplaincy). Content covered trial design, measurement, intervention development and fidelity, recruitment, retention, analytical approaches, and data safety monitoring. Session and overall course evaluations received mean ratings of “Excellent.” Qualitative feedback described the value of interprofessional team-based learning, trial development, and access to experienced faculty mentors. Six months post training, trainees from the first 2 intensives (n=24) reported receiving 21 new grant awards and having 20 grant proposals in preparation.

Conclusion: Advancement of palliative care research requires upskilling of investigators in the conduct of clinical research. With a particular focus on facilitating conduct of rigorous multi-site clinical trials, the PCRC Intensive fosters rigorous multi-disciplinary research by supporting mentorship and hands-on research skills acquisition.

Abstract number: P340
Abstract type: Poster presentation

The Efficacy of Palliative Care Education and Training Programs in Primary Care Settings: A Scoping Review of the Literature
Hsieh, Jessica1, Miroz, Raza M1, McDonald, Lynn2, Aebi, Selina1, Chaffey, Sarah1, Mercer, Marlee1, Underwood, Quinn1, Wong, Sarah Jade1, Klinger, Christopher A1,2
Background: A large number of palliative education and training programs are currently available, and understanding the benefits and drawbacks of these programs would help to enhance care in the field; evaluating the effectiveness of these palliative education and training programs also serves as a vital aspect towards capacity building. A scoping review of the literature was undertaken in an attempt to gain insight into not only the methods and programs that are available to address primary care providers' palliative educational needs, but also the efficacy of these programs.

Methods: Arksey and O'Malley's scoping review framework was employed. Four scientific databases (EBSCO, OVID, ProQuest, and PubMed), including 16 individual repositories covering the medical and social science fields, were searched in August 2017, alongside the Grey literature and a hand-search of references from included articles. Exclusion criteria were any articles that were not available in English, were published prior to 1990, had a concentration on pediatric palliative care, and specific to residential hospices and/or long-term care.

Results: A total of 5,821 hits were generated, leading to 3,687 titles and abstracts for individual review. Of these, 68 full-text articles were retrieved; 39 articles met the inclusion criteria and were included in the review. Five major themes were identified:

1. Electronic and/or digital approaches;
2. Academic detailing and/or just-in-time learning;
3. Blended learning opportunities;
4. Shadowing of other professionals and/or ride-alongs; and
5. Classroom-based workshops and/or conferences.

Palliative care education was found to improve providers' competency, attitudes towards, and confidence in this area, as well as to positively influence a number of changes in practice. Communication with patients and their families was also reported to have been enhanced. Education and training programs also helped lead to greater creative thinking within patient and family care, such as enhanced system navigation skills. Furthermore, online programs were found to be a very effective method for delivering palliative care education.

Conclusion: This review presented a variety of palliative education and training programs that are offered to primary care providers. Although the level of efficacy varied between the programs, there are many benefits associated with palliative educational opportunities and these are generally well-received by providers.

Abstract number: P341
Abstract type: Poster presentation

Feasibility of an Online Training Package to Assist Services to Implement a Carer-centred Process of Assessment and Support for Family Carers within Palliative Care

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Introduction: The Carer Support Needs Assessment Tool (CSNAT) intervention is a carer-centred process of assessment and support which requires a change in practice. To meet national and international demand for training, an online toolkit has been developed to prepare and support services to implement the CSNAT intervention into palliative care practice.

Aims: To explore the feasibility of an online toolkit to assist services with implementation of the CSNAT intervention.

Methods: The Plan, Pilot, Train, Sustain model was developed from the CSNAT research and training programme; based on feedback from 89 services supporting carers using the CSNAT intervention. This model underpins the online toolkit which consists of two learning units:

1. Individual level: training for practitioners to use the CSNAT intervention;
2. Organisational level: assistance for a project facilitation team to plan, pilot and sustain implementation.

Five UK palliative care services participated and selected 2-4 practitioners to complete the online toolkit. Online surveys were administered following completion of each learning unit for feedback on content and system usability. Survey participants were invited for a follow-up interview. Descriptive statistics were used for survey data and thematic analysis for interview data.

Results: 15 practitioners completed ‘Learning unit 1’ survey, 14 completed ‘Learning unit 2’ survey, and 13 were interviewed. Feedback on content and usability was positive; respondents indicated both learning units improved their understanding of the topic and were useful for practice. Online learning was felt to be suitable. Organisational support important for completion included the provision of IT equipment, dedicated time and space. Recommendations to develop a project facilitation team to lead on implementation were valued. A designated contact for support and to answer questions was reported as needed, particularly once practitioners were actively planning for implementation.

Conclusions: This online toolkit will enable services, nationally and internationally, to respond to increasing pressures to identify and address the support needs of family carers by providing accessible and structured guidance on how to implement and embed a carer-centred process of assessment and support. Whilst online learning is welcomed by practitioners, further support during implementation planning would be welcomed.

Funding
CLAHRC Greater Manchester

Abstract number: P342
Abstract type: Poster presentation

Evaluation of the Benefit of a One-year Clinical Nursing Rotation in a Mobile Pain and Palliative Care Team

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Context and objectives: Our mobile pain and palliative care team (EMASP) consists of a trained palliative care physician, an intern on a rotation of 3 months and three registered specialized nurses. Since the team not only provides palliative care consultations, but also as an educational role for primary care, it welcomes since 2004 two supplementary nurses on a one-year clinical rotational basis. During their year, they are taught basic skills in palliative care and pain management. Furthermore, they develop a personal project which they take back to their usual working unit, once the rotation has ended. The objective of this semi-qualitative study was to analyse the benefit of this one year rotation among the users after 10 years of experience.

Method: A self-constructed questionnaire was sent to all nurses (n=16) who had participated in the rotation from 2004 up to 2014. The
A Case-based Curriculum to Address Pain and Non-pain Symptom Management in Medical Training: A Collaboration with the Harvard Macy Institute

Mikosiakos, Brandi1; Javier, Noelle Marie1

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2Internal Medicine, New York Eye and Ear Infirmary of Mount Sinai, New York, USA

Background/aims: Pain and non-pain symptom management skills are essential to providing high-quality palliative care, yet are difficult to master without experience. The International Association for the Study of Pain published a consensus curriculum in 1983 calling for greater training, but still only 30% of US medical schools require instruction in opioid prescribing1 and on average, trainees receive < 1 hour of education on analgesics2. Comparatively, veterinary schools mandate 87 hours on average to dedicated pain curriculum.3 It is not surprising, therefore, that half of primary care physicians surveyed feel only “somewhat comfortable” managing pain.2 This study set out to demonstrate whether a brief case-based curriculum could increase trainees understanding of opioid prescribing and management of related non-pain symptoms.

Methods: An interactive, evidence-based case series was used to increase resident and medical student competencies in pain and non-pain symptom management over the course of one year. Cases were designed to facilitate discussion and participation by learners rotating on the geriatric and palliative services and be completed in approximately 30 minutes. Core competency areas were selected from the “top 10” list of learning objectives determined by a survey of American Academy of Pain Management educators.7 These included opioid dosing and prescribing, adjunctive therapies, common symptoms in palliative care (dyspnea, constipation, nausea, bowel obstruction, and delirium), and prognosis. Pre and post-tests consisting of 10 questions validated by expert faculty consensus measured comprehension. The curriculum was administered in most instances during the first two days of a learner’s time on the geriatric or palliative medicine service.

Results: Fifteen subjects (n=15) participated in the case based intervention and completed pre and post-test exams. The average pretest score was 4.47 out of 10 and the average posttest score was 8.20 out of 10. The difference in these pre and post assessments was significant at p = 0.04.

Conclusions: A brief, case-based curriculum can effectively teach fundamental principles of pain and non-pain symptom management to residents and medial students. The intervention is applicable to a wide range of learners in various disciplines and stages of training. Further expansion can address the pressing need in medical education and clinical training for increased pain and non-pain symptom management.

Abstract number: P343
Abstract type: Poster presentation

The Impact of Pallium Canada’s Interprofessional LEAP Courses on Generalist-palliative Care Competencies

Pereira, Jose1; Klijnijc, Dragon2; Meadows, Lynn1; Palacios, Maria (Money)1; Strudholm, Tina1; Parsons, Henrique6

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2Research, College of Family Physicians of Canada, Brampton, Canada
3Department of Community Health Sciences, Cumming School of Medicine, University of Calgary, Calgary, Canada
4Family Medicine and Community Health Sciences, Cumming School of Medicine, University of Calgary, Calgary, Canada
5Research, School of Health Sciences, University of Northern British Columbia, Prince George, Canada
6Department of Medicine, University of Ottawa, Department of Medicine, Canada

Background: Pallium Canada is a national program that provides primary level palliative training, including the Learning Essential Approaches to Palliative Care (LEAP) interprofessional courses (different versions for different settings). LEAP Core is a 2-day course for community professionals.

Study aim: Study the impact of the LEAP Core course on learners’ knowledge (K), attitudes (A), comfort levels (C), d commitments to change (CTC) and learning experience (course evaluation).

Methods: Retrospective, cohort, mixed methods study. Pre- versus Post-course scores on a Knowledge Quiz (20 items-MCQ), Attitudes Survey (24 items- Likert Scale) and Comfort Scale (16 items- Likert scale) were compared using paired samples t-tests. Effect sizes (Cohen’s d) and internal consistency (Cronbach’s α) were analyzed. All learners who participated in LEAP Cores from April 2015 to March 2017 who responded to the surveys were included. Learners were divided into five profession groups: physicians (MDs); nurses (RNs); pharmacists (Phs); social workers (SWs); and others.

Results: 4637 learners participated in 244 LEAP Core courses. Response rates varied across tools and professions; 80% to 92% for pre-course tools, and 53.7% to 59.6% post-course.

Knowledge: A statistically significant improvement pre- versus post-course was observed for all professions together (t=−55.84, df=2301; p<0.001). The effect size was large (d=1.16). Large improvement were noted for MDs (t=−28.72, df=529; p<0.001; d=1.25), RNs (t=−44.77, df=1551; p<0.001; d=1.14) and Phs (t=−8.45, df=53; p<0.001). The effect size was large (d=1.16). Large improvement were noted for MDs (t=−28.72, df=529; p<0.001; d=1.25), RNs (t=−44.77, df=1551; p<0.001; d=1.14) and Phs (t=−8.45, df=53; p<0.001). Cronbach’s α 0.68 for all professions and 0.60 and 0.66 for MDs and RNs respectively.

Attitudes: Significant improvements observed for all professions together (t=41.38, df=2622; p<0.001, d=0.81). The differences were significant for each of the profession groups, with large effects for MDs (t=−0.82, Phs (d=−1.19) and SWs (d=−1.05). For RNs, the effect size was medium (d=0.78). Cronbach’s α 0.70.

Comfort: Significant increases in comfort were found for all learners and across profession groups; (t=−0.71, df=2463; p<0.001; d=1.22 for all learners). α was 0.95 for MDs and RNs.

Evaluations: 95.4% of MDs, 98% RNs, 94.6% Phs, 90.3% SWs and 94.5% of others would recommend the course to colleagues.

Conclusions: The LEAP Core courses resulted in significant improvements in Knowledge, Attitudes and Comfort levels related to the Palliative Care approach across all professions.
Abstract number: P345
Abstract type: Poster presentation

Do Learners Implement What They Learn? An Analysis of Pallium Canada’s LEAP Course Commitments-to-Change (CTC)

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Background: Pallium builds primary-level palliative care (PalCare) capacity by delivering interprofessional courses for physicians (MDs), nurses (RNs), social workers (SW), pharmacists (Phs) and other professionals across different settings of care. LEAP Core, one of 10 different LEAP courses, targets community-based health care professionals and teams. After each course learners reflect on what they learned and commit to make four changes in their daily work as a result of the course (CTC statements post course). 4 to 6 months later they are reminded automatically via Pallium’s learning management system about their four statements and asked to reflect on these.

Study aim: Explore the extent to which learners implement what they have learned in the LEAP Core courses in their daily practices as assessed by the CTC statements and reflections.

Methods: Mixed methods study. Quantitative analysis: number of CTC statements (post-course) and CTC reflections (4-months post-course) and the extent to which these were implemented 4-months post course. Qualitative analyses were used to explore the nature of the CTC statements post- and 4-months post-course. All learners who participated in LEAP Core from April 2015 to March 2017 and completed CTC statements and reflections were included. Learners were divided into five profession groups: physicians (MDs); nurses (RNs); pharmacists (Phs); social workers (SWs); and others.

Results: 2574 learners (55.5% of learners) submitted CTC statements post-course. Response rates varied; 55.8%, 63.7%, 88.9% and 89.2% for RNs, MDs, SWs and Phs respectively. A total of 10288 CTC statements were submitted. At 4-months post-course, 1063 learners submitted reflections (22.9% of all learners enrolled) with 4250 statements reflected upon. Of those, 3081 (72.5%) were reported by learners as implemented commitments by the 4-month post-course mark. The extent to which learners implemented their commitments varied across professions; from 60.6% for SWs to 73.9% and 73.3% for MDs and RNs. Commitments related to SWs to 73.9% and 73.3% for MDs and RNs. Commitments related to early palliative care, advance care planning, pain and symptom management, were the most common made and implemented. Variations across professions were noted.

Conclusions: The CTC analyses provide evidence for implementation of learning in everyday practice. The results will guide the development of quality improvement toolkits for learners to implement what they learned.

Abstract number: P346
Abstract type: Poster presentation

Comparison on Expenditure Relating to Investigations between an Inpatient Palliative Care Unit, and Tertiary Adult Medical and Surgical Wards - A Retrospective Chart Analysis

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Introduction: The highest healthcare expenditures occur towards end of life1. Costs relate to hospital admissions and investigations to diagnose, prognosticate and direct treatment1. This Australian study compared cost of investigations in the last 72 hours of life between an inpatient palliative care unit (PCU) and a tertiary hospital.

Method: We retrospectively reviewed fifty adult medical and surgical patients (admitted for >72 hours and who died in hospital) from the PCU and referring tertiary centre, between March and July 2016. Patients in the emergency department, intensive care, medical assessment, paediatric and obstetric units were excluded. All patients had a Not For Resuscitation order and were on the ‘Care of the Dying’ pathway (a modified version of the Liverpool Care Pathway).

Results: Expenditure was less if palliative care were the primary caregivers, with statistically significant differences in amount of imaging (p value 0.00035) and pathology (p value 0.000009) ordered. There was no difference in microbiology (p value 0.1726) and histology (p value 1) ordered. Total cost of investigations for PCU patients was $1,180.29 (4 of 50 patients), compared with $8,440.26 (29 of 50 patients) in the tertiary hospital (Table 1).

Conclusion: Inpatient PCUs are less likely to order investigations and are more cost-effective. A prospective study comparing an inpatient PCU, and patients at a tertiary centre, with and without consult liaison palliative care input, would be worthwhile to see if outcomes remain the same and if consult liaison palliative care affects the investigatory burden.

References

Abstract number: P347
Abstract type: Poster presentation

Comparing Variation in Technical Efficiency1 of Long-term Care Facilities (LTCFs) in 6 EU Countries.

Results from the EU FP7 PACE Study

Wichmann, Anne Barbara1, Adang, Edly M.M.3, Vissers, Kris C.P.1, Szczerbinska, Katarzyna1, Kylänen, Markku1, Payne, Sheila4, Omwateka-Philipsen, Bregje1, Smets, Tinne5, Van den Block, Lieve5, Deliens, Luc4, Vernooij-Dassen, Myra J.F.J1, Engels, Yvonne2
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Background and aim: Societies in the EU are aging, leading to higher needs of long-term institutional care at the end of life. At the same time, healthcare costs rise while resources remain limited. An urgency to extend our knowledge on factors affecting efficiency of LTCFs arises. This study, as part of the PACE project, aimed to investigate variation in efficiency of LTCFs in 6 EU countries (BE, FI, IT, NL, PL, UK).

Table 1. Cost of Investigations.

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<th></th>
<th>Inpatient Palliative Care (4/50 patients)</th>
<th>Tertiary Hospital (29/50 patients)</th>
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<td>$167.98</td>
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<tr>
<td>Total Cost</td>
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<td>$8440.26</td>
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Conclusion: Inpatient PCUs are less likely to order investigations and are more cost-effective. A prospective study comparing an inpatient PCU, and patients at a tertiary centre, with and without consult liaison palliative care input, would be worthwhile to see if outcomes remain the same and if consult liaison palliative care affects the investigatory burden.

References
Methods: Data were collected cross-sectional. LTCFs retrospectively reported all resident deaths over a three month period. An output oriented data envelopment analysis (DEA) was performed, incorporating resource use (personnel and capacity) as input, and quality of life (EQ5D) and dying (QOD-LTC & EOLD-CAD) as output. Scenario analyses were conducted. Regression analysis was performed on DEA efficiency scores, taking into account explanatory (country, LTCF type, ownership, availability of palliative care and opioids) and case mix (disease severity) variables.

Results: A lot of variation in efficiency was found over as well as within countries. Because of heterogeneity, 133 type II LTCFs were taken into account. Differences in efficiency scores were not explainable by country or status of the LTCF, nor by the availability of palliative care or opioids. However, when only taking into account ‘direct hands at the bedside’ as input, Poland (p = 0.00) and Finland (p = 0.04) seemed most efficient. When conducting scenario analyses comparing all LTCF types, public LTCFs appeared more efficient than private nonprofit LTCFs (p = 0.09).

Conclusions: Efficiency of partaking LTCFs considerably differs within Europe, as well as within countries. This variation indicates substantial efficiency improvement might be realized. These differences only seemed explainable by pre-selected variables in our scenario analyses. Our findings should be interpreted cautiously, as the representativeness of the sample and contextual (e.g. cultural) differences will have influenced the international comparison. Also, output variables can be distorted as they were filled in by staff. Answers might be influenced by their knowledge level as they ‘don’t know what they don’t know’.

Funding
EU 7th Framework Program.

Abstract number: P348
Abstract type: Poster presentation
Which Reimbursement System Fits Palliative Care? A Qualitative Interview Study on Clinicians’ and Financing Experts’ Experiences and Views in Germany
Schildmann, Eva1, Hodiamont, Farina1, Maier, Bernd Oliver2, Leidl, Reiner3, Bauswein, Claudia1
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Background: Currently, German palliative care units (PCUs) may choose between two reimbursement systems: diagnosis related groups (DRG), a case-based system mainly classified by main diagnosis or procedure, and per-diem-rates. Both systems are controversially discussed.椎間板炎 in the ‘LY’ component, so that the linear clock time, Chronos, should be used or developed.

Aim: To reflect upon these issues and explore the opinion of (international) experts, using the nominal group technique (NGT).

Discussion: Expert opinions suggest that neither DRGs nor per diem-rates are ideal for funding of German PCUs. Suggestions for improvement resemble approaches to financing found e.g. in Australia. Experiences and views of clinicians as well as experts for PCU financing should be considered when further developing PCU funding.

Funding
Funded by a private charity.

Abstract number: P349
Abstract type: Poster presentation
The Use of Quality-adjusted Life Years (QALYs) in Palliative Care: Findings from (International) Expert Meetings
Wichmann, Anne1, Johnston, Bridget2, Golstein, Lia3, Ohshara, Nild4, Berensen, Madeleine1, Van den Houdenhoven, Mark1, Engels, Yvonne1
1IQ Healthcare, Radboud University Medical Center, Nijmegen, Netherlands, 2Trinity College Dublin, Dublin, Ireland, 3Radboud University Medical Center, Nijmegen, Netherlands, 4Sint Maartenskliniek, Nijmegen, Netherlands

Background: The Quality-Adjusted Life Year (QALY) is often used as outcome measure in cost-effectiveness analyses (CEAs) in healthcare. A debate regarding the appropriateness of the use of the QALY to inform decisions on resource allocation in palliative care is ongoing. This debate was recently mapped in Palliative Medicine.[1]

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Funding
Funded by a private charity.
Abstract number: P350
Abstract type: Poster presentation

Development of Health Economics Resources to Aid Local Health Administrations in England to Support Evidence-based Investment in End of Life Care - A Report, Tool and User Guide

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1Public Health England, Bristol, United Kingdom, 2Optimity Advisors, London, UK

Background: There is great financial pressure on the National Health Service (NHS) in England and a policy to provide more care in the community than in hospitals. End of Life Care (EoLC) services compete with other healthcare services for investment. Surveys show most people prefer to be cared for and die where they normally live rather than in hospital. This would be supported by more community EoLC. It was believed that EoLC in the community is cheaper than hospital based care however, without a summary of the economic evidence or a tool to demonstrate the impact of moving resources from an economic point of view, local health administrations had difficulty making the case for a shift in resources.

Aim: Review the Health Economic Evidence for cost-effective commissioning for EoLC, produce an interactive tool for and a user guide for the tool.

Methods: The National End of Life Care Intelligence Network (NEoLCIN) at Public Health England (PHE) worked with the Chief Economist at PHE to scope the brief. A commercial team of Health Economists (HEs) were commissioned to work with the PHE team. A preliminary literature review was undertaken. A workshop was held with: Palliative Care Experts, HEs, & Local Health Service Commissioners to review and provide more evidence. The HEs worked with the NEoLCIN analysts to populate the tool which was tested in workshops. The critical appraisal of the studies was based on the NICE methods guidelines.

Results: Few studies were designed to assess with certainty the causality between place of care/interventions and patients’ outcomes. Although none of the studies performed a robust cost-effectiveness analysis of EoLC, the evidence seem to suggest that the existing breadth of palliative and end of life care interventions in the primary, social and community care settings are potentially cost-saving or cost-effective. The economic tool explores trade-offs associated with shifting care from an acute setting to a primary, community and/or social care setting although it cannot give definitive answers. These are available at: https://www.gov.uk/government/publications/end-of-life-care-economic-tool.

Conclusions: While the economic evidence base is not as strong as might be hoped it does strongly suggest there is a case for a shift in resources towards community based EoLC. The tool is being actively used by Clinical Commissioning Groups and Strategic Transformation Partnerships to inform service configuration changes.

Reference

Abstract number: P351
Abstract type: Poster presentation

Relative Care Costs and Health Economics Implication of Emerging Trends in the Complexity of Caseload Referrals to a Hospice Inpatient Palliative Care Unit

Ubogagu, Edith, Barnes, Steve, Hempstead, Joanna, Heimann, Rebecca, Monti, Marilina, In-patient Unit Staff St John’s Palliative Medicine, St John’s Hospice, London, UK

Background: Promoting quality and addressing inequalities are the founding principles of the UK National Health Services (NHS) Adult Palliative Care 2011 Funding review (PCFR). Yet 6 years on the challenge for Specialist Palliative Care (SPC) services is how we deliver ‘better outcomes for patients’, ‘better value’ for healthcare, using a ‘fair and transparent funding system’ amidst limited economic resources, increasing elderly population, whilst developing palliative care services for the 75% of the UK population who are estimated to die from non-malignant diseases.

In March 2017, NHS England published its ‘Guidance for using the Adult Palliative Care Currency’ which offers a local pricing system that reflects the complexity of care increasingly provided by modern SPC services.

Aim: To analyse emerging trends in patient admissions, and map this data to the relative cost ratios developed for Hospice Inpatient Units.

Method: We collected ‘Phase of Illness’ and ‘Australian Karnofsky Performance Status (AKPS) scales for all in-patient admissions over a 6-months period to St John’s Hospice (an inner-city, 18-bedded London hospice). The data was coded using the relative cost ratios developed by the 2017 guidance for using the PCFR.

Results: The emerging trend suggests that patients with non-cancer diagnoses incur higher relative care cost than patients with cancer diagnoses (1.123 compared to 1.078).

Non-cancer patients were found to be more likely to be in the lower categories of the AKPS (10-30%), with 33.3% of bed nights coded in this range compared to 27.8% of cancer patients. The highest relative costing units (AH_1 and AH_6) relate to patients in the following categories: stable phase, deteriorating phase, AKPS low category and AKPS medium/high category. We found for cancer patients 9.8% of bed nights were coded in this way compared to 26.8% for non-cancer patients.

Conclusion: Our findings highlight an emerging difference in the relative care cost ratios incurred for non-cancer versus cancer SPC services. How SPC services, policy makers, healthcare commissioners, through to clinicians utilise this emergent trend to develop a more detailed understanding of the complexity of caseload referred to palliative care units is paramount to the implications of such findings on improved patient outcomes and reduced health inequalities across population healthcare services in palliative care, especially for cancer and non-cancer patients.

Abstract number: P352
Abstract type: Poster presentation

Appropriateness of End-of-Life Care in People Dying from COPD.

Ubogagu, Edith, Barnes, Steve, Hempstead, Joanna, Heimann, Rebecca, Monti, Marilina, In-patient Unit Staff St John’s Palliative Medicine, St John’s Hospice, London, UK

Background: Chronic Obstructive Pulmonary Disease (COPD) is a progressive life limiting condition and a major cause of mortality worldwide. People suffering from COPD need access to appropriate end-of-life care while avoiding inappropriately aggressive care. In a previous study, we developed a set of 28 quality indicators that indicate appropriateness of
end-of-life care in people with COPD on a population level. Population-level indicators provide a tool to evaluate the performance of the health care system, to aim public health efforts at high quality end-of-life care for people with COPD. Our study addresses two aims:

1. To assess end-of-life care in people dying from COPD in Belgium using validated quality indicators of appropriate or inappropriate end-of-life care.
2. To compare the quality indicator scores of end-of-life COPD care between all health care regions in Flanders, Belgium, and to establish relative performance standards.

Methods: We conducted a retrospective observational study of all deceased from COPD in 2012 in Belgium. We linked data from eight administratively collected population-level databases. We performed risk adjustment procedures for fair comparison across health care regions.

Results: The study population consists of 4,231 people who died from COPD in Belgium in 2012, (4 percent of all deaths). The mean age at death was 79. 32.8 percent received opioid medication and 42 percent received inhalation therapy in the last 30 days prior to death. 43.3 percent had an increase in family physician contact during the last two weeks. 11.8 percent received specialist palliative care, while 24.4 percent died at home. In the last 30 days, 15.9 percent received more than one period of intubation. 1.8 percent was reanimated after intubation during the last week prior to death. In the last two weeks prior to death, 56.5 percent was submitted to diagnostic testing. During the last 30 days, 40.5 percent were admitted to an emergency department, 60.2 percent to hospital and 48.2 percent to ICU. 54.6 percent of patients died in the hospital. Risk adjusted comparison between health regions is not completed at the time of submission of this abstract, but will be included in the article and presentation.

Conclusion: We were able to provide a snapshot of the performance of the Belgian healthcare system in terms of end-of-life care in people who died from COPD.

Abstract number: P335
Abstract type: Poster presentation

Dying Worlds - The Perspectives of Patients and Relatives on Good Dying

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Background: In the last decades, the public attention for death and dying in Austria has increased. The public discourse is driven by professionals and experts demanding an extension of specialized palliative care and shaped by controversial discussions about euthanasia and assisted suicide. However, the different perspectives of patients and their relatives and their various ideas of ‘good dying’ are often underrepresented. To address this gap, we performed an explorative qualitative research project.

Methods: We conducted 30 qualitative interviews with persons concerned by dying and death, including incurably ill patients, very old persons, and bereaved caregivers. We selected interview partners from three different provinces in Austria; theoretical sampling criteria included age, sex, community size, care settings and the difference patients/relatives. We developed an interview guide, recorded each interview and prepared observation and reflection notes. Audios were transcribed verbally and anonymized. We analyzed the interview transcripts individually and comparatively by single researchers and in team. We developed codes inductively out of the data and created a code map.

Findings: New categories of care, well-being and suffering at the end of life appear. The preliminary findings show that patients and relatives describe their ‘dying worlds’ in different yet very distinct ways. These ‘worlds’ differ from the conception of ‘places of death’ and include social relations and emotions. Of utmost importance for the ‘dying worlds’ are the individual care-networks, consisting among others of families, neighbors and professional carers. Even when exposed to the extraordinary situation of death and dying patients and relatives endeavor to establish an everyday life. The interview partners build their conception of good dying on their biography, some of them speak about beauty and about enjoyment.

Conclusions: The perspectives of patients and relatives on ‘good dying’ are best described by the notion of ‘dying worlds’, they encompass social relations, care networks and individual emotions. When we strive at enabling a dying process that respects the perspectives of those concerned as a public health priority, we have to consider the individual ‘dying worlds’ with their characteristic categories and concepts which are not apparent to professional discourses. Our contribution will highlight some of these aspects of ‘dying worlds’.

Abstract number: P354
Abstract type: Poster presentation

Absence of Medical End-of-Life Decisions in Switzerland: A Mortality Follow-back Study

Penders, Yolandal, Zellweger, Ueli1, Bosshard, Georgi1, Bopp, Matthias2
1Institute of Epidemiology, Biostatistics and Prevention, University of Zürich, Zürich, Switzerland. 2Clinic for Geriatric Medicine, Zürich University Hospital, Zürich, Switzerland. 3Center on Aging and Mobility, University of Zürich and City Hospital Waed, Zürich, Switzerland

Aim: In Switzerland, deaths where no medical end-of-life decision (MELD) - such as withdrawing treatment - is made are now a sizeable minority of cases. We investigate which patient, care and physician characteristics are associated with no MELDs being made.

Study design, methods and population: Nation-wide mortality follow-back survey using a random sample of deaths of those aged 1 and over from 01-08-2013 to 31-01-2014. An MELD was defined as any treatment decision that either took into account the possibility of hastening death or explicitly intended to hasten death and included withholding treatment, withdrawing treatment, intensified alleviation of pain and symptoms, physician assisted suicide and euthanasia.

Method of statistical analysis: Logistic regression.

Results: Of the 8963 questionnaires sent out, 5328 were returned (59% response rate). Of these, 3678 deaths were non-sudden and expected and thus in principle eligible for an MELD. There were 760 non-sudden deaths (20%) that were not preceded by an MELD. Individuals dying from cancer more often had a preceding MELD (OR=1.4, 95%CI=1.1-1.7) than those who died of cardiovascular disease, as did people dying from other diseases (OR1.6, 95%CI=1.3-2.0). People whose death was not preceded by an MELD died less often in hospital (29% vs 39%), where MELDs were more likely than at home (OR=1.6, 95%CI=1.3-2.1). Having an advance care directive (21% of those without and 26% of those with an MELD) was associated with increased odds of having an MELD (OR=1.3, 95%CI=1.01-1.5) as did an expressed wish to hasten death, which only 8% of patients without an MELD had done versus 26% of those with an MELD (OR=4.5, 95%CI=3.3-6.0). Expressing a wish to attempt all life-prolonging treatment was rare (4%) and did not affect the odds of an MELD. The attending physician being trained outside of Switzerland decreased the odds of an MELD (OR=0.6, 95%CI=0.5-0.7), as did having obtained their license more than 1 years ago (OR=0.7, 95%CI=0.5-0.7).

Interpretation: A lack of MELDs is rightly connected to a lack of an expressed wish to hasten death, but not to a wish for life-prolonging
Help or Hindrance? An Analysis of Caring Networks’ Interactions with Health Services across Systems, Organisations, Practices and Individuals

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Background: Dying at home requires complex factors to be in place in health services and informal caring networks successfully provide support. This study examined the ways health systems, services, clinical practice, and individual health care professionals influence care at home at the end of life.

Aims: To identify the interaction between informal caring networks and formal care services.

Method: Participants had successfully provided EoLC to a dying person at home in the past 1-5 years as primary carers, within caring network, or outer networks. 39 caring networks from 8 locations in urban, regional and rural Australia enabled 26 carer interviews, 13 network focus groups and 17 outer network interviews/focus groups to be conducted. Using PhotoVoice and Participatory Network Mapping, participants explored their experiences of caregiving and informal networks, and the nature of their engagement with palliative care, other health care services, and the health system. Critical thematic analysis of narrative data enabled understanding of the discrete experiences of members of informal care networks of the role taken by health services in the support of dying people at home.

Results: Participants’ experiences were understood through four interrelated components: systems-level factors, organisational features; clinical practices by health care professionals towards the dying person, their carers, and network members; and individual behaviours of health care professionals. These components were described across a continuum of helping and hindering experiences.

Conclusion: Service providers are essential to successful and quality care of the dying; however, they are only a part of the total care a person receives. However, the health and palliative care systems were largely experienced as cumbersome and depersonalising bureaucracies, sometimes reflected in the conduct of the personnel. Insensitivity by individuals to the care needs of dying people at home, their carers, and networks hindered the caregiving and diminished the relationship between services and carers. Service providers were most helpful when they recognised the caring network and facilitated good communication, sharing of expertise and promoted relationship-building with informal carers.

Background/aims: There is a growing knowledge on models of alternative housing for persons in need, especially for older people in the German speaking countries. One explicit aim of most of the models is that residents can stay there until their end of life. Nevertheless, in a significant number of end of life care situations a transition into acute care, nursing home or specialised palliative care/hospice becomes inevitable. The aim of the presented paper is to investigate needs, experiences and expertise of residents, relatives and health care professionals concerning palliative and end of life care in alternative housing.

Methods: Within a mixed methods approach questionnaires addressing professionals (n=40), as well as qualitative interviews with residents (n=9) and focus groups with relatives and volunteers (n=6) in three different settings of alternative housing have been conducted. The sampling included case studies in a town of Germany, where alternative housing is already well established. Descriptive statistical analysis of questionnaires and qualitative content analysis of interviews and focus groups have been performed.

Preliminary results: Fist analysis of data show that:

1. residents as well as relatives and professionals have a lot of experiences concerning death and dying.
2. Social inclusion in an active and receiving way is an important factor for living and dying well in alternative housing.
3. Although care giving in general is viewed to be of good quality there exist insecurities concerning palliative care and end of life care.
4. Restrains in resources (time, staff, money) hinder 24h availability of support and care.
5. A need for further education in palliative care and communication across institutional and professional boundaries is formulated mainly by professionals.
6. Advance directives play an important role on one hand, at the same time especially for residents it seems to be impossible to plan for “the unforeseeable”.

Conclusions: Based on these findings of a multiperspective study concerning palliative and end of life care in alternative housing it can be concluded that there is a rich ground of expertise and experience on one hand. On the other hand, there exist areas of improvement on the way to a well-established palliative care culture in alternative housing.

Resources of Nurses Working in Different Settings in Specialized Palliative Care – Results of a Nationwide Study in Germany

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Statement of aims / research questions: Studies in the field of occupational health mainly focus on the negative effects of job demands (particularly work-related stress) on health, whereas studies on the protective factors (i.e. job resources) are rare. In the relevant literature, the promotion of resources as a protective factor is considered to be of particular importance [1, 2]. The aim of the present study was to explore the resources of nurses working in specialized palliative care in Germany.

Presentation of methods: A self-developed questionnaire was used to examine the resources of nurses working in specialist palliative care in a cross-sectional study (April to October 2017). 14 statements featured
these [protective] resources which had to be assessed on a 4-point Likert scale (not at all, little, quite, very).

Presentation of results: The preliminary results of the study content the data of 491 questionnaires answered by nurses working in specialist palliative care in Germany. 430 (87.6%) were women. The ten most important identified resources in descending order are 1. thankful patients (91.9%), 2. thankful family members of the patient (91.5%), 3. meaningfulness of work (91.1%), 4. team / support by colleagues (90.4%), 5. professional dissociation (90.9%), 6. positive thinking (90.0%), 7. friends (88.0%), 8. self-care (87.3%), 9. self-reflection (87.3%) and 10. own family (86.8%).

Conclusion: The most important resources of palliative nurses are thankful patients, thankful family members of the patient and meaningfulness of work. Further resources cover organisational factors and personal characteristics. Future studies should examine the role of organisational and personal resources as protective factors for health of nurses working in palliative care, in order to develop a comprehensive workplace health promotion.

References

*How much death does the team tolerate? Stress and protection factors in hospice work and palliative care

Abstract number: P358
Abstract type: Poster presentation

In Case of Serious Disease with Limited Life Expectancy; What Are People in Norway Most Concerned about?
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Background: The World Health Organisation has advocated palliative care as being a public health issue and claims education of the public is important. Surveys have shown a lack of knowledge and mostly negative perceptions towards palliative care in the public. Low level of awareness can lead to negative impressions and result in consequences for the quality of care provided to the dying and bereaved. According to European research, fear to discuss palliative situations, lack of interaction with health services and perception of lack of resources, are key barriers for future development of palliative care among the public. An increased awareness of the possibilities of palliative care in local and regional health services is necessary to empower individuals, involve communities and to realise the objectives of international strategies for palliative and end-of-life care.

Aims: We explored the current levels of concerns towards a palliative disease among the public in Norway and checked if the respondents’ concerns were associated with gender, age and level of education.

Methods: A structured paper survey with 20 closed questions, including question about concerns in case of serious disease with limited life expectancy, was sent to a sample of the public in Romsdal region, Norway (n=530). A descriptive statistical analysis was used for the demographic data. The Chi-square test showed to which degree gender, age and level of education associated the respondents’ concerns.

Results: The response rate was 63% (n=335); 26% off the responders were most concerned about getting serious pain (significantly most often mentioned by people with high education), 19% getting shortness of breath, 18% being a burden for others, 13% being distressed or anxious (significantly most often mentioned by people with low education), 9% being alone, 9% being without energy, 3% getting nausea, 2% changing in appearance and 1% about missing appetite. Gender and age did not affect the results.

Conclusion: People were most concerned about getting serious pain or shortness of breath and being a burden for others. An understanding of public views is necessary to meet future needs and expectations of palliative care among the public and to target public education.

Abstract number: P359
Abstract type: Poster presentation

Are Healthcare Systems Explaining Financial Distress Inequalities among Patients with Advanced Cancer? A Study in France and in the United States of America (USA)
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Purpose: This study’s goal was to compare the frequency and intensity of Financial Distress (FD) in patients with advanced cancer in France and in the United States of America (USA). Second objectives were to compare patients’ demographics and subjective financial burden results in both countries, to compare results from quality of life (QOL) and cancer-related-symptoms scales, to examine correlation between financial distress and demographics criteria (age/sex/country/marital status) and financial distress with cancer type and stage.

Design: From 2013 to 2014, 292 patients were enrolled whether in a Public Hospital or a Comprehensive Cancer Centre in the USA and in France. In those two cross-sectional studies QOL was assessed using the Functional Assessment of Cancer General and symptoms assessed using Edmonton Assessment System (ESAS) and Hospital Anxiety and Depression Scale. FD was assessed using a self-rated numeric scale from 0 to 10.

Results: In the USA, frequency and intensity of FD were significantly higher than in France. In France 52% (74) declared having FD compared to the USA (88%, N=129, p< 0.0001). About intensity 68% (100) in the USA reported having severe FD whereas in France 34% (48) patients did (p=0.001). American patients had more advanced degree than French patients (21% versus 9%, p<0.001), had been to college more frequently than French patients (27% versus 16%, p< 0.001). Patients QOL was better in the USA than in France. French patients had more psychological symptoms, Correlations were highlighted between financial distress and the country USA, financial distress and marital status and financial distress with the presence of metastasis. On the contrary there’s a negative association between financial distress and the age, financial distress and the country France.

Conclusion: Both American and French health care systems fail to protect its population from FD. With a 100% coverage of specific cancer treatment French policy on health care provide partial protection but not entirely and not as expected. Further research focusing on indirect costs may highlighted other reasons of FD and financial difficulty and reveal a lack of social assistance.
Abstract number: P360
Abstract type: Poster presentation

Associations between Different Area-based and Individual-level Measures of Socioeconomic Position (SEP) and Health Outcomes in the Last Year of Life: A Systematic Review

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Background: There is social inequality at the end of life; people who are more socially disadvantaged die in hospital more often, have increased frequency of emergency department admissions and access specialist palliative care services less. We don’t know which aspects of socioeconomic position (SEP) contribute most to this disparity and this is hindering action to address social inequality.

Aim: To report how SEP has been operationalised and measured in palliative and end of life care research, and to examine the strength of the evidence and direction of association between different SEP exposures and outcomes in the last year of life.

Methods: MEDLINE, EMBASE, PsychINFO, CINAHL and ASSIA databases were searched for studies of adults in their last year of life, reporting any measure of SEP in association with an outcome of interest (quality of care, place of death, advance care planning, use of healthcare services including hospital, specialist palliative care, and community care services). Studies were restricted to observational and quantitative designs. Strength of evidence (weak, moderate, strong) was assigned based on quality of studies (Newcastle-Ottawa Quality Assessment Scale - low, medium, high), quantity and consistency of findings. PRISMA reporting guidelines were followed.

Results: 19,038 papers were screened, 181 papers were included. 7 categories of SEP measure were found; income, education, occupation, social class, insurance, housing, and area-deprivation. Of 151 high or medium quality studies; 71 reported an area-based measure of deprivation, followed by education (n=41), insurance (n=28), housing (n=6) and income (n=5). Almost half of the high and medium quality studies were about place of death (n=73). Overall, the review found moderate to strong evidence of an association between lower SEP and worse end of life outcomes in relation to; place of death, advance care planning, hospital services, specialist palliative care, and community care, but only weak evidence of an association with quality of care.

Conclusions: Studies about place of death dominate the literature on social inequality at the end of life. There is also an over-reliance on area-based measures. More use of individual-level measures such as income and education are needed to generate a better understanding of the mechanisms of SEP, without which we cannot hope to develop successful interventions targeted at reducing social inequality.

Funding
Dunhill Medical Trust

Abstract number: P361
Abstract type: Poster presentation

International Publication Trends in Palliative Care: A Bibliometric Study (1960-2016)

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Background: Evidence based medicine relies on research that tests hypotheses to give information on the effectiveness of interventions. Over the past four decades there has been a dramatic growth in the number of articles published in palliative care. We aimed to explore the types of article that have driven this growth.

Methods: Observational study using publication data. We searched PubMed using the terms “palliative care” or “palliative medicine” from 1980 to 2016. We used PubMed filters to categorise articles according to study types representing three levels of evidence:

1) Low level evidence (expert opinion: editorials, opinion pieces and non-systematic reviews);
2) High level evidence (randomised controlled trials (RCTs)); and
3) Highest level evidence (systematic reviews and meta-analyses).

For context we compared with articles published in neurology.

Results: 61,271 articles were published in palliative care/medicine from 1980 to 2016, an increase from 333 in 1980 to 4,661 in 2016. The most common publication type was expert opinion (15,216 articles, 24.8% of total); 4.8% (n=2,966) of articles were systematic reviews and meta-analyses. 2.7% (n=1,651) of publications were categorised as RCTs. All categories increased over time, but numbers of RCTs remain low. During the 1980s for every RCT published in palliative care/medicine there were 1.4 RCTs published in neurology. This ratio increased to 5.8 RCTs published in neurology for each one in palliative care/medicine from 2010-2016.

Conclusions: Research, particularly that which tests treatments, is essential for better care. While publication in palliative care is increasing, the slow growth of studies that provide strong evidence for the problems faced by patients is concerning. The reasons for this should be explored.

Abstract number: P362
Abstract type: Poster presentation

Developing an Algorithm to Estimate Need for Beds in Palliative Care - The Example of Inpatient Hospice Care

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Background: Various studies estimate the need for palliative care based on mortality statistics, but do not identify the needed level and type of care. An epidemiological needs assessment framework which triangulates current service provision and disease statistics estimates the need for a specific health care service. We use this framework to estimate the need for beds in inpatient hospice care (IHC) in North Rhine-Westphalia (NRW; 17.6 million inhabitants) in Germany.

Methods: All local hospices for adults (n=63; 575 beds) were asked to contribute data on service provision, e.g. patient numbers and characteristics, occupation rate (OcR), length of stay (LoS).

The following data (reference year 2015) was used:

a) number of patients with cancer/non-cancer diseases admitted to IHC;
b) mortality statistics, comparing two different disease ranges (DR) DR1: all diseases relevant to palliative care; DR2: causes of death other than ICD 10 000-Q99 and S00-T98;
c) percentage of all people in NRW dying from cancer/non-cancer diseases (based on DR1 and DR2) who used hospices,
d) LoS and OcR. For non-cancer patients we estimated different utilization rates based on hospice data. Maximum rate was the sum of the highest estimated rates based on hospice data. Minimum rate was the sum of the highest estimated rates based on hospice data. Minimum rate was the sum of the highest estimated rates based on hospice data.

Results: The 34 participating hospices had cared for 129.3 patients (mean); average LoS was 26.1 days, OcR 93.4%. Total extrapolated number of patients was 7.878. Cancer accounted for 92.9% (mean) of admissions, followed by chronic diseases, neurological diseases and AIDS. Minimum/maximum estimated rates for non-cancer patients were 7.1%/15.4%/32%.
Of all people ≥20 years dying of cancer, 14.4% used hospices (need estimated at 15%). The potential utilization was estimated between 0.4% and 2.5% for non-cancer patients (≥25 years). NRW will potentially need between 621 and 776 hospice beds (between 35.3 and 44.1 beds/1 million).

Conclusion: The potential need for beds in IHC can be estimated using mortality statistics and current service provision data on a regional level and across regions. Population-based estimations should be based on the most recent data available. Future estimations should encompass different forms of palliative care services and settings. Profound knowledge on the palliative care needs of patients with non-cancer diseases and how demographic factors influence palliative care needs is needed.

Abstract number: P363
Abstract type: Poster presentation

Community Perceptions of Palliative Care: Exploring Key Opportunities for Strategic Community Engagement
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Background: Community attitudes to palliative care are often cited by health professionals as a key barrier to referral. Yet, community perceptions of palliative care are largely unstudied.

Aims: To describe community perceptions of palliative care and explore key opportunities for strategic community engagement.

Methods: This exploratory, cross-sectional data was collected as part of a larger, online, randomised trial seeking to pilot test a public health educational intervention in an Australian community-based sample. Baseline descriptive data included measurement of community attitudes on a 10-point Likert scale and perceptions of palliative care across 10 key knowledge domains. Descriptive statistics were used to summarise findings.

Results: A total of 159 participants (median age 51, range 23-82; 75% female) participated in the study. The majority (53%) reported they knew what palliative was, though 39% had no prior experience with palliative care. Many respondents reported inaccurate understandings of palliative care:

- 1 in 2 did not know a person with serious illness can request access to palliative care; or that palliative care can be provided at any stage of a serious illness.
- 1 in 3 thought palliative care could not be provided alongside other curative medical treatments.
- 1 in 4 thought palliative care is a type of care provided to people only in the last month of life.
- 1 in 5 did not know palliative care provides support for a person’s family; and thought palliative care is a type of nursing care, provided exclusively by nurses.
- 1 in 6 did not know palliative care could help to manage a person’s symptoms; and thought people must be in the hospital to receive palliative care.

Conclusions: This study demonstrated significant opportunities remain to improve community understanding of palliative care, with many people holding inaccurate perceptions of these services. This empirical data can directly inform evidence-based, public health approaches to improve community engagement with palliative care.

Abstract number: P364
Abstract type: Poster presentation

Beyond Just Talk: Problematising the ‘Action’ in Action Research, Based on the DöBra Research Program
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Background/aim: There are many varieties of action-research, although some features are generally shared among them. These include some level of participation and partnership with stakeholders—research with people instead of on or about people—and a dynamic and iterative process of problem definition, planning, action, and evaluation to continuously inform the process. Stringent research and change processes should occur simultaneously and inform one another. In this series of abstract-based presentations (see also Lindqvist et al and Goliath et al), we critically discuss different meanings and uses of ‘action’ in action research, based on our experiences in six projects in the DöBra research program in Sweden.

Methods: The data derives from the DöBra program, a term in Swedish which literally means dying well, but is a pun also meaning ‘awesome’. This program has the overall goal of working to diminish avoidable suffering related to dying, death and bereavement, and to investigate innovative means of integrating stringent research with sustainable change processes. It is based on theories from new public health and health-promoting palliative care, and presently consists of three research lines derived from the Ottawa charter, addressing both individual and community competency building and supportive end-of-life (EoL) environments.

The six ongoing projects all use some form of action-research approach to investigate how the arts, the environment and conversation can be employed in addressing EoL issues.

Results/discussion: In this presentation we critically discuss our experiences with two forms of action in action-research, i.e. the pros and cons of ‘doing’ things beyond talking to facilitate engagement with EoL issues; and acting in partnership with a wide variety of community organizations and actors with different backgrounds—disciplinary, professional and experiential. We have used a wide range of tools to stimulate engagement with EoL issues, working with indigenous research approaches, with art-and design-based approaches, with walk and talk focus groups and audits, and with a Swedish version of GoWish cards, and eco-mapping. In some cases ‘action’ has clearly facilitated our aims, whereas in others it may have functioned as a hinder. Our collaboration with stakeholders includes different degrees of involvement in research processes and has led us to question some of the assumptions in participatory research. These pros and cons will be discussed here.

Abstract number: P365
Abstract type: Poster presentation

Doing and Not Just Talking: Using Eco-mapping and a Translated and Adapted Version of GoWish Cards in the ACP-naive Swedish Context in Action-research Projects
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Background/aims: Early conversations about values and choices for end-of-life (EoL) care rather than document-based directives alone are increasingly common in advance care planning (ACP). But ACP is not systematically practised in Sweden today in any form. In 2 projects in the DöBra research program (see also Tishelman et al and Goliath et al), we tested action-oriented approaches to promote discussion of values and priorities about EoL care choices before death is imminent. In this presentation, we discuss experiences of using 2 action-oriented tools to support discussions.
Methods: The 1st project was designed and carried out in partnership with Swedish patient and retiree organizations, with participants actively volunteering to participate. We address 2 questions: Who matters? (ecobrading) and What matters? (GoWish cards) for each target person in a face-to-face interview. The American GoWish cards were collaboratively translated and adapted to the Swedish cultural context by the project team and are now called DöBra cards. The DöBra cards consist of 37 predetermined items plus "wild cards", and are sorted to clarify priorities for EoL care and generate conversation about relevant issues. Presented data derives from 4 focus group discussions (n=16) and the study's first 34 participants.

Results: 36 of 37 predetermined DöBra cards were among the 1st study's initial 50 participants' 10 most prioritized choices. Only 8 predetermined items ranked as 1st priority by ≥ 2 participants. Wild cards were used 14 times in individual interviews but not in focus groups; their content will be discussed here. Three workshop iterations of 4 meetings each have been conducted with SCECB staff (n=23) to date.

Discussion: Based on interview analysis and reflective evaluative discussion, we conclude DöBra cards have been met with acceptance and enthusiasm from a wide range of people in both projects. The sorted and ranked cards show broad individual variation in priorities, thereby a potential support for person-based EoL care and SCECB staff suggest various ways to continue using the DöBra cards in SCECB. Eco-mapping was not met with the same positive. Potential reasons for its lack of acceptance will be discussed.

Funding

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Abstract number: P366
Abstract type: Poster presentation

General Population’s Perception about Cancer
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Introduction: Cancer is the second leading cause of death worldwide after cardiovascular diseases, with an ever increasing incidence.

Aim: Assessing the perception of cancer among the general population in order to identify the obstacles in physician-patient communication in the context of this disease.

Material and methods: A multiple choice questionnaire with 30 specific questions was elaborated and pretested in small groups, then refined in a focus group consisting of various professional involved in cancer patients caring, and finally distributed on Facebook social network on 554 groups of Romanian language speakers, between November 2016 - March 2017.

Results: There were 1724 respondents from 18 countries, of which 1,578 (91.5%) from Romania. Distribution by gender showed a women:men ratio of 4:1, the most numerous age-group of respondents belonging to the interval 20-29 y.o. 31% of respondents perceived cancer as a serious malignancy, but with healing opportunities, 45% declared they knew persons diagnosed with cancer/leukemia, and 40% affirmed they had/have had family members affected by this disease. 52% of respondents considered that the likelihood of curing cancer is dependent on the stage in which it was identified, and also on the access to treatment, 63% considered that the chances of healing are small regardless of age, and 26% believed the chances of cure are particularly high in young patients. 75% of respondents believed that cancer could be prevented, and 77% of them would choose regular medical checkups, healthy eating, avoiding tobacco and alcohol consumption as prevention methods. The internet (24%) and the physician (15%) were checked as the main sources expected by respondents to inform on prevention, progress and treatment of cancer. Although 45% of the respondents claimed media as an important source of information, they found it unsafe as they can disseminate erroneous, misleading, false or distorted information. Concerning the 5-year survival rate, most of the responders (47%) considered that more than 50% of patients diagnosed with cancer could survive longer than 5 years.

Conclusions: The results of the research could be a starting point for a more detailed and complex investigation of this sensitive issue, and in the same time very actual, namely the perception of cancer among the general population, in order to develop long-term health strategies and programs.

Abstract number: P367
Abstract type: Poster presentation

How Do People’s Expectations for their Own End of Life Connect with their Perceptions of Palliative Care? Learning Opportunities for the Promotion of Early Palliative Care
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Background: The understanding of public perceptions about palliative care (PC) can help gain overall impressions of people’s attitudes toward advance care planning and end of life topics, as well as to identify opportunities to overcome knowledge gaps. Public perceptions about the conceptualization of PC in Switzerland remain largely unknown. Since perceptions can be influenced by social or cultural norms, we aimed to understand the views of the Swiss population toward PC and end-of-life care.

Method: In 2016, a travelling exhibition in the Canton of Bern promoted PC in the region. Visitors anonymously completed three statements about PC. Through Qualitative Content Analysis we compared and contrasted written responses to two of the items: ‘When I hear the term palliative care, I think of…’ and ‘If I anticipate my own end of life then the following is important to me…’.

Results: Participants (n=230) were in average 47 years old and the majority were female (83%). Thirty percent had completed an Advance Directive and 58% had previous contact to PC.

When defining PC, six main areas were identified: populations in need of PC, ways of PC delivery, timing of PC, locations of PC, providers of PC, and PC outcomes. Dying was often defined as the timeframe for PC, and positive associations with PC were common. When reflecting on their own end of life, four areas were central: maintaining relationships until the end, relief of suffering, organizing affairs, and having their family being cared for. End of life was mainly associated with having close relatives and friends around, and with the ability to autonomously complete unfinished business. Maintaining own dignity and dying without a long period of physical distress were also important.

Discussion: Although most associations with PC were positive and this selected population acknowledged PC as an interdisciplinary approach focusing on supporting patients and families, PC was described mainly as a medical professional intervention reserved for the last days of life. This narrow view of PC may hamper our efforts to improve public health
initiatives such as advance care planning, and the integration of early PC into disease-focused treatment. PC seems not to be directly associated with people’s own end of life and PC interventions were rarely acknowledged. In modifying public misconceptions of what PC entails, professionals should move closer to community perceptions and shape more clearly the profile of PC.

**Abstract number:** P368  
**Abstract type:** Poster presentation

**Facts and Figures of Palliative Care Development in 15 Countries of the Eastern Mediterranean Region**
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**Background and aims:** Information on the state of palliative care (PC) development in the World Health Organization’s (WHO) Eastern Mediterranean (EM) Region countries has been recently published in the Atlas of PC in the EM. The aim of this study is to describe comparatively the status of PC development in the EM region countries with information derived from the Atlas.

**Methods:** Surveys were sent by email to two leaders of PC in each country. A follow-up telephone interview was conducted with one leader from each available country. Additionally, a scoping review of the state of PC in EM countries using the WHO PC Public Health Strategy framework was conducted using PubMed, CINAHL, Embase, and Google Scholar.

**Results:** Sixty-eight percent (15/22) of countries in the EM region responded to the survey, 64% to the interviews, and 73 unique articles were found in the scoping review regarding PC development in the EM. Saudi Arabia had the highest number of PC programs, followed by Egypt and Jordan, while Iraq and the Occupied Palestinian Territories reported none. Saudi Arabia, Iran, and Lebanon report having official licensing programs in PC for physicians, and an additional four countries (Egypt, Jordan, Oman, and Qatar) have developed other advanced training programs. In terms of education, Jordan, Oman, and Lebanon report having at least one medical school teaching PC as an independent subject, though four additional countries (Egypt, Kuwait, Pakistan, and Tunisia) report teaching PC integrated into other disciplines. There are no nursing schools in the region that teach PC as a dedicated subject. In terms of policies, only Tunisia has a stand-alone national PC plan but 11/15 of participating countries reported having a section for PC within their national cancer plan/strategy. In terms of medicines, Saudi Arabia reported the highest consumption of opioids and general availability of medicines.

**Conclusion:** PC development in the majority of the EM region remains poorly developed. All dimensions of the WHO Public Health Strategy should be addressed to enhance accessibility to PC across the region.

**Abstract number:** P369  
**Abstract type:** Poster presentation

**“No Mum, Don’t Talk Like That”: Perspectives of Elders from Black Minority Ethnic Cultures on End-of-Life Discussions with their Adult Children - A Systematically Conducted Metaethnography**
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**Background:** Many older people, of all ethnicities, express a preference for a peaceful death. However, people from Black and Minority Ethnic (BME) backgrounds are more likely to die receiving life supporting measures. Adult children play an important role in the end of life decision making for these elders which can be difficult and cause distress for both the children and the health care professionals involved. Congruence of end of life preferences between elders and their children has been found to be low resulting in care preferences being contravened when elder’s loose capacity. There is limited understanding of end of life planning conversations between BME elders and their children and how this influences the experiences of these elders at the end of life.

**Review aim:** To explore the perspectives and experiences of BME elders about sharing end of life preferences with their adult children.

**Design:** A search was carried out using Cinahl, Medline and Pubmed to find qualitative studies published between 2005 and 2017. Studies that related to BME elders and conversations with family about end-of-life care were included. Citation snowballing and information foraging was used to ensure all appropriate references were identified.

**Results:** 13 studies met the inclusion criteria. The studies were explored for the themes and the following metaphors were identified by two independent reviewers: I leave it in God’s hands; I will go when it is time to go; No mum, don’t talk like that; If I talk about this they will suffer; We don’t talk about those things; My family will do right by me. The line of argument synthesis drawn out reflected the dichotomous balance of trust and burden avoidance that characterises the perspectives of BME elders to end of life care planning with their children.

**Conclusion:** Understanding the factors that influence anticipatory discussions may help to facilitate earlier discussion and congruence of preferences between BME elders and their children.

**Abstract number:** P370  
**Abstract type:** Poster presentation

**eHealth in Palliative Care: Introducing a Prototype to Monitor Comfort in Palliative Care Settings**
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**Background:** Palliative Care Patients at Home (PCPH) have more difficulties in reporting their symptoms, but monitoring comfort is important to address effective Palliative Care (PC). E-health can bring an opportunity to monitor comfort over time, and to enhance PC more efficiently.

**Aim:** To develop a web-based app to monitor comfort in PCPH.

**Methods:** A multi-phase electronic application development process was conducted. A literature review for the characterisation of comfort in literature, a concept analysis study, and a qualitative study about PC patients’ experiences of comfort were conducted (content validity). The Portuguese version of the Edmonton Symptom Assessment System (E-S) and the Spiritual End of Life Portuguese Comfort Questionnaire (a = .84) were used. The construct validity was discussed by 5 experts in PC (Kappa coefficient = .76). The app was designed using a web-based domain. Participants were purposely recruited from 2 hospitals with PC home visits (pre-test). Eligibility criteria included: age over 18 years, be followed by a PC team at home, have a computer device with internet access. Outcomes included: number of SOS messages, loading time, patient’s opinion regarding ease of use, and usefulness. The project was approved by the ethics committee. Descriptive statistics were calculated (SPSS®) and specific data analysis methods were used, according to each phase.

**Results:** A web-based app compatible with Android, iOS and Windows was designed. Holistic comfort includes symptom management and spiritual comfort. The app assesses 11 items (pain, tiredness, drowsiness, nausea, lack of appetite, shortness of breath, depression, anxiety, fear of...
the future, peace and the will to live). The app was used by 7 PCPH during 15 consecutive days (cancer: n=4; amyotrophic lateral sclerosis: n=2; multiple sclerosis: n=1). Electronic devices included smartphone (n=1), tablet (n=3) and laptop (n=2). Operative systems included Android (n=5) and Windows (n=2). Loading time ranged between 11-18 seconds. A total of 117 messages were received (n=12 in SOS: increased pain/anxiety). Most data were sent after 2pm, and SOS messages were sent between 4:45pm-10:33pm. Patients considered the app very useful, simple, and easy to use.

Conclusions: This app could help to monitor comfort and improve early interventions in PCPH. Further studies should encompass larger samples, focus on the loading time and access through devices using iOS technology. No conflicts of interest.

Abstract number: P371
Abstract type: Poster presentation

Patient and Public Involvement in Palliative Care Research: A Qualitative Study to Identify Motivators and Meaningful Outcomes de Wolf, Linda, Susanne1, Witt, Jana1, Pask, Sophie1, Brighton, Lisa Jane1, Daveyson, Barb2
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Background: Patient and public involvement (PPI) is increasingly valued and required in palliative care (PC) research. However, little evidence exists concerning the reasons why patients, their families, the public (collectively known as ‘service-users’) or researchers engage in PPI. This gap in knowledge hinders collaboration.

Aim: To identify and compare different motivations and meaningful outcomes among service-users and researchers in order to optimise PPI in PC research.

Methods: Focus groups were conducted with PC patients/unpaid carers and PC researchers at a research institute in London. Data were audio-recorded, transcribed verbatim and analysed using inductive, thematic content analysis. Core themes arising from the data were compared and contrasted between service-users and PC researchers.

Results: Seven service-users and six researchers participated in three focus groups (two service-user groups, one researcher group). Sixteen main themes emerged for both groups. Service-users were motivated to become involved in PC research to improve care, and as a way to overcome past negative experiences. They felt empowered by their role once involved. Researchers were initially motivated by funders’ requirements. However, after perceived improvements in research through PPI, this also motivated them to continue. Meaningful outcomes for service-users were identifying with a project, therefore developing a sense of ownership and feeling part of the research organisation. Lack of feedback from researchers was a major barrier for service-users, preventing them from identifying with projects and feeling ownership as a meaningful outcome. Researchers felt the outcome was meaningful when there was a collaboration in its true sense with service-users (i.e., every member of the study team is listened to equally), and when service-users gained new skills or confidence in research throughout and after their involvement.

Conclusion: The quality of the interaction and feedback are essential components to ensure that meaningful outcomes are achieved and motivations sustained in PC PPI. Clear synergies emerged about the mutual interest in what service-users gain through involvement. Based on the findings of this study, evaluations of communication and feedback processes, time and money investment, and role definitions should be considered for future research activity with service-users.

Acknowledgements
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Abstract number: P372
Abstract type: Poster presentation

Mend the Gap - Palliative Care Education Students’ Perspectives on Palliative Care Education Pieters, Jolien1, Warmenhoven, F.C.1, Verstegen, D.M.L.1, Courtens, A.M.2; van den Beuken-van Everdingen, M.H.J.; Dolmans, D.H.J.M.1
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Background: The need for palliative care is increasing. Since almost every doctor comes into contact with palliative care patients, it is important that, at the end of their undergraduate medical curriculum, students feel that they have acquired the necessary competencies to deal with this challenge. The objective of this study is to measure undergraduate students’ confidence in, their perceived importance of, and knowledge about palliative care.

Methods: A questionnaire study was conducted with sixth-year medical students of four Dutch medical faculties. The questionnaire measured the self-estimated confidence of the students in dealing with palliative care patients, their perceived importance of palliative care education, and their knowledge about palliative care.

Results: 222 students of four Dutch medical faculties participated. A majority of the students (59.6%) does not feel confident about being involved in caring for a palliative care patient, especially when it concerns incorporating spiritual aspects of palliative care into the care plan. The students are overall neutral about the palliative care education that they received (58.1%). They state however that the psychosocial and spiritual needs are hardly addressed in their curriculum. The majority (86.5%) of the students perceived education about palliative care to be (very) relevant, especially education about patient-oriented care and communication with palliative care patients. The other students were neutral about the importance. The knowledge test shows that students lack knowledge: approximately half of the responding students (47.8%) answered more than half of the questions correctly.

Conclusion: The students in this study are almost junior doctors who will soon have to care for palliative patients. However, the results show that most students do not feel confident and that their education does not cover all important aspects of palliative care. For these reasons, it is important to pay more attention to palliative care in the medical curriculum.

Abstract number: P373
Abstract type: Poster presentation

Palliative Nursing Care: Analysis of the Academic Knowledge Production in Portugal Lobão, Catarina1, Gonçalves, Rui2, Neves, Hugo3, Pereira de Sousa, Joana3, Lopes, Pedro4, Coelho, Adriana1, Parola, Vítor1,3
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Introduction: Palliative care has been recognized as an important social requirement by the Portuguese law since 2012. This acknowledgment is
expected to have impact in the academic production, namely in higher nursing degrees.

Objective: The purpose of this study was to map the scientific contributions of researchers to the understanding of the Portuguese reality regarding nursing care Palliative care.

Methods: A bibliometric study was performed through the analysis of the Open-Access Scientific Repositories from Portugal, using the terms “palliative” and “nursing”. Date ranged from 2012 to October 2017, and only master dissertations and doctoral theses developed in Portuguese academic institutions were included in the study.

Results: A total of 14 studies fulfilled the inclusion criteria, with only master dissertations being obtained from the search. A qualitative approach was used in 13 studies, with only one study using a quantitative approach. Regarding target population, 11 studies investigated nurses developing palliative care, with only one study investigating parents of children in end-of-life, and one study investigating the family caregiver. Regarding analysis of the production per year, the number of dissertations have been decreasing, with no production of academic knowledge in 2016, and only one master dissertation in 2017.

Conclusion: Palliative care is recognized by society and the law, as a specific area of care. Despite this acknowledgement, no doctoral thesis was found in the study, and academic production per year has been decreasing. Another important aspect is as to do with the target population, as only two studies investigated family caregivers, and no study investigated patients in palliative care. This study demonstrates the need to develop more knowledge, especially through higher academic degrees, and to target the clients instead of the nurses, to better understand the client’s expectations and needs.

Abstract number: P374
Abstract type: Poster presentation

Dying 2 Learn: Experience of a Massive Online Open Course
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Aims/background: Massive Online Open Courses (MOOCs) are freely available short online courses that anyone can participate in. There is increasing interest in building community engagement with death and dying to encourage active involvement in decision making, community-based caring and acceptance of death as a natural part of the life cycle. This study sought to determine what effect online learning and discussions offered through the MOOC had on participants’ feelings and attitudes towards death and dying.

Method: During 2016, a five week MOOC was developed covering four main topics (language and humour, representations of death, medicalisation of dying, and digital dying). Engagement in MOOC activities was tracked as part of the educational platform’s infrastructure. Death attitudes were measured at enrolment and at again at the conclusion of the MOOC along with user satisfaction questions. A follow up survey on post MOOC actions was sent at six month after completion.

Results: 1,156 people enrolled in the Dying2Learn MOOC with 895 participating in some way. The majority were female (92.1%). Age ranged from 16 to 84 (mean = 49.5, SD = 12.3). Overall the course modules page was viewed 18,216 times, and almost 10,000 comments were made with on average, 7.5 comments per person (SD=14.3). 211 people provided data on pre and post death attitudes. The majority of participants (93.7%, 99.5%) agreed that death is a normal part of life, most (87.6%, 95.7%) felt comfortable talking about death and dying, but also felt that most people do not feel comfortable talking about death (87.1%, 84.4%). 183 people responded to the follow up survey with 73.6% having started a conversation about death and dying at work and 76.9% having looked for information on advance care planning.

Conclusions: The Dying2Learn MOOC provided an environment that enabled open and supportive discussion around death and dying and influenced attitudinal change.

Abstract number: P375
Abstract type: Poster presentation

Supporting Implementation of Outcome Measures across Hospital and Hospice Settings through Learning Circles
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Background: NHS England and Public Health England have tested outcome measures for palliative care services in England. Their joint report recommends the use of a core set of measures which are currently being implemented in palliative care services across the UK. However there is no evidence as to how this implementation should be undertaken.

Aims:

1) To explore how clinical palliative care services use patient level outcome measures (OMs) in practice
2) Test whether and how Learning Circles (LC) can contribute to implementation of OMs and effective knowledge sharing about them

Setting: This qualitative study involves two voluntary sector hospices (inpatient and community) and two acute hospital advisory teams. Phase 1 - exploration of the use of OMs and establishing LCs within two sites. Phase 2 - adaptation of findings from Phase 1 to establish LCs within two further sites

Parallel mixed methods data collection throughout Phase 1 & 2 including: individual interviews; participant and non-participant observations; focus groups; LC meetings; and process evaluation following LC meetings.

Results: Services were implementing OMs in different ways: using OMs to inform clinical decisions, or integrating into existing care without affecting decision-making. Different disciplines engaged with OMs in different ways. Monthly LCs were successfully established and sustained at 3 sites. There was limited reliance on research evidence within the LCs. LC participants actively sought the experience of clinicians within and external to their organisation to inform implementation strategies. Implementation progress within one hospital team was restricted by factors outside their immediate control (information technology). Participants valued the opportunity provided by LCs to develop and tailor strategies specific to their own context.

Conclusions: LCs are an effective way for palliative care teams to harness the collective knowledge and experiences of practitioners and may be effective is supporting implementation and knowledge sharing. LC are flexible enough to be adapted at different stages of implementation, however wider organisational issues may invalidate what LCs can offer.

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Abstract number: P376
Abstract type: Poster presentation

The Impact of Terminal Diseases on the Family Members
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Background: In the southeast part of Albania, Palliative care is provided only to cancer patients. During these years, with the initiative of Albania Palliative Care Association (APCA), Ministry of Health and with the support of foreign experts, new palliative care units are set up in all Regional Hospitals in Albania. Palliative care in Albania consists mostly as home care.

In the southeast part of the country, palliative care service is provided by “Mary Potter” Palliative care Center, the only inpatient service (day hospice).

Most of the patients in Albania prefer to receive care and die at home. The family members are the persons who care all the time to their loved one and no one is caring for them.

Aim: To assess and identify the psycho-social and spiritual needs for family members of terminally ill patients and to set up new services for them, depending on the identified needs.

Methods: There were distributed 40 questionnaires with 32 questions about physical, social, psychological and spiritual well-being, to 40 family members (spouse, parents, child, other) of terminally ill patients to assess their needs.

Results: Physical well being, was affected by: fatigue, sleep changes, overall physical health, appetite changes, pain, etc.

Psychological well: The illness of the loved one has negative impact in overall quality of family members’ life. They feel themselves very useful but distressed and burden.

Social concerns: For the family members, the illness of their loved one it has been distressted. The amount of support they received, did not meet the needs of them. The terminal stage has interfered the personal relationship they were feel isolated and financial burden.

Spiritual well being, was affected by uncertain for the future, hope, mission for being alive, neutral spiritual well being, half of the interviewed persons get support on prayers, not enough religious activities, no positive changes in their life.

Conclusions: This research identified the negative impact of terminal diseases for family members, how was affect the quality of life from the cancer of a loved one in all aspects: physical, psychological, social and spiritual well-being. These data discovered the need for setting up new services in the nearer future in “Mary Potter” PC center and develop further services in PC, in Albania, ensuring quality of life for both patient and their family members.

Abstract number: P377
Abstract type: Poster presentation

How Is Imminent Death Recognised? A Study to Understand the Decision Making Process of Expert Prognosticators
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Background: The ability to recognise when palliative care patients are imminently dying is important for the delivery of good terminal care. There is little training available to help doctors develop this skill.

Aim: The purpose of this study was to identify a group of expert prognosticators and to understand how they recognise when a patient is dying.

Methods: To identify the expert group, palliative care doctors, as identified by their membership with the Association of Palliative Medicine (APM) were approached to participate in a prognostic test. The test presented summaries of 20 real patients who were referred to palliative care services. Participants were asked to predict whether or not the patient would die within 3 days. The doctors who were most accurate at predicting survival were identified as the “experts”. The experts were then asked to review 50 hypothetical patient summaries and provide a percentage estimate of death in the next 72 hours. Each summary presented information on the same 7 symptoms with differing degrees of severity. Multiple regression analysis was used to look at the association between the symptoms and the estimated survival prognosis.

Results: 99 doctors completed the prognostic test. The top 20%(n = 19) were identified as the experts and were invited to undertake the second prognostic judgment task, of whom 14/19 (74%) did so. The following factors influenced the experts’ estimates: Cheyne Stokes breathing, Palliative Performance Score (PPS), a decline in condition in the previous 24 hours, respiratory secretions, cyanosis, and level of agitation or sedation. A backwards stepwise regression model identified four independent factors associated with predictions, (breathing, PPS, level of agitation or sedation, and rate of decline) which explained 91% of the variance in survival estimates.

Conclusion: The judgment policies of palliative care doctors, who are experts at recognising dying patients, have been identified. These results may be used to teach novice doctors how to improve their prognostic skills.
Results: The new analysis identified three themes: the personal, social and intersubjective dimensions of the FBO. The personal dimension of the FBO relates to the emotional and psychological effects of suffering from an advanced illness, and its impact on a patient’s sense of identity. The social dimension of the FBO concerns the impact of illness on the immediate social environment. Finally, the intersubjective dimension, which encompasses both the personal and social dimensions, refers to the fact that suffering was a common denominator among all patients who expressed the FBO.

Discussion/conclusion: The FBO cannot be understood in isolation from the advanced patient’s personal interpretation of his or her dependency or care needs. A clinical approach to addressing the FBO therefore needs to understand the biographical background of these patients. Indeed, such an understanding is crucial for informing clinical policies based on the moral duty to provide humane care to all patients.

Abstract number: P379
Abstract type: Poster presentation

Research Experiences of Palliative Care Nurses: Surprises, Tensions and Benefits
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Context: In France, few palliative care (PC) nurses are involved in initiating and participating in research; clinical activities take precedence over other activities. Moreover, the work of the few involved in research is not well acknowledged. During a research on the validation of a PC assessment tool carried out in different PC settings (home, hospital and PC unity), 80 nurses were involved in the whole process of this research (selecting appropriate tool, discussing relevant items, being trained in using the tool, participating in patient inclusions, carrying out the assessment, ongoing support from the research team). At the end of the research, a qualitative study was carried out to gain nurses' experiences of undertaking research.

Goal: To describe and understand the experience of PC nurses who participated in research, and to study the impact of their involvement on their clinical practice.

Design: A qualitative study was conducted. Thirty Nurses from PC settings across France, involved in the previous research, participated in 4 focus group sessions of 3 hours each. Measures of rigor were respected; coding was performed by 2 researchers who agreed on a final thematic tree.

Results: All participating rated their research experience as positive. To them, research opens the space for dialogue with their patients and the assessment tool played the role of mediation for speech-release. They were surprised to gain a deeper knowledge of the patient as a result of participating in research, that research allowed them to have a specific and valued time for patients, which ultimately fostered their reflexivity. The research activity contributes to the strengthening of professional identity while questioning the clinical and evaluative competencies of caregivers. The majority of nurses shared that they would like to participate more in research activities because it is a rewarded and valuing experience, legitimizing their positioning within the team and within the institution. Nurses highlight the tension between clinical and research activity. They have difficulty articulating their “double-cup”; the rigor constraints of research process competes with clinical solutions to be sought.

Conclusion: Nurses can and should become key actors in research. Participating in research creates a space different from the usual practice and strengthens the competence of the nurse, his/her identity and well-being at work, and it ultimately improves the practice.

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Abstract number: P380
Abstract type: Poster presentation

Making Outcome Measures Work in the Context of Deteriorating Health - Lessons for Implementation: A Multi-method Qualitative Study
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Background: The routine use of Patient Centred Outcome Measures (PCOMs) in palliative care has been recommended to improve quality of care and enable benchmarking. Use of PCOMs is a relatively recent initiative in palliative care. Understanding their use in practice will be key to wider successful implementation.

Aim: To explore the use of PCOMs in palliative care and identify key considerations for successful implementation.

Design and methods: Multi-method qualitative study using semi-structured interviews and non-participant observation. Patients, family carers and staff were purposively sampled from 9 specialist palliative care services (hospice, hospital and community settings) in London. Data was collected from Dec 2014 to Nov 2015 and analysed using Framework analysis informed by the Consolidated Framework for Implementation Research.

Results: 38 participants were interviewed (27 professionals, 7 patients, 4 family carers). 9 non-participant observations were carried out with staff using PCOMs in specialist palliative care services (5 hospital, 3 community, 1 hospice). Themes identified were:

(1) Benefits of using PCOMs: For patients and family caregivers, benefits included greater confidence to raise important concerns and the ability to recognise improvement in the face of deteriorating health. Clinicians and service providers saw benefits to improving the structure and efficiency of clinical assessments, and the ability to demonstrate the impact and quality of palliative care.

(2) Challenges of using PCOMs: Participants raised concerns about potential added burden to patients and families, as well as increased burden on staff workload.

(3) Lessons for implementation: Key ingredients for successful implementation included: selecting appropriate and valid measures, PCOM specific staff training and education, providing regular feedback to increase motivation amongst staff, and having peer and senior management support, including investment in infrastructure to strengthen the routine use of PCOMs.

Conclusion: In practice, the potential benefits and challenges of using PCOMs (for both patients and staff) need to be balanced. Successful implementation of PCOMs requires careful planning, investment and wide staff engagement.

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Guys’ & St Thomas’s Charity, CLAHRC: South London

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Abstract type: Poster presentation

Health - Lessons for Implementation: A Multi-method Qualitative Study
Pinto, Cathryn, Bristowe, Katherine, Witt, Janaj, Shipman, Cathy, Davies, Joanna, de Wolf-Linder, Susanne, Dawkins, Marsha, Higginson, Irene J, Daveson, Barbara, Murtagh, Fliss E.M
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Identifying Patients in the Last Phase of Life, Barriers and Facilitators - A Focus Group Study with Physicians
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Aim: The Surprise Question (SQ) - Would I be surprised if this patient died in the next 12 months? - is often recommended to identify patients in the last phase of life. However, physicians who treat patients with incurable disease often feel reluctant to use the SQ. We examined barriers and facilitators in marking the last phase and using the SQ.

Methods: Medical specialists and general practitioners (GPs) from the southwest part of the Netherlands who treat patients with cancer or chronic lung disease were invited to participate in one of two focus groups. Participants received a questionnaire prior to the meeting. Results from these questionnaires and several statements were used to guide the discussions during the meeting. Both meetings were audiotaped, transcribed and qualitatively analyzed.

Results: All participants (7 oncologists, 4 GPs, 2 pulmonologists, 1 hospice doctor and 1 anaesthesiologist) agreed on the importance of marking the last phase of life and the use of the SQ for this purpose. The SQ is simple and can motivate the doctor to initiate advance care planning conversations. When using the SQ, participants take into account their clinical experience, medical expertise, and a number of specific clinical factors. Participants agreed that lack of applying the SQ can lead to insufficient marking and communication of the nearing death of the patient. Factors that might contribute are: difficulty to objectively predict death within a year, the doctor’s own denial of the patient’s imminent death and fear of depriving the patient of hope. Marking could be facilitated by using a tool which is composed of objective clinical factors. Communication about palliative care and the imminence of death with the patient should preferably be a step-by-step process that is initiated by the treating clinical specialist.

Conclusions: Although the SQ is perceived by doctors as a useful marker for the last stage of life in chronically ill patients, there seems to be a preference towards marking based on objective clinical factors.

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Abstract number: P382
Abstract type: Poster presentation

Compassionate Leadership in Palliative and End of Life Care - A Focus Group Study
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Background: Effective leadership is essential for the delivery of patient focussed services and leaders have a responsibility to shape and lead a caring culture. If compassionate leadership is to be realised then there is a need to explore what it means in the context of palliative care and end of life care, and in order to do this it is important to listen to the first-hand experiences of staff.

Aim: The aim of this Project was to explore compassionate leadership with those involved in leading system-wide end-of-life care. It focussed on the following:

- Defining compassionate leadership in the context of end of life and palliative care;
- Collecting accounts of compassionate leadership activity from key stakeholders in end of life and palliative care;
- Collating examples of compassionate leadership in practice

Methods: Four focus groups involving staff from a range of health care organisations including hospitals, hospices and community teams, were conducted to access the accounts of staff leading palliative and end-of-life care. The data were analysed thematically.

Results: The themes that emerged from the data included: the importance of leadership as role modelling and nurturing; the need for structured supervision for staff; the importance of stories in leading end-of-life care; the need for resilience on the part of leaders, and a requirement for leaders to challenge existing practice. Rich and detailed examples of leadership in action were shared.

Conclusion: Leadership in palliative and end-of-life care shares many common features with health care leadership more generally, however there are some specific elements related to the nature of the work that require a particular range of skills and processes. These include highly developed communication skills, resilience, and an appreciation of the nature of compassion in end-of-life and palliative care.

Abstract number: P383
Abstract type: Poster presentation

Are the MORECare Guidelines on Reporting Attrition in Palliative Care Research Populations Appropriate? A Systematic Review of Randomised Controlled Trials
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Background: Trials involving palliative care patients are likely to have higher attrition rates which may affect trial results. This is likely to be due to progressive illness or death rather than random event. The MORECare guidance recommends applying a taxonomy of attrition to report attrition to help interpret trial results: attrition due to death (ADD), illness (ADI) or at random (AAR).

Aim: To identify trials of palliative care populations and retrospectively apply the MORECare taxonomy. To estimate the total and subgroup proportion of attrition such as by taxonomy group.

Methods: We conducted a systematic review of four databases (Embase, Medline, PsycINFO and CINAHL) from the 1st January 2010 until the 8th October 2016 for randomised trials of palliative care populations. Attrition taxonomy retrospectively applied using the reasons from the papers. We ran fix effect models without and with moderators, using the Metafor package for R, to calculate the proportion of overall attrition and subgroup proportion of attrition.

Results: We included 136 trials which included data on 17,472 participants. 119 trials had enough data to calculate the total attrition rate of 24% (95% CI 23% to 25%). We could only apply the ADD taxonomy as the data for ADI and AAR was unclear with many participants reason for attrition unclear. ADD resulted in 28% (95% CI 27% to 30%) of cases of attrition based on 91 studies. However, these estimated proportions were heterogeneous. We noted increased attrition in trials with longer durations and outpatient populations.

Conclusion: The MORECare guidelines suggest higher rates of attrition should almost characterise this population and our results support this especially as death was such a large group. Clearer prospective reporting using the MORECare taxonomy should improve our understanding of attrition.

Abstract number: P384
Abstract type: Poster presentation

The Dutch Palliative Care Programme: How Is Quality of Care Assessed in Research Projects?
Background: The fast and widespread development of palliative care in the Netherlands has resulted in the ambiguous use of various guidelines, quality indicators, measures and instruments. There is a need for a comprehensive set of measures and instruments to assess the quality of palliative care in clinical practice and research. We investigated which outcome measures and instruments are used in current palliative care projects in the Netherlands to assess different dimensions of the quality of care.

Methods: We studied grant applications of innovation or research projects funded by the Netherlands Organisation for Health Research and Development (ZonMw) in the Dutch Palliative Care Programme. Data were analyzed using qualitative (categorization) and quantitative (descriptive) methods.

Results: Between 2014 and 2016, 45 projects received funding from ZonMw. Project leaders of 36 projects sent us their applications. Five projects are on education of nursing or medical students, or on attitudes or experiences in the general population. Thirty-one projects concern patient care. Twenty-seven projects evaluate an intervention, either on medical treatment (2) or on the structure or process of care. Outcomes in patients or relatives are assessed in 21 projects, of which four have a qualitative design, seven a quantitative design and 10 a mixed-methods design. Nine out of 21 projects assess the effect of an intervention in an experimental design, such as (cluster) randomized trials or quasi-experimental projects with pre-post testing. Research questions, study populations and research outcomes vary among these experimental studies. Projects use a large variety of instruments to collect data, such as the EORTC-QLQ-Pal15, Caregiver Reaction Assessment and the Clinical Research Form. None of the instruments are used in more than one project.

Interpretation: In the Dutch Palliative Care Programme many innovative interventions are being evaluated. A minority of the funded projects investi-gates the effects of interventions on patient or relative outcomes with a large variety of instruments, which limits opportunities for comparative effectiveness research. Development of a core set of outcome measures and instruments can contribute to scientific and clinical knowledge on the effects of interventions on the quality of care for patients and their relatives.

Abstract number: P385
Abstract type: Poster presentation

Which Outcome Domains Are Important in Palliative Care and When? Results of an International Expert Workshop

Developing and Evaluating PalliAGED Apps

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Abstract number: P386
Abstract type: Poster presentation

Which Outcome Domains Are Important in Palliative Care and When? Results of an International Expert Workshop

Abstract type: Poster presentation

Developing and Evaluating PalliAGED Apps

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Background: Two studies were completed. The first study was a review of reach and usage. This analysis included details on downloads of the apps and information on those accessing app content held on the apps platform directly via the web. The second was an investigation of attitudes and views to the apps through two user surveys. The first dealt with palliAGEDgp through an online survey while the second dealt with the palliAGEDnurse app through an online survey and phone interviews. Ethics for the study was received from the Social and Behavioural Research Ethics Committee of Flinders University (Project No. 7451).

Findings: More than 741 downloads of the palliAGEDnurse app were achieved in the first month. For the palliAGEDgp app there were 941 downloads in the first month of release and the first 12 months there had been 2,866 again far exceeding an initial estimate of total downloads over its life of 1,000. Sixty seven respondents completed at least some of the palliAGEDgp app online survey. The survey showed that most of those who had used the app found it useful. A total of 116 online surveys for the palliAGEDnurse app were submitted. The survey showed that most of those who had used the app found it guided their practice, was easy to use and that the framework and processes were useful. The investigation also showed that a number of organisations had embedded palliAGEDnurse or palliAGEDgp within their resources or processes.

Discussion and conclusions: The download figures for the apps were greater than originally anticipated suggesting a greater interest or need than had been anticipated. Organisations had also embedded the apps in their care providing a further indicator of value. The surveys and the direct feedback highlighted that there are many factors in play which affect the utility of apps within the workplace.
Participants' years of experience in PC ranged from 10.9 to 14.7, and experience in outcome measures ranged 5.8 to 6.4 years. Top ranked domains were 'Overall Wellbeing/Quality of life' (mean score 2.75), ‘Pain’ (mean score 2.06), and ‘Information needs and preferences’ (mean score 2.06). ‘Phase of Illness’ was recommended as the preferred unit of measurement, as it reflects how acute PC needs are, and is already used internationally.

Conclusion: The domains of ‘overall wellbeing/quality of life’, ‘pain’, and ‘information needs and preferences’ are recommended for regular measurement by palliative care clinicians and researchers, with ‘Phase of Illness’ proposed as the most useful unit of measurement. International adoption of these recommendations will help standardize approaches to improving the quality of palliative care.

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Physical Therapy in the Management of Fatigue, Pain, Dyspnea and Physical Function in Patients with Incurable Life-threatening Illness - Systematic Review
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Background: Physical therapy is underutilized in patient with an incurable life-threatening illness. However clinical experience suggest benefit of physical therapy even in advanced phase of disease in which symptom prevalence of fatigue, pain and dyspnea are universal and frequent.

Aims: To identify and evaluate the evidence for physical therapy interventions in the management of fatigue, pain, dyspnea and physical function in adult patients with an incurable life-threatening illness. Second aim, is to provide up to date overview.

Methods: We conducted a 2-step search strategy in PubMed, EMBASE and CINAHL. We sought quantitative studies including randomized/ non-randomized controlled trials (RCT/CT), quasi-experimental studies (such as cohort pre-post studies with or without comparative group) and other cohort studies, that measured the effects of physical therapy provision by a physical therapist on fatigue, pain, dyspnea and physical function.

Results: We identified 3318 references of which 22 studies met the inclusion criteria. We included seven RCTs, three CTs, ten Cohort (one group pre - post) studies and two retrospective chart reviews (1058 participants). Most studies utilized strength and endurance interventions and almost all demonstrated improvements in physical function. Furthermore, of these 75% identified significant improvement. Likewise, most studies in which elements of conventional physical therapy were applied, improvement in physical function was found. Additionally, improvements in fatigue, pain, dyspnea and QOL were shown with strength, endurance training and conventional physical therapy. However the studies were overall of poor to moderate methodological quality. Furthermore, the studies were of small sample size and there was high attrition. In almost halve of the studies, (cancer) treatment, adverse effects and baseline functional status were not reported.

Discussion: Despite several challenges, the findings in this systematic review support benefits for physical therapy interventions in the management of fatigue, pain, dyspnea and physical function in patients with an incurable life-threatening illness. More studies are needed. RCTs with sufficient sample size may not always be practical nor appropriate in patients with incurable life-threatening illness in need of continuously adjusted tailored interventions. A qualitative approach is therefore also recommended.

Abstract number: P388
Abstract type: Poster presentation

Patients’ and Caregivers’ Perceptions of Specialist Palliative Care Services and Palliative Care and their Influence on Preferences for Support
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Background: The international literature demonstrates that a negative perception of palliative care is a common barrier to the introduction of a palliative care approach or the introduction of specialist palliative care (SPC) services. Perceptions of palliative care have also been shown to influence patients’ preferences for place of care. However, there is little empirical evidence on the perceptions of Irish patients and caregivers and how these shape expressed preferences for services and supports near the end of life.

Aim: To explore perceptions of palliative care among patients and caregivers accessing SPC services and identify whether perceptions of palliative care or other factors are associated with expressed preferences.

Methods: The study was carried out in three regions in Ireland. Likert scale items were used during face-to-face interviews to determine the extent to which participants agreed or disagreed with statements about palliative care and SPC services. Preferences for support were also elicited using a discrete choice experiment with respondents making multiple choices between combinations of attributes including: access to information; symptom burden; monthly costs; caregiver burden; shared decision-making; place of care; arranging access to services; and access to SPC. Differences between groups were tested for statistical significance.

Results: 135 people were interviewed (patients=66 & caregivers=69). Participants broadly understood the principles of palliative care, with 80% agreeing that palliative care was about quality of life and supporting family and friends. However, many participants held incorrect assumptions about important aspects of service delivery. Nearly 80% thought palliative care could only be provided by SPC teams. More than half assumed SPC is primarily for people who are near the end of life, and over 25% believed that admission to a hospice could hasten death. Perceptions varied across the study regions and influenced expressed preferences, particularly for place of care.

Conclusion: Despite a long history of palliative care provision in Ireland, significant misperceptions exist, even among people accessing services. The findings of this study demonstrate the need to improve public awareness and understanding of palliative care and highlights the areas that should be prioritised. Appropriate knowledge about services is critical to helping people develop informed preferences about their care.

Abstract number: PO1
Abstract type: Print Only

The “PROAKTIV” Study Protocol: A Cluster-randomized Trial of Primary Palliative Care
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Introduction: In Switzerland, emergency hospital admissions from home occur frequently in the last months of life. Unfortunately, there is no successful structured approach to prevent them in current general practice. General Practitioners (GPs) would be in the best position to provide this type of care, however their crucial role has generally been overlooked in their training. This abstract presents the protocol for a study that will provide GPs with the tools to proficiently identify and address patients’ palliative care needs through a “Systematic Palliative Care Approach”. This approach may increase the change for patients to stay at home during their last months of life.

Research aims: The primary aim of this study is to identify whether a “Systematic Palliative Care Approach” in GP practices influences the satisfaction with end of life care from the perspective of patients, family caregivers and the medical caregivers. The secondary aim is to examine if the intervention affects the health care use and hospital costs.

Methods: GPs willing to participate in this study will be randomized as clusters in the trial. The approximately 58 GPs will recruit adult patients with an advanced disease. Patients in the intervention arm will receive a “Systematic Palliative Care Approach” intervention, while patients in the control arm will receive usual care. The intervention includes five PROAKTIV steps that range from prognostication to integration of specialist palliative care. Patients, family members and medical caregivers will be invited to fill out study questionnaires every two months. Hospital administration will deliver cost data from the last six months of life.

Results: The PROAKTIV cluster-randomized trial is in line with the Swiss “Health2020” agenda. The results of this study will provide evidence of the patients’, family’s, and medical caregivers’ satisfaction with the “Systematic Palliative Care Approach”, as well as the economic benefits of an innovative health care approach that improves coordination and integration of primary and specialist palliative care.

Funding
The Swiss National Science Foundation

Abstract number: PO2
Abstract type: Print Only

Advance Care Planning in the Context of Dementia: Development and Evaluation of a Conversation Tool for Primary Healthcare Professionals

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Aims: Professionals are hesitant of initiating advance care conversations with patients with dementia and their relatives. This study aimed at developing and evaluating a conversation tool that supports primary healthcare professionals, in engaging conversations about patients’ wishes and preferences for future issues.

Methods: First we developed a conversation tool, based on (1) relevant literature (2) semi-structured interviews with 9 people with dementia, 9 relatives, and 4 general practitioners (GP), and (3) two focus group interviews with case managers dementia (CD).

Secondly, we evaluated the conversation tool in a pilot study. Therefore three GPs, three geriatricians and 18 CD used the tool in daily practice after receiving an instructional video. Twelve of them participated in two reflection meetings to support the implementation. Semi-structured interviews were held with the professionals as well as the people with dementia and their relatives who received the intervention. We applied thematic data-analyses with Atlas.ti.

Results: Six relevant conversations topics were elicited:
(1) daily enjoyment,
(2) daily care,
(3) medical treatment,
(4) coping with the dementia and the (nearing) death,
(5) financial and legal issues, and
(6) the social network.

The topics were incorporated in the tool. Preliminary results from the evaluation: professionals indicate the conversation tool provides structure and support in planning and starting conversations. There is variety in the manner of use. The topics were recognizable and appropriate, though professionals also formulated recommendations regarding content and layout of the tool. Long term experiences will be presented at the congress.

Conclusion: Advance care planning in the context of dementia includes issues related to the daily life, and medical and legal issues. The conversation tool provides structure and a visual overview of the important topics, and can be used flexibly. The content and layout requires small adjustments.

Funding
This study is funded by ZonMw, the Netherlands.

Abstract number: PO3
Abstract type: Print Only

Barriers and Challenges to Implementing a Palliative Care Comparative Effectiveness Trial in the U.S.
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Patients with serious illness from cancer, heart failure, and chronic obstructive pulmonary disease often receive poor quality of care, resulting in unmitigated pain and related symptoms, unmet psychosocial needs, and significant caregiver burden. Palliative care has strong evidence for improved outcomes for these seriously ill patients. Yet, despite rigorous evidence demonstrating the effectiveness of palliative care in improving patient outcomes and reducing costs of care, access to community-based palliative care services in the U.S. has been hampered by the lack of reimbursement and evidence for most effective approaches. This study is a comparative effectiveness trial of two approaches to palliative care provision: Home-based Palliative Care (HBPC) or Primary Palliative Care (PPC) integrated within a reimbursement system.

We are conducting a clustered randomized controlled trial among seriously ill patients and their caregivers to determine which study arm is most effective in improving patient and caregiver physical and psychological wellbeing, and in reducing emergency department visits and hospital admissions.

We present our preliminary findings related to barriers and challenges in engaging study stakeholders. Our patient and caregiver stakeholders identified the outcomes of our study. We received enthusiastic response from medical group administrators, however, we encountered numerous challenges in engaging physicians due to overload in clinical practice and lack of understanding and knowledge of palliative care. Finally, we found
enormous variation among our palliative care partners in program staffing, frequency of home visits, and eligibility criterion. Lack of knowledge, inconsistent practice patterns, and current work loads are barriers to study implementation. Significant education and training are required to ensure fidelity to evidence-based palliative care models being tested in our study.

Funding
This study is funded by the Patient Centered Outcomes Research Institute.

Abstract number: PO4
Abstract type: Print Only

Shortening Waiting Times for Palliative Care Patients: Methods and Challenges
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Background: Long waiting time is not acceptable in palliative home care, sometimes it might be even critical. Reduced waiting time makes palliative home care equitable and far reaching which are the goals in management of palliative care. The aim of this study is to show the key factors that decrease waiting time for palliative care patients at home.

Methods: Waiting time refers to the time a patient waits at home before being visited by one of the palliative home care team member. Correlations between the number of recipients and delivered services are revealed as well as correlations between waiting times and staff working hours.

Results: The number of provided palliative care services has increased by 43%. The aim to meet the growing demand has bolstered our need to increase our employee figures by 11% (~3.6% per year) while the total working hours of palliative care team have increased by 17%. The studies revealed that waiting times for palliative care patient have shortened by 29%. The aim to meet the growing demand has bolstered our need to increase our employee figures by 11% (~3.6% per year) while the total working hours of palliative care team have increased by 17%. The studies revealed that waiting times for palliative care patient have shortened by 29%.

Abstract number: PO5
Abstract type: Print Only

Baseline Measure: Access to Specialist Palliative Care Advice Out of Hours
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Background: Many Specialist Palliative Care (SPC) services provide out of hours (OOH) telephone advice services that are operated from inpatient units. However, little is known about these services and the calls received. Therefore there is a need to clarify access to SPC advice and information from SPC services OOH (HSE, 2011 & HSE 2017). This also supports the identified need for research in Ireland about OOH care and support (McIlfatrick, 2015).

Aim: To gather baseline information about calls received from GPs to SPC Consultants OOH in a hospice and general hospital where no local hospice is in operation.

Method: A baseline measure was developed using information retrieved from existing literature relating to the evaluation of other OOH SPC telephone advice systems. A leader from each site was responsible for gathering information over a six month period relating to GP to SPC consultant calls OOH (from 17.00-08.00).

Results: A total of ten phone calls were received by both services. Five calls related to patients with dementia, and two concerned queries on patients with cancer. Of relevance was that over the six month period 2 calls were received by one service from a part of the country not serviced by a SPC inpatient unit.

Conclusion: As per the HSE Three Year Development Framework a complete mapping of current practice regarding 24 hour availability of SPC advice is required. Findings of this baseline measure are currently being explored by IPMCA. Direction from that group is required re next steps that might include:

1. Informing GPs about local SPC advice systems and repeating the baseline measure to measure impact of informing GPs, and
2. Continue gathering data in other SPC sites around the country.

Abstract number: PO6
Abstract type: Print Only

The Experience of Arranging Palliative Care at Home for Personnel and Families of an Armed Force in India - The Carers’ Perspective
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Introduction: Palliative care remains inaccessible to most Indians, especially in remote areas. This is the first study which tries to explore the experience of arranging palliative care at home - from the perspective of the carers in an Indian armed force.

Aim: The aim is to create awareness and help change the attitudes, practices and policies to increase the accessibility and integration of palliative care with available healthcare services in future.

Methodology: Qualitative study based on thematic analysis of semi-structured interviews with carers who are either serving personnel or their dependents.

Results: Lack of accessibility to palliative care in rural areas makes arranging home care challenging for anyone in India, more so for carers in armed forces. The families stay alone and men can’t be there to look after loved ones. Constraints of leave, financial and legal problems, frequent movement and social isolation disrupt care as well as family and community support systems, leading to psycho-social problems and stress for the serving personnel as well as families.

Integration of palliative care into the existing medical services, coordinating with other agencies to provide palliative care at home along with empathetic listening, timely leave, reimbursement of expenses, increased family accommodation, guidance about benefits and considerate implementation of transfer policy can help mitigate some of their problems.

Conclusion: These carers face physical exhaustion, psycho-social, financial, legal and spiritual issues - some common to all rural Indians and others unique to the armed forces. Understanding their experiences will help the providers find solutions, especially in relation to the unique needs of the men in uniform.

Funding
MSc funded by Commonwealth Scholarship Commission.

Abstract number: PO7
Abstract type: Print Only

The Impact of Palliative Care for Patients with COPD: A Systematic Review

EAPC 2018 Abstract Book 209
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Background: Although most patients with advanced COPD are in need of palliative care, most of them do not receive it; palliative care is still mainly restricted to patients with cancer. As the disease trajectory of patients with COPD largely differs from patients with cancer, palliative care interventions will be different too. It however remains unclear which palliative care interventions for this patient group are available, which are most effective and which are most feasible for use by healthcare professionals in practice.

Methods: The aim of this study was to perform a systematic review assessing the content, feasibility and effectiveness of palliative care interventions for patients with COPD and their informal caregivers. PubMed, Embase, Web of Science, COCHRANE Library, PsycINFO, CENTRAL and Emcare were systematically searched. Both quantitative and qualitative research articles and systematic reviews were included, and no restrictions with regard to publication date were employed. References and citations of included studies were searched to identify other potentially relevant studies. Study quality was assessed using the Mixed Methods Appraisal Tool (MMAT). Content of interventions, and process and outcome indicators at the level of the patient, informal caregiver, health care professional and/or the process were extracted.

Results: 4120 articles were screened on title and abstract by two investigators independently. Until now, 198 articles have been identified for full text screening. Where appropriate, quantitative synthesis will be done. For most intervention types however, heterogeneity of the studies will require a qualitative synthesis. Definitive results are expected in December 2017.

Conclusions: This study systematically reviews the content, evidence and feasibility of palliative care interventions for patients with COPD and their informal caregivers. It will provide healthcare professionals with insight on how to provide effective and feasible palliative care for this patient group. This study is part of a 4-year project subsidized by the Dutch governmental ZonMw-program ‘Palliantie. Meer dan zorg’.

Abstract number: PO8
Abstract type: Print Only

Perceived Barriers and Facilitators of General Practitioners’ Palliative Care Provision in their Everyday Clinical Practice
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Background: While structure and service development in palliative care (PC) were strengthened during the last decades in Germany, agreement exists on the pivotal role of the GP in PC delivery. Improving primary care is a current political priority, but successful translation into practice is still due. To date, it has not been adequately examined i) under which conditions GPs in Germany can actually provide PC for their patients within the existing healthcare system, and ii) how PC can best be integrated into GPs’ everyday clinical practice.

Methods: A mixed methods study consisting of a theoretical, a modeling, and an implementation and evaluation phase started in November 2016. Combining data from different subprojects, it aims to provide an empirical basis for the sustainable implementation of primary PC by GPs. During the first phase, ethnographic field studies were conducted in nine GP practices in Lower Saxony to observe everyday clinical practice. GPs were recruited using theoretical sampling and data were analysed according to coding principles of Grounded Theory.

Results: GPs’ delivery of primary PC is both impeded and facilitated by specific aspects on five major dimensions: 1) professional regulations such as the remuneration of PC, 2) structures within the GP’s practices such as delegation of work, 3) attitudes and personal perceptions of all involved parties such as the GPs’ definition of their role, 4) PC knowledge, education, and experience such as having a specific PC training, 5) and the actual interaction, communication and care provision at the interface between GPs, professional assistants, and other service providers such as availability of hospice beds, as well as patients, and their informal caregivers.

Conclusions: Barriers and facilitators of GPs’ PC provision interact on structural, personal, organizational, and care-related levels. The ethnographic methods were proven helpful for experiencing and understanding GPs’ work routine.

Abstract number: PO9
Abstract type: Print Only

Measuring Knowledge toward Palliative Care among Primary Care Health Professionals: Validity and Reliability of the Palliative Care Quiz (PCQ)-Indonesian Version
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Background: Implementation of palliative care in primary health care unit is at the infancy stage in Yogyakarta, Indonesia. Primary care health professionals are in the front line to provide palliative care service in the community. Their palliative care knowledge may influence their quality of care to terminal patients. A measurement to assess palliative care knowledge among primary care health professionals is needed. No study established the Indonesian version of palliative care knowledge measurement for primary care health professionals.

Aims: To establish the PCQ-Indonesian version (PCQ-I) and examine its validity and reliability.

Design: A cross-sectional study was conducted from August to October 2017.

Settings: Twenty primary health care units in Yogyakarta, Indonesia.

Participants: Physicians and nurses working in primary health care units in Yogyakarta province were included. They were unable to give informed consent and taking maternal or annual leave was excluded. A total of 150 primary care health professionals was recruited.

Methods: A two-stage design was carried out. Stage I applied a cross-cultural adaptation of the PCQ following the well-published guidelines including forward translation, synthesis, backward translation, expert committee review, and pilot study. Stage II tested the PCQ-Indonesian Version’s content validity and internal consistency reliability.

Results: Of the 150 participants, 50 were physicians (33.3%) and 100 were nurses (66.7%). The PCQ-Indonesian Version consisted 20 items with true, false, and ‘don’t know’ responses. It included three domains of palliative care: (1) philosophy and principles, (2) pain and other symptoms management, and (3) psychosocial and spiritual care.

The overall content validity index was .97 and the Kuder-Richardson formula-20 (KR-20) test result of .71.
Conclusion: The findings indicated the PCQ-Indonesian Version is valid and reliable to evaluate both of Indonesian primary care physicians and nurses’ knowledge toward palliative care. Although further testing is encouraged to more fully demonstrate the psychometric, it could be useful to identify basic knowledge of palliative care among primary care health professionals.

Abstract number: PO10
Abstract type: Print Only

The Perception of the Patient’s Quality of Life in Palliative Home Care
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Background: To respond adequately to the physical and psychological needs of terminal patients, it is necessary that palliative care unit members can assess appropriately the nature and intensity of these unmet needs. In literature, there is a generally tendency from healthcare workers to underestimate quality of life and to overestimate feelings of anxiety, depression and coping strategies of patients with oncological and degenerative diseases (Lampe & Sjödin, 2009). The disagreement between perception of patient and palliative care unit members could produce unfavorable consequences (e.g. low adhesion to therapy, unrealistic expectations, low rate symptoms relief success).

Aim: The primary outcome measure of this study is the agreement between patient’s perception of the own quality of life and perception of the one evaluated by multidisciplinary palliative home care team at baseline and week 2 and 4 through the administration of Palliative Care Outcome Scale (POOS scale, Italian validation of Costantini et al., 2016). Secondary outcome measure is the agreement of multidisciplinary palliative care team members in the evaluation of patient’s quality of life. We evaluated 50 patients admitted to palliative home care assistance.

Results: Patients show a high perception of their quality of life that tends to increase over time; also, there is generally a good agreement between patients and multidisciplinary palliative home care team, albeit with some exceptions. Members of multidisciplinary palliative home care team reach a good accordance, with some differences based to professional skills (medical doctors, nurses, psychologists, social workers, physiotherapist, health care assistant).

Conclusion: Results indicate a good ability of multidisciplinary palliative home care team members to observe and recognize unmet needs, problems and resources of terminal patients. Outcome measures have an important role to increase quality, effectiveness and accessibility to palliative care.

Abstract number: PO11
Abstract type: Print Only

A Review of Community Specialist Palliative Care Services over a 10 Year Period
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Background: Referrals to community specialist palliative care teams (CPCT) have been increasing in recent years, and demographics suggest that demand will continue to increase. This puts further pressure on stretched services, which need to adapt to accommodate this.

In addition, there has been a change in the patient cohort referred, with a reported increase of patients with non-malignant conditions. Prognostication in these patients is extremely difficult and adds further complexity to a heavy caseload.

Aims: To review CPCT activity data, assess the changing number and type of referrals, and how this has affected the service in the last decade.

Methods: 2006 to 2016 data from a large CPCT was analysed using excel.

Findings: The number of initial visits carried out increased from 536 per annum in 2006, to 1193 in 2016. This equates to a percentage increase of 123% over the ten year period. During this time there was little change in nursing or medical staffing levels. The total number of CPCT visits per annum has increased, with a total of 10,194 visits in 2006, compared to 12,374 in 2016. This equates to a percentage increase of 21%.

The number of visits per patient per annum has however changed considerably, with a drop from 19 visits per patient in 2006, to 10 in 2016. Also notable is the increase in referrals of patients with non-malignant conditions. It has risen from 10% of all referrals in 2009 to 30% in 2016. Although data is incomplete we also note a change in practice with patients now more commonly discharged from the service rather than kept on indefinitely.

Conclusions: Increasing demand on the service and a changing cohort of patients has forced the CPCT to develop and adapt. In the presence of a large increase in referrals, without an equivalent increase in staffing, the average number of visits to each patient per annum has decreased significantly. While the total number of visits carried out has remained relatively stable we believe the complexity of cases has increased.

Additionally, the number of referrals of patients with non-malignant conditions has been steadily increasing, in line with changes noted by hospitally palliative care services and specialist in-patient units. Further work is needed to identify how this change in number of visits per patient has influenced the care provided and to plan for the future when further increases in referrals, particularly in patients with non-malignant disease can be expected.

Abstract number: PO12
Abstract type: Print Only

Effectiveness of a Home Palliative Care Team in Switzerland: Preliminary Results of a 2-years Pilot Study
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Research aims: In Switzerland, home palliative care teams (HPCTs) provide specialized palliative care counselling at the request of general practitioners (GPs) and home nursing teams. This study aims to assess the type of requests addressed to an HPCT and the impact of HPCT before and after the implementation of a 24/7 telephone helpline, by considering patients, caregivers, and professionals opinions. Patient and professional perspectives from the pre implementation phase are reported.

Methods: Patients were evaluated pre/post intervention. When not possible, they were assessed retrospectively 15-20 days post-intervention. Outcomes measures for patients were quality of palliative care (Palliative Outcome Scale – POS; total ‘0’ best quality – ’40’ worst quality, single items ‘0’ best quality - ‘4’ worst quality). Professionals received a questionnaire 3 months following the end of the intervention. Outcomes were: satisfaction regarding the HPCT intervention, professionals’ attitudes and needs regarding palliative care (range 0-10 for each item). Descriptive analyses, Wilcoxon test and independent samples T test were used.

Results: 32 patients were recruited (mean age =74.4; 62.5% women, 78% with cancer diagnosis). Total quality of palliative care did not improve significantly between T1 and T2 (11.3 vs 10.4, p>.05). but time wasted on medical tests decreased; (1.6 vs 0.3; p<.05), information received was less clear (0.3 vs 1.2; p< .05) and patients reported feeling worse as
a person (0.3 vs 1.1; p < .05). Considering professionals, nurses evaluated HPCT interventions as more useful than GPs for “advanced directives,” “patients psycho-social / spiritual supports,” and “transmitting specific knowledge” areas (7.2 vs 5.3; 7.3 vs 6.1; 7.1 vs 4.7; 7.6 vs 6.8, p < .05 respectively). Compared to nurses, GPs felt more confident regarding “ethical” and “legal” issues (6.7 vs 5.8; 6.1 vs 4.8, p < .05 respectively) and reported less need for palliative training (6.8 vs 7.8, p < .05). The main request addressed to the HPCT was “pain management” (28.4%).

Conclusion: Limited improvement in global palliative care quality may be due to low baseline scores (selection bias). Nurses, who have a regular follow-up with patients, reported more benefits from HPCT interventions. A second phase is important to evaluate whether a telephone helpline will result in an enhancement of HPCT performance, compared to current functioning.

Abstract number: PO13
Abstract type: Print Only

Understanding the General Practitioner’s Clinical Recognition of Impending End of Life and Subsequent Clinical Practice: A Qualitative Study
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Background: General practitioners play an important role in end-of-life care. Nevertheless, we know that the majority of people who die are not identified in time to enable appropriate care planning and some general practitioners (GPs) do not offer end-of-life care (EoLC) at all.

Aim: This study aims to describe what triggered GPs to identify approaching end of life (EoL); how their practice changed when they realised EoL was imminent; and the challenges they found in providing EoLC.

Design: A qualitative study, using semi-structured interviews. Interviews were analysed using a general inductive approach.

Participants: 15 GPs were interviewed about the EoLC of one of their deceased patients. The patient was selected at random to prevent selective bias. The interview was conducted by a GP qualitative interviewer to facilitate an in-depth case discussion.

Results: Most patients were diagnosed with cancer (9/15). When a life-limiting prognosis was articulated (by the patient or health professional), GPs integrated end-of-life care, which often included care planning. Even when approaching death was not articulated, GPs were nevertheless aware of approaching end of life. They changed their focus to comfort of the patient, but this was not explicitly discussed. How they provided end-of-life care depended primarily on patient traits (e.g. willingness to discuss death) and the GPs’ characteristics (experience, training, and consulting style).

Conclusion: General practitioners are aware of their patients’ approaching EoL. However, their shift to EoLC was often not explicitly articulated, it was influenced by the personal beliefs and responses of the patient and general practitioner, and their experience and skills. Future studies should investigate if implicit unarticulated EoLC is sufficient to meet patient needs.

Abstract number: PO14
Abstract type: Print Only

Structures and Policy Framework in Specialized Outpatient Palliative Care (SAPV) in Germany - A Nationwide Assessment
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Background: Since 2007, patients with severe advanced life-limiting illnesses and high and complex symptom burden have a right to receive specialized outpatient palliative care (SAPV). Multi-professional teams (nurses and physicians) with heterogeneous organizational structures provide care in cooperation with primary care givers. Different contracts between care providers and health care insurances regulate organizational aspects cooperations, definitions of care levels (counselling, coordination, partial care, full care), service provision and compensation. In some regions model contracts are binding for all SAPV teams in the area; in other regions teams negotiate compensation and other aspects, individually with insurances.

Methods: In 2017, all institutions providing SAPV in Germany were asked to submit data to the “Wegweiser Hospiz- und Palliativversorgung”, an online data base provided by the German Association for Palliative Medicine (DGP). The Wegweiser is based on voluntary information given by institutions and contains data of 252 SAPV providers. A comprehensive list of SAPV providers in Germany does not exist. To complete the data we obtain lists of SAPV teams from local stakeholders.

The organizational data contains information on team size, structures employing team members (e.g. nurses employed by team, hospital or nursing service; physicians employed by team, hospital or in medical practice), participating professions, cooperation with other professions, organizational structure (e.g. all team members employed by one institution; network of medical practices and nursing services with or without central coordination), patient numbers and care levels.

Results: The contracts will be analyzed regarding their differences in regulations. To validate information and assess different practices, interviews with local SAPV providers or stakeholders who are involved in policy making are conducted. In our analysis we will describe organizational aspects and classify typical SAPV teams. Contract differences will be used as predictors of organizational classes.

The study is part of the SAVOIR consortium which evaluates different aspects of SAPV in Germany.

Abstract number: PO15
Abstract type: Print Only

Overview of Length of Stay in a Community Palliative Care Service
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Background/aims: There are few studies of Length of Stay in Outpatient Community Palliative Care Services. Describing the characteristics of Length of Stay may contribute to service planning. This study reviewed all referrals to two community palliative care teams in a one year period to describe the distribution of length of stay within the service.

We defined Length of Stay as: (the amount of time spent within the service from the initial assessment to either discharge or death) minus (periods spent discharged to other services.)

Methods: Review of our Patient Administration System for dates of entry and discharge from the Service.

Results: Length of Stay in Setting A - of 33 cases reviewed, 18% were 10 days or less and 39% were 100 days or more. Of all cases with > 1 episode of care, the average Length of Stay was 145 days. Of these cases, 10% were 10 days or less and 40% were 100 days or more. The average percentage time (between initial assessment to either discharge or death) they were not discharged to other services was 35%.

Length of Stay in Setting B - of 83 cases reviewed, 33% were 10 days or less and 23% were 100 days or more. Of all cases with > 1 episode, the
average Length of Stay was 129 days. Of these cases, 14% were 10 days or less and 66% were 100 days or more. The average percentage time they were not discharged to other services was 37%.

**Conclusions:** Characteristics of Length of Stay appeared broadly similar for each team. In both settings, most patients stayed more than 10 days, with at least 40% of multiple episode patients in each setting staying more than 100 days. Approximately a third of their time from initial assessment was spent 'within' the service.

**Abstract number:** PO16
**Abstract type:** Print Only

“The Is Mum’s Home Now”. Residents’ and Families’ Experiences on Dying in Rural Residential Aged Care

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**Background:** Residential aged care (RAC) is playing an increasing role in end-of-life care. There is a paucity of rural studies reporting the place of death of RAC residents, or the experiences and perspectives on receiving end-of-life care or dying in RAC, from the viewpoint of residents and their families.

**Aims:** To describe the place of death of permanent RAC residents and the characteristics of those who died in rural RAC, within one Australian rural region; and to explore contextual insights of RAC residents and their family caregivers.

**Methods:** A mixed-methods design. Data were collected from:

1. A population survey of place of death (Feb 1, 2015 through May 31, 2016);
2. Ethnography using face-to-face, in-depth, open-ended interviews with residents diagnosed with a condition amenable to palliative care, and their family caregiver.

**Results:** Eighty residents (65 permanent residents; 15 short-term residents) died in RAC during respite or during an attempted step-down transition from hospital to home. Fifty-one (78.5%) of the permanent residents died in RAC. Four residents and six family members were interviewed. When home was no longer possible, the transfer to RAC was usually accepted, providing the resident could remain within their community. Participants were satisfied with most aspects of RAC, except the under-staffing of registered nurses, and did not want a transfer to hospital for end-of-life care.

**Conclusion:** RAC plays a significant role in rural end-of-life care. Many RAC residents consider the facility ‘home’ and an important part of the rural community. More studies are required to explore further the experiences and perspectives of rural RAC residents and their families, and if transfers to hospital are avoidable.

**Abstract number:** PO17
**Abstract type:** Print Only

**Palliative Care for Patients with Dementia**

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**Introduction:** Dementia is incurable and deadly disease. There are different types of dementia. According to certain statistics, Alzheimer’s dementia is the most common form of dementia. In the terminal phase of the disease, patients with dementia are immobile, and completely dependent on the care of their family. Such patients are the most common users of the palliative care homes. The palliative care for patients with dementia is different from the palliative care for patients with carcinoma. Therefore, patients with dementia are transferred to psychogeriatric department. The PHI Gerontology Institute beside the hospice for hospitalizing patients with carcinoma, has psychogeriatric department for hospitalizing patients with dementia.

**Aim:** The aim of the study is to see how many patients in the terminal phase of dementia are hospitalized in the PHI Gerontology Institute, as well as the type of dementia they are suffering from.

**Material and methods:** The retrospective analysis was made over a period of one year (01.01.2016-31.12.2016)

**Results:** During this period of one year, 352 patients aged 17 to 97 (average age of patients 78 years) were hospitalized in the PHI Gerontology Institute. Of these, 109 patients (31%) had been diagnosed with dementia. The most common type of dementia of our patients is the vascular 56%, Alzheimer’s dementia occurs in 30% of the patients. It is noticeable that the average age of the patients with Alzheimer’s dementia is 75 years, while the average age of patients hospitalized with vascular and other types of dementia is 81 and 84 years.

**Conclusion:** According to our study the most common type of dementia is vascular, due to the comorbidities that patients have. The number of patients with Alzheimer’s dementia is smaller, but unlike others they are younger. In the PHI Gerontology Institute the care for the both first and second patients is with multidisciplinary approach with health professionals from different profiles.

**Abstract number:** PO18
**Abstract type:** Print Only

**Selecting and Implementing Palliative Care Tools in Nursing Homes:** First Results of Action Research with Nursing Staff to Accommodate their Preferences

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**Background/aims:** Numerous tools are available for use in long-term care settings to assess and monitor pain and other symptoms and needs, as well as tools to estimate prognosis. However, in many nursing home practices, none of these are used. Our aim is to understand nursing staff preferences for particular tools and challenges around implementation in practice, to ultimately optimize tools for use in practice.

**Methods:** Participatory Action Research with nursing staff of 10 Dutch nursing homes working with 2 anthropologists. We report initial results, taking a close look at staff criteria for selecting tools, by analysing transcripts of focus groups and semi-structured interviews with elderly care physicians, spiritual caregivers, and nursing home managers.

**Results:** The results show that staff is interested in tools to identify when change in care is needed. This was related to a lack of shared understanding of what constitutes the palliative phase in the nursing home setting, and how caregiving should change when this phase arrives. The palliative phase was often either equated with terminal care or generalized across all nursing home residents. Staff demonstrated a preference for tools that determine changes in a resident’s condition and that can facilitate communication between shifts. They further expressed the need for a tool that can verify their observations in communication with the on-staff elderly care physicians. We will present which tools exactly were being preferred and highlight the motivations behind these preferences.

**Conclusions:** Implementation of a tool that is preferred by nursing staff and that corresponds to their needs can be a form of empowerment, by
strengthening their position in communication and support them to provide palliative care.

Abstract number: PO19
Abstract type: Print Only

Predicting Mortality in Nursing Home Residents with Dementia and Pneumonia: Adding Items to Improve Prediction of an Existing Prediction Model in a More Recent Population
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Aims: To evaluate the performance of a model developed in a Dutch 1990s population to predict 14-day mortality risk in antibiotic-treated nursing home residents with dementia and pneumonia, in the more recent Dutch Pneumonitor study (2012-2015). Also, to evaluate if model performance improved by adding items.

Methods: The original prediction model included: gender, respiratory rate, respiratory difficulty, pulse rate, decreased alertness, fluid intake, eating dependency and pressure ulcers. We applied it to 380 recent pneumonia episodes. Missing values were multivariately imputed, generating 40 imputed data sets. The model was updated by considering additional items. Model performance was evaluated by explained variance (R²); Hosmer-Lemeshow statistics (HL) and calibration graphs to assess calibration; and areas under the receiver operating characteristic curve (AUCs) to assess discrimination. Reclassification tables compared patient classifications between models. We internally validated the extended model using bootstrapping.

Results: The newer cohort had lower 14-day mortality and was less often dehydrated or malnourished. Although the original model accurately predicted absolute mortality risks (HL: p=0.91), the median AUC over the imputed datasets was only 0.71 (IQR: 0.70-0.72), compared to 0.80 in the 1990s cohort; and median R² was 13% (IQR: 0.12-0.14). Extending the model with dehydration, bowel incontinence, cardiovascular history and increase in eating dependency considerably improved the AUC: 0.81 (IQR: 0.80-0.82) and R²: 28% (IQR: 0.27-0.29). Calibration remained adequate (HL: p=0.66). Classification of patients at high vs low mortality risk improved (net reclassification index 0.135, IQR: 0.118-0.158). Extending the model with dehydration, bowel incontinence, cardiovascular history and increase in eating dependency considerably improved the AUC: 0.81 (IQR: 0.80-0.82) and R²: 28% (IQR: 0.27-0.29). Calibration remained adequate (HL: p=0.66). Classification of patients at high vs low mortality risk improved (net reclassification index 0.135, IQR: 0.118-0.158).

Conclusions: In the newer cohort with less severe illness, historical transportability of the model was inadequate. An extended model better distinguished between residents at low and high mortality risk, performing similar to the original model in the 1990s cohort.

Abstract number: PO20
Abstract type: Print Only

The Strengthening a Palliative Approach in Long Term Care (SPA-LTC) Program: An Evaluation
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Background: Palliative care is inadequate for residents living in long term care (LTC) homes and their family. The purpose of this study was to evaluate the Strengthening a Palliative Approach in Long Term Care (SPA-LTC) program in terms of its impact on:

(a) resident and family outcomes (i.e., use of Palliative Performance Scale (PPS) to trigger Family Care Conferences (FCCs), bereaved families perceptions of care),
(b) staff comfort in palliative care, and
(c) organization outcomes (i.e., hospital transfers and deaths). In addition, we explored staff and family perceptions about their experiences with participating in the SPA-LTC program.

Methods: A mixed method case study design based on a participatory action research approach was used in four Canadian LTC homes. Pre- and post-intervention surveys were completed by staff to assess their comfort providing palliative care, and also by bereaved family members to assess their perceptions about care and resident comfort at end-of-life. Facility-level data was collected on hospital use over a one-year period both pre- and post-intervention. Residents who scored < 40% on the Palliative Performance Scale and their families were invited to attend a Family Care Conference (FCC). Qualitative interviews were conducted to explore family perceptions about attending a FCC.

Findings: In total, 40 residents/families agreed to participate in the study. Descriptive statistics showed residents who had an FCC tended to have dementia, higher Charlson Comorbidity Index, and were hospitalized more often during the last year. Of the 24 who had a FCC, the most commonly discussed domains were physical issues, end-of-life and social care; loss and grief were the least common. Family felt well supported at the FCC and that it was helpful for them; the majority of families reported that their concerns and the kind of care and services wished for at end-of-life were addressed at the meeting. There were no significant pre-post differences in either: staff comfort in providing palliative care, or bereaved families’ perceptions of residents’ end of life comfort and families’ overall perceptions of care. In the last year of residents’ life, there were slight reductions in the number of ER visits, more planned or appropriate ER visits and fewer ER admissions that became hospital admissions.

Conclusions: The SPA-LTC program shows promise to improve quality of living and dying for LTC residents and their family.

Abstract number: PO21
Abstract type: Print Only

Does an Educational Pain Management Intervention in a Nursing Home Improve Nurse’s Knowledge to Decrease Pain in Patients with Dementia?
de Wolf-Linder, Susanne1, Zigan, Nicole1, Hediger, Hannele1, Volken, Thomas2, Bosshard, Georg1, Koppitz, Andrea1
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Background: The intervention, delivered by a nurse with a Master of Science in nursing (clinical nurse specialist (CNS)), aims to decrease pain in people with dementia. The CNS focuses on the support of all healthcare workers (HCW) (nurses, -assistants, auxiliary staff) to strengthen the systematic pain management by training and coaching on structured, clinical communication techniques. This study is part of an ongoing
quasi-experimental nursing-led intervention trial with repeated measure design (https://dx.doi.org/10.1186%2Fs12904-017-0200-5) aiming to identify care needs of people with dementia suffering from pain living in a Swiss nursing home (NH).

**Aim:** To assess nurses’ knowledge of pain management for patients with dementia in NHs including HCWs satisfaction about the learning outcome following the study intervention.

**Methods:** In line with the Medical Research Council (MRC) Framework for complex interventions, a 7-item, eleven numeric rating scale (0=worst, 10=best) questionnaire was designed to ask HCW about the innovation, organisational, individual, and environmental learning in NHs. All staff in three NHs were invited to complete an anonymous questionnaire. Weekly reminders were sent for two weeks to all HCWs. Data were analysed descriptively followed by a comparison of different job titles and the three different locations using the Kruskal Wallis test.

**Results:** A total of n=115 questionnaires from three different NHs were received with a response rate of 54.7%. Non-parametric data showed that learning improvement occurred in all four categories (median ranging from 6 to 9). Comparing NHs, one stood out where the HCW felt able to maintain learned skills from the intervention (p=0.043), which complemented their rating in increased knowledge (p=0.015). Looking at different job titles auxiliary staff felt the educational component was less adhered to compared to nurse-assistants who thought compliance was very good (p=0.001). The potential for improvement within the organization was also rated higher by nursing assistants than auxiliary staff (p=0.043). Registered Nurses were most satisfied with the intervention (median=9) compared to the other two groups (p=0.049).

**Conclusion:** Education tends to be better understood by nursing assistants than other groups. Our findings suggest that auxiliary staff need specific coaching on pain management.

**Acknowledgements**
Swiss Federal Office of Public Health, SAMS, Alzheimer’s Association (CH), Ebnet Foundation

**Abstract number:** PO22
**Abstract type:** Print Only

**How Do Staff Recognise Clinical Emergencies in a Nursing Home? A Case Study**

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**Background:** Recognising a clinical emergency in older people suffering from highly complex health problems can be a challenging for health care workers (HCW) and may lead to life threatening situations for residents. Although the ongoing quasi-experimental nursing-led intervention trial (https://dx.doi.org/10.1186%2Fs12904-017-0200-5) aims to improve pain assessment and -management, it is unclear whether a clinical emergency is recognised through systematic pain assessment or the HCWs intuition.

**Aim:** To understand the nursing home context of HCWs and to identify likely contributing factors precipitating a clinical emergency.

**Methods:** The case study observes the complexity of pain management of older people in a rural Swiss nursing home, which is involved in the main trial. 100 HCW provide care for 69 residents with dementia in this nursing home. The intervention nurse (IN), a single nurse with a Master of Science in Nursing, delivers a five-week intervention. The intervention focuses on strengthening systematic pain management by training HCWs on a systematic pain assessment and treatment, including the coaching on its correct use using structured, clinical communication techniques amongst colleagues. The IN records in a daily diary the way the HCWs structure and conduct their daily routine. Reflective accounts (5 reflective diary records from 5 different patients) from the INs diaries were thematically analysed using an inductive approach to elicit key themes hindering recognition of a clinical emergency.

**Results:** The complexity of pain management of older people is characterized by HCWs availability of time to address pain, HCWs ability to interpret different signs and symptoms indicating pain, and hierarchical structures that allow HCWs to voice their opinion. Non-Recognition of clinical emergencies were repeating events in all 5 records. Interestingly, the HCWs recognised residents in pain and at risk of a medical complication intuitively (non-systematic) and referred them to the IN for review, rather than defer to the outcomes of a structured pain assessment first.

**Conclusion:** Intuition is not sufficient to recognize clinical emergencies. Based on the initial analysis, we recommend more emphasis on structured symptom assessment and treatment to allow for a timely management of clinical emergencies.

**Acknowledgements**
Swiss Federal Office of Public Health, SAMS, Alzheimer’s Association (CH), Ebnet Foundation (CH)

**Abstract number:** PO23
**Abstract type:** Print Only

**Being ‘In-house’ Matters. Outcomes from a Mixed-method Study Evaluating the Impact of a Specialist Palliative Care Nurse Practitioner Employed in Long Term Care Facilities**

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**Background:** Almost all Australian long term care facilities (LTCFs) rely on external specialist palliative care services to provide a widely varying level of clinical and educational support. A large not-for-profit aged care provider has employed an ‘in-house’ palliative care nurse practitioner (PCNP) since July 2013 to provide clinical services across eleven metropolitan and regional LTCFs. During this time, the PCNP has also facilitated extensive clinical practice improvement initiatives including:

- Developing and integrating a prospective clinical audit of all deceased resident files
- Introduction of the Supportive and Palliative Care Indicators Tool (SPICT) to improve recognition of deterioration and trigger more timely care planning processes
- Three key clinical processes essential for implementing a palliative approach: Advance Care Planning (ACP), Palliative Care Case Conferences (PCCC) and End of Life Care Pathway (EoLCP)

**Aim:** To evaluate the role of the PCNP and palliative care provision to within the organisation’s eleven LTCFs, including the use of the three key processes and whether there were increases in referrals to a PCNP with subsequent improved clinical outcomes.

**Method:** Mixed-method evaluation study including:
Implementation of Tools to Recognize the Palliative and Terminal Phase of Nursing Home Residents through Action Research - Motivations of Nursing Homes to Participate

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Abstract number: PO24
Abstract type: Print Only

Background: Many tools are available for use in long-term care settings to recognize the palliative and terminal phase, and there are also many tools to assess and monitor symptoms and identify physical, psychosocial and spiritual needs. However, these tools are hardly used in nursing home practices. This study aims to find tools tailored to nursing home practice by engaging nursing staff along with the multidisciplinary team in selecting feasible tools that fit with practice. As a first step, we aim to understand why nursing homes want to participate.

Study design and methods: Action research with nursing staff of 10 Dutch nursing homes. In this research, care teams are involved as co-researchers, facilitated by two anthropologists in the cyclic process of selecting, implementing, evaluating and adjusting different tools. Additionally, other relevant stakeholders are consulted, including elderly care physicians, nursing home managers and the residents or their family caregivers themselves. In evaluating the processes that result in selection and implementing tools, focus group discussions, semi-structured interviews and participant observations are used. To understand the motivations of nursing homes to take part in this action research, the recruitment process is analyzed from the first information meeting, the selection of care teams, to the final decision to participate.

Results: We found that nursing homes have been eager to participate. They perceived an urgency to improve palliative care. Managers, as well as care staff involved in the decision to participate in this study experience that care is not always properly adjusted to the resident’s needs, due to late recognition of the palliative and terminal phase, especially in the context of dementia. Additionally, we found that the methodology in which staff is directly involved is seen as a promising approach to bring about actual change. Financial compensation proved not to be an argument in the decision whether or not to participate.

Conclusion: In nursing home practice, timely recognition of the palliative and terminal phase is acknowledged as a first essential step in palliative care that needs improvement. Action research is seen as a promising approach to realize this improvement.

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ZonMw, The Netherlands Organisation for Health Research and Development

Abstract number: PO25
Abstract type: Print Only

Self-determination in a Total Social Institution?: Death Work in Swiss Nursing Homes
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Background: The Palliative Care ideal of self-determined dying is spreading from specialized services into other care institutions confronted with end-of-life care, e.g. the nursing home. From a sociological perspective, however, nursing homes are characterized by traits of Goffman’s ‘total social institution’, i.e. they are struggling with contexts, norms and practices that severely constrain self-determination. Based on an ethnographic research project exploring Swiss nursing home end-of-life care, professional practices to handle this contradiction are discussed.

Objectives: To identify emerging professional practices of nursing home caregivers in dealing with contradictions between Palliative Care ideals of self-determination and constraints of the ‘total social institution’.

Design and methods: Qualitative design based on ethnographic fieldwork in two Swiss nursing homes. Data collection methods: extensive participant observation, ethnographic interviewing, documentation analysis. Data analysis followed the principles of Grounded Theory.

Results: Nursing home end-of-life caregiving is characterized by a pragmatic variation of Palliative Care, focusing on practices that easily integrate into daily care (i.e. not disturbing or newly legitimizing existing routines). Due to scarce institutional resources and the characteristics of dying in very old, multi-morbid age, the norm of self-determination is challenging to fulfill. In the last days of life, residents are most often not in a position to express their will, and caregivers are obliged to interpret minimal bodily signs as expressions of ‘supposed will’. However, professional caregivers’ reflections on dying trajectories, as well as their practices of documenting are characterized by discursive constructions of self-determination.

Discussion: The need to pragmatically decide in situations where residents are not in a position to explicitly express their will is a decisive characteristic of nursing home ‘death work’. The discursive construction of residents as actively self-determined, autonomous subjects may be interpreted as a strategy to deal with these conflicting norms in everyday practice. Speaking in sociologists’ terms, insecurities of framing and the compulsion to interpret are professional constants in nursing home end-of-life care in the context of reflexive modernity.

Funding
This research project has been funded by the Swiss National Science Foundation, NFP67 “End-of-Life”.

Abstract number: PO26
Abstract type: Print Only

Evaluating the Impact of Aromatherapy Massage on Symptoms for Palliative Patients in an Acute Hospital Setting
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Background: Aromatherapy massage (AM) has been shown to be effective for palliative patients across various settings such as hospices and
specialist cancer centres. However, there is limited evidence of its impact in the acute district general hospital setting.

**Aim:** To evaluate the impact of AM for palliative patients in an acute hospital setting.

**Methods:** A composite of the six point Measure Yourself Concerns and Wellbeing (MYCAW) tool and six point general wellbeing score was completed by patients used to evaluate symptoms pre and post AM. Mean pre and post AM scores were evaluated for each symptom using a paired t-test.

**Results:** Data was collected from 88 patients and is presented in Table 1. AM was associated with a clinically and statistically significant improvement in symptoms and well being for pain, low mood, nausea and constipation, but not panic attacks.

**Table 1**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>MYCAW Before</th>
<th>MYCAW After</th>
<th>RRR</th>
<th>ARR</th>
<th>95% CI</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low mood</td>
<td>8.67</td>
<td>5.88</td>
<td>32%</td>
<td>2.77</td>
<td>1.44 - 4.14</td>
<td>0.0001</td>
</tr>
<tr>
<td>Pain</td>
<td>10.03</td>
<td>5.56</td>
<td>44%</td>
<td>4.44</td>
<td>3.37 - 5.57</td>
<td>0.0001</td>
</tr>
<tr>
<td>Nausea</td>
<td>9.83</td>
<td>6.16</td>
<td>37%</td>
<td>3.67</td>
<td>0.8 - 6.53</td>
<td>0.02</td>
</tr>
<tr>
<td>Panic attacks</td>
<td>10.0</td>
<td>7.88</td>
<td>21%</td>
<td>2.12</td>
<td>-0.14 - 4.36</td>
<td>0.06</td>
</tr>
<tr>
<td>Constipation</td>
<td>10.25</td>
<td>4.75</td>
<td>53.6%</td>
<td>5.5</td>
<td>3.02 - 7.98</td>
<td>0.0003</td>
</tr>
</tbody>
</table>

**Conclusion:** AM is associated with a positive impact on symptoms for palliative patients in the acute hospital setting although the conclusions should be interpreted with a degree of caution. Without a comparator group, it is difficult to exclude placebo or evaluate the true impact of AM. Also patients were receiving ongoing medical therapies for symptoms and a future study should look to minimise confounding factors. The feasibility of conducting a blinded RCT with comparing AM with sham AM is in development.

**Abstract number:** PO27  
**Abstract type:** Print Only

**Barriers to Palliative Care in Resource-limited Settings.**

**A Qualitative Study in Kazakhstan**

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**Background:** Palliative care (PC) improves the quality of life of patients and their families facing life-threatening illness through relief of physical, emotional, and psychological suffering and pain. Identification of modifiable determinants of obstacles to universal quality PC in resource-poor settings like Kazakhstan can represent an example for other countries with similar challenges in PC provision. The 2015 Quality of Death Index, which evaluates global distribution of availability and effectiveness of PC, places Kazakhstan 50th out of 80 countries assessed. The Association of Palliative Care of Kazakhstan reports a substantial unmet demand for increased accessibility to pain relief medications, increased numbers of PC facilities, and training courses for medical care professionals. These improvements are supported by legislation and national policies.

**Specific aims:** To identify specific determinants of obstacles to provision of PC in a resource-limited developing country including drug availability, opportunities for healthcare professionals to receive training in palliative medicine and policy development process, as well as to evaluate the status and cost-effectiveness of PC provision in Kazakhstan.

**Methods:** The study employs qualitative research in form of purposive recruiting with content analysis, semi-structured in-depth interviews until targeted participant numbers are completed or saturation is achieved. Consent was provided by participants. The data is then translated into English, coded and analyzed. With the new study findings, supplemented by published literature and government documents, the best practices within the socio-cultural context of Kazakhstan are systematically determined.

**Preliminary results:** The determinants of barriers to palliative care provision in Kazakhstan are associated with the limited availability of opioids, lack of specialist training and insufficient public awareness concerning palliation.

**Abstract number:** PO28  
**Abstract type:** Print Only

**Medical and Surgical Foundation Year One Doctor Perspectives of Do Not Attempt Cardiopulmonary Resuscitation Orders in a District General Hospital**

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**Background:** Do not attempt cardiopulmonary resuscitation order (DNACPR) can aid a patient’s care but can be associated with a great deal of anxiety. Foundation year one doctors (FY1’s) tend to have the most patient contact and tend to be the most inexperienced member of the firm.

**Aims:**

1. To understand how foundation year one doctors (FY1) in medicine and surgery perceive the application of DNACPR.
2. To better understand the culture in our district general hospital from an FY1 perspective towards DNACPR.

**Methods:** A survey to assess DNACPR was created, with input from FY1’s, consisting of twelve questions, five based on a Likert scale of 1-5 (Variations of 1- Not comfortable, 5- Completely comfortable). Paper surveys were circulated to FY1’s. Data collection occurred in October 2017. The results of eleven questions were analysed in Microsoft Excel and one question was processed in a word cloud.

**Results:** Some key results are summarised below:

- 18 out of 20 (90%) FY1’s responded. 12/13 (92%) medicine and 6/7 (86%) surgery
- FY1’s in medicine (75%) and surgery (100%) do not get induction on how DNACPR decisions are arranged in their firm.
- DNACPR decisions occur more commonly in medicine.
- FY1’s in medicine (2.2) feel less prepared than surgery (3.2) to make a DNACPR decision when clinically indicated.
- FY1’s in medicine (4.4) and surgery (4) felt comfortable discussing DNACPR with a senior.
- FY1’s in medicine (33%) and surgery (50%) feel a DNACPR is actioned too late.
- FY1’s in medicine (17%) and surgery (33%) felt the need to voice concerns over a DNACPR of those that did in medicine (50%/2) and surgery (100%/1) felt respected.

**Conclusions:** Very few FY1’s in medicine and surgery do get inductions on how DNACPR’s work in their firm. FY1’s in surgery and medicine felt comfortable discussing DNACPR with seniors. A small proportion of FY1’s have felt the need to raise concerns over DNACPR orders in their firm.
Does General Surgery Have a Cultural Problem towards Do Not Attempt Cardiopulmonary Resuscitation Orders: A Junior Doctor Perspective

George, Jayan1,2; Whitfield, Andrew2; Nathani, Harsh1; Sellers, Lianne1; Snow, Sarah1; Hu, Andrew1; Al-Mukhtar, Ahmed3
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Abstract type: Print Only

Aims:
1) To understand how general surgical junior doctors (JD) perceive the application of DNACPR in general surgery.
2) To better understand the culture in general surgery towards DNACPR.

Methods: A survey to assess DNACPR was created with input from JD consisting of twelve questions, five based on a Likert scale of 1-5 (Variations of 1- Not comfortable, 5-Completely comfortable). Paper surveys were circulated to JD (foundation year one doctors, senior house officers and registrars). Data collection occurred in December 2016. The results of eleven questions were analysed in Microsoft Excel and one question was processed in a word cloud.

Results: Some key results are summarised below:
- 45 out of 55 (82%) JD responded.
- DNACPR decisions occur more frequently at registrar level.
- 66% of junior doctors have not been given an induction on DNACPR arrangements within their firm.
- Most JD felt “somewhat comfortable” discussing DNACPR decisions with the patient, family and seniors.
- 46% of JD felt that DNACPR were made “too late”.
- 37% of JD have not witnessed their senior having a DNACPR discussion with patients. Those that have, used words such as “Good” “Useful” “Empathy”.
- 89% of JD have not felt the need to voice concerns about the DNACPR process.
- Those that did did voice their opinions 100% (5) felt their opinions were not respected.

Discussion: A high proportion of JD felt that decisions were made too late and there is very little guidance in our trust regarding this. The few JD who did voice opinions of concern over the process felt that their opinion was not respected and this could indicate a deeper concern in culture. The main limitation is this is only based in one hospital trust and the practises elsewhere could vary.

Conclusions: There are aspects of DNACPR which JD feel they are somewhat comfortable to deal with. A high proportion of JD feel that DNACPR are done too late. When there are concerns with DNACPR JD feel that their opinion is not respected and this is a potential area of concern.

Predictors of Quality of Life in Older Adult Patients in Lebanon

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Abstract number: PO30
Abstract type: Print Only

Purpose: The world population is rapidly aging. The most rapidly growing segment is that of people over 80 years. As a nation that bridges the cultures of the east and west, Lebanon reports the highest proportion of their population aged 65+ years among its countries in the Arab world, and is predicted to age rapidly in the first half of the 21st century. One distinctive aspect of aging in Lebanon is the lifetime experience of stress resulting from wars and political disabilities as an influence on health, subsequently on quality of life. The aims of the current study were to

1) describe self-reported quality of life among Lebanese hospitalized older patients; and
2) investigate the relationship between 4 WHOQOL domains predictors and self-reported quality of life.

Methods: This is an observational survey design with older adult patients. A convenience sample of Lebanese older adults (N=203) in need of palliative care was recruited at three medical teaching hospitals. Overall quality of life status was measured using Global Health Status sub-scale from the European Organization for Research & Treatment of Cancer (EORTC QLQ-C30 instrument). Physical health was measured using 24 items from the Memorial Symptom Assessment Scale (MSAS). Presence of anxiety and/or depression was assessed using the Hospital Anxiety Depression Scale (HADS). Spirituality was measured using a five-item subscale on spiritual and existential matters from the Needs at End of life Screening Tool (NEST). Social and professional support were measured using items from NEST. Linear regression analysis was used to determine the association between predictors and quality of life among participants.

Results: The participants had a mean age of 78.52 years (SD = 7.80) with the majority being males (58.6%). Higher mean scores were reported for spirituality (Mean = 6.57, SD = 1.92), social support (Mean = 6.86, SD = 2.86) and professional support (Mean = 6.30, SD = 1.83). Most reported symptoms were “Lack of energy” (94%) and “Pain” (72%). In the multivariate regression, results showed that physical and cognitive functioning, as well as anxiety, were significantly associated with quality of life.

In conclusion, hospitals and palliative care teams must pay close attention to cognitive, physical, and psychological functioning of older adults in need of palliative care as they may have a strong impact on quality of life.
Results: 201 patients were included, among whom 140 (69.7%) were admitted. Most were men (63.7%), mean age was 64.9 years (SD 14.3). 116 patients (57.7%) had advanced diseases. Factors decreasing the probability of admission for complex patients were comorbidities, expected quality of life, burden of intensive care, and patient wishes (for ICU physicians only). Conversely, these factors were less influential for complex patients admitted to the ICU compared to complex patients not admitted or not complex patients admitted. Patient age, goals of care determined on the ward, and ICU bed availability had no influence on the admission decision. 

Conclusion: Physicians consider the qualitative benefits and risks of intensive care for patients with advanced diseases, but these factors seem to mostly influence a decision of no admission.

Abstract number: PO32
Abstract type: Print Only

Reducing Variability in Implementation of ‘New’ Models of Care in Clinical Trials; Developing and Testing Benchmark Criteria to Examine if Key Intervention Mechanisms Are Embedded in Practice

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Background: In a clinical trial of a ‘new’ model of care it is essential to embed the intervention into clinical practice to maximise the likely patient benefit. Yet, changing clinical practice to support a trial is challenging; uncertainty often surrounds how best to achieve this and how to assess the extent the intervention is implemented as intended.

Aim: To develop and test criteria to examine implementation of key mechanisms of the AMBER care bundle (ACB) to manage patients’ care with uncertain recovery in a feasibility cluster RCT.

Methods: Feasibility cluster RCT to test the trial criteria on key mechanisms of the ACB developed by Integrating findings from a national quality improvement (QI) programme on ACB. Two acute hospitals involving three general medical wards. Implementation processes, benchmark criteria and methods to test comprised:

Step 1: Clinical facilitator implementation of ACB over 1 month by teaching communication skills, ‘bedside’ role modelling and case review with staff.

Step 2: Assess if ACB is embedded in clinical practice against criteria by observing practice/review patient records over 1 month. Criteria tested:

1. 80% staff received training programme
2. 5 staff randomly selected can correctly describe ACB
3. Staff identify patients eligible for ACB without prompting in e.g. ward rounds
4. Staff discuss clinical uncertainty and care preferences with patients on ACB, and with families
5. Senior staff state ‘what is important to the patient and the clinical escalation plan’ in e.g. staff handovers
6. ACB documentation in patient records < 10% missing data, and discharge letters state escalation plan and preferences for care.

Data analysis descriptive statistics and framework approach for observation/narrative data

Results: The criteria could be used in the trial to minimise variability in how ACB was implemented in practice. We will present findings on the applicability and sensitivity of the criteria. Our preliminary findings suggest the criteria: clarified the key intervention mechanisms required; the role of clinical staff as ‘champions’ to embed and sustain change; and refined implementation criteria for ACB QI programme.

Conclusions: The integration of QI work in a trial design enables us to examine the key mechanisms of an intervention to reduce variability and maximise potential patient benefit. Exploiting findings from QI programmes is a way to enhance trial designs and inform wider implementation of the intervention.

Abstract number: PO33
Abstract type: Print Only

So What Exactly Does ‘Usual Care’ Mean? Characterising the Comparison Group in Randomised Controlled Trials of Complex Interventions in Palliative Care

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Background: Randomised trials of new services or care often compare the intervention to ‘standard’ or ‘usual’ care. Rarely is the comparator explained or measured. Understanding what constitutes ‘usual care’ is crucial to examine the components and effects of the intervention, in addition to unintended changes to care during the trial.

Aim: To examine usual care in a feasibility cluster randomised controlled trial (RCT) of the ‘AMBER care bundle’ designed to improve the management of uncertain recovery for patients with advanced conditions in hospital settings.

Methods: Mixed methods and quality improvement approaches. Four acute hospital sites (control and intervention) involving general medical and care of the elderly wards. Usual care explored in each site using:

1) “Standard or usual care questionnaire” comprising questions on processes, communication, care and structure on wards, completed by 5 purposively sampled healthcare professionals (HCPs) at baseline, mid-recruitment and end of recruitment
2) Focus groups with HCPs exploring care to manage uncertain recovery
3) Non-participant observations of multidisciplinary team meetings
4) Case note review on the care provided to 20 purposively selected patients
5) ‘Heat map’ over one year on deaths during hospital admission and 100 days after admission.

Results:

Descriptive statistical analysis of quantitative data. Qualitative components analysed using framework approach. Integration of data using triangulation to explore areas of convergence and divergence.

Results: Characteristics of usual care in each study site and how care provided at across intervention and comparison sites will be presented. Feasibility of using multiple measures as part of a cluster RCT and guidance on examining usual care for palliative patient population will be provided.

Conclusions: Integration of data from HCPs and objective reviews of the care will provide a comprehensive understanding of usual care.
Characterising usual care in RCTs of palliative care interventions may help reveal the active components of the complex intervention to inform understanding on intervention fidelity, implementation processes, and differences from usual care.

Abstract number: PO34
Abstract type: Print Only

Surgical Foundation Year One Doctor Perspectives of Do Not Attempt Cardiopulmonary Resuscitation Orders: A Comparison between a District General Hospital and Tertiary Centre

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Background: Do not attempt cardiopulmonary resuscitation order (DNACPR) can aid a patient’s care but can be associated with a great deal of anxiety. Foundation year one doctors (FY1’s) tend to have the most patient contact and tend to be the most inexperienced members of the firm. We combined selected data from a tertiary centre (TC) and a district general hospital (DGH) in different trusts.

Aims:
1. To understand how foundation year one doctors (FY1) in surgery perceive the application of DNACPR.
2. To better understand the culture in our general surgery between hospitals from an FY1 perspective towards DNACPR.

Methods: A survey to assess DNACPR was created, with input from FY1’s, consisting of twelve questions, five based on a Likert scale of 1-5 (Variations of 1- Not comfortable, 5- Completely comfortable). Paper surveys were circulated to FY1’s. Data collection occurred in October 2017 for DGH. Data from TC was collected in December 2016. The results of eleven questions were analysed in Microsoft Excel and one question was processed in a word cloud.

Results: Some key results are summarised below:

- 26 out of 33 (79%) FY1’s in surgery responded, 6/7 (67%) in a DGH, 20 out of 25 (80%) in a TC.
- 25% of FY1’s in a TC do not make a DNACPR decision when clinically indicated.
- FY1’s in a TC (2.15) feel less prepared than in a DGH (3.2) to make a DNACPR decision when clinically indicated.
- FY1’s in a TC (3.3) felt less comfortable than in a DGH (3.2) discussing DNACPR with a senior.
- FY1’s in a TC (50%) and a DGH (50%) feel a DNACPR is actioned too late.
- FY1’s in a TC (55%) and a DGH (67%) have witnessed seniors having DNACPR discussions with patients.
- FY1’s in a TC (2/10%) and a DGH (2/33%) felt the need to voice concerns over a DNACPR, 100% in a TC were not given the opportunity to, in a DGH those that did (100%/1) felt respected.

Conclusions: The number of FY1’s in surgery who do not get inductions on how DNACPR decisions work in their firm are more than in a DGH. Half of FY1’s in surgery in both a DGH and TC feel that DNACPR’s are made too late. A small proportion of FY1’s have felt the need to raise concerns over DNACPR decisions in their firm, however, those from a TC were not given the opportunity to do so.

Abstract number: PO35
Abstract type: Print Only

Comfort Code: A Systematic Tool to Guide Rapid Response Teams in End of Life Care in the Hospital Setting

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Background: The rapid response teams (RRTs) are established in hospitals worldwide to urgently respond to and improve outcomes in clinically deteriorating patients. However, in an end-of-life (EOL) care setting, their codes do not meet properly the real needs of patients: prompt symptom control.

Methods: This is a descriptive study of a tool built by a palliative care team to identify and guide attendance for patients with a DNR order who needs comfort measures only.

Results: In 2013, an inpatient palliative care consulting interdisciplinary team was established in 3 units of private general hospital with about 750 beds. After the first year of implementation with almost 300 advance care directives defined of oncology and non-oncology patients, average 80 years and with death outcomes range 40% in this group, we noticed that a great number of RRTs called were unnecessarily in patients in the last days of life. That happens once changes in vital signs may occur at this phase and do not require interventions. With this observation, we promoted an interdisciplinary discussion on our meetings and also literature review based on the most prevalent symptoms in the last days of life. After this, we developed our “Comfort code” a tool of early detection of signs of discomfort for patients with defined advance directives, who are progressing to the final stage of life and are in non-critical units. This could allow appropriate clinical evaluation and early therapeutic intervention focused on symptom control and relief from suffering. This code comprises 6 possible triggers: pain (new or worsening), dyspnea (new or worsening), active bleeding without control, uncontrolled vomiting, restlessness or agitation and subjective impression of discomfort. The identification of one or more of this signs or symptoms by a nurse should initiate de activation of the RRTs. The RRT evaluation must be initiated within 5 minutes of the call and requires systematic revaluation. After created, we initiated the training team to implement the code and data from this tool are being collected.

Conclusions: The perception of signs and symptoms of the EOL should be encouraged and discussed specially in hospital with well stabilised protocols of RRTs in order to promote review and design of new and properly tools to attend this patient profile. This may reduce unnecessarily calls to RRTs and guarantee adequate suffering relief to patient and family in the last hours of life.

Abstract number: PO36
Abstract type: Print Only

How Prepared Are Medical and Surgical Foundation Year One Doctors in a District General Hospital to Deal with Patient’s in the Last Days of Life?

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Background: Foundation year one doctors (FY1’s) tend to have the most patient contact and tend to be the most inexperienced members of the firm. Using work previously presented at EAPC 2017 (P01 - 228), we sought to expand on this work in a district general hospital (DGH).
Aims:

1. To understand how prepared foundation year one doctors (FY1) in medicine and surgery feel at dealing with patients in the last days of life.
2. To better understand the culture in our DGH towards caring for patients in the last days of life.

Methods: A survey was created based input from previously published work consisting of six questions. The scores were based on a likert scale of 1-5 (1 - Not prepared at all, 5 Completely prepared). One further open question was included. Paper surveys were circulated to all FY1s in October 2017. The results of the first six questions were analysed in Microsoft Excel, the last question was processed in a word cloud.

Results: Some key results are summarised below:

- 18 out of 20 (90%) FY1s responded. 12/13 (92%) Medicine and 6/7 (86%) Surgery
- FY1’s in surgery (3.0) feel more prepared dealing with a patient’s pain than in medicine (2.7)
- FY1’s in medicine (2.7) feel more prepared dealing with a patient’s spirituality than in surgery (2.0)
- FY1’s in medicine (2.8) feel more prepared dealing with a patient’s social issues than in surgery (2.2)
- FY1’s in surgery (4.2) feel more prepared speaking with a dying patient than in medicine (3.5)
- FY1’s in surgery (3.8) feel more prepared dealing with a dying patient’s family than in medicine (3.6)
- Words associated with FY1’s when learning they need to action aspects of care for end of life patients most commonly included “family”, “care” and “anxious”

Conclusions: FY1’s in medicine feel more prepared to deal with a patient’s spirituality than surgery however this is still less than what prepared. FY1’s feel more prepared speaking to a dying patient and their family than dealing with other aspects of a patient’s end of life care.

Abstract number: PO37

Abstract type: Print Only

Patients Admitted to an Acute Palliative Care Unit: Characteristics, Reasons for Admission, Advance Directives and Outcomes

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Background/aims: Many aspects of the palliative care approach are developing rapidly in Switzerland. These include: research, education, clinical practice, policies, organization and tariff establishment. The increasing medical and political interest for the palliative care field is due to two elements: the acknowledgment of a demographically aging population and the awareness of the need of good palliative care across all services. This study wants to understand the patients characteristics on admission and on discharge of a palliative care unit, in an acute oncology hospital in Switzerland. The null-hypothesis being that there is no demographic or clinical difference between the patients who died during admission and those who where discharged.

Methods: This study aims to analyze preexisting quantitative data collected routinely on a database as part of patients assessment on admission, and discharge, during the year of 2016. Descriptive statistics were used to explain the sample characteristics. Outcome variables were described in terms of incidence and confidence interval. Pearson, Chi-square test and regression analysis were performed to compare and explore possible relationships between the primary outcome (survival) and patient's demographic and clinical characteristics.

Results: In 2016, 175 patients were admitted to an acute palliative care unit (51% vs 49% women) and 39,4% died during admission. The most common diagnosis was gastrointestinal cancer (34,3%), less than 3% had a non-oncological diagnosis. The average length of stay was 12.27 days (13.82 vs 9.88 for patients who died). The main admission reason was symptom control (97,2%), however in the majority of the cases the patients who died during hospitalization where not recognized as for end-of-life care on admission (more than 2/3). The referral was done mainly by the oncology hospital (53,7%), with the main symptoms being pain (63,2%), astenia (50,2%) and dyspnea (23,5%) with a much higher incidence and prevalence in the group of patients who died during admission. Advance directives were not present in 159 (90.9%) of all the patients on admission and for the 75,5% of the patients who were discharged.

Conclusions: The study reveals the need to improve identification skills of end-of-life patients, public awareness of the palliative care unit and the discussions around advance directives. The study highlights the main clinical differences between patients who died and those who were discharged.

Abstract number: PO38

Abstract type: Print Only

Rethinking Consultation - Investigating the Perceived Work Models of a Palliative Consultation Team

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Background: Previous research has shown that palliative consultation in hospital contexts sometimes face multifaceted challenges. Possibly creating barriers between the consulting team and patients in need of palliative care. Hence, there is a need to consider how we implement and perform palliative consultation to inform future initiatives. This study is part of an ongoing project with the aim to analyse the discourse around implementing palliative care in a hospital context.

Aim: The aim of this study was to identify and analyse various work models applied in a hospital context by a palliative consultation team.

Method: Repeated focus group discussions with a palliative consultation team and its managers. A total of six focus group discussions were held from April 2016 to June 2017. The focus groups were audio recorded and transcribed verbatim. The data was read and analysed; identifying and categorising different work models.

Result: According to what was expressed in the focus groups there were variations in how the consultation team operated in different hospital units and wards. Consulting as a team, consisting of a nurse, social worker and physician, was emphasised. One of the significant features was that they visited several wards on a weekly basis without receiving formal referrals beforehand. Although varying in form, the visits shared the function of being a forum for the wards to raise questions regarding palliative care relating to specific patients with palliative needs. Furthermore, during the introduction of consultation in some of the wards, the consultation team chose to designate time where a nurse from the team were present in the ward and among other things; identified patients with palliative care needs together with the ward staff and paved the way for the weekly palliative consultation.
Conclusion: This study adds knowledge about how consultation teams can operate when implementing palliative care in a hospital context.

Abstract number: PO39
Abstract type: Print Only

Evaluation of the Pertinence of a Screening Tool for the Indication for Specialized Palliative Care
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Background and aims: 20% of the population with an advanced incurable disease should benefit from specialized palliative care (PC), some of them even need to be hospitalized in a palliative care unit (PCU). Our mobile palliative care team evaluates on a daily basis patients who are hospitalised in a acute geriatric hospital and who may need to be transferred to a PCU. We developed therefore a list of criteria indicating specific needs for specialized PC. In order to test the pertinence of this screening tool we conducted a Delphi study with national experts.

Methods: Our 7 criteria were mingled among 30 potential criteria for admission to a specialized PCU. In the 1st Delphi round the three experts were asked to grade the pertinence of each criteria on a 6-point Likert-Scale. In the 2nd round the experts were given the answers of the 2 others and invited to maintain or change their answers and to pick a « hit-list » of the 7 most important criteria.

Results: In the 1st round a complete consensus in favor of agreement was found for 2 criteria: psychological, social or spiritual vulnerability - high level of distress in close relatives. 2 criteria were rejected by all experts: palliative prognostic index of > 6 - patients awaiting transfer to a nursing home. 18 criteria met consensus only in 2 experts and for 8 criteria each expert gave a different opinion.

In the 2nd round: 1 expert maintained all his answers, 1 changed 1 answer and 1 expert modified 8 answers. As for the « hit-list » 5 of our 7 criteria were chosen by at least two experts: 

1. High clinical instability;
2. Need of symptom control for a limited period of time;
3. Uncontrolled pain;
4. Ethical conflict, request for euthanasia;
5. Other decompensated physical symptoms.

All experts chose to include « the need for palliative sedation » in the hit-list, a criteria which doesn’t figure in our tool. 2 of our criteria were not judged to be pertinent for admission to a PCU: high level of distress in close relatives - high need for technical care (ex tracheostomie).

Conclusion: This Delphi study revealed that most of our criteria for admission to a specialized PCU were shared with the national participating experts. However, adjustments may be necessary such as including the need for palliative sedation and reflection on the pertinence of maintaining other criteria. The results of this study will be the basis for a greater Delphi study including also international experts on this subject.

Abstract number: PO40
Abstract type: Print Only

Development of a Palliative Care Needs Questionnaire for Nurses in Portugal
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Introduction: Studies on palliative care needs at Portugal shows that 15-46% of the in-hospital patients had, at a certain moment, criteria to require palliative care. The identification of patients’ palliative care needs by nursing workforce is regarded as a wide research gap, that requires the development of a suitable instrument to assess their needs.

Objective: With this study we intend to create an instrument that aims to identify and provide a systematic evaluation of the patients’ palliative care needs based on the NECPAL-CCOMS-ICO 3.0 (2016) and The Gold Standards Framework (2016).

Methods: A qualitative study was performed using the Delphi Technique with the purpose of developing a palliative care needs questionnaire for nursing, based on experts’ opinions. This technique, based on distance rounds, brings together information and allows the examination of the opinion of experts in a structured way, to construct an instrument to collect the palliative care needs in-hospital patients by the nurses.

Results: After the rounds, we had a consensual version constituted by a group of four main questions addressed to the nurses’ workforce about their patients palliative care needs. The instrument developed through the Delphi technique provides a quick and systematic evaluation of the patient’s palliative care needs, with the potential to provide higher standards of care.

Conclusion: Therefore, we may conclude that the instrument seems to be a well-designed tool to observe the palliative care needs in in-hospital patients. Moreover, we expect that its use in the clinical contexts may provide a more explicit view of the palliative care needs, the improvement of the nursing decision-making options at acute health institutions as well as the early identification of the patient with urgent palliative care needs.

Abstract number: PO41
Abstract type: Print Only

How Prepared Are Surgical Foundation Year One Doctors to Deal with Patient’s in the Last Days of Life: A Comparison between a District General Hospital and a Tertiary Centre
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Background: Foundation year one doctors (FY1’s) tend to have the most patient contact and tend to be the most inexperienced members of the firm. Using work previously presented at EAPC 2017 (P01 - 228), we combined selected data from a tertiary centre (TC) and a district general hospital (DGH) in different trusts.

Aims:

1. To understand how prepared foundation year one doctors (FY1) in surgery feel at dealing with patients in the last days of life.
2. To better understand the culture in a TC and a DGH towards caring for patients in the last days of life.

Methods: A survey was created based input from previously published work consisting of six questions. The scores were based on a likert scale of 1-5 (1 - Not prepared at all, 5 Completely prepared). One further open question was included. Paper surveys were circulated to all FY1s in surgery. Data collection occurred in October 2017 for DGH. Data from TC was collected in December 2016. The results of the first six questions...
were analysed in Microsoft Excel, the last question was processed in a word cloud.

Results: Some key results are summarised below:

- 28 out of 32 (88%) FY1's responded. 22/25 (92%) in a TC and 6/7 (86%) in a DGH.
- FY1's mostly feel less than somewhat prepared to deal with psychological distress, spiritual health and social issues for patients in the last pays of life.
- FY1's in a TC (3.1) feel more prepared dealing with a patient’s pain than in a DGH (3.0)
- FY1’s in a TC (2.5) feel more prepared dealing with a patient’s spirituality than in a DGH (2.0)
- FY1’s in a TC (2.5) feel more prepared dealing with a patient’s social issues than in a DGH (2.2)
- FY1’s in a DGH (4.2) feel more prepared speaking with a dying patient than in a TC (3.3)
- FY1’s in a DGH (3.8) feel more prepared dealing with a dying patient’s family than in a TC (2.7)
- Words associated with FY1’s when they need to act on aspects of care for end of life patients most commonly included “family”, “four letter expletive” and “annoying”

Conclusions: FY1’s in a TC feel more prepared to deal with a patient’s spirituality, social issues and pain than a DGH however this is still mostly, less than somewhat prepared. FY1’s feel more prepared speaking to a dying patient and their family than dealing with other aspects of a patient’s end of life care.

Abstract number: PO42
Abstract type: Print Only

Real-world Early Palliative Care - Do Eligibility Criteria Really Matter for the Aggressiveness of End-of-Life Care in Advanced Cancer? Tavares Filipa
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Previous studies have found less intensive end-of-life health-care use among hospital patients who received early palliative care (EPC) compared with those who did not. A clear, evidence-based definition for EPC is still missing. Different time frames for EPC have been proposed but the effect of this variation in the average effect size or even in the direction of the outcomes hasn’t been well studied.

Objective: To compare, in a real-world setting, the effect of EPC consultation on the aggressiveness of end-of-life care among patients with advanced cancer, according to two distinct eligibility criteria.

Methods: Retrospective study examining the effect of a PC encounter on the place of death, use of targeted therapy, emergency room (ER) visits and hospitalization in the last month of life of 206 consecutive patients who died within a 6-month period. Participants were included in the EPC group if referred within the first eight weeks after diagnosis (definition A) or if they’ve survived at least three months thereafter (definition B).

Results: Seventy-eight participants (38%) were classified as EPC (48 based on definition A). Among these, 54 (69%, including all of those within definition B) had a PC encounter. EPC referrals were more frequent among hospitalized (64% vs 45%, p<0.009). In their last month of life, participants who received a specialized palliative intervention (n=130) but not EPC patients had lower rates of hospitalization (RR 0.44; 95% CI 0.23-0.86), hospital death (RR 0.22; 95% CI 0.11-0.46) and significantly shorter hospital admissions [median LOS 6 days (P75=25 0-17) vs 11.5 days (P75-25 6.5-20)], compared to those who didn’t receive PC.

Conclusions: In this short real-world cohort, and irrespectively to the definition elected, we failed to demonstrate, among EPC participants, the potential benefits of PC on health-care use at the end of life.

Abstract number: PO43
Abstract type: Print Only

Caring in Palliative Care Context, Nurses’ Lived Experiences: A Phenomenological Study
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Background: Providing palliative care involves serious challenges for nurses, such as end-of-life decisions, contact with people’s suffering and dying, and increased risk of burnout. However, studies have revealed that the burnout level of health care professionals working in palliative care is lower than that of health care professionals working in other contexts.

Aim: To describe the lived experiences of nurses caring in a palliative care unit.

Methods: A phenomenological descriptive study was undertaken. Nine nurses were recruited from a Portuguese palliative care unit. Data were collected using individual interviews and analyzed following the method of Giorgi. Data were collected between December 2016 and March 2017.

Results: Five themes reflect the essence of the lived experience:

1) experience centered on the relationship with the Other (i.e., the patient and the family);
2) experience centered on the relationship with one’s own self;
3) exhausting experience;
4) rewarding experience; and
5) the team as a pillar.

Conclusion: These findings can be valuable for understanding the challenges and strategies experienced by nurses caring in palliative care, and for designing interventions that focus on reducing the risk of burnout among nurses—not only those working in palliative care but also those working in other settings who experience as well regular contact with suffering and death.

Abstract number: PO44
Abstract type: Print Only

The Effects of Guided Imagery on Patient Comfort in Palliative Care Coelho, Adriana1,2, Parola, Vitor1,2, Sandgren, Anna2,3, Fernandes, Olga2,4, Apóstolo, João2
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Background: One of the non-pharmacological interventions increasingly implemented in different clinical settings is the Guided Imagery;
however there are no studies on its effect on comfort in palliative care setting.

**Aim:** To evaluate the effects of guided imagery on comfort in patients in palliative care.

**Methods:** A one-group, pretest-posttest, pre-experimental design was utilized to measure the differences in, heart rate, respiratory rate, pain and comfort in patients (n=26), before and after a two-session Guided Imagery program.

**Results:** The intervention of the Guided Imagery program increased comfort (p<0.001), decreased pain (p<0.001), decreased heart rate (p<0.001) and respiratory rate (p<0.001).

**Conclusion:** This study demonstrates that the use of Guided Imagery improves the comfort of patients admitted to a palliative care unit. Thus, the use of Guided Imagery should be strongly encouraged as it is inexpensive, straightforward to implement and readily available, resulting in the provision of comfort care.

**Abstract number:** PO45

**Abstract type:** Print Only

**Construction of a Guided Imagery Program for Patients in Palliative Care Units**

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**Background:** One of the non-pharmacological interventions increasingly implemented in different clinical contexts is the Guided Imagery. In the setting of Palliative Care, however, there are no Guided Imagery intervention programs developed and adapted to this population, which makes impossible the implementation. Thus emerges the need to develop and validate a Guided Imagery program.

**Aim:** To develop and validate a Guided Imagery program.

**Methods:** The guidelines of Medical Research Council for the development of complex interventions were followed consisting of three phases: Identification of existing evidence; Identification and/or development of theory; Modelling process.

**Results:** The development process resulted in a program consisting of two Guided Imagery sessions to be implemented within the same week. The content of the Script for each session is structured in three main sections:

1. General indications that include instructions on the posture to be adopted.
2. Respiratory exercises and muscle relaxation.
3. Induction of a sequenced set of mental images, being evoking natural and comforting scenarios.

Preliminary results regarding the implementation of a Guided Imagery session suggest that the intervention is effective in increasing comfort.

**Conclusion:** The Guided Imagery program demonstrated to have characteristics adjusted to the setting and target population.

**Abstract number:** PO46

**Abstract type:** Print Only

**How Continuous Are our Continuous Subcutaneous Syringe Driver Infusions?**

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**Aim:** The purpose of the quality improvement initiative was to measure delays in the administration of the T34 ambulatory continuous syringe driver infusion pump (CSCI) and improve the standard of care provided to patients in the Specialist Palliative Care Unit (SPC) (NHS Scottish Guidelines 2011).

**Methods:** An assessment tool was completed by the Registered General Nurses (RGNs) in the SPC Unit over a two week period. A total of thirty CSCI pumps were assessed at the allocated administration time. The main objective of the tool was to identify if there was a delay in administration of the CSCI pump and length of time of same. The tool also reviewed the rationale for the delay. The tool explored if the prescription was unavailable, patient or staff were unavailable or any other reason noted. Data was analysed by the Clinical Nurse Manager of the SPC Unit.

**Results:** Our tool noted a compliance of 83.33% with international best practice (NHS Scottish Guidelines 2011). 16.66% of the CSCI pumps were delayed in administration. 10% of these were delayed between 0-30 minutes. The remaining 6.66% were delayed between 1-2hrs. The rationale for the delays of 6.66% of CSCI pumps between 1-2 hours in administration was that the prescriptions were unavailable as the Multidisciplinary Team (MDT) Meetings were ongoing. 10% of the CSCI pumps were delayed because RGNS were unavailable as they were attending to patients physical and symptom management in the SPC Unit.

**Conclusion:** Compliance of 100% is achievable if the SPC unit implements the following Plan-Do-Study-Act quality improvement initiative and remeasures the assessment tool in six months (Adapted from Diming 1982; Langley et al. 2009).

**Plan:** All key stakeholders of the initiative plan to gather and review the results of the assessment tool. (Stakeholders refers to team members in pharmacy, medical, supportive care workers).

**Do:** All key stakeholders should be informed of the quality improvement initiative in order for overall success and prioritisation of same is essential. If MDT meetings are anticipated to be lengthy in duration then prescription of the CSCI should be prioritised. Support workers to attend to patients physical needs at administration times of CSCI.

**Study:** Review current literature on delays in CSCI pumps.

**Act:** Remeasure the quality improvement initiative in six months.

**Abstract number:** PO47

**Abstract type:** Print Only

**Metamorphosis of a Physiotherapy Palliative Cancer Care Service Provision: A Qualitative Case Study Research Design**

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**Background:** In the United Kingdom changes in palliative cancer care have been instigated by policy makers in response to improved cancer treatments, demographic and population changes. Patients are living longer with more complex conditions and side effects of treatments. Physiotherapists need to respond to these changes and discover innovative approaches to practice.

**Aim:** This study aimed to explore the context and provision of a palliative care physiotherapy service provision in light of best practice recommendations.

**Method:** A single case study research design using qualitative methods with multiple sources of data (interviews [healthcare professionals, patients], observations [physiotherapists working with patients] and policy document collection [National Institute for Health and Care Excellence guidelines, white papers]) was chosen within a methodological framework of constructivism.
Analysis: Thematic analysis within an analytical strategy was used to identify, analyse and report patterns within and across the 4 data sets.

Findings: Two key themes emerged:

1) Metamorphosis of physiotherapy service provision,
2) Metamorphosis of the physiotherapy profession.

Transforming the physiotherapy service from ward to the community highlighted a number of issues: lack of outcome measures for service evaluation; sense of vulnerability by the physiotherapists in proving their worth; confusion from the ward staff about the transition and confusion from the patients about the role of the physiotherapist. However, through the metamorphosis of physiotherapy service delivery the physiotherapists have been able to develop their skills and knowledge in palliative cancer care, which highlighted, the need to: develop a different mindset to treatment planning; integrate professional boundaries; develop specialist palliative care skills and knowledge, emotionally adjust to caring for people who are dying and find ways of dealing with difficult situations.

Conclusion: This study highlights key physiotherapy skills required to respond appropriately and as specified by policy documents when working with advanced cancer patients, as well as the need to apply suitable outcome measures to show the crucial involvement of physiotherapists in this patient group.

Funding
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Abstract number: PO48
Abstract type: Print Only

Exploring Hospice Care from the Perspectives of People Living with Multiple Sclerosis: A Qualitative Study
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The research aimed to understand the lived experience of people living with multiple sclerosis, their perspectives of hospice care and particularly the supportive care group they attend. The participants attend 1 of 3 hospice based, MS Support Groups which are based around exercise and wellbeing. The attendees make a small donation therefore the groups are self-sustaining financially. As hospices consider their role in rehabilitative palliative care and for people with a palliative illness not in the last 12 months of life, this study aims to contribute to strategic thinking. The groups are a model of service provision for people with MS in addition to other people who may benefit from this type of service. Whilst the service itself has been evaluated, exploring attendees’ perspective in more depth and whether ‘hospice’ was a barrier to access hadn’t been done. The research study involved a lead university and a partnership with a hospice. It was a qualitative study involving three focus groups with 25 people participating and the opportunity for follow up with a semi structured interview, 7 interviews were undertaken. A thematic analysis was then completed.

Focus Group 1 N=6 Four females, 2 males
Focus Group 2 N = 7 Five females, 2 males
Focus Group 3 N = 12 Eight females, 4 males
Semi-Structured Interviews N = 7 Six females, 1 male

[Participant Information]
Person Centred Culture in a Hospice: Myth or Reality?
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Aim: To evaluate and develop a person centred culture in a hospice setting.
Method:
- Participatory action research using a cooperative inquiry approach involving key stakeholders within the hospice.
- Research Group established with staff members being coresearchers.
- Values and beliefs exercise around the meaning of person centred care across the hospice.
- Baseline data collection including observations and interviews to identify the existing culture.
- Analysis of base line data and mapping against the Person Centred Practice Framework.
- Identifying key areas for further exploration and development.
- Development and implementation of an action plan.

Results:
- Staff relationships and communication, identified as a key area needing further exploration.
- A fourth generation evaluation (Guba and Lincoln 1989) workshop with all teams in the hospice highlighted a lack of time for staff to reflect on practice and engage in meaningful relationships with each other and thus neglecting the positive impact of effective teamwork.
- Action plan, including development of strong team relationships was implemented.

Conclusion: McCormack and McCance (2017) consider the existence of ‘healthful relationships’ as central to a person-centred culture. This research highlights a practical approach for teams to explore their own micro level structures in order to develop healthful relationships in teams.

Abstract number: POS2
Abstract type: Print Only
A Review of Inpatient Activity Data in a Specialist Palliative Care (SPC) Unit over a Ten Year Period
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Background: Demographics suggest that demand for inpatient palliative care services will continue to increase over the coming decades. Bearing in mind that inpatient beds are limited in number and that increases in bed capacity can take some years to implement it follows that services need to forward plan and adapt to cater for the increasing demands on their services.

Aims: To review inpatient activity data and identify areas that could be addressed to facilitate the predicted increased demand on inpatient palliative care services.

Methods: Patient data from a thirty-six bed specialist palliative care unit was reviewed and analysed using Excel. Data from 2006 to 2016 was utilised.

Results: The number of admissions per bed per annum increased from 11.9 in 2009 to 17.2 in 2016. Patients length of stay is decreasing overall, with a median length of stay of 14 days in 2009, compared to 10 days in 2016. However there remains a significant percentage of inpatients whose length of stay exceeds 28 days - 13.75% of patients in 2016. This accounted for 49.5% of occupied bed days.

Conclusions: It is clear from the above results that a disproportional small number of inpatients currently account for almost half the occupied
Safety and Effectiveness of Indwelling Percutaneous Drainage in Hospitalized Terminally Ill Cancer Patients with Recurrent Ascites

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Background: Terminally ill cancer patients in hospice palliative care are often managed in hospital settings. For patients with recurrent ascites, indwelling percutaneous drainage (PCD) might be more beneficial for recurrent ascites than repetitive paracentesis, tunneled catheter, or intraperitoneal port. The purpose of this study was to investigate the safety and efficacy of the PCD in hospitalized terminally ill cancer patients with recurrent ascites.

Methods: A retrospective review was conducted in patients who underwent PCD at the Pusan National University Yangsan Hospital from January 2017 to September 2017. All PCDs were inserted by an interventional radiologist with radiological guidance. We monitored the function of PCD such as patency and the incidence of PCD-related complications. The primary end points were functional PCD maintenance rate, which is PCD maintained with patency for drainage until the intended time (discharge, transfer, or death).

Results: A total of 15 terminally ill cancer patients underwent PCD during the study period. Patient's median age was 61.0 years old (range: 36-70). Cancer types were composed of gastrointestinal cancer (5, 33.3%), biliary tract cancer (6, 40.0%), pancreas cancer (4, 26.7%), and ovary cancer (1, 6.7%). Twelve patients (80%) showed peritoneal seeding based on imaging studies, and the other 3 patients had liver metastasis or lymph node metastasis. The success rates of PCD were 100% and 1 patient had trivial bleeding. The median time from admission to the insertion of PCD was 14.0 days (95% CI, 10.8-17.2). Totally 5 complications occurred (33.3%, obstruction, 3 cases; obstruction and leakage, 1 case; obstruction and pain 1 case). There was no serious PCD-related infection. The median time from PCD to death was 19.0 days (95% CI, 9.1-28.9).

Conclusion: Our study showed relatively favorable results for maintenance and safety of PCD in hospitalized terminally ill cancer patients with malignant ascites.

Abstract number: POS8
Abstract type: Print Only

Knowledge of Hospice Palliative Care in Terminal Cancer Patients in Korea
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Background: There are many studies about caregiver’s knowledge of hospice and palliative care, but there are few studies about terminal cancer patients' knowledge of hospice palliative care in Korea. The purpose of this study was to examine terminal cancer patient’s perception and knowledge of hospice palliative care in Korea.

Methods: A cross-sectional survey was performed in 105 terminal cancer patients admitted to an university hospice palliative care center in Korea. Data was collected from March 1, 2017 to October 30, 2017 using structured questionnaires consisting of 21 items about knowledge of hospice palliative care.

Results: The correct answer rate was 47.0% in terminal cancer patients' knowledge about hospice palliative care. The highest scored item was ‘Palliative care is provided by a team of physicians, nurses, and other health professionals’. The lowest scored item was ‘Hospice care is a place where patients die’ (33.3%).

Conclusion: Hospice and palliative care unit is increasing in Korea, because of cancer patients are increasing and national hospice insurance is applied to the patients. But hospice unit operating rate is not high in Korea, because of low knowledge about hospice and palliative care in patients. So an increased awareness of hospice and palliative care is needed in every social class patients by community based education, and medical care team approach is more required.

Abstract number: POSS
Abstract type: Print Only

The “Push” and “Pull” Factors for Nurses Working in a Community Palliative Care Setting: A Qualitative Study
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Background: Research indicates that community palliative nursing might not be attractive to hospital nurses as it can be a challenging field of work. It is widely perceived by nurses to be emotionally draining. These factors may have discouraged many nurses from venturing into this line of practice. Conversely, there are nurses who persevere on despite the seemingly negative impact. It would be helpful to explore individual motivations and barriers working as a palliative home care nurse, and find ways to build nursing capacity and sustainability.

Methods: We aim to elicit perspectives from home hospice nurses who have worked for at least 2 years, and spending more than 80% of their time performing clinical duties. A qualitative study design using interviews, and thematic analysis of data collected are planned. The projected sample size is up to 20 registered nurses, or when saturation is reached during analysis. Face-to-face interviews, lasting for approximately 45 minutes to an hour will be conducted with each participant, using a semi-structured interview guide. The scope covered in the questions include: nurses' perception on the benefits of palliative care, experiences in providing home palliative care, challenges faced and suggestions for...
improvements in home palliative nursing. Consent will be obtained for the interviews, including audio recording and verbatim transcription thereafter. Field notes will also be documented.

Results: The study is still ongoing. Preliminary categories that have been identified include employment terms, job scope, work processes and environment, relationships and communication. Method of constant comparison would be used throughout the process. Relevant extracts from respondents are anticipated to be shared, when broad themes are eventually derived.

Conclusions: Results from this study will facilitate identification and in-depth understanding of various factors that can affect recruitment and retention of nurses in the field of palliative care nursing. Agency managers and even policy makers can then apply these findings to plan mitigating strategies in future.

Abstract number: PO56
Abstract type: Print Only

Valuing Opinions, Individual Communication and Experience in Palliative Care: Overview of the VOICE Study Research Study
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Aims: The study aims to determine the acceptability and feasibility of providing Patient-Centred Family Meetings in an inpatient specialist palliative care unit. The study will also assess the suitability of the selected outcome measures, and provide an understanding of the impact of participating in a Patient-Centred Family Meeting.

Methods: A mixed methods pre-post design study will be used. A planned Patient-Centred Family Meeting will be the intervention in one of two specialist palliative care facilities. The other facility will be the control site where standard care for palliative care inpatients, that may include a family meeting, will be observed. Inpatients aged over 18 years with a terminal illness newly admitted to one of the two specialist palliative care facilities who are able to consent and have a family member willing to participate will be included. At each site, 20 patients and 20 family members will be recruited.

Results: Validated outcomes measures will be used to assess patient and family outcomes of the Patient-Centred Family Meetings. The QUAL-EC and QUAL-E (Family) questionnaires will assess patient and family satisfaction with quality of life at end-of-life. The Distress Thermometer and Patient Health Questionnaire (PHQ) - 4 will assess patient and family distress. Semi-structured interviews with patients and families, Family Meeting Feedback questionnaires and clinician focus groups will be undertaken post-Meeting to understand the impact and participants’ experience of Patient-Centred Family Meetings. A Family Meeting Observation Sheet will capture key elements of both types of family meeting to enable comparison of family meeting practices. Descriptive statistics will summarize pre-post meeting data including the QUAL-EC and QUAL-E (Family) questionnaires, the Distress Thermometer and the PHQ-4. Differences in variables between the intervention and control groups will be assessed. Qualitative data from semi-structured interviews, questionnaires and clinician focus groups will be analyzed using grounded theory. Preliminary results will be presented.

Conclusion: This study will determine whether planned Patient-Centred Family Meetings are feasible and acceptable to participating patients, families and clinicians. It will also assess the impact of Patient-Centred Family Meetings on participants and the suitability and feasibility of the selected outcome measures for patients and families.

Investigation of Symptom Control and Palliative Care Quality in Hospice Palliative Care Patients
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Background: The evaluation of palliative care quality can understand care quality and it can be as an evidence for improving quality. In order to understand the internal consistency of medical professionals, patients and caregiver, health care system needs to be assessed appropriation of patient and caregiver.

Objectives: Evaluate the palliative care quality for terminal patients as a reference for prospective service improvements. Use of an expanded The Support Team Assessment Schedule (STAS) has previously been validated as an evaluation tool for community palliative care teams and inpatient units, to determine symptom prevalence and outcome for inpatients and outpatients referred to a multi-professional hospital palliative care team.

Methods: Adopted a longitudinal research methodology, STAS forms were completed on patients at referral and weekly thereafter between September 2016 and September 2017. Applying 17 categories of audit criteria rated on a scale of 0 to 4 (0-no symptoms, 4-significant symptoms). The quality audit criteria were scored Day 3 and weekly for patient admission. A prospective study was conducted to analyze the quality audit data collected from 505 samples in one medical center’s palliative care unit.

Results: Patients in hospice care received adequate symptom relief. Total quality audit scores declined progressively over the 2 weeks following patient admission, indicating efficacy of palliative care quality.

Leadership in Specialist Palliative Home Care Teams: Possibilities and Challenges
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Teamwork has been described as crucial for high-quality care since teams effectively combine diverse skills and perspectives to better meet the complex needs of patients and families. Tasks of leadership have been identified as envisioning goals, affirming values, motivating, managing,
Looking Back, Moving Forward: A Twelve-year Retrospective Review of Care Trends in an Academic Palliative and Supportive Care Program

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Objective:

Examine the HBPC program experience and historical trends in mature hospital-based palliative care (HBPC) programs serving a racially diverse, rural-dwelling population.

Method:

Very little has been reported about longitudinal trends in mature hospital-based palliative care (HBPC) programs serving a racially diverse, rural-dwelling population. The newly-founded Southeast University of Alabama at Birmingham, School of Nursing, Birmingham, AL, USA, is a racially-diverse, rural-dwelling population. The newly-founded Southeast University of Alabama at Birmingham, School of Nursing, Birmingham, AL, USA.

Results:

Inpatients were a mean age of 63.7, male (50.1%), white (62.3%), general medicine referred (19.5%), primarily for goals of care (84.4%); 47.1% had DNR/DNI status and 46.9% were transferred to the PCCU after consultation. Median time from hospital admission to PC consultation was 3 days, median PCCU length of stay (LOS) was 4 days, and median hospital LOS was 9 days. Increased emergency department and cardiology referrals were notable in later years. Outpatients’ mean age was 53.02 years, 63.5% were female, 76.8% were white, and 75.6% had a cancer diagnosis. Fatigue, pain, and disturbed sleep were the most common symptoms at the time of the visit; 34.6% reported mild to moderate depressive symptoms. Of patients reporting pain (64.8%) one-third had 50% or less relief from pain treatment.

Conclusions: The CPSC has demonstrated robust growth and serves a racially diverse, rural-dwelling population. The newly-founded Southeast University of Alabama at Birmingham, School of Nursing, Birmingham, AL, USA, is a racially-diverse, rural-dwelling population.

Abstract number: PO60

Abstract type: Print Only

Desired End of Life Care for People with Dementia and their Loved Ones

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Objective and aims: Dementia is a terminal illness which demands a palliative care approach, where in the main care goal should focus on comfort and quality of life. The majority (92.3%) of dementia related deaths in the Netherlands occur in nursing homes. Only half of the residents die peacefully, which echoes the need for challenges to be addressed. Firstly, nurses stress they lack knowledge to provide basic palliative dementia care, concerning burdensome symptoms and multilevel care demands. Moreover, healthcare providers face difficulties communicating timely about end-of-life (EoL) care. Secondly, care is often too fragmented. In the care for people with dementia, a variety of professional caregivers is involved which requires interdisciplinary collaboration that addresses the personal needs of patients and their loved ones. Not only in the home and nursing home settings, but also in case of a transition from home to the nursing home, to guarantee continuity of care.

Method: The current 4 year research and implementation project (started 1 September 2017) aims to target these challenges. It consists of two sub-projects: part 1 develops a toolkit to support basic palliative care knowledge and EoL communication; part 2 builds an interdisciplinary collaboration strategy. The process will be informed by an investigation of needs from different perspective (caregivers, people with dementia and loved ones)Mixed methods will be used to gain insight in palliative dementia care needs (basic care, communication and collaboration): a literature review, survey among nurses (N=200), in-depth interviews with people with dementia (N=20) and their loved ones (N=40), and interdisciplinary focus groups (N=4). Matched to these needs, a toolkit and collaboration strategy will be developed stepwise in close collaboration with stakeholders. After implementation, barriers and facilitators will be evaluated in interdisciplinary focus groups. Validated questionnaires will be used to assess the perceived effectiveness of using these tools, the satisfaction of people with dementia and their loved ones with EoL care, and quality of dying.

Results: During EAPC 2018 we will present this project and the preliminary results of our needs analysis.

Conclusion: The project will deliver in 2021 a feasible evidence based competency toolkit and collaborative strategy, which have potential to improve the quality of palliative care delivered to people with dementia and their loved ones.
Introduction: Palliative care is still suboptimal due to issues like late identification of the palliative phase, insufficient communication about patient needs and wishes. This results in a suboptimal quality of end of life care. Since December 2015, we have been implementing a pro-active, transmural Palliative Care Pathway with the objective to overcome the aforementioned issues. The pathway is built upon eight principles:

1) early identification of palliative patients (Surprise Question, RADPAC and SPICT),
2) assessment at intake (all domains of palliative care),
3) a weekly multi-disciplinary meeting palliative care,
4) a medication review
5) a timely conversation about end of life wishes and needs, resulting into a care plan 5),
6) good coordination and transmural communication,
7) a postmortem interview with informal caregiver(s), and
8) continuous monitoring of outcomes (e.g. quality of dying).

Method: Process and effect evaluations are carried out continuously during the 2.5 year pilot including 10 Primary Care Facilities (PCFs) (plus seven PCFs in a control group), 12 specialists oncology, geriatrics and pulmonary and eleven pharmacists), using a mixed method intervention action design. The process evaluation was guided with interviews and focus groups with GPs, medical specialists, and informal caregivers. Results are constantly fed back to the project group, sharpening the implementation process. Effects of the intervention are measured both cross-sectional (assessment at intake and focus groups) and controlled implementation process. Effects of the intervention are measured both cross-sectional (assessment at intake and focus groups) and controlled implementation process.

Results: Preliminary results. Process: one of the main barriers for inclusion appeared to be proactive end of life communication. Therefore, two additional communication workshops were held. Effects:

1) better experienced Quality of dead and dying (QOD-LTC)
2) more patients die at usual place of residence
3) proactive inclusion in the pathway, and anticipation on death by GPs;
4) more bearable burden for informal care givers (EDIZ);
5) informal caregivers report good quality of care (FAMCARE);
6) more intense communication between GPs and medical specialists and with patients.

Conclusion: Overall, the TMZP is evaluated as a valuable innovation that increases awareness about the palliative care phase, end of life communication and specific care needs and increases the quality of palliative care and quality of dead and dying.

Abstract number: PO62
Abstract type: Print Only

Effect of a Care Process Program on Frail Older People’s Life Satisfaction
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Background: Frail older people appear to have low levels of well-being and life satisfaction. They often have several chronic conditions and complex care needs, and they are dependent on several care providers. There is a high priority need to improve co-ordination between care providers and implement care process programs for this group. The aim of this study was to analyse the effects of a full-scale implementation of a care process program on frail older people’s life satisfaction as compared to those receiving usual care.

Methods: The study includes participants from a full-scale care process program (n=77) and participants from a historical control group (n=66). The care process program includes different components to establish a comprehensive continuum of care, such as case management, interdisciplinary teamwork, and care planning meetings in the older people’s own homes. Questionnaires were used and data collection was made at baseline, and at three-, six-, and 12-month follow-ups.

Results: From six-month to 12-month follow-ups there was a higher proportion of participants with positive outcome on life satisfaction in the care process program as compared to the historical control group (OR 2.99, CI 1.50-5.98).

Conclusions: The implementation of a full-scale care process program had some benefits for frail older people, as regards their life satisfaction. There is a need to further promote programs including components to establish a comprehensive continuum of care.

Abstract number: PO63
Abstract type: Print Only

Cultural Elements in the Provision of Palliative Care: Finding of an Ethnographic Study in Indonesia
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Background: In Indonesia, palliative care services have been established since the 1990s to provide care for patients mainly with cancer. As models of palliative care were first developed in well-resourced countries, there is a need to explore how the ongoing growth of palliative care in the developing countries, such as in Indonesia.

Aims: This study aimed to explore the current provision of palliative care to describe, understand and explore the implications for provision of culturally appropriate palliative care services.

Study population: This study involved palliative care professionals, patients and their family caregivers from two facilities that provide palliative care services.

Study design and method: A contemporary ethnography was adopted that incorporate multiple methods of data collection including observations, surveys, interviews and collection of relevant documents.

Method of data analysis: Ethnographic data analysis framework from Spradley was adopted to assist in the analysis of data at domain, taxonomic and cultural themes.

Result and interpretation: Five major cultural themes were emerged: ‘the provision of care: meeting many challenges’, ‘building relationships’, ‘family caregiving’, ‘spiritual and religious practices’, and ‘dealing with dying and death’. The culture of palliative care provision was described as having many challenges relating to the patients’ complex need while maintaining his/her dignity. The patients were primarily being cared in their own home, as a result the family played significant role in providing care for them. Spirituality/religiosity was identified as significant element in the provision of care. This study showed that all the
cultural actors were affiliated to particular religions and performed their religious practices in their daily life. It was also observed that the patient’s relatives commonly acknowledged and addressed the patient’s needs for spiritual care. The palliative care staff provided spiritual care for the patients (e.g. religious/spiritual discussion, encouraging to pray). A particular cultural issue emerged in this study around discussions about end of life. Discussions between the palliative care team and the patient’s relatives were overt and frank. However, discussions about impending death between the palliative care team and the patients, where often oblique at best or even not discussed.

Abstract number: PO64
Abstract type: Print Only

Association between Surgical Fears and Socio-demographic, Clinical and Physiological Variables of Patients with Colorectal Cancer in the Preoperative
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Background: People who will undergo surgery usually feel fear and this feeling can be detrimental to patient recovery.
Objective: To investigate the correlation between surgical fears and socio-demographic, clinical and physiological variables of patients with colorectal cancer in the preoperative.
Method:
Design: quantitative, cross-sectional study conducted in a general hospital in southeastern Brazil; Sample: fifty patients hospitalized for surgical treatment of colorectal cancer; Data collection: took place in the hospital, after approval of the Ethics Committee of the institution;
Instruments:
   a) questionnaire composed with characteristics of the participants (age, gender, education, economic and marital status and religion, diagnostic confirmation time, previous treatment for cancer, type of surgery, location of the neoplasm) and
   b) Surgical Fear Questionnaire (SFQ) (the instruments was anonymous);
Data analysis: regression analysis (Generalized Estimating Equations), significance level of 0.05.
Results: The variables female sex ($\beta$=0.7276, $p=0.0094$) and longer time of discovery of the disease ($\beta$=0.0207, $p=0.0143$) contribute to the increase of the mean score of the SFQ, while the education level between 5 to 11 years of study ($\beta$=-0.7057, $p=0.0069$) and the higher levels of cortisol ($\beta$=-0.0120, $p=0.0097$) are associated with its reduction.
Conclusion: The surgical fears of patients with colorectal cancer who will undergo surgery are associated with female sex, time of discovery of the disease, education level and cortisol. Fears related to surgery are a particular cultural issue emerged in this study around discussions about end of life. Discussions between the palliative care team and the patient’s relatives were overt and frank. However, discussions about impending death between the palliative care team and the patients, where often oblique at best or even not discussed.

Abstract number: PO66
Abstract type: Print Only

Men’s Expectations on Life-prolonging Treatment of Advanced, Incurable Prostate Cancer
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Every man who lives long enough with prostate cancer eventually becomes resistant to hormonal therapy and develops metastatic castration-resistant prostate cancer (mCRPC). For this, often symptom heavy, stage of prostate cancer the treatment landscape has changed remarkably during the last decade. Previously, the focus for treatment was limited to symptom management, while today medical advancements has made several life-prolonging treatment options available. Although proven successful regarding increased survival and decreased symptom burden, these treatments are also challenging and often with severe side effects. Therefore, in this palliative phase of the disease, a careful weighing between possible treatment benefits and negative consequences has to be done, especially with regard to the men’s individual priorities and wishes concerning their remaining life.
Thus, the aim of this study was to explore patient expectations on life-prolonging treatments of metastatic castration-resistant prostate cancer. Sixteen men; undergoing or about to start life-prolonging treatment of mCRPC were recruited from three hospitals located in different parts of Sweden. Qualitative, narrative interviews were conducted between...
March 2016 and August 2017. The interviews were analyzed using content analysis. The results show that there are different dimensions related to patient expectations on treatment in this situation. No beliefs that the treatment would be curative was expressed, rather the participants described the treatment as a possibility to “buy time”. Thoughts on death and dying, and fear of unmanageable symptoms at the end of life, emerged in relation to that. Previous experiences of friends’ or relatives’ cancer disease, treatments or deaths were influential. Adjacent to this, reflections on how one would want to spend the remainder of one’s life also came forth.

Funding
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Abstract number: PO67
Abstract type: Print Only

Patients Experience Major Changes in Life and Significant Others Struggle with Caregiving during the Course of Incurable Cancer: A Systematic Review and Meta-synthesis
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Background: There are currently no systematic reviews related to patients’ and significant others’ experiences of transitions during the course of incurable cancer. However it is important to identify and synthesise findings from these existing qualitative studies in order to illuminate what is known and gaps in knowledge.

Aim: To explore experiences of patients and significant others concerning transitions during the course of incurable cancer.

Methods: The search was based on five databases (PubMed, CINAHL, Scopus, PsycInfo and Embase) and fifty studies were finally included and critically appraised. The review was inspired by the methods of Joanna Briggs Institute, Kvale and Brinkmann and illustrated with effect size, inspired by Sandelowski and Barroso.

Results: Based on experiences from 496 patients and 320 significant others, three main themes with three sub-themes each were identified and from these, a meta-synthesis was developed: Patients experience major changes in life and significant others struggle with caregiving during the course of incurable cancer.

Main themes:

1. Patients living with incurable cancer experience major changes in life;
2. Patients’ experiences of both living and dying;
3. Significant others living and loosing.

Relating findings to the theory of Irvin D. Yalom revealed that patients and significant others experience transitioning into living most of life in an ontological mode of existence.

Conclusion: This review underlines the complexity within planning individualised palliative care and contributes with evidence-based knowledge relevant to healthcare professionals in palliative cancer care.

Funding
The Health Research Fund of Central Denmark Region, Familien Hede Nielsen’s Foundation, Denmark
in two interviews either individually or as dyads across a period of up to 6 months. Twelve health care professionals participated in one-off focus group discussions and in-depth individual interviews for their expert opinion. A thematic analysis approach was used to explore relevant content and contexts of the experiences of living with and or caring for prostate cancer.

Findings: This paper focused on the men’s experiences of prostate cancer. Although a biomedical disease with the similar symptom manifestations, participants’ experiences are varied and challenging with varied impacts on their quality of life. Issues include managing stigmatising cultural responses to prostate cancer and managing illness in the context of masculinity. The study also offers insights into management of advanced cancer where palliative care services and resources are not well-developed and/or not accessible/affordable.

Conclusion: This study identifies the need to improve palliative care in Ghana, particularly in managing care at home. A need for further palliative care coordination, resources, and training for patients and their family caregivers is thus evident. Findings will inform health and social care policy with the aim of optimising and coordinating palliative care management both in institutional and home-based settings.

Abstract number: PO70
Abstract type: Print Only

What Should I Eat?: Cancer Organisation Websites Diet and Nutritional Advice
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Introduction: Nutrition-impact symptoms are common at all cancer stages and increase the risk of malnutrition. Despite this, cancer patients are not routinely referred to a dietitian. Those with cancer may therefore seek information from alternative sources, National Cancer Organisations (NCO) offer both dietary and nutritional advice but the utility has not been evaluated. Diet advice refers to how and when to prepare and serve food and nutritional advice instructions about macro and micronutrient intake.

Aim: To review the dietary and nutritional advice for cancer on NCO websites and its utility.

Methods: We identified and searched English-language NCO websites for nutritional and dietary advice under four headings; cancer sites, disease stages, nutritional-impact symptoms and treatment. We report the nutritional-impact symptoms data.

Results:
- Nine websites were searched.
- Nutritional advice for anorexia, sore mouth and dysphagia often recommended high-protein and high-calorie intake. Examples of food and recipes were provided, but none defined the diets (i.e. grams per day).
- No micronutrient advice was provided (except increase sodium and potassium for diarrhoea).
- Little or no nutritional/diet advice for early satiety and smell abnormalities.
- Dietary advice for anorexia and nausea & vomiting (small frequent meals), constipation (increase fluids) and dysphagia (soft food) was consistent between sites, but other advice was not.
- Healthcare professional input universally advised for specific guidance.
- Websites contained links to other pages so accessing information was not straightforward.

Conclusions:
1. Nutritional advice for symptoms varied and was non-specific.
2. High-calorie, high-protein diets recommended but were unclear.
4. Dietary advice practical.
5. Advice for early satiety and smell abnormalities nearly absent.
6. Website navigation was challenging and negatively impacted information access.

Abstract number: PO71
Abstract type: Print Only

Measuring Quality of Life in Patients with Advanced Cancer: A Systematic Review of Self-administered Instruments
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Background: Patient reported outcome measures (PROMs) are increasingly important in clinical practice. Monitoring symptoms and quality of life (QoL) is especially important in advanced cancer care, because it increases awareness among health care professionals to better anticipate on patients’ changing needs and improves clinical outcomes. The implementation of PROMS in routine practice is challenging because information regarding psychometric quality of instruments is fragmented and standardization is lacking. The aim of this study is to evaluate the quality of self-administered QoL instruments for use in patients with advanced cancer.

Methods: A systematic literature search was performed in PubMed, Embase, PsyicINFO, and CINAHL to identify studies concerning self-administered QoL instruments in patients with advanced cancer between January 1990 and September 2016. Quality of the instruments was assessed by predefined criteria derived from the COSMIN checklist.

Results: Seventy articles relating to 42 instruments met the inclusion criteria. Information regarding important measurement properties was often incomplete. None of the instruments performed sufficient on all measurement properties. Considering available information, the EORTC QLQ-C15-PAL appeared to have adequate psychometric properties, together with the EORTC QLQ-BM22.

Conclusions: Many QoL instruments have not yet been evaluated in an improved manner. Validation of self-administered QoL instruments is an ongoing development and should be prioritized. This review contributes to improved clarity regarding the availability and quality of QOL instruments for patients with advanced cancer and supports health care professionals in an adequate selection of suitable PROMs in clinical practice. Being able to accurately and routinely measure QoL in patients with advanced cancer will stimulate the personalized health care approach leading to improved cancer care, clinical outcomes, and QoL.

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Abstract number: PO72
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Adherence to Oral Opioids In Cancer: A Multicenter Study
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This paper focused on the men’s experiences of prostate cancer. Although a biomedical disease with the similar symptom manifestations, participants’ experiences are varied and challenging with varied impacts on their quality of life. Issues include managing stigmatising cultural responses to prostate cancer and managing illness in the context of masculinity. The study also offers insights into management of advanced cancer where palliative care services and resources are not well-developed and/or not accessible/affordable.
Surgery for Bowel Obstruction in Advanced Cancer

Background: Cancer pain is a relevant problem because of the high number of people affected, between 30 and 65% of patients with cancer, and because it affects the daily life of this patients. Cancer pain can be treated effectively in most cases. However, published studies tell us that adherence is low. Studying the aspects that influence adherence will allow us to know the problems that patients meet to follow the treatment, allowing the design of future improvement interventions.

Objectives: To establish the profile of cancer patients not adherent to treatment with oral opioids, and to analyze the factors dependent on health professionals that influence this adherence.

Methods: A descriptive study by interviewing cancer patients with pain receiving chemotherapy. The final sample was 158 patients treated at three different hospitals in the city of Valencia.

Results: The mean age was 59,53 (SD 11,645) and 61% of the sample were women. The drug most commonly used for pain is tramadol followed by morphine. Most patients can carry a normal level of activity according to the Karnofsky index and show an adequate quality of life (FACT-G total 66; SD 15,164). Good adherence to analgesic treatment is 47%, with a predominance of intentional poor adherence. The main reason for stopping medication is the absence/lack of pain. The relief provided by the treatment is adequate in 66% and the satisfaction with the care of the health professionals is high. Regression tests indicate that schedule of drug administration, pain relief experienced and the importance that professionals give to the treatment of pain could be predictive variables of poor adherence.

Conclusions: The schedule of treatment administration, the relief experienced and the importance that professionals give to the treatment of pain could be predictive variables of poor adherence.

Abstract number: PO73
Abstract type: Print Only

Surgery for Bowel Obstruction in Advanced Cancer

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Background: Bowel obstruction is a common occurrence in advanced cancer patients. It occurs more frequently in patients with neoplasm of the alimentary tract or other intraabdominal tumors.

Aims: To study the results of surgery in advanced cancer patients with bowel obstruction in an oncological center.

Methods: The files of patients who underwent surgery for bowel obstruction between January 2011 and August 2013 were recorded.

Results: The total number of patients was 29, 16 (55%) were female and the median age was 57 years (27 to 85). The most frequent diagnosis was colorectal cancer 11 (38%), followed by gastric cancer 10 (35%). The most common metastatic site was the peritoneum - 20 (69%). 14 (48%) patients had no comorbidities, and the others had various types of comorbidities the most frequent were diabetes and hypertension. The ECOG at the time of surgery for bowel obstruction was 1 - 3 (10%); 2 - 13 (45%); 3 - 10 (35%); 4 - 3 (10%). The median survival after surgery for bowel obstruction was 85 days (4 to 491). The median survival after surgery was 111.5 days (26 to 491) for the combination of patients with ECOG 1 and 2, and 52 days (4 to 240) for the combination of patients with ECOG 3 and 4, p = 0.028. In 20 (69%) patients the bowel obstruction was solved with surgery with a median survival of 111.5 days (23 to 491) and the 9 patients who surgery did not solve the obstruction had a median survival of 42 days (4 to 240) (p = 0.007). The difference between the two groups was significant, p = 0.007. Age and gender did not significantly influenced survival.

Conclusion: Surgery may have a role to treat bowel obstruction in patients with advanced cancer. However, in about 1/3 them the obstruction was not solved and if the survival difference between the groups of patients with the obstruction solved and not solved was significant, individually there was survival overlap, with patients short and relatively log survival in both groups.

Abstract number: PO74
Abstract type: Print Only

Biliary Stenting in Patients in Palliative Care

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Background: Biliary stents are used in neoplastic biliary tract obstruction to palliate symptoms associated that condition, when a more definitive solution is not possible.

Aims: To study patients’ benefits and burden associated with biliary stents.

Methods: The files of patients in which the insertion of a biliary stent was recorded, between 30 October 2011, and December 31, 2015, were reviewed. Besides the demographic data, were collected: the technique used, stent type, complications associated with the stent.

Results: Insertion of a biliary stent was performed in 70 patients. 41 (59%) were male and the mean age was 67.5 years (SD ± 12.5). The most common cancer type was gastric cancer, 20 (29%), followed by cholangiocarcinoma, 14 (20%), colorectal and pancreatic cancer with 12 (17%) each. Biliary stents were placed by interventional radiology, 68 (97%) and for gastroenterology, 2 (3%). At the time of stent insertion, 36 (51%) patients were on antineoplastic treatment, 26 (37%) had not initiated any treatment and 8 (11%) were on palliative care. After the stent placement, 15 (21%) had a plan to initiate antineoplastic treatment, 23 (33%) to maintain the antineoplastic treatment and 32 (46%) for referral to palliative care. Actually, 67 (96%) were referred to palliative care. Complications were seen in 31 (44%) patients and the most common was cholangitis, in 21 (68%) patients. 66 (94%) patients died, and the median survival was 70 days (3-1243). There was no difference in survival related to treatment plan after stent placement (p = 0.53).

Conclusion/discussion: Biliary stenting is usually carried out in cancer patients when the disease is far advanced or in cancers with very poor prognosis. Although some patients had a relatively long survival, there was a high rate of complications and the treatment undergone after stenting had no influence in survival.

Abstract number: PO75
Abstract type: Print Only

Health-related Quality of Life among Cancer Patients in their Last Year of Life.

Results from the PROFILES Registry

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Background: Determining the course of advanced cancer patients’ quality of life (QoL) during the final year of life will serve to identify goals for timely interventions to improve patients’ QoL. This study aimed to assess health related quality of life (HRQoL) in the last year of life of advanced cancer patients stratified by four periods of time before death.

Design and study population: Between 2008-2015, cancer patients were invited to participate in PROFILES (Patient Reported Outcomes Following Initial treatment and Long term Evaluation of Survivorship) registry studies. Patients were eligible for this secondary analysis if they had been invited to complete the EORTC QLQ-C30 questionnaire in their last year of life (N=892). 458 patients (51%) completed the questionnaire. Descriptive statistics were used to describe the HRQoL of cancer patients in the last 3 months of life (N=61), last 3-6 months (N=110), last 6-9 months (N=138), or last 9-12 months of their life (N=129). Differences in HRQoL between these groups were analysed with a one-way ANOVA, followed by a Bonferroni post-hoc test and compared with an age and gender matched normative population. Additionally, clinical relevance of the differences was assessed.

Results: Significant differences in HRQoL, symptoms and functioning between patients in different time periods before death were found (p < .001), the QLQ-C30 summary score of patients in the last 3 months of life (62(SD 22)) was statistically significantly lower compared to patients in the last 3-12 months of life (73-77 (SD 17-19)) (p < .001). Large clinically relevant differences were found for global QoL, cognitive and social functioning between patients in the last 3 months and in the last 9-12 months of life, respectively 17, 14 and 18 points. Higher symptom burden of fatigue and appetite loss was found in the last 3 months of life compared to previous time periods (p < .001) and the difference in fatigue was a large clinically relevant difference. HRQoL of advanced cancer patients was significantly lower in patients in their last year compared to the normative population, respectively 73 and 87 (p < .001).

Conclusions: All aspects of HRQoL are considerably impaired in patients with advanced cancer, with a marked lower HRQoL in the final months of life. This marked decline of HRQoL may be an indicator of approaching death and serve as an important trigger for end-of-life communication and decision-making about subsequent treatment and supportive care.

Abstract number: PO76
Abstract type: Print Only

The Unpredictable Nature of Head and Neck Cancer: Assessing Data from the National UK Cohort Study ‘Head and Neck 5000’
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Research aims: Head and Neck 5000, a national UK prospective clinical cohort study in head and neck cancer, follows all patients with a new diagnosis of head and neck cancer including those receiving palliative support. Using data from Head and Neck 5000, we aimed to:
- compare and contrast the ‘palliative’ patient cohort with those on a ‘curative’ trajectory
- assess outcomes at 4 and 12 months post diagnosis
- assess the mode and place of death.

Study population: All people with a new diagnosis of a primary head and neck cancer.

Study design and methods: Patients who consented to participate were classified into cohorts depending on the initial treatment intent i.e. either ‘palliative’ or ‘curative’ intent. Data capture forms were used to collect information at baseline, and 4 and 12 months post-diagnosis. Any patients who died during the study period, information about the circumstances of death was collected using a mortality form. Descriptive statistics were used to analyse the data.

Results and interpretation: Of the 5366 patients recruited, 184 (3.4%) were treated with ‘palliative’ intent and 5182 (96.6%) with ‘curative’ intent. Compared with the ‘curative’ cohort, the ‘palliative’ cohort were older (68.0 years versus 61.0 years); approximately twice as likely to have stage 4 disease (80.4% versus 43.8%); more likely to have cancer of the hypopharynx (16.9% versus 4.0%) and less likely to have oral cancer (19.6% versus 25.7%). 123/5182 (2.4%) ‘curative’ patients had died at 4 months compared with 34/184 (18.5%) ‘palliative’ patients. 354 (6.8%) ‘curative’ patients had died 12 months post-diagnosis. Additionally, at 12 months, 15 patients initially treated with ‘palliative’ intent were subsequently reclassified as having potentially curative disease. To date, 528 mortality forms have been completed following the patients’ death. 31 (5.9%) had a catastrophic bleed and 16 (3.0%) sustained airway obstruction as a terminal event. The most common place of death was hospital (37.0%), and least common was a care home (1.5%). A significant proportion of patients (22.6%) died in a hospice setting. Results suggest it is challenging to accurately define the initial treatment intent for head and neck cancer patients with some patients dying earlier than expected and others exceeding their initial prognosis. This may be in part due to the unpredictable nature of the illness and the risk of acute catastrophic death.

Abstract number: PO77
Abstract type: Print Only

Complexity of Palliative Care in Patients with Symptoms That Are Difficult to Control
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Introduction: It is estimated that 63% of the deaths are due to chronic diseases, because of this is important to introduce palliative care in the care of the disease with the modification therapies. This study is outline to indentify the possible patient who are liable to need palliative care and capable to diagnose the possible complexity.

Objective: Diagnose the complexity in patients admitted at home with advance and terminal stage associated to the symptoms of difficult control.

Methodology: This is an observational, prospective, descriptive and transversal study. With a sample of 266 patients admitted at home, with the toll IDC-Pal. The criteria of exclusion are: patient under 18 and refusal to use the private information.

Results: Of the total sample of 266 patients, 4 (2%) do not present criteria of complexity, 33 (12%) present criteria of complexity and 229 (86%) present criteria of high complexity. The two criteria that have more positive responses are: Symptoms of difficult control with 184 responses in positive and Abrupt change in functional autonomy level with 128.
Conclusion: It is concluded that symptoms of difficult control according to the IDC-Pal tool is a criterion of High Complexity and is the criteria most suffered by patients.

Keywords: Palliative care, complexity, symptoms of difficult control and cancer.

Abstract number: PO78
Abstract type: Print Only

Hyponatremia in Advanced Cancer - Preliminary Report
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Background/aims: Hyponatremia is the most prevalent hydroelectrolytic abnormality in patients in general. It has been reported in cancer patients and in palliative care where it seems to be independently associated with a bad prognosis. However, only a few studies were carried out in palliative care, and so we studied the prevalence of hyponatremia in palliative care.

Methods: This is a prospective study that was carried out in 2017 in a palliative care service of an oncological center. No blood tests were collected specifically to this study for ethical reasons. The study was based on the blood tests which had been collected in the 3 days before admission or after admission when it was justified for other reasons. Normal blood sodium (Na) level was defined as between 135 and 145 mEq/L, mild hyponatremia as Na between 130 and 134 mEq/L and significant hyponatremia when Na < 130 mEq/L.

Results: 267 patients were included, 158 (59%) were male, and the median age was 70 years (19 to 99). The most prevalent diagnosis was esophageal/gastric cancer, 52 (20%), followed by colorectal, 36 (14%), lung, 32 (12%), head/neck, 28 (11%) and breast cancers 27 (10%). ECOG performance status scores were: 4 - 55 (58%); 3 - 88 (33%); 2 - 7 (7%); 1 - 4 (2%). 152 (57%) patients had a serum Na blood test: 86 (53%) normal; 72 (45%) low; 3 (2%) high. In 21 (13%) the blood sodium level was < 130 mEq/L.

Discussion/conclusion: Hyponatremia is a common occurrence in far advanced cancer patients, but it is usually mild. Most patients included in this study had a poor prognosis as their performance status suggest. In those circumstances, blood tests are not indicated. On the other hand, hyponatremia may explain, by its own, the worsening of a patient status. Therefore, blood tests, including blood Na, should be reserved to very selected cases.

Abstract number: PO79
Abstract type: Print Only

Unmet Supportive Care Needs and Psychological Distress among Parents of Children with Cancer in Indonesia
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Background/aims: Having children diagnosed with cancer is a stressful condition for parents, facing physical, psychosocial, and financial burdens in life. These problems parents face are frequently neglected by health care providers and people around them when in reality parents play a significant role in caregiving children with cancer. The aims of this study was to investigate the needs and its associated factors, as well as the occurrence of psychological distress among parents taking care of children with cancer in Indonesia.

Methods: A cross-sectional study was conducted among 100 parents of children with cancer from pediatric ward of two public hospitals in Central and East Java, Indonesia. Parents were assessed using the Supportive Care Needs Survey for Partner and Caregiver (SCNS-P&C45) Indonesian version to measure unmet supportive care needs, Hospital Anxiety Depression Scale (HADS) Indonesian version to revealed psychological distress, and self-developed demographic questionnaire.

Results: Among parents surveyed, 83% had more than ten unmet needs, need for information (66.6±23.07) was the highest needs among the domains of supportive care needs. Also, 49% of the parents encountered anxiety, and 25% had depression. Caregiver with lower education and higher anxiety associated with the more number of unmet supportive care needs.

Conclusions: Most parents of cancer children report the need for more information and attention to degrade their psychological distress. Health care providers should provide clear, honest, and transparent information to the parents. Further, parent’s training program and psychological support are needed to promote parents’ role in caregiving activity to their children. Future research is required to explore the causal effect of unmet needs and psychological distress.

Abstract number: PO80
Abstract type: Print Only

The Effect of Cancer Rehabilitation in the Palliative Care Team
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Research aims: Rehabilitation is a critical element of palliative care in cancer. Cancer rehabilitation aims to treat patients’ physical, psychological and cognitive impairments to maintain or restore function including prevention of skeletal-related event with bone metastases, reduce symptom such as pain relief, maximize independence and improve quality of life. However, the collaboration between rehabilitation and palliative care is still in the developing stage in Japan. At our hospital, a physiatrist, or rehabilitation physician and rehabilitation therapists started working as a core member of the palliative care team (PCT) in 2015. The purpose is to clarify the role of rehabilitation professionals in the PCT.

Study population: Patients who received PCT services from April 2014 to March 2016 at National Hospital Organization Tokyo Medical Center.

Study design and methods: This is a historical cohort study. We retrospectively analyzed the medical records and compared data of current period (FY2015) after rehabilitation professionals joined as a PCT member with data of historical period (FY2014).

Methods of statistical analysis: Unpaired t-test was used to examine the general characteristics. Statistical analysis involved comparison of categorical variables using χ2 test. The setting of the significance level was at less than 5%.

Results and interpretation: The number of new patients who received PCT services were 201 in FY2014 and 257 in FY2015. The rate of patients with bone metastasis was approximately 25% in both years. Among them, the percentage of patients who received rehabilitation services increased (28.9% vs. 48.1%, p<0.01). Mean ECOG-PS were 2.77±1.0 vs. 2.45±1.0 (p<0.05). The rate of discharge to home significantly increased (29.3% vs. 46.0%, p<0.01).

We demonstrated that rehabilitation professionals joined as a PCT member could detect patients’ unmet needs related to function and activities...
daily living, sharing patients’ physical, psychological, social, and spiritual problems with PCT members. The collaboration between rehabilitation and palliative care might have a positive effect on home discharge and QOL of cancer patients.

**Abstract number: PO81**

**Abstract type: Print Only**

**Preliminary Validation of an Spanish Version of the New Demoralisation Scale (DS-II)**

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**Background:** Between 22% to 33% patients with cancer or advanced disease may experience a demoralization syndrome with more existential or spiritual suffering than psychological. To identify the case is necessary to develop therapeutic interventions. For this purpose, Kissane developed in 2004 the Demoralisation Scale (DS-I). From the original scale, Robinson, Kissane and cols., in 2016, refined and revalidated the previous scale to a shorter one (DS-II). They reduced the number of items from 24 to 16 and consequently, they grouped this items in 2 subscales called “Meaning and Purpose” and “Distress and Coping Ability”.

**Objective:** To obtain and validate an Spanish version of the new Demoralization Scale (DS-II) and to establish cut-off points for different levels of demoralization.

**Method:** The translation and cross-cultural adaptation of the demoralization scale was made according recommendations of European Organization for Research and Treatment of Cancer. Internal consistence was measured with Cronbach Alpha. Concurrent validity was studied with HADS and ESAS. A confirmatory factorial analysis of the two subscales was performed. The perception of the evaluator was tested again with the total score, and cut-off points for the demoralization scale were established with Spearman correlation between the perception and the total score.

**Results:** A total of 49 advanced cancer inpatients and outpatients were invited to participate. 42 accepted to participate and 40 completed the study. The DS-II (es) showed strong reliability with an Cronbach Alpha of 0.9. The Spearman coefficient shows correlation with symptoms (0.73), anxiety (0.67), depression (0.75), and anxiety plus depression (0.85). A confirmatory factor analysis of the 2 subscales was performed with all items being significant except for item 10 that has been improved in its translation after deep statistic and linguistic analysis. Two cut-off points (5 and 12) were established to classify the intensity of demoralization.

**Conclusion:** A Spanish version of the demoralization scale DS-II (es) is available and shows good validity and reliability being easy to complete. An international larger study is under development, including some Latinamerican countries, to confirm a revalidate the Spanish version.

**Abstract number: PO82**

**Abstract type: Print Only**

**The Experience of Living with Advanced-stage Cancer: An Approach from the Phenomenology of Practice**

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**Background and statement of aims:** Cancer incidence has increased, but its mortality is reducing, so each day more people are living with this disease. Most of the knowledge about living with advanced-stage cancer has been explored from the career’s and professionals’ perspectives. A better understanding of the perspective of the ill person is needed to identify relevant issues to the care of these patients and establish more effective nursing interventions. The aim is to explore and understand the adult experience of living with advanced cancer and its meaning.

**Study design:** A phenomenological hermeneutic study following van Manen

Three palliative care and oncology specialized units based in Navarra (Spain) participated. Patient selection criteria were:

1) having been diagnosed with advanced-stage cancer at least three months ago,
2) being conscious about prognosis,
3) receiving care in hospitals or outpatient,
4) being physically and mentally able to participate in the interview,
5) being able to maintain a conversation in Spanish.

Twenty-two patients purposively selected participated in the in-depth interviews until data saturation.

A phenomenological interview was carried out, lasting between 45 minutes and 2 hours. Question guided was used. A thematic analysis of transcripts was conducted, following van Manen.

Ethical approval was granted.

**Results:** It’s a phenomenological text, as suggested by van Mannen, gathering the essence of meaning of living with advanced cancer in three themes:

1) The person lives his/her finite nature and the immense value of the daily life,
2) The person is aware of his/her own body and how he/she relates to the world through it;
3) The person lives his/her disease in family.

These are the main ideas of each theme:

1) He/she lives the proximity of death, values the present and changes his/her life priorities;
2) He/she notices the unity of the body and soul and the impact of the illness in his/her identity;
3) He/she is worried of the burden that produces in the family and the love received from the beloved ones helps person to follow his/her daily life.

**Conclusion:** This study shows the huge importance that the person gives to live their normal day to day life. Likewise, the illness helps the person to focus on all the good that there is in every small detail of his/her life and to enjoy each moment of every day.

**Funding**

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**Abstract number: PO83**

**Abstract type: Print Only**

**The Features of Palliative Radiation Therapy for Advanced Cancer Patients in Hospice Care**
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Purpose: Radiation therapy (RT) is one of the management of relapse in advanced cancer patients. The study was aimed to evaluate the actual features of palliative RT in cancer patients with hospice care.

Methods: In the patients who underwent palliative RT, we reviewed the records of the general characteristics, presenting symptoms for palliation, radiation dose, number of fractions, whether the course was completed as planned, and cause of uncompleted RT, and survival time of patients.

Results: In 325 patients who had been admitted for hospice care, 42 (12.9%) of them received palliative radiation therapy (RT) from March 2013 to December 2015. The main indications of RT included brain metastasis, pain control for bone metastasis, obstructive shortness of breath by cancer mass, spinal cord compression. The median delivered dose and fractions were 2,500 cGy (150-4,840 cGy) and 12 fractions (1-25 fractions). Radiation therapy was completed in 67% who started before the last 30 days of life (DOL), but 33% of patients could not complete the treatment course of RT delivered in the last 30 DOL (p=0.038, Fisher’s exact test). Among the uncompleted group, 25% of population, reduced radiation dose less than 1/3 of initial planned. The most common cause to be failed of planned treatment was decreasing general condition of patients. Median survival time after RT was 21 days (range 1-58 days) in statistical analysis.

Conclusions: Palliative RT is effective for management of symptoms in patients with advanced cancer in hospice care. With appropriate selection criteria of patients and shorter modification of radiation dose or fractions coordinated in multidisciplinary collaboration then, more patients would be beneficial with palliative RT, even for the patients less than last 30 DOL.

Abstract number: PO84
Abstract type: Print Only

The Role of Nurses in Increasing the Awareness of Women about Cervical Cancer
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Background: According to the WHO, more than 600,000 cases of cervical cancer (CC) are registered annually in the world, and despite the measures taken, up to 50% of patients die from this disease. In Uzbekistan, cervical cancer among all oncopathology ranks fifth, and in the structure of oncological morbidity in the reproductive system of women - the 2nd place after breast cancer, and does not have a stable tendency to decrease.

Aim is to study and find out through the questionnaire the awareness of the female population of the city of Tashkent about the diseases of the cervix and their medical activity.

Material and methods: The study 503 involved women ranged from 15 to 60 years. 30% of the women surveyed have higher education, secondary special education -54%, secondary-16%. Married - 86%, not married - 14%. The number of women who started sexual activity at the age of 16-18 was 31%, at the age of 20-25 - 53%, at the age of 25-30 - 13%, over the age of 30 - 3%, 54% of women had one sexual partner, 30% - 2, 4% - 3 or more, 2% did not answer the question. Of them: adenitis - 22%, erosion - 38%, cervicitis - 15%, endometritis - 15%, colpitis - 10%, 43% of women have no history of gynecological diseases.

Result: Information on CC, 65% of women received from medical professionals, 15% - from the media, 20% - from other sources. However, 70% of respondents could not correctly answer questions about risk factors. If symptoms of CC occur, only 70% of women turned to a gynecologist, general practitioner or oncologist, with only 60% of them seeking medical help within one month, 25% for three months, 15% for complicating the disease. Only 34% of women turn to a gynecologist with a prophylactic goal, of which 2/3 - once a year, 40% - 2 times. It should be noted that 25% of respondents visit the gynecologist with gynecological complaints. 60% of respondents are aware of the presence of some screening methods for identifying CC, such as the papist -10%, cytology - 37%, colposcopy - 13%, the rest could not answer this question.

Conclusion: Thus, the level of women’s awareness of CC issues, their causes, pathogens and symptoms is not sufficient, which is the reason for low oncological alertness among women. All this speaks about the need to intensify the explanatory work among women on the prevention of CC by optimizing the activities of nurses and midwives, which will cover more women by screening methods of early detection of CC.

Abstract number: PO85
Abstract type: Print Only

Do Advanced and Non-advanced Cancer Patients Admitted to a Comprehensive Cancer Center Have Different Multidimensional Needs?
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Aim: To compare the multidimensional needs of recently-admitted patients (pts) with advanced (AD) and non-advanced cancer (NAD) in a comprehensive cancer center.

Methods: All pts (regardless of reason for admission) were proactively screened within 2-4 days of hospital admission. Screening consisted of a nurse-led multidimensional needs assessment [denominated “Oncoscreening”(OS)] to assess five dimensions (symptom burden, physiotherapy, emotional, social, and nutritional needs). Pts whose expected hospital stay was < 4 days, in the last days of life, or who refused to participate were not screened. Symptoms were scored using the Palliative Outcome Scale. The 5 dimensions were assessed as follows:

1) Symptom burden: the sum up of the symptoms scores;
2) Physiotherapy: decline of ≥30 points on the Barthel I. from the previous 7 days of admission or current score<60);
3) Need Nutritional Assessment: current BMI<18.5 Kg/m² or weight loss in the past 3 months ≥5% (in NAD) or 10% (in AD);
4) Emotional: sum of scores on Anxiety & Sadness Distress Thermometers ≥10;
5) Social: any positive answer to the two Feisbuc questionnaire questions.

Categorical data were compared using Pearson’s χ² and Fisher’s exact tests (two-tailed). Continuous data were compared using the Student’s t-test or Mann-Whitney test, or Wilcoxon signed-ranks tests depending on the distribution (normal or non-normal).

Results: From March 2 to July 5, 2017, 307 pts were admitted and 222 (72.3%) underwent OS. Significant between-group (AD vs. NAD) differences were observed in mean symptom burden AD 8.03(SD4.4) vs. NAD 9.02(SD4.3) (P=0.008) mainly in reported pain severity AD 42% vs. NAD 23.8%, P=0.006 & asthenia AD 87% vs. NAD 69%; P=0.002. No significant
differences were observed on the other dimensions: physiotherapy need: AD 36.8% vs. 24.7% NAD; P=.029. Nutrition AD 37.3% vs NAD 47.1%; P=.029. Emotional: AD 38.6% vs NAD 28.4%; P=.236. Social: AD 24.6% vs HM 33.3%; P=.169. None patient or relative refused OS. Mean hospital stay was 11.6 (AD) vs. 12.3 (NAD) days. Mortality was 14.1% (AD) vs. 6% (NAD).

Interpretation:
Significant differences between AD and NAD patients were observed in symptom burden (mainly pain & asthenia) but not on the other needs. Early and proactive needs assessment seems feasible and detects substantial numbers of patients with specific multidimensional needs. These findings support the use of OS regardless of disease stage.

Abstract number: PO86
Abstract type: Print Only

Implementing “Supportive Collegial Meetings” (SCMs) for Cancer Inpatients

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Background: Mandatory in France for therapeutic decisions in cancer patients, “Multidisciplinary Team Meetings (MTMs)” bring together the patient’s oncologist and at least two physicians of different specialties. In addition to MTMs, we set up “Supportive Collegial Meetings (SCMs)” including caregivers, palliative care team, an intensivist and a psychologist, targeting hospitalized patients which require complex multidisciplinary and multi-professional management.

Clinical cases: Three exemplary clinical cases are presented in this poster, illustrating the interest of such SCMs through three thematic:
- Ethical complexity of the sedation decision
- Divergence between palliative and oncologic project of care
- Need to reassess the projected stratification of care.

Discussion: Since 2015, weekly SCMs are moderated by a palliative care physician and an intensivist one, without hierarchical relationship with the patient unit. Complex clinical cases are proposed by the caregivers themselves, depending on the occurrence of difficulties and/or specific events. All involved staff study treatment, stratification of care, ethical and psychosocial issues, and patient objectives. As a result, a consensus statement is done, that can change or complete the MTMs statement. Thus, oncologic treatment can be stopped in favor of a palliative pathway, or complemented by other alternatives. Starting in one oncology unit, SCMs have expanded to the entire oncological department since 2016, probably because these innovative and multidisciplinary meetings allow sharing difficulties and therefore bringing comfort to the patient, their relatives and caregivers.

Conclusion/lessons learned: Complementing MTMs and drawing on consensus findings from all involved medical care workers, SCMs appear to improve the overall management of hospitalized patients with cancer and the well-being of staff. The scientific objectivity of these findings is underway in order to propose a dissemination of their realization.

Abstract number: PO87
Abstract type: Print Only

Changing Mindsets through the Introduction of Enhanced Supportive Care

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Background: Following work showing increased quality & length of life for advanced cancer patients through focused attention to symptom management by early palliative intervention, NHS England invited hospitals to be part of a pilot project to incorporate the principles & skills encapsulated in palliative medicine earlier in the disease trajectory. The target patient group are those with incurable cancers who’re being offered palliative chemotherapy. Our hospital embraced the challenge. To be effective, this requires a shift in the mindsets of both oncologists and palliative care teams, and closer co-operative working.

Method:
1. TEAM - As this is a ‘bridging’ project between two specialties, we set up a team led by a senior nurse & a consultant, who are both jointly trained (& accredited) in oncology & palliative medicine, working with a General Practitioner & nutritionists, with easy access to a clinical psychologist, pharmacist & chaplains.
2. AWARENESS - We have done a lot of talking! We have -
   (a) talked with the palliative care teams in hospital & community
   (b) presented to the oncologists as a group & individually
   (c) discussed with the clinical nurse specialists (CNS) for each cancer type how this fits in & compliments their roles
   (d) got the chemotherapy nurses on board
   (e) produced patient & staff information leaflets/packs.
3. PATIENT IDENTIFICATION - Multi-pronged approach, via cancer site multi-disciplinary team meetings, from CNSs, joint consultations with oncologists & at pre-chemo chats between chemo, nurses & patients. We’re targeting 4 cancer sites initially.
5. DATA COLLECTION - specific clinic codes & via oncology data manager.

Results: We are currently very early in the process with respect to patients but all the talking & effort put into the set up has resulted in great enthusiasm, with oncologist requesting that their cancer type be next to be incorporated and nurses excited about more joint working.

Conclusion: Setting up a new service is hugely challenging & exciting. However, to have any chance of being successful we recognized how vital it was to -
1. set up a team of appropriately trained people, who work well together, with a clear remit, enthusiasm (and ability to enthuse others), vision, imagination & patience
2. have joint medical & nursing leadership
3. dispel scepticism through initial & ongoing dialogue with colleagues
4. be clear but flexible.

Abstract number: PO88
Abstract type: Print Only

Factors Affecting Uptake of Cervical Cancer Screening Services among Women of Reproductive Age in Buwolya Village, Mayuge District

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Introduction: Cervical cancer screening is as an early strategy to prevent cancer of the cervix by finding and treating early anatomical changes that may occur at the cervix (WHO 2015). This intervention can help to control the escalating numbers of women reporting to health facilities with advanced cervical cancer and the associated financial and psychosocial challenges.

Aim: This study aimed to assess the factors that influence uptake of cervical cancer screening services among women of reproductive age in Buwolya Village, Mayuge District.

Methods: The study adopted a descriptive cross-sectional study design in which quantitative approaches of data collection and analysis were used. Information was derived directly from respondents by use of face-to-face interviews using structured interviewer guided questionnaires. The study population for this study was reached by simple random and comprised of women of reproductive age (18-years and above) who had resided in Buwolya village for at least one year.

Results: Four socio-demographic factors had a statistically significant influence on the uptake of cervical cancer screening among women of reproductive age in Buwolya Village. The Age of respondents influenced cervical cancer screening uptake (p = 0.021, X² = 7.117), and so did the Marital status (p = 0.000, X² = 15.784), Education level (p = 0.000, X² = 27.249), and the number of children the respondent had (p = 25.465, X² = 0.000).

Conclusion: Results from this study indicated that uptake of cervical cancer screening by women in their reproductive age stands at 5%. For that reason therefore, the District Health Team and the Local leadership need to institute drastic measures to launch a health education campaign in this community in order to demystify any myths and misconceptions that may be existing and to create demand for the service. A more robust study to better understand uptake of cervical cancer screening in the whole district needs to be undertaken.

Abstract number: PO89
Abstract type: Print Only

Cancer of Unknown Primary Origin (CUP) - The Perfect Marriage between Oncology and Supportive Palliative Medicine
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Background: Being diagnosed with cancer is tough enough, but to have metastatic cancer without a clear origin is devastating and hard to comprehend. It’s tended to be addressed medically as an ‘also ran’ tagged on to the end of one or several MDTs due to organs of metastatic disease, but without a specific remit for care. Thus, in 2013, following a NICE Report, we set up a specific team and MDT for CUP patients led by a consultant jointly accredited in oncology & palliative medicine, by 2 other interested oncologists, a clinical nurse specialist, a radiologist & a pathologist both of whom like a diagnostic challenge. Here we present an audit of the CUP’s work.


Results: 64 patients discussed, 29 female & 35 male, aged 32 - 96. 32 patients were seen by a consultant before or on the day of the MDT. Many patients had been discussed at multiple other MDTs (1-3). Of the 64, we achieved a definite diagnosis for 36 (including 8 who did not have cancer at all) & a ‘probable’ cancer site diagnosis in 9. Twelve were unfit for treatment, so we advised curtailment of investigations and concentration on symptom management. This left seven who, after appropriate radiological, biochemical & pathological investigation remained ‘cancer of uncertain primary origin’. Of these, two had chemotherapy and three radiotherapy. The longest survival was 16 months, 15 of good quality, in a man who had initial chemotherapy, & supportive care throughout all under one consultant. Repeat audit currently underway - 179 patients discussed.

Conclusion: To maximize the effectiveness of a CUP MDT, all members to the team need to be interested in the diagnostic challenge, be prepared to see patients as early as possible in the diagnostic pathway to advise on the appropriate investigations, extent of investigation and use of resources. It is also crucial to ensure that patients are offered open and honest conversations and information sharing, to the level/extent they want throughout, including discussing their preferences, resuscitation, etc. Having a jointly accredited clinician enables greater continuity of care for patients. A large part of the MDT’s role is diagnosis and onward referral to site specific teams and accelerating and streamlining of the diagnostic pathway. The CUP MDT profile, workload and value is rising.

Abstract number: PO90
Abstract type: Print Only

Moral Distress Process with Oncology Nurses Related to the Care Provided for Patients with Advanced Cancer and their Families
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Introduction and aims: Considering the continuing exposure of nursing professionals to the poorly adaptive psychological responses related with care, associated with gaps in the literature of moral distress in the context of oncology, this study was proposed aiming to understand the occurrence of moral distress in nurses’ professionals and their experience regarding the process of moral distress in an oncology hospital. The final objective was to construct a theoretical model of the experience of nurses about the phenomenon of moral distress.

Method: This study used the explanatory sequential model of the mixed methods approach, which is composed of two phases in sequence: first a quantitative study was held, followed by a qualitative phase. In the first phase, a prospective observational study was carried out aiming to know the correlations between moral distress and the biosocial, occupational and health profile of oncology nurses. The qualitative phase aimed to elucidate the results obtained in the first quantitative phase, helping to explain the phenomenon in a broader way. Focus groups and semi-structured interviews was conducted based on Symbolic Interactionism and Grounded Theory(1). The analysis of the questionnaires data used Pearson’s correlation test to verify the correlations. The qualitative data analysis involved the transcription, reading and re-reading of data, codification and categorization for the formation of themes.

Results: Moral distress was significantly associated with severe burnout and stress symptoms, evidencing consequences for the health of nursing professionals in the context of oncology. Qualitative analysis allowed to identify three categories linked to the moral distress process: Practicing moral agency; living moral distress related to palliative care and experiencing moral resilience. The synthesis of these categories formed the central category: Moral Distress and its duality in strengthening or weakening the nurses to care of oncology patients.

Conclusions: The quantitative and qualitative findings allowed a broader comprehension of the phenomenon of moral distress in oncology nurses. Implications and recommendations include moral distress evidences to palliative care policies and open spaces in clinical setting as a mechanism to strengthen nurses to care of patients with advanced cancer and their families and to prevent psychological distress as consequence of therapeutic obstinacy and the provision of futile care.

Abstract number: PO91
Abstract type: Print Only

Palliative Approach in Neuroblastoma - A Retrospective Study in the 3rd Pediatric Clinic of “Louis Turcanu” Childrens Hospital
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Neuroblastoma (NB) is an important cause of cancer in children. The survival rate has increased in the last decade due to improved diagnostic accuracy and therapeutic approach.

Objectives: A retrospective analysis of NB cases admitted in our clinic during 2000-2016 has been done to highlight the importance of palliative approach from diagnosis, due to the rapid progression of the disease and its high mortality.

Material: The study group consisted of 48 patients (selected out of 58 cases of NB), aged 1 month to 15 years, 25 girls (52.08%) and 23 boys (47.92%), of whom 41.66% from a rural area, 58.33% had an urban background.

Method: The study group was analyzed by clinical criteria and laboratory data, allowing diagnosis and staging. Data were statistically analyzed, the Kaplan-Meier survival curve was calculated. The need for a holistic approach was recognized from the start and applied throughout the treatment.

Results: In the study group, 18.75% were aged <1 year at the onset, 31.25% aged 1 to 3 years, 14.58% between 3 and 6 years and 35.41% ≥6 years. The disease onset was anatomically located: 50% abdominal (4.16% stage I or II, 25% stage III and 70.83% were diagnosed with stage IV), 25% mediastinal (8.33% in stage II or III and 91.66% had a stage IV), intrathoracic (8.33% (all stage IV), paravertebral (4.16% (all stage IV), 2.08% sacrococcygeal (stage IV) and 2.08% had in the jaw (stage IV). Metastases were present in 50% of NB cases with abdominal onset, 25% of the patients with thoracic onset, 50% in those with paravertebral onset, and a 100% by sacrococcygeal diagnosis. The histopathological examination provided the following results: 75% were neuroblastoma, 20.8% ganglioneuroblastoma, 1.6% other types of NB. Evolution within a year after chemotherapy was favorable in 64.58%, 11 patients died (22.91%) and for 6 cases (12.5%) there is no data. Progress after 3 years was positive in 45.8%, 41.66% of the cases died. In all cases psychological and spiritual support was provided for the family and patient by a multidisciplinary team. 2 patients received bone marrow transplant.

Conclusions: NB is a malignant tumor with favorable evolution in less than half of the patients. At the onset more than half were in advanced stages, which explains the poor outcome. Due to the unfavorable outcome and the rapid progression of the disease the patients and their families profit by a palliative approach implemented from the start and adjusted to the different needs arising during the treatment.

Abstract number: PO92
Abstract type: Print Only

Preparation of a Patient Booklet to Monitor Needs for Palliative Care Interventions Delivered by Cancer Clinicians as Part of the INSPIRE Study (Patient Needs Palliative Interventions), a Randomized Phase II Trial

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Background: Early integration of patient-needs based Palliative Care Interventions (PCI: education, counselling, coordination, drugs, procedures, etc.) delivered by oncology professionals (ONC) mutually collaborating with PC specialists is an emerging demand for cancer care. Patient needs for PCIs are underestimated as prior data shown, Clinical Practice Tools to monitor needs may increase PCIs by ONC.

Aim: To develop a patient booklet to monitor patients’ needs for 7 main PCIs as sentinel element of the INSPIRE intervention in non-curable advanced cancer outpatients.

Results: For the development of the patient booklet (Clinical Practice Tool): cognitive interviews with 12 patients have been conducted to test an ESMO booklet on comprehension, acceptability and face and content validity. Based on the result that volume, layout/ design of the booklet was unsuited, the patient booklet has been adapted, simplified and tested again with cognitive interviews with patients (n=5). Based on these outcomes and on a systematized literature review on tools for screening for unmet needs in advanced cancer patients that is useful as clinical practice tool and is intervention oriented, a further version of patient booklet has been developed. Two validated tools (NAT: PD-C; SCNS-34SF-G) are integrated in the patient booklet to assess, reflect and document a patient’s actual questions and palliative needs and plan interventions. Oncologist and nurses oncology (O-HCPs) will be asked about usefulness in clinical practice. As next elements self-management education interventions for patients with cancer are developed and structured education for oncology clinicians provided to interpret the patient booklet and deliver PCIs.

The RCT will use IPOS as primary outcome, as secondary outcomes patient unmet needs are monitored, delivered PCIs by cancer clinicians and specialist Palliative Care, and patient empowerment interventions.

Discussion: The INSPIRE intervention: The study will provide

a) an understanding of the importance of components of the intervention to achieve outcomes,

b) how inter-professional collaboration including specialist palliative care occurs in delivering PCI,

c) clinical data on routine delivery of PCI by ONC and ON in the control group, and
d) experiences of nurses on PCI-specific patient empowerment for self-management.

Abstract number: PO93
Abstract type: Print Only

Evaluating Nurses’ Action Outcomes and Exploring their Perspectives of Implementing the POS-S (Renal) Assessment Tool for Haemodialysis Patients

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Background/aims: Globally, nurses working in haemodialysis settings face challenges caring for a growing population of older and sicker people with end stage kidney disease (ESKD). This study aimed to formally evaluate nurses’ action outcomes and explore their perspectives of the implementation of the Patient Outcome Scale symptom (Renal Version) (POS-S (Renal)) assessment tool as a strategy to assist with addressing symptom burden, advance care planning (ACP) and quality end-of-life (EoL) care for patients, their families and carers in an Australian regional location.

Methods: An ethics approved sequential mixed method design was used comprising 2 year retrospective audit of patient symptom reporting followed by thematic analysis of focus groups with nurses.

Results: Between 11-24% of patients (n=54) indicated moderate to severe symptom burden. Half or more of these ratings had a corresponding progress note and a nursing action. Analysis of focus groups discussions revealed increased confidence/willingness to take ownership to effect change within nursing roles, co-existing with prevailing personal, cultural and structural barriers which create a sense of powerlessness to effect further change.
Conclusions: The POS-S (Renal) tool is useful for identifying and tracking symptom deterioration, supporting nurse-led actions to address chronic symptom burden and as a prompt for commencing conversations about EoL. Renal nurses in regional dialysis settings face many challenges and require ongoing support and assistance to progress toward the adoption of timely ACP and the provision of patient-centred EoL care to their patients.

Funding
Grampians Region Palliative Care Consortium

Abstract number: PO94
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What Are Patients with Severe and Very Severe COPD Experiences of a Specialised Palliative Care Intervention: A Qualitative Study
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Introduction and objectives: Despite having similar palliative needs than patients with lung cancer, studies have shown that COPD patients are much less likely to receive palliative care. Furthermore, little is known about the views of severe and very severe COPD patients on palliative care interventions. In order to better understand the experiences of patients with severe and very severe COPD with a specialised palliative care consultation and their specific needs, we undertook a qualitative study as a supplement to a randomized control trial.

Method: A research psychologist carried out 18 semi-structured interviews with patients alone at their home. In order to obtain in-depth qualitative information, two topic guides (one for the « intervention » group, one for the « control » group) were developed from reference to the literature and brainstorming with the multidisciplinary research team. The interview guides focused on patient’s participation to the study (expectations), their opinions on the specialised palliative care received/usual care received overall appreciation.

Results: The key findings of this analysis can be grouped into the following topics:
(1) “nothing was done to me”,
(2) “I’m not sick”,
(3) functional limitations,
(4) overwhelming anxiety,
(5) focus on the present and
(6) perceived helplessness.

Indeed the components of the palliative care consultation such as symptom management, nutrition, disease information, socio-spiritual support or alternative approaches like massages were rarely mentioned by the patients. Furthermore it appeared through the interviews that the patients tended to focus on the present and avoid talking about the future. When asked about their specific needs, they mostly reported practical needs to help with their daily functioning and frankly didn’t wish for any spiritual support. Finally most participants expressed wanting to be cared, to breathe and some shared the wish to feel surrounded and to have their anxiety removed.

Conclusions: Our findings revealed a need to further assess specific needs in advanced COPD before implementing palliative care. It may be assumed that care for these patients should first focus on addressing anxiety and functional limitations issues before discussing advance directives or spiritual support for example.


Abstract number: PO95
Abstract type: Print Only

Development of a Complex Intervention for Early Integration of Home-based Palliative Care in the Standard are for People with Severe COPD: A Phase 0-1 Study
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Background: Research suggests that palliative care (PC) should be integrated early in standard care for severe COPD. Most people with COPD express the wish to be cared for and to die at home. However, a practice model to implement early integrated home-based PC in the standard home care is lacking.

Aim: To develop an intervention for early integration of home-based PC in the standard home care for people with severe COPD.

Methods: We conducted a Phase 0-1 study according to the Medical Research Council Framework. Phase 0 consisted of seven focus groups with GPs and community nurses on perceived barriers and facilitators of early integrated home-based PC for COPD, expert consultations, and a literature review to identify potential components for the intervention. In Phase 1, the intervention and its components were refined by one expert panel and expert opinions.

Results: Phase 0 resulted in barriers and facilitators to early integrate home-based PC in standard home care for COPD and components of successful interventions on early integration of PC. Based on these findings, a nurse-led intervention was developed consisting of: a training on care for severe COPD for the Specialised Palliative Home Care (SPHC) team, home visits by SPHC nurses, two educational booklets on self-management of COPD, a semi-structured documentation template to record the outcomes of the home visits, and integration of care by enabling communication between involved caregivers in hospital and home care.

Conclusion: From barriers and facilitators for integrating home-based PC for severe COPD, and key factors from successful interventions on early integration of PC in other health care settings, a complex intervention for early home-based PC for COPD was developed. Using three methods in phase 0 gave reliable and rich data with clear directions for the intervention. The feasibility and acceptability of the intervention will subsequently be tested in a Phase II study.

Funding
IWT-SBO.

Abstract number: PO96
Abstract type: Print Only

Clinical Profile of Patients under Care of the Intro-PAC-WDC Protocol Development Process
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Background: Cessation of life-support treatment is an appropriate option for situations in which the burdens of therapy substantially outweigh the
beneﬁts. Patients should be managed via Withdrawal Dialysis Care (WDC) based on bioethical and palliative care principles.

Aims: To describe the clinical proﬁle of patients who were under WDC during the development process of the Intro-Pro-Active Care (PAC)-WDC protocol.

Methodology: A retrospective, descriptive, consecutive case series. An electronic clinical records review was performed from April 2016-July 2017 for 19 patients who met the criteria for limitation of therapeutic effort (LTE) and were presented to the Renal Palliative Care Team (RPCT) to approach WDC. The Ethics Committee approved the study.

Results: Dialysis intolerance was described for eighteen patients. Three patients opted not to participate. Two of them are still currently being followed up on by the RPCT. One was redirected to receive a renal transplant. Thirteen of them received care via the development of the Intro-PAC-WDC protocol. The nephrologists’ answer to the surprise question was “No, I would not be surprised” for those patients. Eight of 13 were men. The patients’ mean age was 72.1 y.o. (r:49-91). The mean period on dialysis was 5.9 years (r:0.7-28 years). Eleven on haemodialysis and 2 on peritoneal dialysis. The Palliative Performance Score mean was 36. In terms of comorbidity, the mean on the Charlson Index was 8.38. The most common symptom was asthama (13) followed by ischaemic pain (8). The mean PaP Score was 9.3. The Barthel Index mean was 18.5 (r:5-70). The Pfeiffer test mean was 2.91 (r:0-7). The serum albumin mean was 3.12 (r:2.1-4.0 g/dL). The follow-up mean time by the RPCT was 4.7 months (r:1.2-7.8m). The interval between the last dialysis and death was 7.28 days (r:2-11 days). For six patients, the palliative sedation therapy was needed: in 4 cases with consent by the patient and in 2 cases by relatives. The refractory symptoms presented were delirium (3), seizures (2) shortness of breath (1). Twelve patients’ relatives received condoleance letters from the RPCT a month after the deaths.

Conclusion: In this limited sample, the most common proﬁle was a man aged 62-83 with more than 3 years on dialysis and a low level on the prognosis assessment scales, high comorbidity, extremely low functional assessment and mainly suffering from asthama and ischaemic pain. This group seems to be the most vulnerable.

Abstract number: PO97

Abstract type: Print Only

Intranasal Fentanyl Uses to Control Pain during Withdrawal Dialysis
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Background: Pain management at the end of life is challenging in the presence of renal failure. Withdrawal dialysis (WD) is increasing. In those cases, death is expected to occur in seven to 10 days on average. This brief period affords a precious opportunity for patients and families to be together, strengthen relationships, forgive past transgressions and achieve closure. Ineffective pain control and opioid-induced neurotoxicity (OIN) can disrupt this opportunity.

Aims: To describe the use of intranasal fentanyl (INF) as monotherapy for pain related to low cardiac output (PRLCO) during DW, independently of the presence of an irruptive pain component.

Methodology: A retrospective, descriptive serial case study. A review of eighteen electronic clinical records of patients meeting these three criteria: 1) Fit into the categories of WD proposed by Murphy’s Coding 2013; 2) Opioid prescriptions for PRLCO in WD for the period of April 2016-July 2017; 3) Treated with previous ineffective analgesia.

Results: Thirteen patients met the criteria; seven of them used (INF) exclusively in WD. The mechanism of pain was identiﬁed as cardiac ischaemic pain in two cases, intestinal ischaemic pain in three, and peripheral vascular ischaemic pain in two. The lower range for intensity of pain previously used for INF was 4-6 on the numerical scale assessment (NSA) and the higher 6-9. Cognitive failure was present in one case by the Pfeiffer test, and two were positive for anxiety by the Hospital Anxiety and Depression Scale. Irruptive pain was described in five cases. The average duration for WD was 7.28 days, and the average of well controlled pain (NSA lower than 3) was 5.8 days with no signs of OIN. Palliative sedation therapy was initiated for two patients each lasting 4 days. One had refractory delirium and one had refractory seizures. INF plus pectin was used at a dosage of 100mcg per administration 2-4 doses per day.

Conclusion: This limited serial case of patients in WD with PRLCO who used INF experienced well controlled pain and showed enough awareness for interactions with relatives during a signiﬁcant number of days at the end of life. This is a highly valuable experience in terms of providing quality care in one of the most challenging clinical scenarios for renal failure. This limited study provided us with a hypothesis that INF could be potentially useful to control ischaemic pain in renal settings and needs to be explored in future controlled studies.

Abstract number: PO98

Abstract type: Print Only

Relationship of Quality of Life and Vegetative Nervous System in Patients with Chronic Obstructive Lung Disease
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Background: At present, the interest of clinicians to study the functional state of the autonomic nervous system (VNS) has increased signiﬁcantly. The VNC mediates its inﬂuence on the functional state of the bronchi through sympathetic and parasympathetic regulatory mechanisms. It was found that with COPD there is a signiﬁcant decrease in the quality of life in patients.

Aim: To study the relationship between the quality of life (QOL) parameters and the autonomic nervous system in patients with COPD.

Materials and methods: Clinical and functional studies of 57 patients with COPD on the basis of pulmonology department were carried out. The quality of life was determined by the Seattle questionnaire, which included 29 questions assessing the physical condition, emotional state, the state of professional suitability and satisfaction with treatment. The state of the autonomic nervous system was evaluated by the method of cardiontentialgrammetry (CIG) according to Bayevskiy (1976).

Results: Studies of the initial vegetative tone in COPD patients showed that in 43% of patients with COPD there was a state of overstrain of the adaptive capacity of the body, which was determined by hypersympathicotonia and signiﬁcantly less frequent among patients with COPD: eutonics (ET)(28%), sympathicotonic vegetative reactivity and only 28% deﬁned normotropic vegetative reactivity, reﬂecting the preservation of the compensatory capabilities of the body.

Discussion: In patients with COPD, stress and disruption of adaptive-compensatory capabilities of the organism and a decrease in the quality of life parameters are more often noted. In patients with COPD, there was no correlation between the decrease in QOL parameters and the state of...
the initial vegetative tone. However, in patients with COPD, the connection between the loss of compensatory possibilities and the more pronounced decrease in the QOL parameters by professional suitability has been proved.

Abstract number: PO99
Abstract type: Print Only

Breakthrough Dyspnea: Use of Fentanyl Nasal Pectin with Chronic Respiratory Failure in Progress of Disease
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Research aims: The aim is to evaluate the impact of Fentanyl Nasal Pectin (FPNS) on Reduction of Breakthrough Dyspnea related to Patient Movement with IRC (Chronic Respiratory Failure) in Palliative Care. Patient in Hospice, with Chronic Respiratory Failure by Chronic Obstructive Pulmonary Disease (COPD) or Idiopathic Pulmonary Fibrosis (IPF) in an advanced disease stadium manifests in the autonomous or passive movement a dyspnea worsening. The study wants to demonstrate how the FPNS’s procedural insertion reduces the number and the duration of dyspnea. This evaluation will be accompanied by a psychological evaluation for the detection of anxiety and depression related dyspnea symptoms. Such evaluation and the use of relaxation techniques will help to reduce the psychogenic component of dyspnea and improve the management of the crisis.

Study population: Patients with non- oncological pathologies with IRC with episodes of 1 to 4 breakthrough dyspnea per day. Considering the document from Hospital Pneumology Italian Association (AIPO) and SICP on refractory dyspnea in chronic respiratory failure, for both groups it is required the presence of at least two of the conditions envisaged on the document.

Study design and methods: In Hospice we are examining 10 patients. The established protocol provides: Assessment of start of dyspnea crisis (O2 saturation, borg’s scale, triggering causes); Drug Administration (in the expt, group 1 FPNS poud, in the control group a SC or EV bolus of morphine 10 mg diluted in 10 ml of PS is injected 3 ml); crisis re-evaluation after 5 min for a max time of 1 hour. Possible re-administration after 10 min of the same dosages; Evaluation of the daily number of dyspnea disorder and the intensity perceived. We are combining this procedure with all patients in Hospice at the entrance a psychological evaluation of anxiety and depression with HADS and Distress thermometer. We are using it for the patients, during of the hospitalization, the protocols of mindfulness, autogenic training. We are training our nurses with the use of relaxation techniques to be used during the patient’s dyspnea crisis. This helps decrease the psychogenic component of dyspnea and evaluate the effective reaction to the drug. Results and interpretation: In all 10 patients we are testing the quickness of FPNS combined with psychological assistance vs morphine. In Italy will be planned a multicenter pilot study (Pneumology Units, Hospice, Home Care).

Abstract number: PO100
Abstract type: Print Only

The Views and Experiences of Older People with Conservatively Managed Renal Failure: A Qualitative Study of Communication, Information and Decision-making
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Background: Conservative Kidney Management (CKM) is a non-dialytic, palliative alternative to dialysis for older people with end stage kidney disease and comorbidity. We know that how staff communicate about treatment influences patients’ treatment decision-making and that communication practices vary across renal units. A result of this is un warranted geographical variation in rates of CKM among older patients. For renal care to be equitable and person-centred, more evidence is needed of patients’ experiences of communication with staff and the information they receive.

Aim: To explore views and experiences of communication, information provision and treatment decision-making among older patients receiving CKM.

Methods: In-depth qualitative interviews with a purposive sample of older patients with chronic kidney disease stage 5 in 3 UK renal units. Sampling continued until data saturation. Data were analysed iteratively using inductive thematic analysis.

Results: 20 patients participated (median age 82, range 69-95); 11 men). Findings were in 4 themes:

1. Staff-patient communication and information provision;
2. Missing conversations and gaps in information provision;
3. Information preferences;
4. Dialysis decision-making.

Although participants described positive experiences of communicating with healthcare providers and being provided with information, negative experiences involving clinicians rushing or being insensitive/ambiguous were also reported. Patients recounted clinicians omitting or avoiding conversations regarding diagnosis and prognosis. They wanted information about their treatment options and disease, but were ambivalent about knowing details of the next illness stage. The decision to have CKM was framed as choosing not to endure the negative quality of life associated with dialysis, and was strongly influenced by clinicians’ views, recommendations and reassurances.

Conclusions: Older patients report variable quality in their communication with clinicians and gaps in the information provided. Ambivalence regarding prognostic information among some patients can make communication challenging. Tailoring information to patient preferences and conveying it clearly and sensitively is critical. Renal clinicians’ perceptions and recommendations regarding treatment play an important role in patients’ decision-making. Clinicians need training and guidance to support person-centred decision making among older patients.

Abstract number: PO101
Abstract type: Print Only

Between Heart Transplantation and Palliative Care - A Case Report
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Introduction: Heart failure is a syndrome with high impact in patient’s quality of life and with increased incidence in developed countries. When the cardiac function is very low, heart transplantation is suggested as the last therapeutic line. When this option is not possible and there is shortened survival, palliative care must be started by health professionals.

Objective: Describe nurses’ experiences and feelings during an end-of-life situation when waiting for a heart transplant that never arrived.
Methods: An individual case report of a situation that took place in a heart failure intensive care unit.

Results: At 17th of November 2014 a Caucasian, 61 years old female appealed to Emergency Room with symptoms of heart failure decompensation, NYHA class IV: tiredness, fatigue, cachexia and orthopnea. She also had fever as she was on septic shock, due to a nosocomial infection, and required with drainage of eight liter following paracentesis due to ascites. As a usual patient in this hospital and because of her poor heart function she was already waiting for heart transplantation. Because of the septic shock she was admitted to a single ICU bed for isolation. As clinical situation became worse, patient and family anxiety and depression increased. Doubting that heart transplant would be performed, nurses at the ICU suggested a patient-family palliative care plan.

In the beginning of December of 2014, patient’s muscles were weakened, her anorexia and cachexia were worse presenting several vomits after meals and she was still tired and with fatigue, which induced difficulty in accomplish self-care. Even waiting for a heart transplant, nurses at the ICU started palliative care, whilst patient clinical condition was not improving, as part of a symptom burden reduction and hope supporting to life-prolongation until she would be called for the expected heart transplant. The nurses biggest concern was to provide physical, psychological and spiritual comfort. Family could stay near their relative as long as needed, bring her favorite food because of diminished appetite, and also priest could come and counsel patient and family. This helped nurses understand how they could be and feel significant in this stage, instead of feeling the burden of a “defeat” against death.

Conclusion: This case allowed the ICU nurses to analyze palliative care with a different perspective of end-of-life care, helping structure the way care was centered on the patient and family.

Abstract number: PO102
Abstract type: Print Only

End of Life Care for Older People in Subacute Care

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Background: Significant challenges exist in meeting the healthcare needs of older people. Care is often provided for older people in subacute hospital settings where, despite a focus on optimising functioning, many older people will die.

Aim: To investigate end of life care provision for older people in a subacute hospital setting.

Design: A retrospective chart audit of all inpatient deaths in a 183-bed subacute hospital.

Results: Of more than 3000 admissions in one year, 54 inpatients died. Most were transferred from an acute hospital, had multiple comorbidities including cognitive impairment (42.6%), with a mean age of 83 years (SD=9). There was no evidence of advance care planning, hence admission to the subacute hospital was considered to be temporary. 53.7% were referred for specialist palliative care review. While the average wait time for review by the palliative care team was 0.6days (SD=0.8), 11.1% of patients died before review. Two key time points were identified, the first was information-related, representing the first documented evidence of patient deterioration towards death. The second time point was decision-related, representing the first documented evidence of a decision to provide end of life care. The use of unclear and ambiguous written language to communicate patient deterioration and dying may have impacted clinician understanding and delayed end of life care.

Conclusions: Pre-hospital advance care planning is sub-optimal and should be prioritised in older people. Education is needed to improve recognition of patient deterioration and dying by clinicians. How patient deterioration and dying is documented in the medical record and communicated amongst the treating team requires further attention to facilitate timely, high quality end of life care.

Abstract number: PO103
Abstract type: Print Only

Social Robots - Improving the Quality of Life of Elderly

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Background/aims: The current demographics show that the world’s population is rapidly growing older - Between 2000 and 2050, the proportion of the world’s population over 60 years will double from about 11% to 22% as birth rates will continue to drop. As people are living longer, the prevalence of noncommunicable diseases also increases which, consequently, increases the need for long term care rises, as many elderly lose the ability to live independently and look after themselves. This greater need for care poses a problem taking into account the estimated shortage of health workforce in the future.

The need to look for other solutions ties with the rapid developments in the field of technology, that has been exploring new ways to improve the quality of life of elderly patients. This includes the development of robots, namely of social robots, which are developed to interact with the human being.

The presentation will consist in a brief presentation on social robots, some results of their application and make participants familiar as they can be an important tool to improve the quality of life for patients, namely the ones suffering from neurodegenerative diseases.

Methods: Review of the literature published in PubMed, from 2013 to 2017 on the keywords “Robot assisted therapy”, “Human-Robot interactions” and “social robots”.

Results: Different types of social robots have already been developed for elderly and the clinical trials have shown positive results, not only in terms of providing support regarding mobility and memory-loss associated problems, but they are also showing an important role as human companions. Robots that follow the steps of animal assisted therapy (AAT) have shown important, similar results to AAT as they help reducing the level of aggressiveness and agitation, reduce medication on demand, promote social behavior and reduce the felling of loneliness. Social robots have also shown positive effects on care takers and nursing home staff.

Conclusions: The development of robotics, namely of the social robots, show that they may be an important help when it comes to improving patients’ quality of life and the caregivers’ tasks when caring for a frail, elderly patient with long term supportive care needs. More research still needs to be conducted in this field, however the results of the current clinical trials show promising results in terms of helping elderly people’s daily life.

Abstract number: PO104
Abstract type: Print Only

Perceived Burden for Caregivers of Patients in Geriatric Palliative Care
Background: The illness of a family member brings many changes in family structure, such that the family caregiver may face physical, emotional, social and spiritual burden in caring of elderly in oncologic palliative care.

Aims: To analyze the perception of burden of caregivers of elderly patients in oncologic palliative care.

Methods: This is a cross-sectional and exploratory study, with quantitative methodology conducted on a sample of 100 subjects stratified according to the score of the Karnofsky Performance Scale (KPS) to the elderly in oncologic palliative care:

- Group 1: 25 family caregivers of elderly subjects with a KPS score less than or equal to 40%.
- Group 2: 25 caregivers of elderly subjects with KPS scores between 70% and 50% and Control Group: 50 family caregivers of elderly with a KPS score of 80% or more.

A clinical and sociodemographic questionnaire and the following protocols were applied: Brazil Economic Classification Criteria and the Caregiver Burden Scale. Analysis were performed using descriptive statistics and group comparisons by Fisher’s exact test and a Regression Quantiles Model, the SAS 9.0 and Stata version 13 software.

Results: The family caregivers are mostly middle-aged to older women, daughters or wives, predominantly in the 56-71 age group, Catholic religion, poorly educated, belonging to low economic class, performing no remunerated activity, spending 24 hours per day in caring tasks and not receiving any kind of help. Most patients are not aided in proper palliative care services. The largest burden rates were seen in female caregivers and caregivers of seniors who have lower functional capacity scores and when they are at the proximity of death, considering that ill persons gradually lose autonomy in their daily lives. Elderly people with KPS scores below 40% require continuous care on the part of their caregivers, who have higher burden rates, particularly in the fields of Isolation, followed by General strain and Environment.

Conclusion: The aggravation of the disease, the functional decline of the elderly and the possibility of death increase the burden. Findings suggest the need of effective interventions and appropriate palliative care services to caregivers as early as possible and to the development of public policies.

Abstract number: PO105
Abstract type: Print Only

Physician Orders for Life-sustaining Treatment (POLST) Facilitation in Complex Care Management: A Pilot Study

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Background: The Physician Orders for Life Sustaining Treatment (POLST) form is an Advance Care Planning (ACP) tool widely used in the United States (US) to document the treatment preferences of seriously ill patients as medical orders. POLST forms include decisions about code status, medical interventions, artificial nutrition and antibiotics. The discussions needed for high quality POLST decision making are time intensive and often do not occur in the outpatient setting.

Methods: We conducted a single arm pilot study with pre/post assessment of outcomes to assess whether facilitated conversations improve POLST completion for community dwelling, frail older adults. Participants were community dwelling adults aged 65 and older enrolled in a complex care management (CCM) program in a US urban hospital. Surrogate decision makers were enrolled if the patient was unable to make medical decisions. CCM staff underwent Respecting Choices Last Steps training to learn a standardized, structured approach to facilitating POLST conversations. Staff met with patients in their homes to deliver the intervention. The primary outcome was completion of a POLST form that was scanned into the electronic medical record. Engagement in advance care planning was assessed post-intervention using a standardized tool. Chart review assessed orders inconsistent with POLST preferences.

Results: We enrolled 18 patients, with a mean age of 78 (SD 7.0); 12 were African American and the rest white. Three required a surrogate to make decisions. POLST facilitation was delivered to all 18; 10 completed POLST forms that were scanned into the electronic medical record (56%). At 4-6 week follow-up, there were non-significant improvements in the total score and subscales of the ACP Engagement Survey; 14 of 16 decision makers (88%) agreed or strongly agreed that “Talking about the POLST form helped me think about what I really wanted”. Chart review at 12 months found 3 patients of 10 patients had one or more orders or treatments inconsistent with POLST preferences.

Conclusions: POLST facilitation can be successfully implemented for frail older adults and their surrogates in a CCM setting, leading to a substantial increase in POLST form completion. Success of the project was facilitated by implementation in the patient’s home by a trusted clinician and by close involvement of the CCM clinicians in the planning process. Further research is needed to demonstrate the effectiveness of this approach.

Abstract number: PO106
Abstract type: Print Only

Impact of Attending Day Care for Frail Older People Living at Home with Multiple Long Term Conditions

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Background: Many older people living at home with multiple long term conditions require palliative care. In the UK, non-hospice Day care for older people is usually delivered within 3 settings - paid staff services (often funded by local authorities) volunteer run services and services with staff and volunteers (blended).

Aims: To examine impact of day care on older people’s wellbeing, independence and social isolation across the 3 settings and investigating outcomes across services.

Population: Older People aged 65 years and over, living at home, with more than one long term condition, attending day care provision.

Design and methods: New referrals at each centre were recruited into the study. Baseline data included demographic data; EQ5D3L and De Jong Giervald and follow-up at 6 weeks and 12 weeks. Statistical analysis Chi square test, t-test and one-way anova. Associations between service type and score changes during follow-up explored using univariate and multivariate modelling.

Results: 94 participants consented to take part in the study; 64% female; age range 65-99 years, (mean age 82). 53% widowed and 52% lived at home with more than one long term condition. 73% completed the follow-up at 12 weeks. Satisfaction with services was highest in the hospital setting (66%) compared with community day care (60%) and home based services (45%). Day care provision is associated with an improvement in quality of life.
Parents' Perspectives on Losing a Child due to Life-limiting Diagnoses: A Population-based Study

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Background: Approximately, 300 children die in Denmark every year. In order to support future implementation of specialized pediatric palliative care, the aim of this study was to investigate the needs, quality of life and severity of distress of parents who lost a child with life-limiting diagnoses.

Method: A register-based study identified causes of death in children 0-18 years who died in the period 2012-2014 in Denmark. Potential palliative diagnoses were identified through a “Directory” elaborated in 2015. The views expressed are those of the authors and not necessarily those of the NHS, NIHR or Department of Health.

Conclusions: Day Care provides vital support for frail older people living at home and we suggest that volunteers deliver effective support with favourable outcomes. This study revealed no difference in morbidity as measured by LTC’s and outcome in older frail people accessing paid services compared to those delivered exclusively by volunteers. Hospices may wish to explore how linking with volunteer run day care centres can increase access and improve palliative care for the increasing number of frail older people living with LTCs in the community.

Acknowledgements

Danish Child Cancer Foundation for financial support
Background: While work with adolescent in Paediatric Palliative Care we need to notice their development (psychosocial and cultural). The adolescence is characterized by social questions, where the adolescents need to belong to some group and their friends are very important. The technological growth changed the adolescent communication, nowadays, within the cyberspace, the adolescents can use the social networks and instant messaging platforms for communication with their friends, so they can keep connected constantly with, regardless of where they are or what are they doing and promote a sense of belonging to a group of friends.

Aim: The aim of this study was to explore the use and the content of the cyberspace by adolescents in palliative care with life limiting conditions and life treatment.

Methods: This is a qualitative study that used the combination of two ethnography’s methods in two different environments - the virtual and the real one. In a period of six months, ten adolescents in palliative care were observed and interviewed in an outpatient clinic. In the virtual environment, their social network profiles were observed since the begging of use. We have collected 8861 posts. All the posts with the ten interviews were decoded for the Symbolic Interactionism analysis.

Results: It was possible to identify themes that include: “Being an important space for me”; “Using the cyberspace for being a normal adolescent”; “My disease in the cyberspace” and “Expressing my feelings”.

Conclusion: The social networks are an important tool to promote care for adolescents with life limiting disease, because the social network encourage then for the communication with their friends and family, besides of being a space for the adolescents can share their experiences and learn with others. The health care professionals need to work with adolescents and families who are in Palliative Care using those tools to interact with them and promote more care and support.

Abstract number: PO110
Abstract type: Print Only

Supporting Nursing Staff to Facilitate Children Visiting Dying Relatives on Intensive/Critical Care
Marshall, Steve, Oldcroft, Nicola
King’s College Hospital NHS Trust, London, UK

Aim: Families often want to protect children from the challenging environment of intensive/critical care (ICU), and therefore restrict or deny children from visiting a dying relative. There is no evidence that visiting ICU is damaging to children and studies have shown that children report benefits of visiting a dying relative on ICU. Bedside nurses are in a unique position to encourage and facilitate such visits, but often feel unskilled when working with children. The aim of this project was to support bedside nurses on ICU to encourage and facilitate children visiting their dying relative.

Methods: Based upon the literature and professional experience, an interactive teaching session was developed. This session was delivered to newly appointed ICU nurses as part of a team day.

Results: Participants have been very engaged in the sessions and gave a positive evaluation on the day. In order to assess whether the sessions have resulted in a change in practice, all attendees are to be sent a short questionnaire six months after attending the session.

Conclusion: Initial findings suggest that ICU nurses value being able to express their concerns about children visiting ICU and welcome guidance on facilitating such visits. Whether the sessions have resulted in a change in practice is yet to be established, and future sessions will incorporate feedback from participants. This project challenges the widely held view that children should be protected from the ICU environment, which denies them the opportunity to visit a relative prior to death. The death of a family member is a life-changing experience for everyone in the family and children should not feel excluded from this significant event. This innovative project is intended to empower nurses to facilitate children visiting ICU and thus enable more children to be involved in the death of their loved one.

Abstract number: PO111
Abstract type: Print Only

The Relationship between Adolescents, in Palliative Care, and the Cyberspace: An Ethnography Model
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Background: To take care of adolescents with some life limiting and / or long threatening disease we must take some importance into the fact that in this period the adolescent will pass through two transitions - the infant stage to adulthood and the pediatric treatment for to adult. all these changes in a life of a adolescent in palliative care can affect the social and psychological development. Cyberspace has become an alternative social space, causing a great technological, social and cultural change in society, especially for adolescents, becoming a very important tool in their lives.

Aim: To know the relationship between adolescents in palliative care and the cyberspace and to propose an explanatory model for this relation.

Methods: This is a qualitative research supported in two ethnography methods (usual and the netography). Ten adolescents were submitted for a double data collection, where they were interviewed and their social network has being observed. In a total we have three hours of interviews and 8861 posts from the each adolescent on Facebook profile.

Results: The adolescent in palliative care use the cyberspace in their routine looking for support, distraction, communication and for manage their pain. When the cyberspace are used, the adolescent in palliative care can assumed two personas, one’s who there are inside the internet an adolescent that doesn’t have any problem, have a lot of friends, receive a lot of likes and comments. In an other hand, when they assume who they are in real life, they post about their disease, treatment and feelings, but always looking for something, like emotional support in a sad moment or for self-promotion.

Conclusion: Cyberspace are an important tool to promote care for adolescents with life limiting disease, because the social network encourage then for the communication with their friends and family, besides of being a space for the adolescents can share their experiences and learn with others. The health care professionals need to work with adolescents in Palliative Care using those tools to interact with them and promote more care and support.

Abstract number: PO112
Abstract type: Print Only

The Qualitative Study on the Experience and Perception of Healthcare Professionals in Pediatric Palliative Care
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Introduction: In Italy there are approximately 12000 children affected by life-limiting illnesses, which require palliative care services. The national reality, however, confirms the lack of a proper palliative care services network to ensure relief continuity. Therefore, there is an increase for need to find and develop effective methodologies and services that grant adequate assistance and continuous care to children affected by terminal and incurable diseases. Sensitizing society and empowering the health care environment about this theme could be the first step to improve the life of children and families who are subject to this situation.

Research aim: The aim of the study is to analyze healthcare professionals’ experiences involved in pediatric palliative care to identify their difficulties during the assistance.
Implementing Best Practices in Palliative Care for People with Intellectual Disabilities: Lessons Learned

de Veer, Anke J.E.1, Voss, Hille1, Francke, Anneke L.1,2,3
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2Expertise Center for Palliative Care Amsterdam, VU Medical Center, Amsterdam, Netherlands

Aim: Professionals in organizations for people with intellectual disabilities (ID) are increasingly faced with people in need of palliative care. Nevertheless, professionals in this setting often have limited knowledge and experiences regarding palliative care. Therefore it is important that best practices in ‘regular’ palliative care are translated to and implemented in settings for people with ID. What lessons can be learned when it comes to implementing best practices within organizations caring for people with ID?

Methods: Nine organizations implemented a best practice. A qualitative process evaluation was performed in each organization and consisted of an analysis of

(a) the implementation plan,
(b) the written report of the implementation trajectory one year after the start,
(c) a semi-structured interview with the project leader and
(d) a group interview with care staff. A data extraction form was used to analyze the data.

Results: Three different best practices were implemented: support by a specialist palliative care consultant (n=4 organizations); use of signal box to identify palliative care needs (n=3 organizations), and STEM-inspirational cycle to tailor professionals’ communications about end-of-life issues with patients’ and relatives communication preferences and abilities (n=2). The duration of the implementation process was underestimated. Facilitating and impeding factors influencing this process were identified at the level of

(c) the professionals,
(d) the organization,
(e) the context.

Best practices developed for other patient groups required small adjustments to the specific target groups of people with ID.

Conclusion: Professionals in the care for people with ID can learn from best practices in other health care settings. The implementation and continuation require a clear vision on palliative care as well as strong support from the management.

Funding
ZonMw

Abstract number: PO113
Abstract type: Print Only

Implementing Best Practices in Palliative Care for People with Intellectual Disabilities: Lessons Learned

de Veer, Anke J.E.1, Voss, Hille1, Francke, Anneke L.1,2,3
1Netherlands Institute of Health Services Research (NIVEL), Utrecht, Netherlands, 2Amsterdam Public Health Research Institute (APH), VU Medical Center, Amsterdam, Netherlands, 3Expertise Center for Palliative Care Amsterdam, VU Medical Center, Amsterdam, Netherlands

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Funding
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Abstract number: PO114
Abstract type: Print Only

South Asians’ Perceptions and Experiences of Compassion in the Healthcare System: A Grounded Theory Study

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Background: Compassion plays a major role in providing quality health care to the patients, especially in the context of patient suffering. However, a vast majority of studies on compassion in healthcare have been conducted in Western settings, thus significantly limiting the generalizability of their findings. There is a lack of understanding of ethnic patients’ perspectives and experiences of compassion while receiving healthcare. A recent scoping review on compassion in healthcare also recommended the need for conducting cross-cultural studies on the topic in order to determine if compassion varies across cultures.

Objective: This study explored how South Asians perceive and experience compassion in the healthcare system.

Methods: Twenty South Asian participants with recent interactions with acute care were recruited in Calgary, Alberta, Canada using snowball sampling techniques. In-depth semi-structured interviews were conducted, which were translated and transcribed, and analyzed using Straussian grounded theory.

Results: South Asians’ understandings of compassion; cultural and ethnic influencers of compassion; and patient recommendations for overcoming barriers to compassion emerged from the data. The results of this study can inform the provision of culturally sensitive compassionate care by palliative care providers to South Asian patients.

Conclusions: This study uncovered the perceptions, experiences and cultural nuances of South Asians in receiving compassionate care. Data from this study will be used to develop a more culturally relevant model of compassion that could improve care and alleviate patient suffering among South Asians, along with laying a basis for future research and improving healthcare outcomes.

Abstract number: PO115
Abstract type: Print Only

"There’s an App for That": Development of the CoMPACT App - A Customisable Multi-lingual Patient Communication Tool

Bhattarai, Priyanka1,2,3, Aggarwal, Ghauri1,4, Fang, Asta1, Guthrie, Christiana1, Horrex, Diana1, Kaura, Paul1, McCaffrey, Nikki1, McDonnell, Cathy1, Mittal, Dip1, Urban, Kat1, Lee, Jessica1,4
1Concord Centre for Palliative Care, Sydney Local Health District, Concord, Australia, 2University of Notre Dame Australia, Perth, Australia, 3InPACCT, University of Technology Sydney (UTS), Sydney, Australia

Objective: The aim of this study was to develop an application for use by patients, carers, healthcare providers and professionals who wish to communicate with patients during advance care planning.

Methods: A web-based application was developed to prompt communication during advance care planning discussions using innovative featurestailored to suit cultural and linguistic needs of patients. The application was designed to prompt decision-making discussions and encourage open communication among those involved in decision-making.

Results: The application was designed to be used in moments of decision-making during advance care planning discussions in a culturally and linguistically appropriate manner. The application was designed to be culturally and linguistically appropriate and to encourage open communication among those involved in decision-making.

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Funding
ZonMw

Abstract number: PO116
Abstract type: Print Only

"There’s an App for That": Development of the CoMPACT App - A Customisable Multi-lingual Patient Communication Tool

Bhattarai, Priyanka1,2,3, Aggarwal, Ghauri1,4, Fang, Asta1, Guthrie, Christiana1, Horrex, Diana1, Kaura, Paul1, McCaffrey, Nikki1, McDonnell, Cathy1, Mittal, Dip1, Urban, Kat1, Lee, Jessica1,4
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Funding
ZonMw
Aim: The aim was to use routinely available national data to examine place of death by ethnic group and specifically to test whether the proportion of people from BAME groups dying from cancer was lower in hospices.

Methods: A national data set for England was used which linked Office for National Statistics mortality data to National Hospital Episodes (HES) data (ONS-HES). Ethnicity was identified from HES. Place of death was classified as: hospital, home, care home (residential and nursing) and hospice. For all causes of death the data was examined by age < 65 and > 65 years at death. For cancer diagnosis the effect of gender was examined.

Findings: For all causes of death aged < 65 years, 56.3% of White British died in hospital (lowest) compared with 80.8% (highest) Pakistani, 65.7% Caribbean and 76.6% of African origin. For all causes of death in people aged > 65 years 17.2% of British White (highest) and 1.5% (lowest) people of Pakistani origin died in a care home. There was a large difference between the % of White British males (19%) and females (14%) who died at home but none for people of Pakistani origin. Among people who died from cancer: 18, 11, 20 and 22% people of White British, Pakistani, African, and Chinese origin died in a hospice respectively.

Discussion: Many factors related to ethnicity may influence the likelihood of patients dying in different locations: family structure, knowledge of health service, health literacy, religious and cultural beliefs. Higher proportions of people with cancer from African and Chinese groups die in a hospice but lower proportion of those from Pakistani origin than people from White British backgrounds. The health service and voluntary sector need to understand how best to meet the end of life care needs of people and their families from all ethnic groups in society.

Abstract number: PO117
Abstract type: Print Only

Providing End-of-Life Care to the Trans* Population: A Case Study
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Aim: The trans* population is one of the most marginalised groups in UK society. There is evidence that the trans* population are reluctant to access health services due to fears of discrimination, including accessing palliative care. As a result, they often have worse outcomes in end-of-life care compared to other cohorts. The aim of this abstract is to present a case, in order to illustrate some of the issues and challenges involved in providing end-of-life care to the trans* population.

Methods: The lack of visibility and ‘hard to reach’ nature of this cohort of patients makes a case study methodology appropriate.

Results: John was a 38-year-old man referred to community palliative care. His oncology notes revealed a diagnosis of metastatic ovarian cancer. At assessment John appeared cachectic and had large abdominal ascites. He reported pain, low appetite, weight loss and fatigue as his major issues. John was guarded around his social history and gender was not discussed. John had several subsequent interactions with the palliative care team, although these were all out-patient or complementary therapy. John’s mother unexpectedly called the team and requested an urgent home visit. Without John present, she explained that he had been physically deteriorating over several weeks, but had refused any help with personal care, as he did not like having to explain that he had female genitalia. She suspected that John was incontinent and asked for assistance with personal care. On examination John was barely rousable. John was given reassurance that he would be cared for by a nurse, who needed to check if he had soiled himself, in case his skin was sore. John nodded his permission to check his underwear for incontinence. Personal care was provided, a pad was applied and he was repositioned comfortably. John died a few hours later.
Conclusion: This case study can be used to inform the practice of professionals working with the trans* population at the end of life. Key issues that have arisen are:

- the need to develop a trusting and therapeutic relationship;
- the need for continuity in staff, particularly when providing personal care;
- the need to be proactive with this cohort;
- the need for training around appropriate communication skills with the trans* population.

Abstract number: PO118
Abstract type: Print Only

Reflection on an Annual Remembrance Service Provided by a Specialist Palliative Care Team in Rural Ireland
Freiherr von Hornstein, Wilhelm, Dolan, Edel, Wilson, Maureen, Burke, Marina, Mohan, Elaine, Coogan, Liz
Specialist Palliative Care Service Cavan & Monaghan, Health Service Executive Dublin North East, Cavan, Ireland

Background: This Specialist Palliative Care Service established in 2003, covers two rural counties in Ireland, population of approximately 125,000 people, aims for holistic and comprehensive palliative care including bereavement follow-up. However due to limited human and financial resources a sufficient level of bereavement support could not be achieved. In response to this unmet need the idea to offer a remembrance service arose. The first service was held in 2010 for families and friends of 149 patients who had died in the previous year. To date the number has continued to steadily grow to 340 patients in 2017.

It is an annual nondenominational service held on an evening in October in a centrally placed church at the border of the two counties. It is led by the team manager and contains singing, prayers, readings and dancing, focused around a central ceremony of lighting of candles and the reading out of the names of all whom we remember. After the service everyone is invited to the parish hall for refreshments. This provides an opportunity for families to meet with staff and other grieving families.

Aims: The aims of this study were to assess the challenges arising in organizing the remembrance service. To analyse the impact on bereaved family members attending the service.

Methods: Analysis used: feedback from staff, feedback received from attending family members.

Results: The staff feel the preparation of the service as a heavy workload burden in addition to their busy daily professional activity. However afterwards the staff are relieved and very satisfied by the many moving testimonies and encounters of the evening. Bereaved family members can often feel deserted in the period after intensive contact with the Specialist Palliative Care Team due to the lack of bereavement follow-up. However the reading out of the names and the acknowledgement of the deceased loved ones provided great comfort. Those who attended the remembrance service felt it was a positive and supportive experience but, it was also very difficult to see team members again.

Conclusions: Overall the remembrance service brings beauty to the need to be with the child and the need to take care of the child were identified as the main needs of the bereaved parents.

The preservation of one’s identity of parent and the influence of the surroundings. The need to be with the child and the need to take care of the child were identified as the main needs of the bereaved parents. The influence of the surroundings is characterised by the support provided by the health professionals taking care of the child and the family. Issues identified by the parents included, among others, the issue of doctor-parent communication, the lack of psychological support, and the importance of support provided to parents after the child’s death.

The results of the study indicate the need for a complex approach to the family and the need of paediatric palliative care.

Funding
This research did not receive any external funding.

Abstract number: PO120
Abstract type: Print Only

Novel Approaches for Economic Evaluations in Palliative Care: Considering Family Caregivers
Gardiner, Clare1, Ingleton, Christine1, Ryan, Tony1, Ward, Sue1, Gott, Merryn2

1Nursing and Midwifery, The University of Sheffield, Sheffield, United Kingdom, 2The University of Sheffield, Sheffield, United Kingdom

Background: Economic research in palliative care is limited and little is known about the range and extent of the costs that are involved in palliative care provision. In particular, there is a lack of evidence around the costs of family caregiving.

Aim: To explore current approaches to economic evaluations in palliative care, and to present a framework for considering these costs that incorporates the viewpoint of family caregivers.

Methods: A systematic review of empirical literature. The databases CINAHL, Cochrane, PsycINFO and Medline were searched from 1995 to November 2015 for empirical studies which presented data on the financial costs associated with palliative care. Study quality was evaluated using the Weight of Evidence Framework and thematic synthesis was used to combine the data.

Results: A total of 38 papers met our inclusion criteria. Components of palliative care costs were incurred within four broad domains: hospital care, community or home-based care, hospice care and informal care provided...
through family carers. These costs could be considered from the economic viewpoint of three providers: state or government, insurers/third-party/not-for-profit organisations and patient and family and/or society. **Conclusion:** Our review presents a framework which identifies the core cost components that are relevant for economic evaluations in palliative care, including the cost to family caregivers. We suggest that methods for economic analysis should reflect the cost to family caregivers given the magnitude of their financial contribution. Further research is required to gain insight into the inter-relationships between different cost domains and different provider viewpoints and could build on the cost framework proposed here.

**Abstract number:** PO121  
**Abstract type:** Print Only

**Measurement Properties of the Texas Revised Inventory of Grief in a Sample of Bereaved Family Caregivers**  
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1Sophiahemmet University, Stockholm, Sweden, 2Ersta Sköndal Bräcke University College, Stockholm, Sweden, 3Capio Palliative Care, Dalen Hospital, Stockholm, Sweden, 4Lund University and Region Skåne, Lund, Sweden, 5, 6Sahlgrenska Academy, Gothenburg, Sweden, 7Linnaeus University, Kalmar, Sweden, 8Kalmar County Hospital, Kalmar, Sweden

**Background:** The Texas Revised Inventory of Grief (TRIG) is a well-used instrument designed to measure the intensity of post-loss grief. It consists of two subscales; Past Behaviours involves thinking back to the time just after a loved one’s death and Present Feelings focuses on the current situation. The two subscales consist of 8 and 13 items respectively and lower scores indicate more intense grief. Because family caregivers in palliative care may be in need of support during bereavement, the TRIG could be an important instrument to measure their grief reactions. Hence it needs to be validated for further use in palliative care.  

**Aim:** The aim was to evaluate measurement properties of the TRIG in a sample of bereaved Swedish family caregivers.  

**Methods:** In this psychometric study, the TRIG was translated to Swedish according to standard principles. Data were collected from 129 bereaved family caregivers whose loved ones had been enrolled in palliative care units. The family caregivers completed the TRIG and demographic questions six months after the death of the patient. Separate exploratory factor analyses for ordinal responses were used to evaluate the factor structure (i.e. construct validity) for each subscale. Ordinal alpha (α) was used to estimate internal consistency.  

**Results:** The exploratory factor analyses showed that both the Past Behaviours and Present Feelings measure one underlying construct, supporting construct validity. Internal consistency was satisfactory for both scales, α=0.92 and α=0.95 respectively.  

**Conclusions:** The results show that the two subscales of the TRIG Past Behaviours and Present Feelings are unidimensional, i.e., measuring one underlying construct. Hence, the two subscales could be used in palliative care after the patient’s death in order to capture both the past and current levels of grief in family caregivers. However, it is also necessary to continue validating the TRIG in a larger sample.  

**Funding**  
This study was supported by the Swedish cancer society.

**Abstract number:** PO122  
**Abstract type:** Print Only

**Assessment of Caregiver Needs - A Training for the Use of the German Carer Support Needs Assessment Tool (KOMMA Approach)**  
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The Carer Support Needs Assessment Tool (CSNAT) is an evidence-based, comprehensive tool to identify carer support needs in palliative home care. For use in practice, it is integrated into a person-centred approach to assessment and support (the CSNAT Approach). As this represents a change from usual practice, training of staff is crucial. In a larger project to implement the validated German version of the CSNAT (KOMMA - Kommunikation mit Angehörigen) in four palliative home care services a suitable training was required. The aim was the development and evaluation of training for use of a carer needs’ assessment (KOMMA Approach).  

Based on the UK-training and the results of the validation of the German version of CSNAT (KOMMA) a training program was developed, including translation and adaption of the CSNAT training package, train-the-trainer workshop, and staff training. A focus group discussion with the champions (= staff with multiplier role) (n=6) and a written questionnaire with palliative home care staff (n=17) were used for evaluation.  

Two champions in each service attended the train-the-trainer workshop conducted by one of the researchers, using the training package. Champions subsequently trained staff in their service applying a 3 step method:  

1. Initial training (3 hours),  
2. field phase for practical use of the CSNAT Approach with at least 3 carers,  
3. follow up module (1,5 hour).

The train-the-trainer workshop was rated as well developed and conducted. The training package was perceived as comprehensive and useful. The champions appraised themselves as well prepared for carrying out their staff-training. Staff members rated the training as very good to good: the 3-step method was perceived as especially useful. Time constraints led to limited practical use in the field phase ahead of the follow up. Communication training for the assessment-conversation stage of the KOMMA Approach was requested.  

The innovative training method seems to be effective in preparing practitioners in Germany for use of the KOMMA Approach in palliative home care. Time between initial and follow up training should be extended, so that practitioners have the chance to use the KOMMA Approach with at least 3 carers. Cost effectiveness of training in comparison with the UK will be of interest in future research and practice.

**Abstract number:** PO123  
**Abstract type:** Print Only

**Family Carers’ Behaviour in the Initiation of Palliative Care: A Qualitative Study Using Face to Face Interviews**  
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**Background:** Although palliative care leads to improved quality of life it is often initiated late, insufficiently or not initiated at all. Family carers can play an important role in initiating palliative care. However, little is known about family carers’ behavior and related determinants that can contribute to the (timely) initiation of palliative care.  

**Aim:** To identify and understand behaviors performed by family carers regarding the initiation of palliative care, by
1) exploring family carers’ experiences of the initiation of palliative care
2) identifying behaviors contributing to the initiation of palliative care
3) identifying determinants of these behaviors.

Methods: We conducted a qualitative study, using semi-structured face to face interviews. We individually interviewed family carers (N= 15) who provided care support in the last 18 months before the interview. All family members already died at the time of the interview. Two researchers independently coded the transcribed interviews and discussed about the codes and the code tree in case of disagreement until consensus was reached. We used an inductive approach by fitting identified behaviors and their determinants into existing individual behavior theories (eg the determinants ‘attitude’, ‘subjective norm’ and ‘perceived behavioral control’ defined by the Theory of Planned Behavior).

Results: A too late initiation of palliative care was a recurring experience of family carers. A number of behaviors of the family carers were reported as having influenced the initiation of palliative care: having an open conversation with the family member about their care needs and wishes, having a conversation with professional carers, gaining information about palliative care, and consulting people working in palliative care. Determinants such as attitude (eg associating palliative care with more qualitative days), risk assessment (eg making an adequate estimate of the approaching death), knowledge (eg knowing the palliative care options) and skills (eg communication skills and coping skills) and social influence (eg attitudes of professional carers) were experienced as having influenced the behaviors.

Conclusion: Family carers identified a number of performed behaviors contributing to the initiation of palliative care. Behavioral interventions, which focus on the most important and modifiable determinants, could encourage carers to perform these behaviors more and more timely.

Abstract number: PO124
Abstract type: Print Only
Support Groups for Family Caregivers
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Family caregivers of terminally ill patients need support in order to master the role as relatives. The Palliative Care Team in Aarhus plan to offer family caregivers participation in a support group program, as a supplement to present individual support. However, whether the family caregivers’ need for support may be accommodated in a group, has never been described in a specialised palliative care setting in Denmark.

The aim was to gain insight into how family caregivers of terminally ill patients experience the support received by the palliative care team. What kind of support needs do they have and can some of the requested needs be met by participating in a support group program?

A qualitative study with a phenomenological - hermeneutic approach based on five semi-structured individual interviews with relatives. Data was analysed using a Recour inspired analytical method.

The family caregivers all expressed a high satisfaction with the support they got.

In the analysis of what kind of support they had, four themes emerged:

1. Need for support to be prepared, including gaining knowledge about the disease, symptom relief and to be at the forefront.
2. Need for support to handle changing of everyday life and roles, and the feeling of being alone.
3. Need to have available, close and continuous relationship with health professionals including availability to get specific advice and guidance as well as being greeted and recognized in relation to their own needs.

4. Need to relate to other family caregivers in the same situation, including being able to reflect on other’s experiences and share thoughts. The relatives pointed out that structure of the potential support group and the circumstances of life of the participants would have great importance in order to relate to others in the group.

Family caregivers experience a great extent of support by the present individual support, if the support is based on a relationship of empathy and professionalism. However, an additional support group program can fulfill some specific support needs, particularly the need to meet other caregivers in the same situation.

Abstract number: PO125
Abstract type: Print Only
Families Taking Care of Patients with Advanced Illness at Home: A Qualitative Study Finds Overlooked Caregiving Burden and Group of Carers
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Background/aims: Family carers (FCs) are one of the pillars of home palliative care (HPC), tackling multiple roles (practical, emotional, social, and financial). However, there is limited evidence of FCs’ experience of caregiving at home to inform caregiver support services. We aimed to understand the experiences of FCs when palliative care takes place at home, where the role of the carer, the relationship with the team and the overall process of care in the home setting are considered comprehensively.

Methods: Secondary analysis of qualitative data (responses to open-ended questions, spontaneously occurring comments, and interviewers’ field notes) collected during a cross-sectional, face-to-face survey on preferences for HPC. We used maximum variation, purposive sampling to select adult FCs from 4 home HPC services in Portugal (Apr’15-Sept’16). Interviews were recorded and transcribed verbatim. We used thematic analysis by Braun & Clark (2006) to analyse the qualitative data.

Results: The study included 37 carers (32 women; median age 56, range 32–81). They had been caring for the patient for a median of 1 year (range 2 weeks–5 years), currently for a median of 16 hours/day (range 2-24). Their relationship to the patients (23 with cancer, 14 with neurological conditions) differed: 15 were spouses, 18 were adult children, and the rest were a sibling, a parent, a grandchild and a daughter-in-law. Three themes emerged from the analysis: (1) being a carer in home setting, (2) interacting with the HPC team, (3) structural burden of caregiving. FCs are often isolated in their own home, which affects their well-being. They want better support, especially psycho-social. Those caring for more than one patient simultaneously or sequentially (multiple carers) may especially be at risk. HPC team brings sense of security and orientation but this is not sufficient for successfully meeting the needs that develop over the time. Consequently FCs look for additional support for patients and themselves within the family and other healthcare and social care services. Complex interactions needed to activate, negotiate and manage all of the involved services/institutions result in structural burden of...
caregiving. Deprived FCs may especially be at risk for hardship due to this burden.

**Conclusions:** When planning caregiver support services the FCs’ needs should be considered within a wider context of healthcare and social care system.

**Funding**
Calouste Gulbenkian Foundation

**Abstract number:** PO126
**Abstract type:** Print Only

Moving from Distressed to De-stressed: Piloting a Problem-solving Intervention for Family Carers in Palliative Oncology

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**Background and aims:** Family carers of cancer patients face numerous stressors, often leading to poor psychosocial outcomes. In this pilot study, we tested a structured problem-solving intervention to determine its effect on the anxiety, depression, and quality of life experienced by carers of cancer patients receiving palliative care.

**Methods:** We conducted a randomized clinical trial of a problem-solving intervention delivered to family carers of cancer patients receiving outpatient palliative care from an academic health center in the Midwestern United States. Participants (N = 83) were randomly assigned to receive usual care or usual care plus the problem-solving intervention, which was delivered over three sessions via web-based videoconferencing or telephone.

**Data analysis:** Data were analyzed using ordinary least squares multiple regression. We estimated beta coefficients and confidence intervals with a bootstrapping procedure whereby each estimate was generated based on 1,000 resamples. We used the regressor variable method to isolate the effect of the intervention on participants’ change scores. Other covariates (e.g., carer’s age, gender, clinic attendance, and number of days enrolled in the study) were included in each model to further delineate the unique impact of the intervention.

**Results:** Carers who received the problem-solving intervention had statistically significantly less anxiety than those receiving only usual care (p = .027) when measured 30 days after the conclusion of the intervention. No statistically significant differences were noted for depression (p = .071) or quality of life (p = .058).

**Discussion:** Problem-solving training is a promising approach to reducing carer anxiety. Further testing in multiple, diverse sites is needed.

**Funding**
The National Cancer Institute (R21CA191165) funded this research.

**Abstract number:** PO127
**Abstract type:** Print Only

A Map through the Forest

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Palliative Care philosophy recognizes the value of the family carer and the increasing demands and pressures placed on family as they care for their family member. Family carers play a crucial role in the journey of their loved ones illness. The only certain thing they know is that it an unknown journey. They know their loved one will not recover, but how long will the journey take and how will the journey end? Although education takes place informally through the day to day contact between health professionals and family carers, the education team at a hospice identified a need for the hospice to provide a targeted support for caregivers to help them negotiate the many twists and turns that happen on the path through the forest of wellness.

To determine the form the support should take, the education team surveyed the family carers of all people on the hospice programme to ask what they would find useful to make their situation easier to navigate. The most significant response to the survey was the question “What changes can we expect at the end of life and how to manage this?” From the survey responses a course was developed. There were three key objectives which aimed to:

* Create a warm supportive group environment to family members who are caring for their loved ones at home.
* Provide a space where families can meet other families in a similar situation and perhaps offer each other peer support.
* Share knowledge and resources, to build confidence and courage to empower carers to cope with the challenges of caring for a sick person in the home.

To explore the outcomes of the family carers course, a written evaluation was sent out to all participants and a selection of video recorded interactions were analysed. “Their” trail gave valuable insight into the light and dark of “their” forest. It clearly showed the viewpoint of the family carer which can be very different from the viewpoint a health professional may expect.

The family carers became the teachers of the health professional and validated the power of listening to family in order to plan authentic care. In turn the family carers received immense support from each other which gave them the confidence and courage they needed to sustain the journey; a map through the forest.

**Abstract number:** PO128
**Abstract type:** Print Only

Mapping Financial Support for Caregivers of Those with Life Limiting Illness across Six Countries

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**Background:** Informal caregivers of patients at the end of life can face significant financial burden. Some form of caregiver financial support is advised in most countries with developed healthcare systems, and appropriate support can reduce the financial burden for informal caregivers and improve health and wellbeing. However, little is known about the range and scope of financial support for informal caregivers across countries with similar healthcare systems.

**Aim:** To identify and compare sources of financial support for informal caregivers of those at the end of life across six countries with similar healthcare systems.

**Methods:** The mapping exercise was undertaken in two phases. Phase one involved grey literature searches and searches of academic databases to identify sources of financial support in the UK, New Zealand, Australia, USA, Norway and Canada. Phase two comprised an expert consultation involving key experts from each of the six countries, who were invited to complete inventories of financial support for their country.

**Results:** Some form of financial support for caregivers was available in all six countries and included national strategies and policies, support aimed at the carer, and support aimed at the patient which benefitted the carer. The type, extent and reach of financial support varied across the six
countries with funding administered by multiple agencies including healthcare providers, government and charities. **Conclusion:** Financial remuneration for caregiving is considered to be one of the most important sources of support for informal carers. This study identified that sources of financial support are available but may be inconsistent in implementation. Financial support may not be sufficient to forestall significant financial burden for caregivers. The possibility for policy-makers to learn from other countries’ experiences is significant.

**Abstract number:** PO129  
**Abstract type:** Print Only  

**Identifying a Complex Bereavement Process by Palliative Care Professionals**  
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**Background /aims:** In a palliative care holistic approach bereavement support represents an important and indispensable part. People in the process of bereavement are in need of different types of support. Only small part of people requires specialized interventions during their bereavement period. In our country there is a lack of knowledge how to predict “complex bereavement process and for that reason such support is often overlooked. At the moment, we don’t have any official national bereavement strategies. Most people are supported in their grief by family, friends and community, only some of them might look for more advanced support. The aim of the study was to conduct an overview about the current situation in the field of complex bereavement process identification and available specialist bereavement interventions.

**Material and methods:** A non-experimental quantitative study design was employed. Data were collected with a structured questionnaire in October 2017. We included 138 experts who are involved in palliative care from different parts of our country: 24.6% physicians, 42.8% registered nurses, 8.7% nurse assistant, 7.3% social workers, 2.2% psychologists and others 14.4%. Data obtained were analysed with the Excel.

**Results:** The majority of respondents’ opinions are that the bereavement is unrecognized 80%, only 5% believe that it is properly identified, others 15% don’t know. Half of them 52.2% provide bereavement support. If they refer the bereaved person to another professional they are most common psychologists. They provide support to the family and relatives in 37% at the time of the patient’s death, some also in a period of 1 month 9.7%. Early bereavement support (before death) provides 15.6%. None of our respondents is familiar with a diagnostic tool for recognizing a complex bereavement process. None of them use any of the international guidelines or recommendations. Only 9.4% were educated in this field.

**Conclusions:** According to our analysis in our region there is no diagnostic tool in active use for complex bereavement process identification. Therefore we need to adopt a proper tool, educate the professionals in its use and implement basic recommendations on structured patients and caregivers support according to their need.

**Abstract number:** PO130  
**Abstract type:** Print Only  

**Volunteers Working for a Charity in Hospice and Palliative Care in a German University City.**

**Analysis of Changes in Role and Motivation over 25 Years**  
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**Background:** In 1991 in a German university city a charity was founded to promote hospice and palliative care. The charity started to train and coordinate volunteers to ensure high-quality experience for users of hospice and palliative care.

**Aims:** The aim of this study was to assess the changes over 25 years of the role, motivation and the challenges facing volunteers and their employing body in providing compassionate companionship in hospice and palliative care.

**Methods:** Analysis used: demographic data, socio-cultural background, motivation, roles, tasks, training, location of activity, time of service.

**Results:** Initially the volunteers were asked to participate. It was important to be part of a well established organisation and to belong to a group. They remained with the organisation for many years. There was a high sense of duty and an altruistic basic motivation. There was a great willingness to accept a hierarchical structure of governance. Transparency was not important. The volunteers came from a high socio-cultural background.

The volunteers are now looking for more specific projects. The timely engagement is much more limited and less flexible due to full diaries. Motivations have a broad spectrum from altruistic to gaining personal experience and growth. The institution has to be much more transparent and participation should be allowed. The socio-cultural background has become much broader.

**Conclusions:** Volunteers have generously supported vulnerable patients and families and advocated for a better care over the last 25 years. They have been filling changing gaps. As a result hospice and palliative care has been more and more institutionalised. The volunteers find themselves now confronted with an increasing number of competing services. It is a particular challenge to keep the ageing first generation of volunteers and to use their wisdom and mix it with the ideas of the younger generations.
**Results:** The importance of volunteers in hospice and palliative care varies between the three levels of investigation. As there is a lack of volunteer involvement on the macro level of healthcare structures and concepts, volunteers’ roles on the meso and micro level vary a lot and highly depend on the involvement of individuals and organisations. A certain degree of organisational involvement and tokens of gratitude are common for volunteers, who provide a wide range of activities (social events, infrastructural support, non-medical caring tasks).

**Conclusion:** Volunteers play an important role in hospice and palliative care in Japan especially in hospital-based hospices. Involving volunteers on the level of healthcare concepts and structures and on the level of facilities and organisations could expand volunteers’ tasks in care and thereby improve patients and caregivers quality of life.

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**Abstract number:** PO132  
**Abstract type:** Print Only

**Complementary Therapy in an Acute Hospital: Training Volunteers to Provide Hand Massages to Palliative Care Patients**

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**Aim:** Complementary therapies are well-established within hospices, supplementing the holistic care provided to patients with life-limiting conditions. However complementary therapies are rarely available to palliative care patients in the fast-paced acute setting. The aim of this project was to introduce light touch hand massages into the support provided by the hospital palliative care team.

**Methods:** With input from leading therapists experienced in providing complementary therapies in both hospices and hospital settings, a project training volunteers to provide light touch hand massages to palliative care patients in an acute hospital was developed. Existing hospital volunteers were invited to participate, and were offered training and on-going support to deliver hand massages to in-patients known to palliative care.

**Results:** Between February and October 2017, 11 volunteers were trained and 43 patients received a total of 99 hand massages. Participants are asked to complete a short feedback form before and after each session, and the project has been well-received and evaluated positively by patients. The main benefits have been identified as relaxation and a reduction in anxiety.

**Conclusion:** Initial findings suggest that it is possible to introduce light touch hand massages into the services offered by a hospital palliative care team. It is hoped that the project will be developed further and embedded into services provided by the team. Other specialisms within the hospital have requested that the service be provided to their in-patients and senior members of hospital staff have also commended the innovative project. Palliative care teams within other acute hospitals should be aware of the success of this project and are encouraged to consider introducing similar types of complementary therapies into their own services.

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**Abstract number:** PO133  
**Abstract type:** Print Only

**Appropriate Care at the End of Life … In Informal Caregivers’ Perspective**

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In 2016 the Belgian health care Knowledge Centre (KCE) commissioned a study on opinions about (in)appropriate care at the end of life in the Belgian community aiming to support the societal debate and provide guidance to policy makers. An online survey, available in Dutch (D) and French (F) and administered in Belgian patients, their relatives, health care professionals, spiritual counselors from different moral and volunteering persons, revealed (among many other items) that the support for informal caregivers should be part of appropriate end of life care. We performed a qualitative follow-up study, consisting of online focus groups, conventional focus groups and in-depth interviews with different stakeholders performing data-driven qualitative analyses. In total 143 persons participated.

First, informal caregivers lack psychological support: caring for a loved one in this phase of life is not easy. Second, they also lack practical support: one’s personal housekeeping often gets neglected. Furthermore, informal caregivers often are poorly involved in the care pathway, leaving them insufficiently informed about the illness and treatment possibilities. Also, the allowance associated with care leave is described as not sufficient to live by some informal caregivers, whereas others complain about the complex administrative procedures to obtain the allowance. Finally, respondents state that there is insufficient respite support, as well as societal support - one easily gets isolated when one turns off a couple of invitations in a row.

In current society, irrespective of the existing emotional burden, progressively more tasks are directed towards informal caregivers. At the same time, most informal caregivers are not aware in advance of the weight and duration of the role they engaged in. The needs of informal caregivers, identified in this study, could add to a better developed, supportive approach for informal caregivers, affecting their well-being and, in turn, the appropriateness of care towards patients.

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**Abstract number:** PO134  
**Abstract type:** Print Only

**Steroids Alleviated Chemotherapy-induced Peripheral Neuropathy with CRPS-like Symptoms: A Case Report**

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**Introduction:** Chemotherapy-induced peripheral neuropathy (CIPN) is a well-known neuropathy that may occur following chemotherapy. However, there are currently no case reports on the onset of complex regional pain syndrome (CRPS) after chemotherapy. We herein present a case accompanied by CRPS-like symptoms, which were alleviated by the administration of steroids.

**Case:** A 70-year-old male was diagnosed with advanced lung adenocarcinoma. After four courses of carboplatin and nanoparticle albumin-bound paclitaxel, he developed difficulties walking due to intractable pain in both feet. He was referred to our Palliative Care Department. He exhibited CRPS-like symptoms, including abnormal perception, edema, perspiration, and changes in skin color. Following a diagnosis of CRPS, 4 mg of betamethasone was administered. Edema and pain markedly improved several days later and he was able to walk with a stick. Therefore, the dose of betamethasone was gradually tapered to 0.5 mg over two months, and symptoms did not deteriorate.

**Discussion:** In the present case, we observed sympathetically elicited symptoms such as edema, sweating, and changes in skin color as well as pain; therefore, we administered steroids, as recommended for the early stage of CRPS. It currently remains unclear whether this case had CRPS, as reported after trauma without this treatment. The present case may have had a different condition in which similar symptoms to progressive CRPS after trauma developed following chemotherapy. Regardless of the condition, this case indicates that the administration of steroids is effective for CIPN accompanied by symptoms due to edema or altered sympathetic tone after chemotherapy. Therefore, in future consultations on
CIPN, we need to consider symptoms associated with CRPS, and the possibility that steroids are useful for such symptoms.

**Conclusions:** Steroids were effective in the present case of CRPS-like symptoms due to chemotherapy.

**Abstract number:** PO135  
**Abstract type:** Print Only

**Evaluation of the Primary Check List for Switching of Methadone from Other Opioids among Patients with Refractory Cancer Pain**

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**Background:** Oral administration of methadone is approved for patients with cancer pain. However, methadone exhibits complex pharmacokinetics, with inter-individual differences, numerous drug interactions and rare but serious adverse effects, such as QT prolongation and respiratory depression. Because we must consider these factors when switching to methadone from other opioids, a primary check list may be useful.

**Aims:** To evaluate the utility of our newly-established primary checklist for the initiation of methadone administration.

**Methods:** As of July 2017, the list is comprised of 5 elements: 1. Indication for cancer pain: refractory cancer pain uncontrolled by other opioids, oral morphine equivalent daily dose >60 mg, probable difficulties in the relief of pain even if other opioids are increased, renal impairment or side effects of other opioids. 2. Matters related to the state of the patient: no poor prognosis, possibility of oral intake without severe nausea and vomiting, no severe diseases (ischemic heart diseases, respiratory depression, etc.), risk of drug nonadherence. 3. Prescription of multiple interacting drugs: causing QT prolongation, CYP3A4 or CYP2B6 inhibition, electrolyte abnormality, respiratory depression. 4. Required clinical examinations: ECG (QTe), blood electrolytes (K, Ca, Mg, etc.). 5. Team consent: patient consent, family’s wishes, interprofessional agreement. In the proper use seminar for methadone at 2 different venues, we presented this list to the medical personnel and administered the questionnaire.

**Results:** Among the attendees, responses were obtained from 33 persons (5 doctors, 17 nurses, 7 pharmacists). With respect to whether or not the primary checklist can be useful for the initiation of methadone administration, 29 persons (88%) responded yes with some comments.

**Conclusion:** Though more studies are necessary based upon the opinions of the medical personnel.

**Abstract number:** PO136  
**Abstract type:** Print Only

**Development of Telementoring to Enhance Assessment and Management of Pain in Advanced Dementia (TEAM Pain AD) teleECHO© Clinics for Healthcare Professionals in Primary, Secondary, Nursing Home and Hospice Settings**

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**Background:** Pain assessment and management in advanced and terminal stages of dementia are widely recognized to be challenging; extensive cognitive decline often precludes the possibility of reliable patient self-report, increasing risk of under-assessment and under-treatment of pain. Qualitative interviews with physicians, nurses, and healthcare assistants from primary, secondary, nursing home and hospice care settings advocated needs-driven education and training in symptom management and end of life care in dementia, which balanced didactic training with patient case discussion. The Project ECHO© (Extension for Community Healthcare Outcomes) Model connects a multidisciplinary expert panel with healthcare professionals (HCPs) from multiple specialties and professions in real time clinics using teleconferencing technology.

**Aim:** To develop an educational intervention for HCPs using the Project ECHO© Model: Telementoring to Enhance Assessment and Management of Pain in Advanced Dementia (TEAM Pain AD).

**Methods:** A one-day multidisciplinary workshop was held in April 2016 to present the TEAM Pain AD intervention and to elicit input into curriculum, clinic frequency and duration.

**Results:** 21 HCPs attended the workshop, including physicians (n=11), nurses (n=9) and pharmacists (n=1) representing psychiatry, general practice, geriatric medicine, palliative medicine and pain specialties, and primary, secondary, nursing home, community and hospice care settings. A curriculum of five clinics, held weekly and comprising 20 minutes didactic training by a specialist, and 55 minutes of patient case discussion, was agreed. The curriculum covered: routes of administration in pain management, non-pharmacological approaches to pain management, pain assessment tools, pharmacology in advanced dementia, and differentiating behavioural indicators of pain from anxiety, agitation, and other non-pain related behaviours.

**Conclusion:** TEAM Pain AD and development of ECHO© services in other clinical areas have the potential to establish cross-specialty networks of practice which bridge discipline/HCP type, care settings, and geographical areas, supporting delivery of high-quality care for complex patient populations.

**Funding**

HSC Research and Development, Public Health Agency, Northern Ireland

**Abstract number:** PO137  
**Abstract type:** Print Only

**Does Breakthrough Cancer Pain Have Any Role in the Prognostication Survival in Advanced Cancer Patients?**

Canals-Sotelo, Jaume1, Gonzalez-Rubó, Ramona2, Arrarás-Torrellas, Nuria1, Lopez-Ribes, Jesus3, Trujillano-Cabello, Javier3, Curtá-Fabregat, Aida1, Barallat-Gimeno, Eva1  
1Hospital Universitari Santa Maria, Lleida, Spain, 2Hospital Universitari Arnau de Vilanova, Lleida, Spain, 3Hospital Hestia Balaguer, Balaguer, Spain, 4Universitat de Lleida, Lleida, Spain

**Introduction:** Prognostication survival (PS) in advanced cancer patients is a key issue due to the important decisions that can be taken after its evaluation. The EAPC guidelines on PS include both biological parameters and clinical skills when determining PS. None of the most widely used scores (PPI, PaP, PiPv2, GPS…) includes the existence of BTcP on its items. The main objective of this study is to determine the role of the number of different types of BTcP and patients age in the 180 days-survival gap in a sample of advanced cancer patients attended at the outpatient clinic (OPC) in a teaching hospital in Catalonia.

**Population and methods:** Patients attended at the OPC during 2014-2015 and diagnosed of BTcP according to the Davies algorithm were included in the study. Variables included are: age, gender, civil status, type of cancer, metastatic disease, number of different types of BTcP per patient and survival at 180 days after the first evaluation carried out at the
OPC. Population was divided according to the number of different types of BTP (1 vs. 2) and the patients age (< 75 vs. ≥ 75 years). Descriptive statistics were used. For survival analysis, we used Kaplan-Meier curves to estimate 180 days survival rates and the log-rank test to compare the curves. Statistical significance was assumed at a 0.05 level (P<0.05).

Results: 277 patient fulfilled inclusion criteria. Mean of age 68, 2±13 years. Men 67, 9%. Lung cancer 31%.

% mortality at 180 days (N=277) 76.5%
1 type of BTP (N=138) 72.5% P=0.194
≥ 2 types of BTP (N=139) 80.6%
Age ≤ 75 years (N=177) 77.4% P=0.420
Age ≥ 75 years (N=100) 75%

Conclusions: No significative statistic differences were found regarding mortality at 180 days in a sample of advanced cancer patients with BTP compared with group of age and number of different BTP per patient.

Abstract number: PO138
Abstract type: Print Only

Barriers to Pain Management in Older Cancer Patients in Outpatient Settings in Japan as Perceived by Nurses and Pharmacists
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Background: The rate of pain relief is low among older patients in outpatient settings in Japan. As perceived by nurses and pharmacists.

Method: Four focus group interviews were conducted with 11 visiting nurses, five outpatient nurses and five community pharmacists in Sapporo and Yamagata.

Result: Qualitative analysis identified the following eight categories of barriers to pain management in older cancer patients in outpatient settings as perceived by nurses and pharmacists:

1. difficulty with drug compliance,
2. cannot report pain adequately to medical staff,
3. pain-related attitudes and beliefs,
4. negative image and misunderstanding of narcotic analgesics,
5. difficulty with pain assessment and evaluation because of individuality,
6. difficulty grasping the actual medication,
7. lack of time to give instruction on medication compliance,
8. lack of communication and cooperation between medical staff.

Conclusion: Even though patients and medical staff only have a short period of time to interact in outpatient settings, there is a need to build a system that allows medical staff to share patient information with each other. In addition, it is necessary to give older cancer patients guidance based on the specific characteristics of the elderly so that they are able to properly report pain.

Abstract number: PO139
Abstract type: Print Only

Prevalence and Characteristics of Breakthrough Pain in Cancer Patients Treated at Home in Poland
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Research aims: The aim of this study was to assess the prevalence and characteristics of breakthrough pain (BTP) using Breakthrough Pain Assessment Tool (BAT) in cancer patients treated at home in Poland.

Methods: Eligible patients were recruited from all adult patients treated at home by a palliative care team. In a cross sectional survey patients were asked to complete several questionnaires: Cognitive Assessment Scale, Edmonton Symptom Assessment System revised, Karnofsky, Memorial Pain Assessment Card as well as BAT. Clinical and demographic data were also gathered.

Results: Out of 384 patients treated at home by palliative care team 303 (78.9%) patients suffered from pain and 173 (57.1%) declared BTP. The average duration of BTP pain episode reported by patients was as follows: less than 5 minutes 16 (9.2%) patients, 5-15 minutes 32 (18.5%) patients, 15-30 minutes 62 (35.8%) patients, 30-60 minutes 41 (23.7%) patients and over 60 minutes 23 (13.3%) patients. The intensity of the most severe episode was described by 120 (69.3%) patients as 7-10 in Numerical Scale (NRS), whereas the typical episode intensity was assessed by 91 (52.6%) patients as 5-7 in NRS. As far as frequency of BTP is concerned, 30 (17.3%) patients declared less than 1 episode a day, 51 (29.4%) patients 1-2 episodes a day, 47 (27.1%) patients 3-4 episodes a day and 45 (26.0%) patients over 4 episodes a day.

Conclusions: Pain and BTP are common among cancer patients treated at home. BTP intensity is in most cases severe and majority of patients experience 1-4 BTP episodes per day with its most frequent duration of an episode 15-30 minutes.

Abstract number: PO140
Abstract type: Print Only

Specialized Interdisciplinary Approach for Cancer Patient with Aberrant Opioid Use
Edwards, Tonya, Arthur, Joseph, Reddy, Suresh, Nguyen, Kristy, Bruera, Eduardo, Hui, David, Yennu, Sriram
Supportive Care Center/Palliative Care, MD Anderson Cancer Center, Houston, USA

Background: Data on the development and outcomes of effective interventions to address aberrant opioid-related behavior (AB) in cancer patients is lacking. Our outpatient supportive care clinic developed and implemented a specialized interdisciplinary team approach to manage patients with AB. The purpose of this study was to report clinical outcomes of this novel intervention.

Methods: The medical records of 30 consecutive patients with evidence of AB who received the intervention and a random control group of 70 patients without evidence of AB between January 1, 2015 and August 31, 2016 were reviewed.

Results: At baseline, pain intensity (8.5 vs 6, p=0.002) and opioid dose (65 mg/day vs 25 mg/day, p=0.001) were significantly higher among patients with AB. During the course of the study, the median number of ABs per month significantly decreased from 3 pre-intervention to 0.4 post-intervention (p<0.0001). The median morphine equivalent daily dose decreased from 165mg/day at the first intervention visit to 112mg/ day at the last follow up (p=0.018) although pain intensity did not significantly change (p=0.984). ‘Request for opioid medication refills in the clinic earlier than the expected time’ was the AB with the highest frequency prior to the intervention and the greatest improvement during the study period. In a multivariate analysis, younger age (p<0.0001) and higher ESAS anxiety score (p=0.005) were independent predictors of the presence of AB.

Conclusion: The intervention was associated with a reduction in the frequency of AB and opioid utilization among cancer patients receiving chronic opioid therapy. These findings have implications for healthcare providers’ approach to a complex clinical issue and offers a promising
starting point for the creation of a standardized strategy for clinical teams dealing with patients on chronic opioid therapy. More research is needed to further characterize the clinical effectiveness of this intervention.

Abstract number: PO141
Abstract type: Print Only

Clinical Assessment and Management of Constipation in Specialist Palliative Care: A Multi Method Study
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Constipation is a common symptom in patients with advanced disease in the specialist palliative care (SPC) setting, yet there is a dearth of evidence reporting on its clinical assessment or management. This study aims to examine the clinical assessment and management of constipation for people with advanced cancer in SPC settings. Retrospective analysis of patient medical records (n=150) and practice was further queried via focus groups with twenty-seven palliative care professionals. Twenty-seven palliative care professionals (PCPs) from across the United Kingdom participated in six focus groups. One hundred and fifty patient charts reviews were retrospectively collected from three hospices. Qualitative data was analysed thematically and quantitative data was descriptively analysed using SPSS. Findings reveal that whilst 96% of patients admitted to the hospice were assessed within 24 hours, assessment tools for constipation varied. The most common patient symptoms reported were infrequent bowel movements (43%) and nausea (38%). Management was pharmacologically led with sodium docusate and Senna most frequently administered. Focus groups data revealed that symptoms of constipation were often under- addressed as staff lacked skills to carry out a full assessment. Communication with the patient was reported to problematic, and information often sought from family members. Whilst the value of non-pharmacological interventions was recognised, professionals’ management of constipation was focused on pharmacological treatments. Clinical processes for constipation assessment and management are problematic at an organizational and individual/staff level. Further education is needed to equip PCPs with the knowledge and skills to perform a full assessment, and to utilize appropriate non-pharmacological strategies which are currently neglected. SPC settings need to put structures in place to support improvement to practice.

Abstract number: PO142
Abstract type: Print Only

Prognostic Factors, Symptoms and Consequences of Electrolyte Imbalance in Patients of Palliative Care Unit
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Aims: Dyselectrolytemia is a common problem in patients with terminal cancer. It worsens the quality of life and increases the amount of complications. The aim of our study was to determine factors connected with dyselectrolytemia in patients with terminal cancer.

Methods: 522 terminal cancer patients admitted to Palliative Care Unit were retrospectively analyzed. Detailed physical examination, medical history and laboratory parameters were taken upon admission. Univariate and multivariate logistic regression analysis were used to determine possible predictors, symptoms and consequences of dyselectrolytemia.

Results: On admission 70,11% of patients had dyselectrolytemia. They had more often chronic antidepressant use (OR=Odds Ratio=1.63, p=probability value=0.0476), had more often constipation (OR=1.796, p=0.00059). They had 295% higher risk of death (OR=2.949, p=0.000000008). Multivariable logistic regression analysis after adjustment for possible confounders revealed that admission to hospital from Emergency Department (OR=2.837, p=0.00001), higher PS scale note (OR=1.513, p=0.0004), opioids administration (OR=2.775, p=0.0002), cachexia (OR=1.742, p=0.017) and lower albumin level (OR=0.962, p=0.048) remained independently associated with dyselectrolytemia.

Conclusions: Admission to hospital from Emergency Department, opioids administration, higher PS scale note; occurrence of cachexia and lower albumin level are factors associated with dyselectrolytemia. Patients with electrolytes imbalances had 295% higher risk of death.

EAPC 2018 Abstract Book 259
Conclusion: Preliminary results indicate that about half of the patients did not fill in PG-SGA as intended since they chose more than one response alternative. When total score of PG-SGA is calculated, only the “worst” score is included, and thus the patient’s attempt to present the total picture is lost.

Abstract number: PO144
Abstract type: Print Only

The Influence of Esketamine Analgesia on Emotional Distress of Palliative Inpatients.

A Retrospective Analysis
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Background: Depression and anxiety are common among palliative care patients. Current pharmaceutical treatments take weeks to unfold an effect. Thus, there is a need for fast acting therapy options in addition to psychological interventions. The NMDA-antagonist ketamine is known to be a fast acting antidepressant and anxiolytic agent. In our palliative care ward a subset of inpatients were treated with ketamine (esketamine, IV infusion 0.25mg/kg over 45 minutes) for efficient analgesia. The goal of this retrospective study is to investigate if there is a positive influence of esketamine analgesia on perceived emotional distress of palliative inpatients through depression and anxiety.

Method: Retrospective analysis of inpatient data treated in our clinic in an one year time interval after positive ethics votum (Register-ID: 2017064323, Study-no.: 6021R and study registration (DRKS00013208). Included variables were sex, age, diagnosis, length of stay, mode of discharge, global score (GS) of the State Trait Anxiety Depression Inventory (STADI), which operationalizes emotional distress through depression and anxiety. STADI scores >60 are considered as pathological. Statistic analysis via Wilcoxon signed rank test with STADI GS as dependent variable and timepoint of STADI evaluation before (T1) and within 4 days (Mean=2.13; Range=1-4) after (T2) esketamine administration as independent variable.

Results: A number of 8 patients (4m; 4w) were included into the analysis with a mean age of 57 years. Seven inpatients survived from an oncological and one inpatient from a non-oncological disease. The mean length of stay in our clinic was 15 days. Five inpatients died in our clinic and three went to a hospice. There was a significant reduction of STADI GS on T1 (Median=69) to T2 (Median=59); T=1; p< 0.05; r= 0.55.

Conclusion: There is evidence for a reduction of emotional distress of palliative inpatients after a single administration of esketamine. Limits of our study are the retrospective design, the low number of included inpatients and the missing consideration of moderators and confounders. There is a need for further studies.

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Abstract number: PO145
Abstract type: Print Only

Clinically Significant Drug-drug Interactions Involving Medications Used for Symptom Control in Patients with Advanced Malignant Disease. A Systematic Review

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Background: Most patients with advanced malignant disease need to take drugs to control symptoms. These drugs represent multiple classes of medications, with variable mechanisms of action and pharmacokinetics. This treatment raises risks of serious adverse effects and drug-drug interactions (DDIs) which should be adequately identified and managed.

Objective: To identify studies reporting clinically significant DDIs involving medications used for symptom control, other than opioids used for pain management, in adult patients with advanced malignant disease.

Design and data sources: Systematic review with searches in Embase, MEDLINE and the Cochrane Central Register of Controlled Trials, from the start of the databases (Embase from 1980) through April 2016. In addition, reference lists of relevant full-text papers were hand-searched.

Results: Of 9300 retrieved citations, 454 were considered potentially eligible. After full-text reading, 26 were included in the final analysis, together with 13 papers identified through hand-searching of reference lists. All of the 39 included publications were case reports, letters to the Editor or retrospective studies. Drugs most often involved were antiepileptics (phenytoin in particular), antidepressants (mostly selective serotonin receptor inhibitors), non-opioid analgesics, corticosteroids and anticoagulants. Clinical manifestations of DDIs of medications used for symptomatic treatment included: serotonin toxicity, seizures, delirium, bleeding, liver and kidney failure, sedation and respiratory depression, cardiac arrhythmias, rhabdomyolysis and others. The most common mechanisms eliciting DDIs were alteration of CYP450 dependent metabolism, and pharmacodynamic interactions due to overstimulation of serotonin receptors in the CNS. About 1/3 of the reports were related to DDIs of symptomatic drugs and oncologic agents.

Conclusion: Evidence for clinically significant DDIs associated with drugs used to relieve symptoms is limited and focused mostly on a few drug classes. The cases give important suggestions for clinical practice. Physicians treating cancer patients should monitor the patients closely for the risk for DDIs, avoid drug combinations with high risk of DDIs, and limit polypharmacy.

Declaration of conflicting interest
The Authors have no conflict of interest to declare.

Abstract number: PO146
Abstract type: Print Only

Variation of the Occurrence of Agitated Delirium during the Day in Palliative Care
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Background: Delirium is often associated with alterations in the sleep-wake cycle and it has been stated that agitation is more common in the evening and at night than in other periods during the day. However, in the medical literature there are no research data supporting this aspect, as opposed to what happens in dementia, where there are several studies on this issue. The aim of this study is to examine if there is, in fact, any period where agitation is more frequent in patients with delirium.
Methods: Based on the study of a protocol for the control of agitation, the records of the time of its application were assessed to check if there are different frequencies during the day.

Results: During the period under study, the protocol was used 584 times in 135 patients. 102 (76%) were males and the mean age was 65.75 years (SD ± 12.09). The most frequent diagnosis was head and neck cancer, 37 (27%), followed by lung cancer, 27 (20%). There was a clearly uneven distribution of the episodes of agitation during the 24-hour period. The number of episodes of agitation started to rise from 4 pm, increased in the 2-hour period between 10 pm and midnight and then decreased progressively. These differences are statistically significant (P < 0.001).

Conclusion: This study shows that agitation is more frequent in the evening and at night than in other periods in patients with delirium.

Abstract number: PO147
Abstract type: Print Only

Episodic Dyspnea Definition in Cancer Patients: A Consensus Agreement among Spanish Experts. The INSPIRA Study
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Background: Dyspnea is common in cancer patients. It is usually suffered in the form of exacerbations called episodic dyspnea. An accepted definition of episodic dyspnea is lacking.

Aim: To reach a consensus among multidisciplinary cancer experts in Spain with regard to a definition of episodic dyspnea in cancer patients.

Methods: A nominal group (experts in pall. care, medical oncology, radiation oncology, pneumology and pain medicine) analyzed a 1st proposal for the definition of episodic dyspnea and proposed 16 assertions about aspects related to the definition. Assertions were subjected to evaluation by 100 specialists (panel) of the mentioned disciplines through a modified 2-round Delphi methodology (April 2017 - June 2017). Assertions that did not reach consensus in the 2nd round were analyzed by the nominal group to achieve agreement and elaborate the final consensus on episodic dyspnea definition. 9-point Likert scales were used (1: “strongly disagree”, 9: “strongly agree”). An item was agreed when experts who scored outside the 3-point region ([1-3], [4-6], [7-9]) which contained the median were < 1/3 of the respondents; then, the median value determined the group consensus achieved: “disagreement” if median was ≤ 5/9, “agreement” if median was ≥ 7/9. If median was 4-6 the item was considered “doubtful”. There was “discrepancy” when ≥ 1/3 were in the region [4-6] and another ≥ 1/3 in the region [7-9]. Remaining items were considered “undetermined”. Items that were not observed “consensus” or “non-consensus” or were considered with an “undetermined” level [4-6] passed to the 2nd round. Items that showed an inter-quartile range ≥ 4 points (scores contained between the p25 and p75 values of the distribution) were also revaluated.

Results: Rate was 61%. The panel reached consensus in 1st round in 9/16 assertions (56%), 8 in the agreement and 1 in the disagreement. In 2nd round consensus was achieved in 3/7 items (43%). A consensus was reached in 75%; 56% in the agreement and 19% in the disagreement.

Conclusions: Consensus definition: Episodic dyspnea is the appearance or increase, in a cancer patient, of a dyspnea crisis characterized by transient and disproportionate respiratory distress caused by a known or unknown trigger and with the presence or absence of dyspnea at rest. The consensus reached is a previous step that must allow studies of high methodological quality that allow to improve its treatment and increase the quality of life of patients.
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**Background/aims:** To explore the delirium experience for patients, relatives, staff and volunteers in specialist palliative care (PC) settings. Delirium, a common syndrome affecting patients with life-limiting illness, is distressing for patients, relatives and staff. It is important to understand palliative care staff and volunteers’ current attitudes and practice in relation to delirium care as well as patients’ and relatives’ perspectives to inform effective interventions to prevent and manage delirium.

**Methods:** We conducted a systematic review and thematic synthesis of qualitative studies, using a pre-specified protocol. Searches of six electronic databases were conducted. Two reviewers independently screened titles and abstracts and full texts. The quality, rigour and trustworthiness of included studies was assessed using a study appraisal tool. Study findings were extracted and synthesised in NVivo, using line by line coding to develop descriptive and analytical themes.

**Results:** The searches identified 1657 records. From 70 full text articles, 16 were included in the qualitative synthesis. The views of PC staff, particularly nurses, and relatives are strongly represented, whereas patients’ and volunteers’ perspectives are under-represented. The majority of studies are based in specialist-in-patient units, only two include community services. Provisional themes include: patient, relative and staff distress; impact on patient-relative relationships; challenges in recognition, assessment and management of delirium; valued approaches to care and communication; ambivalence on the role of sedation; relatives’ information and support needs; the need for increased staff knowledge, skills and systems for effective delirium care.

**Conclusions:** Our findings will inform the development of effective interventions by identifying barriers and facilitators to practice change and exploring the potential roles of PC staff, volunteers and relatives in improving delirium care.

**Abstract number:** PO150
**Abstract type:** Print Only

**Investigation of Olfactory Dysfunction in Patients with Terminal Cancer: Are There Any Factors That Cause the Olfactory Dysfunction and Are There Any Differences in the Sense of Smell between Patients with Cancer and Healthy Young People?**

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**Background:** It is known that olfactory dysfunction and taste disorder are caused by aging and cancer treatment. However, the prevalence of olfactory dysfunction in patients with terminal cancer, and whether the relationship between taste and psychosomatic symptoms, and sensing the odor is the same as that in healthy people is unknown.

**Purpose:** To clarify the actual condition of the olfactory disorder in patients with terminal cancer.

**Methods:** Fifty-eight patients (mean age = 75.7 years) with cancer who were admitted to the palliative care unit of Ashiya Municipal Hospital in Japan were administered olfactory tests, taste tests, and Hospital Anxiety and Depression Scale (HADS). For the olfactory test, a card kit consisting of 12 types of smells familiar to Japanese people was used. Patient information was extracted from medical records. A univariate analysis was used to examine the factors causing olfactory disorder in patients with terminal cancer. In addition, the olfactory test was also conducted on 20 young healthy volunteers (age [mean] = 22.5 years).

**Results:** Olfactory dysfunction was found in 44 (75.9%) of the patients with terminal cancer. Age was significantly associated with olfactory dysfunction in patients with terminal cancer (odds ratio = 1.10 [1.02–1.19], p = 0.006). In patients with terminal cancer, the rate of correct answers for “Japanese cypress (Hinoki)” in the olfactory dysfunction and normal groups exceeded 50%, and, there was no significant difference between the two groups (Table 1). In addition, the smells for which the rate of correct answers was not significantly different between the young healthy volunteers and patients with terminal cancer included “Chinese ink,” “timber,” “menthol,” “Japanese cypress (Hinoki),” and “condensed milk” (Table 2).

**Discussion:** In this study, we found that olfactory dysfunction was present in many patients with terminal cancer. Furthermore, it was suggested that “Japanese cypress (Hinoki)” would be a useful odor in the palliative care of Japanese patients with terminal cancer (for example, in aromatherapy).

**Table 1. Rate of correct answers of olfactory test.**

<table>
<thead>
<tr>
<th></th>
<th>Olfactory normal group in patients with terminal cancer (%)</th>
<th>Olfactory dysfunction group in patients with terminal cancer (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japanese cypress (Hinoki)</td>
<td>79</td>
<td>55</td>
</tr>
<tr>
<td>Chinese ink</td>
<td>79</td>
<td>32</td>
</tr>
<tr>
<td>Timber</td>
<td>64</td>
<td>34</td>
</tr>
<tr>
<td>Menthol</td>
<td>100</td>
<td>57</td>
</tr>
<tr>
<td>Condensed milk</td>
<td>100</td>
<td>34</td>
</tr>
<tr>
<td>Rose</td>
<td>64</td>
<td>32</td>
</tr>
<tr>
<td>Perfume</td>
<td>64</td>
<td>20</td>
</tr>
<tr>
<td>Curry</td>
<td>100</td>
<td>73</td>
</tr>
<tr>
<td>Fried onion</td>
<td>43</td>
<td>14</td>
</tr>
</tbody>
</table>

**Table 2. Rate of correct answers of olfactory test.**

<table>
<thead>
<tr>
<th></th>
<th>Patients with terminal cancer (%)</th>
<th>Young healthy volunteers (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japanese cypress (Hinoki)</td>
<td>60</td>
<td>80</td>
</tr>
<tr>
<td>Chinese ink</td>
<td>43</td>
<td>40</td>
</tr>
<tr>
<td>Timber</td>
<td>41</td>
<td>55</td>
</tr>
<tr>
<td>Menthol</td>
<td>67</td>
<td>80</td>
</tr>
<tr>
<td>Condensed milk</td>
<td>47</td>
<td>65</td>
</tr>
<tr>
<td>Rose</td>
<td>40</td>
<td>75</td>
</tr>
<tr>
<td>Perfume</td>
<td>31</td>
<td>60</td>
</tr>
<tr>
<td>Curry</td>
<td>79</td>
<td>100</td>
</tr>
<tr>
<td>Fried onion</td>
<td>21</td>
<td>90</td>
</tr>
</tbody>
</table>

**P-value by Fisher’s exact test**

<table>
<thead>
<tr>
<th></th>
<th>Japanese cypress</th>
<th>Chinese ink</th>
<th>Timber</th>
<th>Menthol</th>
<th>Condensed milk</th>
<th>Rose</th>
<th>Perfume</th>
<th>Curry</th>
<th>Fried onion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olfactory normal</td>
<td>0.10</td>
<td>&lt; 0.01</td>
<td>0.046</td>
<td>&lt; 0.01</td>
<td>&lt; 0.01</td>
<td>0.03</td>
<td>&lt; 0.01</td>
<td>0.02</td>
<td>0.03</td>
</tr>
<tr>
<td>Olfactory dysfunction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Background: Accurate prediction of prognosis of patients is key to clinical decision-making factor in therapeutic strategies. Depression is common in patients with advanced cancer and is related to survival in numerous studies.

Aims: The aim of this study is to assess whether depression is associated with survival

Methods: Prospective, single-center study. Survival was assessed from the date of entry in the Palliative Care Unit. Depressive disorder was evaluated with clinical interview and DSM-IV-TR; depressive symptoms with Hospital Anxiety and Depression Scale and sadness with ESAS (0-10). Univariate analysis was performed to assess which factors are significantly associated with survival.

Results: 959 cancer patients admitted to acute care palliative UCP. Mean age 70 years (SD = 14), 57% are male. Average stay 10.44 ± 8.4 days. 48% died in the first income. Median survival (sv) of 20 days (range 7-54 days IQ): 12% meet clinical criteria for depression. The HADS depression subscale income, shows a 24% score > or = 11. The scale suggests that anxiety had significant depressive and anxiety symptoms. 31% had moderate sadness and 41% severe sadness in the ESAS (Univariate analysis shows that the clinical diagnosis of depression is associated with survival so depressed patients lived 34 days (95% CI 15.9 to 22.0) vs 19 days (95% CI 28.1 to 39.8). However depressive or anxiety symptoms as measured by the HADS and sadness ESAS had no statistically significant relationship with survival.

Conclusion: We found no relationship between sadness and depressive symptoms and survival. However patients who met clinical criteria for depression had higher survival.

Abstract number: PO152
Abstract type: Print Only

Akathisia in Palliative Care Patients on Metoclopramide - An Underestimated Phenomenon? A Retrospective Chart Review

<table>
<thead>
<tr>
<th>Gender, age</th>
<th>MCP route and dose</th>
<th>Time until MRL occurred</th>
<th>Concomitant antiparkinsonian drugs</th>
<th>Interpretation by team</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>m, 57 years</td>
<td>10 mg orally PRN</td>
<td>38 hrs</td>
<td>olanzapine 5 mg orally</td>
<td>delirium</td>
<td>haloperidol 2 mg, midazolam 1.5 mg iv.</td>
</tr>
<tr>
<td>f, 55 years</td>
<td>20 mg CSCI until 28 hrs before MRL</td>
<td>28 hrs</td>
<td>haloperidol 2 mg CSCI until 28 hrs before MRL</td>
<td>delirium</td>
<td>lorazepam 1 mg orally</td>
</tr>
<tr>
<td>m, 90 years</td>
<td>10 mg iv PRN</td>
<td>28 hrs</td>
<td>-</td>
<td>delirium</td>
<td>quetiapine 12.5 mg, lorazepam 1 mg orally</td>
</tr>
<tr>
<td>f, 98 years</td>
<td>10 mg orally PRN</td>
<td>24 hrs</td>
<td>-</td>
<td>no interpretation</td>
<td>lorazepam 1 mg orally</td>
</tr>
<tr>
<td>f, 89 years</td>
<td>10 mg orally tds</td>
<td>N/A</td>
<td>-</td>
<td>delirium</td>
<td>lorazepam 1 mg orally</td>
</tr>
<tr>
<td>f, 52 years</td>
<td>10 mg orally tds</td>
<td>N/A</td>
<td>-</td>
<td>Opioid side effect or withdrawal</td>
<td>lorazepam 1 mg orally</td>
</tr>
</tbody>
</table>

Abstract number: PO153
Abstract type: Print Only

Assessment of Palliative Sedation in Patients at Palliative Care Units - Brazilian Literature Review

Torres, Leandro, Silva Pinto, Cristiane
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Introduction: The palliative care approach focuses on the integral care of individuals with life-threatening conditions. During the treatment of the disease, in some situations, patients may present a refractory symptom, that is when a symptom escapes the habitual clinical control. In this cases, we can make use of a technique called Palliative Sedation, or Controlled Sedation.

Aim: The purpose of this study was to collect data from the current literature, focusing on the use of controlled sedation technique; in palliative care patients with advanced cancer at specialized palliative care centers and institutions.

Methods: Current literature review, article, were compiled from the world literature, from the last 10 years until 2015. The data analyzed contained patients hospitalized in health institutions: hospices and hospitals. In these studies, the medication of choice for palliative sedation, in 100% of the cases, was midazolam. Midazolam was chosen because it is the most common medication used in the world for controlled sedation, easy handling, safe ability of management by the professionals, and
your relative low price. Many different techniques were used, from superficial to deep sedation, other medications, besides Midazolam, were removed.

Discussion and conclusion: Comparing data from the literature it was observed that the most common refractory symptom was dyspnea, followed by delirium. The indication of palliative sedation may vary according to the country. In homecare patients, the use of sedative drugs for symptom control occurred in 52% of the cases, already in a palliative care centers, showed a prevalence of 16%. In the City of São Paulo, at a Palliative Care unit, were observed a statistics of sedation in 36.7% in their patients. The indicators of National Institute of Cancer (INCA), showed similar statistics, although there is a need for adequate formal study of the data. In current literature, the studies present qualitative characteristics, although we could observe similarities between the studies, especially when we analyzed the most common pathologies of sedated patients and the main symptoms that indicated sedation.

Finally, patients in palliative care have advanced disease, often with treat-refractory symptoms. For the comfort of these patients, we need to be cautious and critical about the indications of controlled sedation, as well as having mastering of the technical abilities, making correct use whenever indicated.

Abstract number: PO154
Abstract type: Print Only

Frequency, Intensity and Correlates of Financial Distress among Advanced Cancer Patients Assessed in a Supportive Care Outpatient Center
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Background: Advanced cancer patients (AdCa) and their caregivers often experience physical, psychological, social, existential/spiritual distress and financial distress associated with the disease or its treatment. Regular assessments of these issues in the outpatient setting are limited or not available. We modified the Edmonton Symptom Assessment Scale adding two items following the same scale (0 to 10) to evaluate: Spiritual Pain and Financial Distress (FD), (ESAS-FS).

Methods: We reviewed 289 consults of AdCa evaluated by our Supportive Care Outpatient Center between October 2012 and January 2013. To assess symptoms we started using the ESAS-FS. We determined the frequency, intensity and correlates of self-reported Financial Distress (Distress/Suffering experienced secondary to financial issues) among these AdCa.

Results: Mean (range): 60.1 years (22-92). 53% were male. 189(65%) were White, 45(15%) African American, and 34(12%) were Hispanic. Type of cancer: head and neck 62(21%), gastrointestinal 57(20%), breast 40(14%), lung 32(11%), urological 32(11%), and others 45(16%). 187/289(65%) AdCa had FD: mean (95% Confidence-Interval) 5(4.5-5.3). AdCa with FD had worse Pain [mean(95% CI) 5.1(4.7, 5.6) vs. 4.3(3.6, 4.9)] (p=0.028), depression [3.8 (3.3, 4.2) vs. 1.5 (1.1, 2.1), ]<0.0001], anxiety [4.1(3.6, 4.6) vs. 1.6(1.1, 2.1), ]<0.0001], drowsiness [3.8 (3.4, 4.3)] vs. 2.6(2.0, 3.2), ]<0.0001]. Well-Being [5.2 (4.9, 5.6) vs. 4.3 (3.7, 4.9), ]<0.006], and Spiritual Pain [2.4 (2.0, 2.9) vs. 0.5 (0, 1.0), ]<0.0001]. FD correlated (Spearman) with Pain r=0.25, p<0.0001; Sleep r=0.29, p<0.0001; Depression r=0.41, p<0.0001; Anxiety r=0.45, p<0.0001; Drowsiness r=0.26, p<0.0001; Well-Being r=0.25, p<0.0001; and Spiritual Pain r=0.44, p<0.0001. Logistic regression multivariate analysis showed association with Spiritual Pain [OR (95% Wald CI) 1.575 (1.284, 1.932), p<0.0001] and Anxiety [1.261 (1.083-1.488), p=0.0001]. FD at follow up correlates with depression (r=0.32, p<0.0001), anxiety (r=0.29, p=0.001), Well-being (r=0.19, p=0.01), sleep (r=0.30, p<0.0001), and spiritual pain (r=0.36, p<0.0001).

Conclusion: FD was reported in more than 65% of AdCa. It correlates with physical and psychological, and spiritual distress. The use of ESAS-FS allows identifying AdCa with FD evaluated in a Supportive Care Outpatient Clinic. More research is needed.

Abstract number: PO155
Abstract type: Print Only

A Feasibility Study of a Novel Peer Mentor Intervention for People with Advanced Cancer Using a Randomised Controlled Trial Design (PACT): Feasibility of Recruiting and Training Peer Mentors
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1International Observatory on End of Life Care, Lancaster University, Lancaster, UK, 2Clatterbridge Cancer Centre NHS Foundation Trust, Liverpool, UK, 3School of Psychological Sciences, University of Manchester, Manchester, UK, 4Faculty of Health Sciences, University of Southampton, Southampton, UK, 5Institute of Psychology, Health and Society, University of Liverpool, Liverpool, UK, 6Division of Health Research, Lancaster University, Lancaster, UK, 7Division of Nursing, Midwifery and Social Work, University of Manchester, Manchester, UK

Aim: The aim is to determine the feasibility of delivering and investigating a novel peer mentor intervention to promote and maintain psychological wellbeing in people with advanced cancer using a randomised controlled trial design. Here data are presented on issues of recruitment, retention, training and attrition of peer mentors.

Methods: This study employs a mixed methods design:
- a) A two armed controlled trial of a proactive peer mentor intervention plus usual care vs. usual care alone.
- b) Qualitative process evaluation.

Prior to patient participants being recruited, peer mentors are recruited, undertake a rigorous 2 day training programme, undergo police checks, and sign consent and volunteer agreements.

Patient participants are people with advanced cancer (any type), defined as metastatic disease at diagnosis, and/or with local or metastatic spread following treatment and/or where prognosis is estimated as less than a year. Peer mentors are people who have experience of living with cancer, 6+ months post diagnosis and recruited via advertising within two hospital cancer centres, local print and online media, volunteer bureaux. Descriptive data are presented on the feasibility of recruiting, training and attrition rates of people to be peer mentors who themselves have an experience of cancer.

Results: Over an 8 month period (2016-17) 48 people enquired (Table 1). Of these, 44 asked for further information, 31 wanted to receive training. Attrition at these stages due to eligibility (n=2), lost to follow up (n=4), time commitment issue (n=2), own ill health (n=8). Four 2 day training sessions were held. 23 completed day 1 training, 14 both days. Attrition at these stages include waiting for suitable training date (n=4), time, commitment issue (n=2), own ill health (n=8).

Four 2 day training sessions were held. 23 completed day 1 training, 14 both days. Attrition at these stages include waiting for suitable training date (n=4), time, commitment issue (n=2), own ill health (n=8).

Table 1. Mentor characteristics.

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer centre (A&amp;B)</td>
<td>Centre A 25 (52%)</td>
</tr>
<tr>
<td>Gender</td>
<td>Female 33 (70%)</td>
</tr>
<tr>
<td>Referral source</td>
<td>Social media 17 (44%) Cancer information centre 4 (10%) Support group 4 (10%) Newspaper/radio 3 (8%)</td>
</tr>
<tr>
<td>Cancer diagnosis</td>
<td>Breast 14 (36%) Prostate 2 (4%) Colorectal 2 (4%) Gynaecological 6 (15%) Other cancers 15 (38%)</td>
</tr>
<tr>
<td>Total enquiries</td>
<td>48</td>
</tr>
</tbody>
</table>
have been made to date, and data are being currently collected on feasibility issues throughout intervention delivery.

Conclusions: We have demonstrated it is feasible to recruit peer mentors to support people with advanced cancer who themselves have recent or ongoing diagnoses of cancer.

Abstract number: PO156
Abstract type: Print Only

Attitude of Population to HIV-infected People in Uzbekistan (Based on the Results of Sociological Research)
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Tashkent Medical Academy, Tashkent, Uzbekistan

Introduction: Despite the activities carried out for many years, the society still has a certain level of stigmatization and discrimination against people living with HIV. This phenomenon has a negative impact on the ability to counteract the epidemic and reduce the dynamics of its spread. In this regard, the formation of a tolerant, adequate attitude towards HIV-positive people and the very topic of HIV infection in Uzbekistan continues to be an urgent task.

Aim: To assess the attitude and level of tolerance of the population of the city of Tashkent to people living with HIV.

Materials and methods: Quantitative questioning by the method of personal formalized interview. The sample size is 100 respondents (40 aged 15-30 years, 60 at the age of 31-55 years). The study error with a confidence probability of 0.95 and a fraction of the 50% indicator for the entire population of the city of Tashkent is ± 3.46%, for the group of 15-30 years, ± 5.46%, for the group of 31-55 years, ± 4.48%.

Results: The majority of those surveyed are ready to take care of a sick relative if necessary in case of HIV infection (70%), only 6.5% said they are not ready to care. In case of infection of relatives, more than half of the respondents will try not to disclose this information to others (58.1%), it will not be hidden by 15.3%. Above the level of tolerance among women (45.4%), respondents 31-40 (48%), people married (47.9%), having children. In addition, respondents who practice risky behavior tend to be tolerant. In relation to the HIV-infected teacher of the educational institution, the interviewed audience demonstrates less tolerance than to other people. About one in five (19.3%) says they want to help, 16.9% feel pity for HIV-infected people, 12.8% of respondents feel fear of HIV-infected people. Every tenth feels disgust or indifference.

Conclusion: Based on the results of the survey, it can be concluded that respondents are not tolerant enough to HIV-infected comrades and teachers. In this regard, one of the primary tasks for ensuring the targeted use of resources and an agreed response to this problem should be the elaboration of issues of coordination of efforts and development of a social partnership between the state and society.

Abstract number: PO157
Abstract type: Print Only

Differences in Well-being and Fear of Death of Hospice Employees and Volunteers in Hungary
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Institute of Behavioural Sciences, Semmelweis University, Faculty of Medicine, Budapest, Hungary

Background: In Hungary voluntary work has not got a strong tradition. In the existing 90 hospice services only 208 trained volunteers worked among the 1255 hospice workers in 2016 (number of inhabitants is 9.8 million).

Aim: To improve the acceptance of volunteers in hospice teams by the analysis of different attitudes of paid and non-paid hospice workers.

Methods: Target population of the cross-sectional questionnaire survey has been the hospice care providers in Hungary (N=1255). Response rate is 15.5% (N=195); 91.8% of them are women; mean age is 45.8 years (SD=10.46 years, range: 23-73 years). 28.1% of the respondents are volunteers (N=50). Multidimensional Fear of Death Scale, Perceived Stress Scale, shortened version of WHO Well-Being Index, Beck Depression Inventory, Maastricht Vital Exhaustion Questionnaire, Effort Reward Imbalance Questionnaire have been used.

Results: The volunteers are significantly older (p=0.014), their vital exhaustion is lower (p=0.026) and their perception of well-being is higher (p=0.040) than the paid employees’ values. The volunteers’ fear of death of is significantly less in factors Fear of the dying process (p=0.017), Fear of the dead (p=0.042), Fear for significant others (p=0.004), Fear of body after death (p=0.026) and Fear of premature death (p=0.003) than paid employees’ fear of death.

Conclusion: The higher levels of well-being and lower fear of death of hospice volunteers indicate that they are less exhausted than paid employees and more motivated for hospice work (see eg. the response rate). The better acceptance of volunteers in hospices can help reduce the overload and exhaustion of paid employees.
By way of conclusion, this paper will highlight the potential of making reception of one owns life story observable. Recognizing this potential, a transfer function can be made to other forms of biographical work with palliative patients.

**Abstract number:** PO159  
**Abstract type:** Print Only

**Towards a Model for Promoting the Resilience of the Couple in Palliative Care: A Multi-method Qualitative Research Project**

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Mental Health and Wellbeing Research Group (MENT)  
1Vrije Universiteit Brussel, Brussels, Belgium, 2Interfaculty Institute for Family and Sexuality Studies, University of Leuven, Leuven, Belgium, 3Faculty of Medicine and Health Sciences, University of Antwerp, Antwerp, Belgium, 4Public Health, Vrije Universiteit Brussel, Brussels, Belgium

**Aim:** Palliative care providers are confronted daily with couples whose relationship is under significant stress. Offering psychosocial support to these couples is considered to be one of their tasks.

However, palliative care providers indicate they don’t have the tools to support relationship issues, and psychological interventions targeting couples in palliative care are very sparse. Therefore, we researched how palliative care providers support couple relationships, in order to build a practical model on how to deliver relationship support.

**Method:** We performed a multi-method qualitative study in the palliative care setting in Flanders, Belgium.

We conducted in-depth interviews with 78 patients, 7 partners and 6 bereaved partners to acquire insights about their experiences with relationship support in palliative care. Also, we conducted in-depth interviews with 21 palliative care nurses and 2 psychologists to acquire insight about their experiences with dealing with relationship issues. The interviews were analysed with thematic analysis.

The results were used as a preliminary framework for conducting a 3-month participative observation study in a palliative care unit and in ambulant care, where we observed how palliative healthcare providers support couple relationships.

We presented the results of the interviews/observations to 5 palliative care teams (3 palliative units, 2 ambulant care), with whom we constructed together -via feedback rounds- a practical model on how to deliver couple-centred care.

**Results:** The results show that palliative care providers support couples in two main ways: by “compassionate care” and “promoting the resilience of the couple”.

Differently factors affect how caregivers give relationship support: the importance they attach to it (is it a “basic task”, or “additional care”), their vision on relational problems (are they disease-related or structural), factors inherent to the philosophy of the palliative setting (dual thinking vs systemic thinking); organizational factors (the degree of delineation between the tasks of nurses and psychologists). A combination of these factors makes that most caregivers tend to remain “compassionate” and are hesitant to “promote the resilience of the couple”.

**Conclusion:** The results, after consulting 5 palliative care teams, lead to a practical model that promotes resilience of the couple in palliative care.

**Abstract number:** PO160  
**Abstract type:** Print Only

‘We Are Not Paid to Cry’ - Developing Support for Nurses Working with Death and Dying in Critical Care

Oldcroft Nicola  
Cecily Saunders Institute of Palliative Care, Policy & Rehabilitation, King’s College London, Clinical Palliative Care Team, London, UK

**Aim:** Morrissey (2005) wrote that ‘the need for support is not a sign of professional inadequacy or personal weakness, but rather one of maturity and the recognition that staff need help to work well.’ The aim of this project was to develop a supportive group for nurses on the critical care wards to reduce stress, encourage debrief and discussion and open communication around death and dying. There was a strong evidence discovered in research completed before the group was set up and demand also demonstrated by exploration with the junior and senior staff.

**Methods:** The data for this study was collected over an initial 6 month period from March to September 2017. There was a quantitative approach to the study using an evaluation form to assess demand and effectiveness through a tick box and question and answer sheet.

**Results:** Numbers of nurses attending the weekly group was low in comparison with the numbers of nurses employed in the critical care department of the hospital. Only 25 nurses attended in a 6 month period. Those who did attend gave very positive comments about the group and everyone said they would go again, however no-one did. Feedback was taken from other that hadn’t attended and used to form conclusions for the next 6 months of development running until March 2018.

**Conclusion:** Themes collated from the feedback of those who didn’t attend included short staffing, lack of information about the group and a strong culture of having to be resilient. Comments were also gathered from those who did not attend amongst the staff group and included responses such as ‘we are not paid to cry’. There is also an outcome of an identified a need for further study into the reluctance to talk about death and dying in the intensive care setting.

**Reference**  
(Morrissey, J (2005) Staff support after trauma in A&E; Emergency Nurse vol 13 no 6 october 2005

**Abstract number:** PO161  
**Abstract type:** Print Only

To Assess Stress and Coping Capability between Working and Non Working Caregivers of Terminally Ill Cancer Patients

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**Introduction:** In a developing country like India, majority of the primary caregivers of cancer patients are female. Chief reasons could be that most of the women population are non working and low literacy rates. Since terminally cancer patients require holistic care (physical, emotional, spiritual care) a good amount of time needs to be spent with them to improve quality of life. Working status may affect caregivers’ stress and coping abilities which in turn would affect care of the terminally ill.

**Objective:** To assess the effect of working status on incidence of stress and coping capabilities amongst primary caregivers of terminally ill cancer patients.

**Methodology:** 60 primary female caregivers (30 working and 30 non-working) with age ranging between 25-50 years of terminally ill cancer patients were selected. The variable caregivers stress was assessed using Kingston Caregiver Stress Scale (KCSS) by Hopkins and Kilik (2004) and coping was assessed using coping responses Inventory Adult (CRI-Adult) by Rudolf H.Moose (1992). These scales consist of set of questions based on answers which add up to categorize self into mild, moderate or severe.

**Result:** The average mean score of stress among non working caregivers was 36.9 (severe) and working caregivers 6.57 (mild). Two types of coping were assessed - avoidance and approach coping. Coping capabilities were poor irrespective of working status. In Non working group mean approach coping was 36.40 compared to working caregivers 36.08 . And mean avoidance coping was 42.16 in non working population compared to working group 42.06.
Conclusion: Even primary caregivers require care and support to maintain care continuum. Working status alters their stress levels and coping capabilities, severity of which maybe calculated using above psychometry scales and proactive counseling maybe done to improve patient related care.

Abstract number: PO162
Abstract type: Print Only

Early Psychological Distress Screening in Home Care Palliative Care Services: A Way to Help Patients and Caregivers Who Don’t Express a Need of Psychological Support.

An Italian Multicenter Study
Cason, Eleonora1,2, Doglotti, Federica1,3, Bazzo, Lucia1,2, Toschetti, Federico1,4, Baldi Guarrinoni, Teresa2, Bullo, Stefania2,3, Poles, Giovanni2
1Home Care Palliative Care Service, Associazione Volontari Assistenza Pazienti Oncologici AVAPO-Venezia Onlus, Venice, Italy, 2Home Care Palliative Care Service, Azienda ULSS 3 SERENISSIMA, Venezia-Mestre, Italy, 3Home Care Palliative Care Service, Associazione Volontari Assistenza Pazienti Oncologici AVAPO-Mestre Onlus, Venezia Mestre, Italy, 4Università degli Studi di Padova, Padova, Italy

Statement of aims: Our Palliative care units (Home Care and Hospices) were involved in an Italian multicenter study, evaluating satisfaction in caregivers: 90% of 124 caregivers were very much satisfied for the service. It was found even that in Hospices 60.8% of users had Psychological help, instead in the Home Care Palliative Care Services (HCPCS), only 23.6% had it. This low score was significantly correlated with high scores of volunteers help. The aim of this study is to evaluate this discrepancy in psychological help into the same area of service, but different settings.

Methods: To analyze distress level for patients and caregivers in the starting moment of two different HCPCS (multicenter evaluation). In 2015 and 2016 we administered validated and standardized questionnaires: Hospital Anxiety Depression Scale (HADS) to 91 patients of the HCPCS and to 80 caregivers SFQ-SF (Family strain questionnaire-short form) to evaluate caregiver distress, and the CBI (Caregiver burden inventory) modified. Participation was free.

Results: For the 91 Patients it resulted that only 27% had a “normal” emotional state, 72% had mild (23%) or severe (49%) distress. About 80 care-givers, according to SFQ-SF just 11% of 39 caregivers had “normal emotional state”, 19% had a situation of mild emotional risk, 51% high risk, 19% urgent risk. For the other 40 analyzed with CBI mod: 13% had low, 33% light, 35% mild and 20% high burden of care.

Conclusions: Our data confirmed the data of Hospices psychological care. It was found even that in Hospices 60.8% of users had Psychological help, instead in the Home Care Palliative Care Services (HCPCS), only 23.6% had it. This low score was significantly correlated with high scores of volunteers help. The aim of this study is to evaluate this discrepancy in psychological help into the same area of service, but different settings.

Abstract number: PO163
Abstract type: Print Only

Anybody Out There? Ecograms as Facilitator to Engage Patients in Enhanced Supportive Care
Garcia-Baqueró Merino, Maria Teresa1, Franks, Alison2
1Medicina. Bioetica, Universidad Catolica de Murcia, Murcia, Spain, 2Coordenadora Regional de Cuidados Paliativos, Servicio Madrileño de Salud, Madrid, Spain

Background: Enhanced Supportive Care offered at the time of making the MDT decision to plan oncology treatment with palliative, rather than curative intent from the outset, or with the first recurrence, changes the patient’s illness trajectory. However, patients often find it hard to engage in non curative interventions as this seems to diminish their expectatives and hope.

Aims: To identify the interventions that could help patients accept enhanced supportive care to promote early palliative care provision.

Methods: Outpatient facilities within the oncology department were offered as a mean to maintain some normality within clinical routine. Six appointments continued the perception of continuity of clinical care as similar to number of Chemotherapy cycles and place of delivery.

Results: During the first appointment - when patient’s and family’s expectations were assessed separately, the “topic of the next 5 appointments outlined, 90% of our population was interested in knowing more about how we’d assess their support environment from all levels of social interaction and supportive networks.

Conclusions: Drawing together with patient and their significant others an Ecogram is a very powerful way of establishing points of safe social interactions, meaningful support areas and potential convective relationships.

Full of meaningful information, it was very acceptable and not threatening to the patient or family.

Abstract number: PO164
Abstract type: Print Only

The Use of the Genogram and Ecomap as Tools of Assessment in Palliative Care: A Pioneering Study in Portugal
Henríques, Joana1, Martins, Lima Sofia1, Sapeta, Paula1, Reigada, Carla2
1Escola Superior de Saúde Dr. E. Tôrres Dias, Instituto Politécnico de Castelo Branco, Castelo Branco, Portugal, 2University of Navarra, Institute for Culture and Society, Pamplona, Navarra, Spain

Background: Working with family carers is not a simple task. In the Palliative Care (PC) field, all stages of the family life cycle should be considered, giving rise to adequate and timely intervention. The Genogram and Ecomap are tools that allow understanding the family structure, as well as its dynamics, relationships and interactions. It is considered as efficient tools for the care planning, especially in situations of high complexity.

Aim: To understand the real use of the Genogram and Ecomap on the PC teams daily clinical work. Specifics aims:
1. Puchalski CM, Vitillo R, Hull SK, Reller N. Improving the spiritual care for Palliative Care. Presented at the 10th World Research Congress of the European Association for Palliative Care. Results of the pretest will be expected in March 2018 and can be pre-sent by email to PC teams at the national level.

Method: Pioneer empirical study, exploratory and descriptive nature, based on a mixed approach, with PC teams in Portugal. The data collection was carried out between April 2017 and August 2017, through an online survey sent by email to PC teams at the national level.

Results: Forty teams (47.62%) of the 84 invited, answered the study survey. Twenty-two (55%) teams responded that they had used the Genogram, but only seven (18%) use it in daily clinical practice. Social workers are the team members who usually start the family assessment using this instrument (n=14; 35%), followed by physicians and psychologists with the same results (n=12; 30%). The combined use of both instruments is very scarce, being the Genogram the preferred resource.

Conclusion: Several studies recognize the benefits of the Genogram and Ecomap simultaneously, for an efficient psychosocial diagnosis and clinical evaluation in PC. While the Genogram verifies the family evolution by identifying relatives of consanguinity, the Ecomap classifies family functioning identifying formal and informal networks. This study concludes that PC professionals in Portugal know about the Genogram; however, just a few teams use it. The training of professionals in these techniques could allow them to recognize it as useful, fast and efficient instruments for measuring the internal and external structures of the patient/family.

No funding has been provided for this study.

Keywords: Palliative Care; Family; Genogram; Ecomap; Assessment tools


Abstract number: PO165
Abstract type: Print Only

Spiritual Competences of Dutch Health Care Professionals, Providing Palliative Care
Roorda Carriene
Via Christian University of Applied Sciences, Health Care, Zwolle, Netherlands

Spiritual care is an essential domain of palliative care. The WHO Definition of Palliative Care includes the treatment of spiritual problems. While a majority of patients and caregivers would like to discuss their spiritual concerns, healthcare providers report several barriers in meeting the spiritual needs of patients, such as insufficient time, training, and support. Dutch guidelines recommend that spiritual care should be provided by all health care providers to a certain extent. In October 2017, The Palliative Care Consortium serving the Northeast Netherlands, started a research project on spiritual care in 30 organizations, providing palliative care to patients and their families. The aim of this project is to implement spiritual care in these 30 organizations by using an digital tool with several instruments on spiritual care and by training staff members. During this project, spiritual competences of health care professionals will be measured using the Spiritual Competence Scale in a pretest-posttest design. Results of the pretest will be expected in March 2018 and can be presented at the 10th World Research Congress of the European Association for Palliative Care.

References
Spiritual care is an essential domain of palliative care, which focuses on the needs of the whole person and their family. Spirituality can impact all dimensions of a person’s life including physical, psychological, and social—and vice versa.

The purpose of this research were

1) to describe and compare the spiritual needs and spiritual well-being among Thais with terminally ill who were receiving care from four different settings, including: home-based care, faith-based organization for people living with HIV; faith-based organization for people living with cancer, and hospice care units;

2) to compare the spiritual well-being by the frequency of spiritual practice.

This is a descriptive-comparative study. One hundred and seventy Thais with terminally ill receiving treatment in one of four selected settings were recruited to complete a demographic questionnaire, a spiritual need form, and a spiritual well-being questionnaire. The descriptive statistics were used to analyze the subjects’ demographics, spiritual needs, and spiritual well being. Analysis of variance (ANOVA) was used to compare the spiritual needs and Kruskal-Wallis was used to compare the spiritual well being by the subjects among the four selected palliative care settings and frequency of spiritual practice.

The results revealed that the most spiritual needs in the first three are:

1) to forgive someone;
2) to ask for forgiveness;
3) to receive advice or assistance from people around them.

Regarding spiritual needs, subject receiving care at faith-based organization for people living with cancer and home-based care had a significantly higher mean score than those in the other settings. With respect to the spiritual well-being, the terminally ill patients receiving care at faith-based organization for people living with cancer had a significantly higher mean score than those receiving care in the other settings. Subjects having more frequency of spiritual practice (making merit, mental development, wisdom development) had a higher score of spiritual well-being significant value of p < .001, p < .05, p < .001, respectively. The spiritual needs was positively correlated with spiritual well-being significant value of p < .01 (r = .265).

The results suggest that nurses should assess and respond to the spiritual needs of the patients to enhance the spiritual well-being. Spiritual practices have been shown to improve spiritual well-being so that incorporating spiritual practices as appropriate.

Abstract number: PO168
Abstract type: Print Only

"Life within the Person Comes to the Fore": Pastoral Workers’ Perspectives on Using Arts in Palliative Care

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Background: Pastoral workers (chaplains, spiritual carers) provide spiritual care through assisting people to find meaning, personal resources, and connection with self, others, and/or a higher power. Although essential in palliative care, there remains limited examination of what pastoral workers do.

Aim: To understand how pastoral workers use arts-based modalities and consider their usefulness in palliative care.

Methods: Qualitative research was used to examine the practice wisdom (tacit practice knowledge) of pastoral workers experienced in using visual arts and music in palliative care. In two, 2-hour focus groups pastoral workers discussed experiences and perspectives. Comparative, inductive, and cyclic thematic data analysis was informed by grounded theory. Pastoral workers were co-researchers and verified findings.

Results: Six pastoral workers with mean 6-years experience of using arts in palliative care at three hospitals in Melbourne, Australia, shared information. Three themes emerged. Pastoral workers use the arts as “another tool” to extend scope of practice by assisting patients and families to symbolically and more deeply contemplate what they find “sacred”. Pastoral workers’ art affinities inform their aims, assessments, and interactions. Clinical experiences inform pastoral workers’ beliefs that arts-based modalities can validate, enlighten, and transform patients and families through enabling them to multi-sensorially (through many senses) feel recognised, accepted, empowered, “lightened”, and/or close to God. Key elements involved in the work’s transformative effects include enabling beauty, ritual, and the sense of “home”, being heard, and leaving a legacy.

Conclusion: Pastoral workers interpret that offering arts-based modalities in palliative care can help patients and families to symbolically deal with painful memories and experiences, creatively engage with what and who matters to them, and/or encounter a sense of transcendence. The arts allow symbolic representations of otherwise unarticulated and unrecognized personhood. Training in generalist arts-based care needs to be offered in pastoral education. Locating the arts within pastoral care intervention codings would assist interdisciplinary communication about this valuable work. Further examination of pastoral workers’ interactions will enable deeper appreciation of how art enables the possibility of a life being lived, heard, valued, and healed until its mortal completion.

Abstract number: PO169
Abstract type: Print Only

Spiritual Pain Learning Using a Clinical Approach

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Background: Attention to spirituality is acknowledged as one of the spheres which conform adequate holistic care delivery. Yet, approaching it systematically remains challenging even in the most specialist settings

Aims: To assess the effectiveness of a clinically grounded model to identify, assess and treat spiritual pain in the dying.

Methods: This is a retrospective observational study. It looks at acceptance and professional impact of learning spirituality from different cohorts which include Specialist PC Services, Master degree students and undergraduates. It analyzes informal feed-back, surveys, impact on palliative care provision and how that changed after the teaching and societal based outcomes over 18 years of teaching over 1500 students involved

Results: The teaching format has a high acceptance rate in all groups. The impact of the teaching is highest the less experience the group members have, as more junior staff incorporate it with ease to their habitual care practice.
Meanwhile, the highest societal changes at professional levels came from the groups with most senior practitioners. More senior staff tend to use it in daily practice and helps those with an established way of working to lose their reservations and work towards giving their normal practice a spin with some interesting cases.

Abstract number: POI70
Abstract type: Print Only

Tracing the Memories of Persons Facing Advanced Cancer through a Life Review Intervention

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Background: Facing a life-threatening illness places the individual at the heart of existential questions. We developed an intervention, called Revie©, which target existential needs and was specifically designed for people with advanced cancer. The intervention promotes person’s growth and dignity, which are tenets of a palliative care approach. The intervention driven by specialized nurses included a life-review while integrating a positive approach. As a conclusion to the intervention, a booklet describing the patients’ life was created, integrating photos, citations or pictures. This booklet was subsequently given to the participants.

Aim: The purpose of this exhibition is to present a selection of passages from the booklets that illustrate the experience lived by patients facing life-threatening illness. The selections trace some significant live events, their current projects and important messages left for loved ones.

Method: A qualitative content analysis methodology was used to investigate booklets created in collaboration with 41 patients facing advanced cancer. The study took place in an ambulatory and inpatient setting of a Swiss university hospital.

Results: The main categories identified by two researchers after coding the content of the booklets were: focus on childhood, professional activities, important roles, impact of illness, values, resources, words left and life project. The majority of the booklets included pictures, poems, quotes chosen by the participants illustrating their experiences and emotions. The messages left to close relatives or to caregivers were words of love and notes of thanks.

Conclusion: Booklets describing patients’ life, integrating photos, citations or pictures helped to recognize the patient in his single existence. The intervention also addressed the concerns around death and ultimately helped clarify life plans.

Abstract number: POI71
Abstract type: Print Only

Back to the Future: A Historical Analysis of Sympathy, Empathy, and Compassion within Medicine, Nursing and the Humanities

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Background: While the perspectives of current patients, healthcare providers, policy makers, researchers and contemporary thinkers can help distinguish between sympathy, empathy and compassion, informing expression of these care concepts within clinical practice, history remind us that contemporary thoughts on the nature and differences of these concepts may not be as novel, revolutionary, and enduring as we might think.

Aim: The purpose of this presentation is to provide an account of the evolution of these terms within history and contemporary healthcare in order to provide clarity and to understand the clinical implications within current practice.

Methods: A literature review of the terms sympathy, empathy and compassion within the nursing, medicine and humanities literature (utilizing Proquest, Pubmed and the grey literature) was conducted. A synthesis of the evolution of these terms within the health care literature was then conducted in order to provide a historical understanding of the evolution of these terms throughout history and how they compare and contrast with contemporary understandings.

Results: The findings of this review revealed that while these terms share a common lineage, they also evolved, developed and borrowed from each other over time. While sympathy has become associated with a purely based response based in a lack of understanding and action, prior to the 20th century it shared a number of commonalities with contemporary understandings of compassion. Empathy, was a product of early 20th century psychology, describing the ability to project the self into another persons situation by understanding and resonating with what others are feeling and thinking. Compassion, traditionally has held a deeper and more spiritual meaning, being motivated by love and a spiritual connection to all living beings that requires practical action in order to alleviate the suffering of a person in need.

Conclusions: While patients have been considered palliative care providers greatest teachers, history provides important wisdom from the perspective of hindsight related to the origins, evolution and implications of these terms. This knowledge has bearing on clinical practice, while also helping to ensure that history doesn’t repeat itself within the contemporary healthcare literature related to these topics.
Hence, to validate a certain instrument empirically, it should

1) be corroborated that it is significantly and substantially associated with self-descriptions as spiritual and
2) clarified how it is associated with self-descriptions as religious.
   To show the potential of a certain instrument for health-related research
3) it should be tested whether it can substantially predict outcomes such as well-being or quality of life. However, in order to avoid contaminated results,
4) it should be checked that effects are not due to implicit operationalizations of positive psychological states within the spirituality measure itself.

This validation procedure will be exemplified using Hood’s Mysticism Scale (M-Scale) which has been administered to three samples: a German (N = 773) and a U.S. American sample (N = 1113) of persons interested in spirituality and a German sample (N = 919) representative for the general population. By ways of structural equation modeling the components of the M-Scale are used to significantly and substantially predict self-rated spirituality (1) and religiosity (2), as well as psychological well-being (3). Additionally, it will be shown that deleting the component ‘positive affect’ of the M-Scale from the models does not decrease effects substantially (4). Hence, the M-Scale can be regarded as a valid measure of spirituality which can be used successfully in health and palliative care research.

Abstract number: PO173
Abstract type: Print Only

Unmet Information Needs of Family Caregivers of Egyptian Patients with Advanced Cancer
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Background & aim: In cultures where there are strong family bonds, like in Egypt, family caregivers play a crucial role in the care of patient with advanced cancer and they have their own needs. Little is known about the needs of family caregivers in our region, including the information they need to know. The aim of this study was to explore the information needs of cancer patients’ family caregivers in Egypt.

Methods: The study included 50 family caregivers of patients with advanced cancer. Caregivers were asked to enumerate what information they need to know about their related cancer patient. The expressed information needs were grouped according to their themes.

Results: The median age of family caregivers was 36 years (range 21-78), and were mostly a spouse (52%) of a person with advanced cancer. To introduce the concept of palliative care, caregivers wanted routinely available written resources about palliative care, supplemented by conversations that are ideally staged overtime. Education about the tasks of palliative care should be separated from referral process, allowing time for gradual adjustment, and re-visiting discussion to enable patients and families to take some control in the process of transition. Once death is imminent, carers wanted health professionals to clarify how much they want to know about the dying process; provide spoken acknowledgement when death is close; include the words ‘death’ and ‘dying’; use direct language and avoid euphemisms; and communicate about death with the patient present.

Conclusions: This study builds upon existing guidelines and offers health professionals some important considerations around how to communicate with family caregivers about death, dying, and the introduction to palliative care.

Abstract number: PO175
Abstract type: Print Only

Attitudes and Opinions of Elderly Patients and Family Caregivers on End-of-Life Care Discussion
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Background: End-of-life (EOL) care decisions have become an urgent issue in Korea in response to recent legislation called the Life-Sustaining Treatment Decision Act of 2016. The present study attempted to explore attitudes and opinions on EOL discussion among elderly patients and their family caregivers since communication regarding EOL care has been argued to be a major premise leading to the best decision making.

Methods: The attitudes and opinions of elderly patients and their family caregivers were solicited through focus group interviews. The final sample consisted of 12 patients and 16 family members.

Results: Guided by content analysis, 5 themes were revealed. The identified themes were individual approach for delivering bad news and
stakeholders involved in the discussion, contradictory attitudes toward advance care planning, mutual understanding, hope for the EOL care discussion process, and resistance to discussion of hospice-palliative care.

Conclusion: Study findings suggested that an approach focusing on the individualized needs of patients and family members is required in EOL care discussion for elderly patients.

Abstract number: PO176
Abstract type: Print Only

Development and Advancement of Hospice and Palliative Care Networks - Recommendations for Action
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Background/aims: Hospice and palliative care (PC) networks facilitate access to services and quality of care. The Bavarian State Ministry of Health and Care fosters regional network building and strengthening in Bavaria, Germany. The research project aimed at systematically documenting networking practices.

Methods: Data were collected in six mixed-methods study phases.
1) To gain information about general conditions under which networks perform, 10 semi-structured interviews were conducted (March-June 2015).
2) Information was augmented by an online survey (n=12; April-June 2016) to quantitatively assess partners.
3) Interview data were discussed with 8 network representatives in a workshop (November 2015).
4) A recommendation for regional hospice and PC networks was drafted in cooperation with key findings.
5) Relevance and feasibility of the individual draft recommendations were rated via online consensus survey (n=11; November-December 2016).
6) In an expert workshop (March 2017) with 7 participants examples of realisation were developed to enrich the revised recommendations.

Results: Missions and aims, roles and responsibilities, coordination, communication and information channels, public visibility and funding emerged as key themes of those working in networks. A total of 23 recommendations were drafted for the six thematic fields. For the 23 recommendations, 90.6% of the participants fully or somewhat agreed that feasibility is given regarding the building and development of hospice and PC networks and 93.2% fully or somewhat agreed that the individual recommendations are important for network building and development.

Conclusions: This study was the first to develop empirical recommendations for the establishment and development of hospice and PC networks. The recommendations will aid those working in the field of emerging and developing networks.

Funding
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Abstract number: PO177
Abstract type: Print Only

Emotional Labour in End of Life Care Communication: A Qualitative Study of Generalist Staff
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Background: Most end of life care (EoLC) is provided by staff without specialist palliative care qualifications (known as generalist providers). EoLC includes ‘difficult’ conversations with patients and families about disease progression and dying. This challenging work involves emotional labour: inducing or expressing feelings for the benefit of others. Understanding the impact of this work is essential to better train and support staff, however current evidence is limited.

Aim: To explore how generalist staff experience and manage their emotions in relation to EoLC conversations with patients and families.

Methods: Semi-structured qualitative interviews were conducted with delegates of an EoLC communication skills workshop run in hospital and community settings. Participants were sampled purposively (e.g. by discipline). Data were analysed using a framework approach, with a sample of transcripts dual coded for rigour. Data collection and analysis were informed by Hochschild’s (1983) theory of emotional labour.

Results: 10 professionals participated: 4 ambulance staff, 2 community nurses, 2 speech and language therapists, 1 therapy assistant, and 1 healthcare assistant. Five themes emerged: emotions experienced, emotion ‘display rules’, emotion management, perceived impact on care and support needs. Emotions experienced were skills focused (e.g. job satisfaction) and situation focused (e.g. empathic distress). Although often not taught in professional training, participants felt a need to limit emotional expression to benefit patients, and balance ‘human’ and ‘professional’ expressions. Emotion management strategies during interactions included avoidance, putting emotions on hold, controlled expression, and afterwards using reflective practice and cathartic activities. Support needs included time for emotion management, a workplace culture that normalises emotional experiences, formal support structures, and skills training. Addressing emotional needs was seen as crucial to professional wellbeing and high-quality care.

Conclusion: Generalist staff prioritise management of patients and families’ emotions during EoLC communication, necessitating emotional labour for staff. To promote professional well-being and high-quality care, formal staff support and training are required, in addition to a culture that normalises emotional experiences and allows time for emotion management.

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Sharing Expertise in Palliative Care: A Cross-sectional Survey among Physicians in the Southwest Region of the Netherlands
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Aim: In the Netherlands, all healthcare professionals are expected to be able to provide palliative care. Expert advice is available through Palliative Care Consultation (PCC) teams. However, not all physicians know or use these teams. We aimed to study physicians’ awareness of, experiences with, and attitudes towards PCC teams.

Methods: A sample was drawn from a professional registry of physicians working in primary care, hospitals and nursing homes (n=2117). We also
invited physicians to participate via professional palliative care networks. Questionnaires were provided on paper and online.

**Results:** 543 physicians participated. Access to expert advice on palliative care was perceived as (very) important by 88%. A majority consulted fellow physicians for palliative care advice (82%, median=3 times a year). PCC teams were consulted by 51% of all responding physicians (median=2 times a year). They rated the quality of the obtained advice at 8.1/10. The percentage of physicians who knew about the availability of a PCC team in their region ranged from 78% among hospital physicians, to 86% among nursing home physicians and 91% among general practitioners (GPs). Of the GPs who knew about a PCC team, about 4 in 5 had also contacted the team for advice; this was 2 in 5 among nursing home and hospital physicians. Motives to contact or not contact PCC services and preferred methods of sharing palliative care expertise varied across medical disciplines.

**Conclusion:** Most physicians agree that access to expert advice is important and their satisfaction about PCC team advices is high. However, about 1 in 5 hospital physicians and 1 in 10 primary care physicians are not aware of the availability of PCC teams. Among the physicians working in hospitals or nursing homes who are aware of the availability of such teams, a minority actually use PCC services. Our results can inform PCC teams on new, tailored strategies to optimize sharing of expertise in palliative care.

**Funding**

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**Abstract number: PO179**

**Abstract type: Print Only**

**Development and Preliminary Evaluation of a Complex Intervention on Communication for Hospital Physicians**

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**Back ground and aims:** In the last 20 years it has been a rapid escalation of communication training in oncology and palliative care. These training are based on the assumption that healthcare professionals’ communication competencies can be actively learned and improved. The improvement of a different training course looking to the evidenced limitations from the literature is mandatory in the hospital health system. The aim of this study was the development and the preliminary assessment of a communication training program for hospital physicians working with advanced oncologic patients.

The training was developed and implemented by an hospital Palliative Care Unit (PCU).

**Methods:** This is a Phase 0-1 study, according to the MRC Framework for the assessment of the complex interventions. A literature review was performed to identify the effective intervention components. A mixed method approach was used to preliminary assess the intervention. A semi-structured questionnaire was administered to enquire trainees on the perceived usefulness of each component. At the end of the implementation, trainees who did not complete the programme were interviewed, in order to explore strength and weaknesses of the intervention.

**Results:** From the literature review the novel communication training was developed, comprising six potentially effective components: didactic lessons; educational videos; role play with peers; encounter with real patients at the presence of the trainer (bedside training); small groups of physicians for didactic lessons and role plays; intervention delivered in the same ward where physicians usually work. The intervention was proposed to the 18 physicians of 2 hospital wards (Oncology and Hematology department), and 100% accepted to participate but only one third of them participated in the bedside training. Finding from questionnaires showed that the physicians respond on the usefulness of each component, and particularly of role plays and bedside trainings.

The implementation was successful in oncology in the established timing (2 months) but not in hematology (6 months) where physicians have more difficulty to identify opportunity for the bedside training. Qualitative analysis of the interviews are ongoing.

**Conclusions:** Preliminary results support the feasibility of 5 out of 6 components. The qualitative research planned after the quantitative results will give us some suggestions concerning the failure of the bedside component of the program.

**Abstract number: PO180**

**Abstract type: Print Only**

**Patient Involvement in the Decision Making Process of Transfer: Palliative Patients’ Perspective**

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**Background:** Seamless integration of patient centered care is a challenge when transferring palliative patients from one care setting to another. Demographic changes (people living longer, having multiple chronic diseases etc.) and social changes (more people living alone), make palliative care more complex and transfers more usual. Transfer to another care setting (from home to hospital or hospital’s palliative unit etc.) is needed for medical (symptom control; complications…) or social reasons. Palliative patients’ involvement in the decision making process when being transferred is however unclear. This research focuses on palliative patients’ involvement: what are the perceptions and expectations of palliative patients towards involvement in the decision making process about transfer?

**Methods:** Semi-structured interviews with 20 palliative patients in different settings: home, nursing home, hospital’s palliative care unit, oncology unit, palliative day care center. Variation in age, gender and main pathology was taken into account. Thematic analysis was used to analyse data.

**Results:** Patients perceived transfer from home or nursing home to the hospital mainly as the physicians’ decision. Patients felt more involved in the decision making process if the transfer concerned the palliative care unit or palliative day care center. In hospital settings, patients reported to be hardly or not involved. On the contrary, they were informed without mutual deliberation about the feasibility of discharge. In general, patients expected to be involved in transfer decisions. There was variance, depending on age and setting. Younger patients expected active involvement. Elderly patients in nursing homes preferred the general practitioner to take decisions. In home care situations physicians’ decision for transfer to the hospital was accepted, due to patients’ medical condition. The perceived need for involvement in the decision process was high when patients were transferred from the hospital to the home situation.

**Discussion:** The findings show room for improvement for palliative patients’ involvement in decision making. Patients accept less involvement in decision to the hospital, as they might experience this as a medical decision. Patients’ age is an influencing factor for shared decision making. Further research on transfer conditions and patient involvement is recommended to optimise patient care.
Abstract number: PO181
Abstract type: Print Only

The Preferences of Cancer Patients and their Families Prefer That When Physicians Delivery Bad News
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Background: This study collected data by the measure for patient’s preference-Japan (MPP-J). The objective of this research aims to realize the preferences of breaking bad news, and differences of conveying related information of cancer patient’s conditions among physicians, patients, and the families.

Methods: Duration of data collection was from January 2014 to December 2014. Sixty-five cancer patients who are suffering from lung cancer, gastroenterology and hepatology related cancers, oral cancer, breast cancer and cervical cancer, and thirty-five family members were attending in this research. They all had acknowledged the diagnosis and current medical circumstances. One Way ANOVA test indicated that patients and family members preferred physicians breaking bad news without difference of gender, religion, stage of disease and diagnosis. Regression analyzes indicated that the age (p<.01) has positive correlation between the total scales, the Setting subscales and the Additional subscales. Regression analysis also indicated that age (p<.001) and education (p<.01) has positive correlation among the Setting subscales.

Results: According to this study result, physicians did not break bad news to patients and family members at the first interview. Old age of attendees showed a significant higher preference of “medical information”, “clear explanations”, “warm and decisive tone of voice” than young ages. In addition, low education attendees showed a significant higher preference of “medical information” and “clear explanations” than high education attendees.

Conclusions: Given that the families were recruited as study subjects in addition to the cancer patients, it would be beneficial to conduct a qualitative research on the families. It will help look into how they feel upon attending in this research. They all had acknowledged the diagnosis and current medical circumstances. One Way ANOVA test indicated that patients and family members preferred physicians breaking bad news without difference of gender, religion, stage of disease and diagnosis. Regression analyzes indicated that the age (p<.01) has positive correlation between the total scales, the Setting subscales and the Additional subscales. Regression analysis also indicated that age (p<.001) and education (p<.01) has positive correlation among the Setting subscales.

Abstract number: PO182
Abstract type: Print Only

Filipino Patients’ Awareness of their Prognosis and Participation in Decision Making and Treatment Planning
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Introduction: The trend in recent years has been one of greater patient participation in illness management decisions. Patients or their surrogates should be involved in decisions if they wish to do so, and their preferences and values need to be better taken into account. Such conversations are never easy because sadness, grief, and fear of the unknown are inevitable. In order for the patient to be able to participate positively in this process, he has to be provided with accurate information in the appropriate language at the appropriate time in the course of his illness. There is complete centrality of the family for the Filipino. The family tend to shield their patient from bad news and would request doctors not to disclose diagnosis and prognosis.

Objectives: To determine advanced cancer patients’ awareness and preferences for prognostic information, their preferences for treatments and role in decision making in the Philippines.

Methods: Two hundred patients with Stage IV cancer admitted to the inpatient and outpatient clinics at the Cancer Center, The Medical City are recruited to the study.

The previously validated survey instrument (APPROACH) has questions on awareness of and preferences for prognostic information and role in decision making and treatment preferences.

Results: The following are the cited reasons why patients prefer disclosure over non-disclosure of their diagnosis: ability to resolve unfinished business, right to know the truth, fostering cooperation between patient and physician, and relief from unnecessary treatments. There are fewer patients who prefer not to know their real medical condition. Their reasons: disclosure can cause them psychological and emotional distress, and it may be meaningless and could not give help to them. Some patients believe that what they don’t know cannot hurt them. Thus, they prefer not to be informed of the gravity of their sickness. Filipinos, specifically tend to leave things up to fate or destiny, thinking that everything happens for a reason; and this includes their illness and anticipated death.

Conclusions: A greater awareness and understanding of cultural and family structure factors influencing end-of-life decision-making will assist the hospital staff in providing optimal supportive oncology and palliative care.

Abstract number: PO183
Abstract type: Print Only

What Are the Views of Palliative Care Patients Living in Malaysia on Advance Care Planning?
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Introduction: Advance care planning (ACP) is a process of communication among patients, their health care providers and their loved ones to inform future clinical care when patients lose their ability to make informed decisions. Research has shown that the use of ACP has a positive impact on the quality of end-of-life care. However, many studies have shown that the extent to which patients wish to engage in ACP discussions varied considerably.

Aims: The aim of this research is to gather information on the views of palliative care patients living in Malaysia on ACP.

Methodology: A qualitative method, using the concepts derived from grounded theory, is used. Semi-structured interviews with a purposive sampling of fifteen participants were conducted. All interviews were audio-taped, transcribed verbatim and analyzed.

Results: The two themes emerged from this research were individualized planning, awareness and education. In individualized planning, factors which shaped future planning included spirituality, prior experiences and psychosocial process. Personal belief and religion were important factors in deciding future care. Some participants wanted to plan for better end-of-life care, others wanted to take a one-day-at-a-time approach. Personal and health care experiences in the past also played a role in participant’s perception of future care. Planning for advance care needs to include potential psychosocial impact on the participants for example burden to family. Awareness and education described participants’ wish for more information on ACP, palliative care, their diagnosis and prognosis. Participants wanted doctors to initiate discussions on ACP. Public awareness campaign were suggested to improve public’s perception on ACP and to break the taboo of talking about death and dying.

Conclusions: This research study has given better insight on the views of palliative care patients living in Malaysia on ACP. Exploration of ACP has to be individualized because each palliative care patient’s story is unique, shaped by their own belief system, prior experiences, psychosocial factors as well as their awareness and knowledge of their disease, palliative care and how ACP can help them plan for the future. Health care professionals should give more information on diagnosis and prognosis in a sensitive manner and be ready to initiate ACP conversations.
Abstract number: PO184
Abstract type: Print Only

Integrating Palliative Principles in Cirrhosis Care: A Look into How Cirrhosis Patients Respond to Advance Care Planning Issues

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Introduction: Survival in cirrhosis is poor and symptom burden is high. Liver transplantation is the only definitive treatment option, but it is not universally available. Despite poor prognosis, many patients are unfamiliar with advance care planning (ACP). There has been little research about ACP and GCD specifically among cirrhosis patients. The objectives of this prospective quantitative analysis were to assess the familiarization with ACP in an outpatient cirrhosis population and to evaluate their experience with ACP discussions.

Methods: 361 patients screened and 141 patients were enrolled, and results underwent qualitative analysis. Patients were recruited from two subspecialty cirrhosis clinics in Edmonton, Canada. Ethics approval, inclusion and exclusion criteria are outlined.

Results: Results presented will summarize the demographics of the enrolled patients, and the clinical characteristics of the enrolled patients, including aetiology of cirrhosis and prognosis. 71.3% were Child-Pugh Class A (71.3%) and correspondingly based on the MELD score, 95% had a 3-month mortality of <4.5% had a 3-month mortality of <6%. Forty-four patients were on the liver transplant waiting list at the time of the study. Eight months after beginning the study, 23 patients (22.8%) had been hospitalized, and 7 (6.9%) patients had died. All patients indicated they were aware they had liver disease, and 97% of patients indicated it was extremely important to know the truth about their illness. Only fifty-three patients (52.5%) felt that having liver disease would affect their quality of life. Discussion will summarize the responses to categorical questions regarding their knowledge about and the importance of ACP. Responses from an open-ended question asking patients to list other qualities that are important to ACP discussions will be shown. Nearly 43% of patients with completed GCD forms indicated the forms were completed by a hospital physician, rather than their family physician or Hepatologist.

Conclusion: This study found that there is a significant gap in the knowledge and understanding of ACP in cirrhosis patients. Nearly half the patients were not aware that cirrhosis would affect their quality of life and most patients were unfamiliar with ACP. Despite this, the majority of patient indicated they want to know the truth about their health and they want ACP discussions to occur early. Work is ongoing to promote these discussions early in illness.

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The Development of a Awareness Tool for Identifying Palliative Care Needs for Nurses

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Background: It is important to early identify patients with palliative care needs to avoid curative overtreatment or palliative undertreatment. Nurses play an important role in identifying palliative care needs. The aim of this research was to develop a tool to improve the awareness of nurses for patient identification for a palliative care approach in the hospital.

Method: We conducted a literature search on existing identification tools of Cochrane, Pubmed, Invert, Springerlink, Google Scholar, Medline, Science direct, CINAHL, EBSCO and PiCarta. Abstracts were reviewed and included if an identification tool was described for patients with COPD, heart failure or cancer. Subsequently we conducted 11 semi-structured interviews with 4 medical specialists, 2 physician assistants and 5 nurses working with these patients on which indicators they found important for nurses. We applied thematic data-analyses.

Results: We extracted relevant indicators for nurses from existing tools for identification: increased dependence on others, weight loss and frequent hospitalisations. These indicators were complemented with two indicators within the spiritual dimension: experiencing fear and the need to discuss spiritual concerns. The interviews showed that diagnostic parameters, poor physical condition and patient’s wishes to complete life in a good manner are relevant indicators, as well as a clinical view which indicates the end of life is imminent, frequent hospitalisations, high age and comorbidity.

Conclusion: We found several indicators for nurses to improve their awareness for patients with palliative care needs. These indicators are included in a tool, which will be tested at our hospital. These results will be presented during the congress.

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Advance Care Planning in Palliative Care for People with Intellectual Disabilities: An Explorative Study

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Introduction: Advance Care Planning (ACP) is a process in which patients and relatives, together with professionals, discuss wishes and preferences for future care and treatment. The purpose of the study was to investigate the ways in which ACP has been carried out for people with intellectual disabilities (ID), and learn about barriers and facilitating factors for ACP.

Methods: The study was done in four institutions providing care for people with a mild to severe ID. Data from medical records were analysed of a total of 15 patients in the palliative phase and 15 deceased patients. Patients in the palliative phase were identified by their doctors with the surprise question. Additional semi-structured interviews were conducted with their relatives (n = 30) and professionals (n = 30).

Results: Nearly all (93%) patients had a do-not-resuscitate declaration. In a smaller group other (medical) decisions were reported, mainly the absence of treatment or hospitalization (43%). In the interviews, all relatives stated they were satisfied with the information they received about the expected course of illness and possible treatment options. Due to low cognitive and communicative abilities, most patients were not involved in ACP. Relatives and professionals experienced difficulty in deciding on behalf of someone else.

Conclusions: In the records, mainly medical decisions were reported. Professionals should be informed about the need to register medical as well as nonmedical decisions and learn about the content and benefits of ACP. The importance of intensive collaboration between professionals, relatives and patients with ID for ACP should receive attention. In addition, there is a need for training professionals in communication skills to discuss wishes and preferences for future care with patients with ID and/ or their relatives.
Primary Care Physician Attributes Associated with Promoting Advance Care Planning Conversations: Analysis of an International Survey

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Background: Sparse data exist concerning the characteristics of primary care providers (PCP) and practice attributes associated with advance care planning conversations (ACPC).

Aims: To describe the frequency which PCPs report routine ACPC with older or sicker patients, and to identify practice attributes, including being a patient centered medical home (PCMH), associated with physician-patient ACPC.

Methods: The 2015 Commonwealth Fund International Survey of Primary Care Physicians in 10 Nations contains representative data from PCPs in 10 developed countries. Our main outcome is PCP reported frequency of ACPC with older or sicker patients. Variables include: PCP/practice characteristics, practice related stress, and reimbursement mechanisms. Using these data, we first analyzed US PCP responders based on reported PCMH affiliation. We will show an index of PCMH, developed using appropriate survey questions, and apply the PCMH similarity index to non-US responders. Bivariate analyses used chi squares; variables with significant associations (p < 0.05) were included in multivariable logistic analyses.

Results: Among US PCPs, 458/977 (47%) reported routine ACPC with older or sicker patients. PCPs age 45+ years (73%) and male sex (60%) had more ACPC (p < 0.001). When PCPs saw patients with multiple chronic conditions (83%), palliative needs (22%), or provided home visit (39%) they had more ACPC (p < 0.001). PCPs in organizations responsible for managing patient health costs had more ACPC (p < 0.01), while being in a PCMH or integrated healthcare systems was not associated. All reimbursement mechanisms (e.g. fee-for-service, capitation, salary-based) were associated with ACPC. PCPs considering their work stressful (44%), had less ACPC (p < 0.01). Multivariable logistic modeling (N=726) identified seeing patients with multiple chronic conditions, seeing patients with palliative care needs, providing home visits, and capitation as independently associated with ACPC (p < 0.001). We will report similar analyses with the PCMH similarity index for all 10 countries, using country as random effect in multivariable modeling.

Conclusions: Among US PCPs and practices, seeing patients with multiple chronic conditions or palliative care needs, and providing home visits are strongly associated with having ACPC with older or sicker patients. We will present findings from all 10 countries to describe the potential association of PCMH-like primary care practice attributes and ACPC.

Abstract number: PO189
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Improving Advance Care Planning in People Diagnosed with Dementia: Insights from Prochaska’s Transtheoretical Model

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Abstract number: PO188
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“What If...?” Preferences and Needs of Patients and Caregivers Regarding Comprehensive, Coordinated Anticipatory Planning - A Qualitative Study

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Introduction: The Swiss National Strategy for Palliative Care (2013-2015) identified Advance Care Planning (ACP), so far less well established as in other countries, as a field for action. To implement this strategy and to raise awareness, the Inselspital Bern will introduce a systematic approach to anticipatory planning including ACP support. However, little is known about patients and caregivers needs regarding the ACP process, and what they could gain from it.

Aim: Our aim was to employ a participatory approach to learn about the preferences and needs of patients and caregivers regarding anticipatory planning / ACP.

Methods: A qualitative study was based on analysis of published and unpublished sources, from which an interview guideline was developed. A total of 25 participants in three focus groups shared their views in sessions lasting two hours on average. Participants were either members of the hospital’s patient and caregiver advisory board, or members of patient support groups of the cantonal cancer and lung leagues. Group discussions were recorded and transcribed. The texts were analyzed using a summative qualitative content approach.

Results: The willingness to collaborate in this project and the attendance for the focus group interviews was remarkable. Patients and caregivers readily accepted the hospital’s strategy to improve anticipatory health-care planning:

- Discussions of anticipatory planning should be offered regularly as a mandatory part of best care
- Patients accept physicians and nurses to discuss preferences, whereas family carers expect physicians to take the lead
- Open-minded, direct dialogue in easy to understand language is desired
- IT solutions accessible in all settings are necessary for the exchange of information between all levels of the healthcare system
- Advice and support with handling advance directives are welcome
- Specific needs of groups such as migrants need to be considered
- Patients advise to avoid pseudo-participation in decision making if theory does not match with clinical practice

Participants pointed to being aware of the danger that a topic such as anticipatory planning/ ACP can be misinterpreted as a step towards cost reduction.

Conclusion: Patients and caregivers want to actively participate in the design and implementation of a program on anticipatory planning. Their feedback has been integrated into an information booklet on this topic responding to the often unheard needs of patients in this highly sensitive area.

Abstract number: PO189
Abstract type: Print Only

Improving Advance Care Planning in People Diagnosed with Dementia: Insights from Prochaska’s Transtheoretical Model

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Background: Even though most patients with dementia expectedly lose communication and decision-making capacity, advance care planning (ACP) is yet to become widespread. Barriers include not considering dementia a terminal disease, lack of specific interventions and difficulties in identifying the window of opportunity to initiate a conversation about ACP.

Aims: Based on a literature review, we use an innovative approach based on the 5 stages posited by Prochaska’s behavioral model - namely “pre-contemplation” and “contemplation” (“I wish”), “preparation” (“I will”) and “action-maintenance” (“I did”) - to discuss specific processes and tools to promote ACP in dementia.

Results: The awareness of people in the first two stages may be raised by information campaigns explaining the incidence, evolution, prognosis, and implications of dementia for patients and their relatives. Public
A Mix Method Study

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Statement of aims: Advance Care Planning (ACP) facilitates the expression of values, goals and preferences of people with advanced chronic conditions (ACC) and it enables the decision-making process. The literature describes many benefits of ACP. However, professionals state that there are many difficulties involved in its implementation and demand specific training on this topic. A mix method study (MMS) has been designed and is being implemented in one primary care team in Catalonia (Spain).

Aims: The aims of the study are:

a) to measure the self-efficacy in ACP prior and after the implementation of an ACP training program, through the Advance Care Planning -Self Efficacy (ACP-SE) questionnaire, which was previously translated into Spanish;

b) to explore the engagement, barriers and beliefs of ACP.

Presentation of methods: The MMS includes physicians and nurses working with people with ACC and complexity in primary care (PC). The ACP-SE questionnaire will be used to measure the impact pre, post and 6 months after the training.

Two levels of training (basic and advanced) have been designed:

1) E-learning training (ET) for general contents and
2) Face-to-face training (FTFT) for specific contents.

Contents are focused on conceptual aspects of ACP (ethics, legal aspects, benefits, difficulties and barriers of ACP) and practical aspects of ACP implementation (who, when and how to lead the ACP process).

Two focus groups (1 for Nurses, 1 for physicians) were conducted to identify the individual approach to the ACP understanding. A transcription of the surveys and a qualitative analysis per subject of the content of the participants’ discourse will be performed. Data will be analyzed with Atlas.ti.

Presentation of results: 6 participants took part on the nursing group; 7 on the GPs. Preliminary results show participants know the meaning of ACP but mainly associated to end-of-life processes. They express many barriers regarding communication issues (difficult conversations).

The self-efficacy questionnaire will be facilitated to those participants in the ET and FTFT, before and after the courses. We expect an improvement of competences in ACP after the training.

Conclusion: This study explores the professionals’ understanding of ACP, and enables the adaptation of the training to their beliefs. To measure the impact on the self-efficacy competency in ACP before and after the training activities might validate the importance of the ACP-TP.

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Impact on the Self-efficacy of a Primary Care Group of Professionals after an Advance Care Planning Training Program (ACPTP).

Funding
This work is partially funded by the Swiss Academy of Medical Sciences.

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Training and Certifying Advance Care Planning Community Guides Using the RELATE™ Model of Communication and A Long-standing Community-academic Partnership

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Aims: This project aims to develop, pilot, and implement a community-based certification program that rigorously trains volunteers in Advance Care Planning (ACP) communication skills.

Study population: Using an untapped resource in the community – volunteers – we describe the development of an ACP community guides certification program with goal of increasing community capacity and influencing cultural change to support improved ACP.

Study design and methods: To improve both the quality and quantity of ACP, we leveraged expertise in communication theory, volunteer training, and strategies for ACP engagement. We developed the program using 3 phases: Program Development, Pilot, and Implementation. Evaluation of the Pilot phase focused on participant feedback and communication quality through direct observations, de-briefing between the ACP trainee and a community volunteer they spoke with as part of their certification, and brief follow up interviews with both participants. The iterative development of this program led to the parallel development of the RELATE™ Model of Communication for ACP (Rapport, Explore, Listen, Adapt, Tailor, Empower), a novel communication model designed for peer-to-peer community-based interactions.

Results: The Program Development and two Pilot phases are complete; we have trained 39 ACP Community Guides. The Program includes 16 training hours over 4 sessions covering 5 areas:

1) The RELATE™ Model of Communication;
2) ACP document proficiency;
3) Sensitivity to culture and diversity;
4) Connecting to healthcare systems and
5) Creating a learning community among ACP guides. As part of earning certification, ACP guides complete 3 real-world ACP conversations and demonstrate competency in communication and knowledge of ACP forms and strategies for linking ACP to the healthcare system. Participation rates and post-session feedback support the feasibility and acceptability of the Program. Additionally, trained volunteers demonstrated use of the RELATE™ Model of Communication.

Interpretation: The ACP Community Guides Program can attract and train community volunteers to have quality ACP conversations in the
community. Moreover, trained volunteers may be able to increase the quality and quantity of ACP discussions and documentation thereby decreasing the burden placed on healthcare providers and increasing the link between the community and the healthcare system.

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Introducing Advance Care Planning for Patients with Life-threatening Pulmonary Disease in the Hospital Setting - What Do Patients Talk about?
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Background and aim: Advance care planning (ACP) is a tool for communication about and mapping of patients' wishes, priorities and preferences for end-of-life care. ACP is not routinely used in any hospital in Norway. We have completed a project piloting ACP conversations at a Department of Thoracic Medicine in a Norwegian teaching hospital. The aims of this study were to explore which themes were brought up among patients with life-threatening pulmonary diseases and their relatives, and how they experienced the conversations.

Methods: We conducted a qualitative study of ACP conversations with 53 patients (41-86 years, mean 69; 9 with COPD and 44 with lung cancer), 11 of them women, and 18 accompanied by a relative. Nineteen patients were approached, and 66 refused to participate, for reasons spanning from disinterest to 'bad timing'. All participants gave written, informed consent. Using a list of topics as a guide, a study nurse or the attending physician invited the participants to talk freely about matters of importance for their present and future situation. Each conversation was summarized in a written report, and the reports analyzed using systematic text condensation.

Results: Participants talked about four main themes:
(i) Disturbing symptoms and management of these,
(ii) existential issues such as resilience and death,
(iii) planning of their future treatment and care, and
(iv) important relationships, mostly within their own family.

Rather than focusing on an approaching death, many of them talked about symptom control now and in the future. Patients and relatives appreciated the ACP conversations and recommended them to be offered on a routine basis. The summaries revealed personal views and values previously unknown to the health care professionals. Important information was passed on to the primary care services.

Conclusions: ACP conversations answered an unmet need and brought forth important information about the individual patients. Issues crucial for further care and coordination were noted in the ACP summary, supplementing the ordinary medical record. Our results support the use of ACP on a routine basis.

Abstract number: PO193
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What Differences Are There between the Wishes and Values of the Patients with Chronic Conditions (PCC) and Advanced Chronic Condition (PACC) Cared in a Nursing Home Center versus Patients at Home?

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Background: Go Wish Card Game (GWG) is an advanced care planning tool developed to facilitate conversations about end-of-life (EOL). We have little knowledge of wishes and values in PCC and PACC

Aims: To Identify the main wishes and values of PCC and PACC in an EOL conversation at Nursing Home and compare to wishes and values of patients at Home

Methods: PACC and PCC from Nursing Home (NH) admitted to the inpatient unit of intermediate and long term care and PACC and PCC from the Chronicity Home-Care-Team were recruited. Their competency was registered by Drane’s sliding scale (DSS). The Cognitive Impairment was registered with Pfeiffer Questionnaire (PQ). Sociodemographic data were recorded. We used the GWG as a tool to talk about EOL. Patients were asked to categorize these wishes as important or not important; which 10 wishes were the most important; and to assess the usefulness and appropriateness of the interview. A standard descriptive analysis was carried out by SPSS 21.0

Results: 18 women and 12 men from NH were included; average age was 82.9 ± 7.8. The DSS Levels were: I (3.3%), II (53.3%) and III (43.3%). PACC (60%); PCC (40%). The PQ was: 0-2 errors:70%; 3-4 errors:30%.

The PACC (40%) and PCC (60%) at Home were 16 women and 14 men, average age was 82.5 ± 7. The DSS Levels were: I (10%), II (0%) and III (90%). The PQ was: 0-2 errors:90%; 5-7 errors:10%.

The 3 wishes identified as most important to patients from NH were: not being a burden to my family (90%); not being connected to machines (73.3%); to be free from pain (66.7%); whereas at home the 3 wishes most important were: not being short of breath (70%); to be free from pain (66.7%); to have my family with me (66.7%).

The 3 least common wishes identified at Nursing Home were: to know how my body will change (90%); to be able to talk about what death means (90%); to meet with clergy or a chaplain (83.3%). And at home the 3 least wishes were: To be able to talk about what death means (83.3%); to meet with clergy or a chaplain (73.3%); to know how my body will change (73.3%). The interview was useful in 93.3% and appropriate in 96.7% at Nursing Home and 91.3% and 95.7% at Home respectively.

Conclusion: Not being a burden to my family and not being connected to machines were the most important wishes for the PACC and PCC at NH whereas Not being short of breath and to be free from pain were the most important wishes at Home. The GWG was a good tool for the conversation about EOL.

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LagunAdvance Planification Steps (LAP-S).

Advance Care Planning in Patients with Advanced Disease. Individualizing the Approach: Chronic Obstructive Pulmonary Disease (COPD), Amyotrophic Lateral Sclerosis (ALS), Dementia and Cancer

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Thinking Ahead about Medical Treatments in Advanced Illness: The Complexities of Supporting Diverse Communities in Leicestershire, Zoebia1, Taylor, Lucy2, Ehorrall, Helen2, Fauil, Christina4
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Background: Advance care planning (ACP) supports people who are seriously ill to be cared for in the way, and in the place that they prefer. Yet, evidence suggests there are lower levels of ACP in people from Black, Asian and Minority Ethnic (BAME) communities. Little is known about how the model of resuscitation decision-making fits with the social, cultural and religious values and beliefs of BAME groups. Health care professionals (HCPs) also report a lack of confidence in having culturally appropriate discussions with BAME patients and their families.

Aims: This study explores professional views and experiences of ACP with patients from BAME backgrounds. With a focus on making decisions about resuscitation, it aims to identify barriers and enablers and person-centred outcomes to such discussions and provide evidence for training professionals.

Methods: Thematic analysis of qualitative semi-structured interviews with HCPs across primary, secondary and tertiary care in Leicester, including GPs, hospital doctors and nurses.

Results: There was an emphasis on building rapport, the timing of discussions and navigating communication barriers. Barriers to decision-making included: patients’ and their families understanding of both prognosis and resuscitation; and differing values amongst generations of migrants. Professionals struggled with how to find a balance between acting in a non-discriminatory way whilst respecting cultural differences. Professionals made assumptions based on ethnic background and religious beliefs and the model of resuscitation decision-making was different according with the pathology. The model for advanced COPD patients was different from that for ALS patients with 24 OEQ for COPD and 27 OEQ for ALS patients. Fieldwork was conducted over a period of 3 months, January 2017 to March 2017. Sociodemographic data, frequently-asked questions, how long the interview lasted, patient satisfaction with the interview and utility to develop their ACP were recorded. In addition, an assessment of the usefulness of interview in the development of the ACP from the point the interviewer was recorded. Results: 45 patients were recruited (COPD, ALS, dementia, and cancer). Table 1 summarizes the main characteristics of the patients, caregivers and interviews in the four groups. All interviews were divided into three progressive stages of intervention, making an analogy with the World Health Organization ladder: LagunAdvance Planification Steps (LAP-S).

Step 1: values assessment and coping mechanism of disease.
Step 2: decision making process.
Step 3: strategies for final stage of the disease.

We design as advujnt the values assessment and social network of the primary caregiver.

Conclusions: ACP should be design specifically for each kind of pathologies. We should keep in mind ACP takes a lot of time. A planning in stages could facilitate its use in clinical practice.

Abstract number: PO195
Abstract type: Print Only
Methods: Design: We used an ethnographic approach including
(1) participant observation of ACDs between HCPs and parents, and
(2) semi-structured interviews with all participants after the discussion.

Conversation analysis and descriptive coding were used for data analysis.

Setting/participants: We observed 15 discussions and conducted 31 inter-
views with 15 HCPs and 20 parents of eleven children cared for by three
different palliative care teams in southern Germany.

Results: HCPs evaluated the quality of ACD based on their perception of
the emotional state and capacity of self-reflection of parents, and on the
degree of correspondence between the HCP’s and the parents’ perspec-
tives. In contrast, parents’ evaluation focused on
(1) perceived support in deciding upon medical treatment for their child,
(2) the HCPs understanding of their family situation and
(3) the structure provided by HCPs throughout the conversation.

They appreciated when HCPs did not have time restrictions and stressed
the importance of confidence and sympathy towards their discussion part-
ners. Knowing each other made the discussion easier for parents and HCPs.
Both sides supported the idea of two HCPs from different professions par-
ticipating in ACD, even though parents preferred that physicians lead the
conversation in order to provide them with the necessary medical informa-
tion.

Conclusions: HCPs and parents perceive ACD differently. Parents
wish for structure and clear instructions that help them to prepare and
decide for future crisis situations. Therefore, HCPs should adapt the
structure of their ACDs to the parents’ needs. In addition, our findings
suggest that ACD should be conducted by HCPs familiar to family and
child.

Abstract number: PO197
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Analysis of Perroca Scale in Palliative Care Unit
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Introduction: The Patients’ Classification Instruments (PCIs) have been
applied in the decision making regarding care management. The use of
those scales in nursing professional practices focuses on the evaluation of
care profile and workload.

Objective: to analyze, with the Perroca Scale, the complexity of nursing
care in a Palliative Care Unit.

Method: Retrospective and descriptive study with quantitative
analysis.

Results: From 2008 to 2016 were admitted a total of 2486 patients with
an average stay of 12 days. From this total, 1568 patients were submitted
to at least one evaluation by the Perroca Scale. They were classified in
minimal or intermediary care (910, or58%); of whom 602 (66%) got dis-
charged. As semi-intensive and intensive care were 658 (42%) patients;
from which 64% died and only 36% got discharged.

Conclusion: The Perroca Scale is as a tool to identify patients with major
need for care and possible prognosis for admitted patients.

Keywords: Scales. Palliative Care. Nursing Care. Patient discharge.
Clinical management

Abstract number: PO198
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Values and Wishes of Patients with Chronic Conditions (PCC) and
Advanced Chronic Conditions (PACC) from Caregiver’s Point of
View.

Differences between Nursing Home and at Home. End-of-Life Dis-
cussions
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Background: When the patient cannot communicate, family is central to
decision-making at the end-of-life (EOL). Go Wish Card Game(GWG) is
a tool developed to facilitate conversations about EOL.

Aims: To identify the wishes and values of PCC and PACC through con-
versation with caregivers using the GWG. Talking about the End-Of-Life
at Nursing Home (NH) and compare with wishes and values from car-
egiver’s point of view at home.

Methods: Patient’s family admitted to the in-patient unit of intermediate
care, long-term care from NH and the Chronicity Home-Care Team were
recruited. Sociodemographic data and Zarit Burden Interview (ZBI) were
recorded. The GWG was used to speak about EOL. Relatives were asked
about patient’s wishes in a EOL conversation. Families categorized these
wishes as important or not important; after that we asked for the 10 most
important. The utility and appropriateness of the interview were asked.
A standard descriptive analysis was carried out by SPSS 21.0.

Results: Caregivers at NH: 10 men and 23 women, average age was
55.7 ± 1.8. PACC (66.7%); PCC (33.3%). Couples 18.2%; Children
63.6%, Others 18.2%, 24.2% of relatives at NH had burden. Caregivers
at Home: 8 men and 22 women; average age was: 66 ± 1.3. PAC
(40%), PCC (60%), Couples 46.7%; Children 53.3%. 23.3% of relatives
had burden. The three wishes identified as most important by relatives
from NH were: to be free from pain (84.8%); to maintain my dignity
(75.8%) and not being a burden to my family (72.7%). And the three
wishes identified as most important by relatives at Home were: to be free
from pain (73.3%); to have my family with me (73.3%) and not dying
alone (66.7%). The three less common wishes identified at NH were:
To be able to talk about what death means (93.9%); to meet with clergy or
a chaplain (87.9%); to go to a place of unfinished business with family and
friends (87.9%). And the three less common wishes at Home were: to meet
with clergy or a chaplain (83.3%); To pray (73.3%); To be able to talk
about what death means (73.3%). The interview was useful and appro-
riate in 93.9% for both at Nursing Home. And 89.5% and 89.4% at Home
respectively.

Conclusion: To be free from pain was most important wish from car-
egiver’s point of view in both places. To be able to talk about what death
means and to meet with clergy or a chaplain were the two less common
wishes in both places. The GWG was useful and appropriate for the con-
versation about EOL.

Abstract number: PO199
Abstract type: Print Only
Challenges of Advance Care Planning Facilitators’ Training in an International Trial of the Respecting Choices Intervention: Report from the ACTION Cluster RCT in Six European Countries

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Background: ACTION is a cluster RCT of an advance care planning (ACP) intervention called ACTION Respecting Choices conducted in Belgium, Denmark, Italy, Netherlands, Slovenia and the United Kingdom. To maintain fidelity with the ACP intervention, a standardized ACP training for facilitators was adopted. It consisted of an online pre-course training package and a 2-day workshop. Lectures and videos on ACP topics, role-playing and reflective discussions were supported by various materials including: facilitator’s manual, presentations, ACP interview guides, role-play guides and checklists of facilitator’s performance competency and fidelity. To refine the training process, teachers of the ACTION trial attended mock training before the training of facilitators in each country.

Aim: To evaluate and report the process of delivering the ACP training in the context of international research.

Methods: Descriptive analysis of the training report templates in ACTION trial, where teachers from 6 countries reported about fidelity to the agreed ACP training process. They completed a checklist about each step in the process, methods and materials used and about translation provided if needed. They offered explanation where any variance occurred. Collected data were assessed for fidelity against the planned ACP training.

Results: 38 ACP facilitators (25 nurses, 6 psychologists, 5 physicians and 2 social workers) were trained in Feb-Mar 2015. All ACTION partners delivered the online pre-course and the 2-day workshop with the agreed methods of teaching and materials. Exceptions occurred because of shortage of time for training: participants in 2 countries did not fully complete the pre-course training package assessment but did so after the workshop; the 2-day workshop was spread over 3 afternoons in one country. Two countries translated all the training materials from English to native languages, one did it partially, while the rest used them in English. Some details in the training and materials were adapted according to the local cultural and legal circumstances, i.e. small adaptations in the ACP interview guides, different presentation of patient leaflets.

Conclusion: With careful planning and coordination it is possible to deliver standardized training in an international context and to monitor its execution. However, some minor variance may occur for the training to be suitable and accepted in different circumstances and cultures.

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Nurses’ Caring Experiences during the End of Life in a Resource Poor Setting

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Background: Palliative and end of life care is an international issue but is receiving very little formal attention in Sub-Saharan Africa in general and Nigeria in particular, there is inadequate information and lack of accessibility to care. Research to inform adequate end of life care in Africa is at an early stage and many research areas need to be explored. Previous studies were carried out in western countries, but the information is culturally incongruent and not transferrable to poor resource context like Nigeria. This means that the information exists will not necessarily be helpful because of the cultural sensitivity, values and beliefs attached to end of life care in Nigeria and other Sub-Saharan African countries.

Aim: The study explored the process and experiences of delivering nursing care to patients during the end of life.

Method: An ethnographic case study approach was used to explore nursing care of patients during the end of life in medical unit of a Nigerian University Teaching hospital. The ethnographic approach in this study was embedded in case study in order to understand a contemporary phenomenon in real-life situations within the context of the study. Interviews and participant observations were used as the tools for data collection.

Results: Thirteen nurses were interviewed separately, and each interview was preceded by a week of observations. Preliminary analysis identified six overarching themes: Challenges / barriers to end of life care, Facilitators to end of life care, Nurses experiences of end of life care, Nurses responsibilities during the end of life, Nurses’ perception about end of life care and Educational needs and support of nurses during the end of life care.

Conclusion: Majority of the nurses in the study had no prior palliative and end of life care education, indicating lack of emphasis on palliative and end of life care at pre-registration level and within clinical practice, needs of patients during the end of life care were commonly not met and recommend general end of life care training for all clinical staff. The study generates evidence based clinical and health services data to inform policy, practice and further research. At the same time to ensure that end of life care provision in Nigeria is effective, appropriate, acceptable, ethical and culturally competent.

Abstract number: PO201
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Conversations about Good Dying

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Background: The project “Dying worlds - the perspective of patients and relatives on “good dying”” aims to give a voice those persons concerned. We are interested in the different realities of living and dying of people with incurable diseases, of very old people and of people that have recently cared for a dying person - i.e. of lay people that have intensive experiences with death and dying. To explore these experiences, we conducted 30 qualitative interviews. In this paper, we reflect on our methodological approach to engage with people concerned into such conversations.

Methods: The interview partners live in three different provinces of Austria in communities of varied sizes; they are of different age and sex and are cared for in different settings. In several workshops, the research team constructed an interview guide. We combined the methodology of problem centered interview (Witzel 2000) and narrative interviews.
The wish to hasten death (WTHD) has been the subject of growing interest in recent years, in particular because it is often associated with the public discourse on ‘good dying’. As part of a study funded by the Swiss National Science Foundation in the context of a national program “End of Life”\(^\text{1}\), we aimed to assess, within Switzerland’s three linguistic regions, (i) the level of WTHD and (ii) to what extent non-physical determinants (quality of life (QOL), psychological and spiritual factors) can be considered as predictors of WTHD.

Methods: A cross-sectional study involving face-to-face interviews with palliative patients in a Swiss university hospital was performed. WTHD was measured with the Schedule of Attitudes toward Hastened Death (SAHD, total score: 0-20), spiritual issues were assessed with the Schedule for Meaning in Life Evaluation (SMILE, total score: 0-100) and the Spiritual Subscale of the Functional Assessment of Chronic Illness Therapy (FACIT-Sp, total score: 0-48); psychological distress was assessed with the Hospital Anxiety and Depression Scale (HADS, total score: 0-42); QOL was measured with a visual analogue scale (0-10). One way ANOVA and multivariate analyses were performed.

Results: Between September 2012 and January 2015, 206 patients consented and completed the protocol (51.5% were female and mean age = 67.5 ± 10.9). First, results indicated that WTHD was higher in German and French than in Italian patients (respectively 5.2 ± 4.5, 5.6 ± 3.5 and 2.6 ± 3.6; \(F=7.430; p<0.001\)). Second, in the French part, the model explained 10.5% of the WTHD variance and psychological distress appeared as the only significant predictor (\(\beta=4.75, p<0.05\)). In the Italian part, the model explained 16.2% of the WTHD variance and psychological distress also appeared as the only significant predictor (\(\beta=4.24, p<0.01\)). In the German part, the model explained 19.4% of the WTHD variance and QOL appeared as the only significant predictor (\(\beta=4.75, p<0.001\)).

Conclusion: WTHD scores and predictors of WTHD differ by linguistic regions, revealing a particular sensitivity to this issue among the Italian patients, compared to the French and German patients. These results show the importance of considering the cultural background of the patients when addressing this thematic, for both research and clinical areas.

Abstract number: PO203
Abstract type: Print Only

International Perspectives of Health Professionals’ Roles and Challenges with Medical Assistance in Dying (MAiD): A Scoping Review
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Research aims: With an increase in MAiD legislation, understanding health professionals’ roles and experiences in handling requests is necessary to evaluate the quality, consistency and efficacy of current practices. In response, this study sought to map existing literature on healthcare providers’ perspectives of their involvement in MAiD.

Methods: A scoping review was conducted to address the following research questions:

1. What are the roles of diverse healthcare professionals in decision-making and provision of MAiD?
2. What professional challenges arise when confronted with MAiD requests?

A comprehensive literature search in MEDLINE, EMBASE, CINAHL, PsycINFO and grey literature sources was performed. Two independent reviewers screened articles and abstracted the data. A thematic content analysis synthesized key findings.

Results: After searching 1725 citations and 148 full-text papers, 34 articles were included in the final review. Evidence was drawn from the United States, Netherlands, Belgium, Canada, Switzerland and other jurisdictions with legalized MAiD. Perspectives of nurses, physicians, mental health providers, pharmacists, social workers and medical examiners were explored. Key professional roles included consulting/supporting patients and/or other staff with requests, assessing eligibility, administering/dispensing the lethal drugs, providing aftercare to bereaved relatives, and regulatory oversight. Professional challenges included lack of clear guidelines/protocols for MAiD, role ambiguity, evaluating capacity and consent, handling conscientious objection, and lack of interprofessional collaboration.

Conclusion: Despite the emergence of MAiD worldwide, little is known about health providers’ perspectives and experiences in handling requests. Further research is needed to understand the roles of providers outside physician practice/nursing. To ensure MAiD is implemented effectively, clear professional guidelines defining scope of practice are necessitated.

Abstract number: PO204
Abstract type: Print Only

Do UK Palliative Care Patients and their Relatives Think that Use of a Particular Type of Objective Monitoring Technology Would be Acceptable in Palliative Care? A Qualitative Study for I-CAN-CARE

Abstract number: PO202
Abstract type: Print Only

Wish to Hasten Death in Swiss Palliative Patients
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Statement of aims: The wish to hasten death (WTHD) has been the subject of growing interest in recent years, in particular because it is often associated with the debate about allowing or not assisted suicide for people with a life threatening illness. As part of a study funded by the Swiss National Science Foundation in the context of a national program “End of Life”\(^\text{1}\), we aimed to assess, within Switzerland’s three linguistic regions,

1. to engage in therapeutic conversations,
2. to convey a legacy, 3. to communicate teaching cases.

The interview guide was not equally useful for all three types. Particularly the interview partners that wanted to convey their legacy gave us the impression that they had preconceived messages. In these cases, interview partners preferred to share their opinion rather than to tell their own experiences and stories. We observed that the opinions of our interview partners strongly mirrored the public discourse on ‘good dying’ while biographical narrations often revealed surprising aspects and innovative insights.

Conclusion: Thus, we propose to employ narrative approaches and/or put a focus on questions about experiences and biographical aspects in investigating the perspectives of patients and relatives on death and dying.
Background: Previous work for the I-CAN-CARE Marie Curie funded research programme has shown that palliative care clinicians in the UK generally use clinical judgement and observation to assess patients’ level of consciousness after receiving sedative medication. Bispectral Index (BIS) technology, a monitoring system using electroencephalographic readings, is used to monitor depth of sedation in other settings, and might also be of benefit in palliative care.

Aim: To explore the perceptions of UK palliative care patients and their relatives about BIS technology, including its acceptability in palliative care.

Methods: Focus groups and individual interviews with UK hospice patients, their relatives and previously bereaved relatives were audio-recorded, transcribed verbatim, and analysed by topics from the guide and for any additional themes.

Results: We conducted three focus groups with ten current hospice patients, one focus group and one interview with four of their relatives, and three focus groups plus two interviews with eleven bereaved relatives. Most participants viewed BIS as non-invasive, and considered that it might usefully provide additional information on patients’ conditions and so be of assistance to clinicians. In a participant’s own words: “This monitoring system could provide a more accurate way of understanding what level of sedation a patient’s at and whether that’s appropriate for what their needs are at the time”. Some participants specifically commented that clinicians should involve patients and families when considering whether to use BIS. A few participants said that the monitoring strip could look “more sophisticated” or “prettier”, others saw it as equivalent to wearable technology devices, commenting that “it’s almost like wearing your smart watch”.

Conclusions: Participants in this study had no objections to trialling BIS technology in palliative care, perceiving BIS as a potentially non-intrusive means of assisting clinical decision-making when seeking to make patients more comfortable at the end of life. We have therefore begun a prospective observational study with patients in the same hospice, exploring the feasibility and utility of BIS technology in that setting.

Abstract number: PO205
Abstract type: Print Only

The International ERANet-LAC CODE (Care of the Dying Evaluation): Developing an International Measure for Quality of Care for the Dying

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Aims: The ERANet-LAC CODE project (2017-2020) aims to use the CODE questionnaire with bereaved people to assess the quality of care for dying cancer patients in hospital settings within 7 European and Latin American countries. In the first part of this study, our objectives were to:

- refine and pilot the existing CODE questionnaire (used within the UK) across participating countries
- ensure the methods for the international survey were culturally appropriate.

Study population: Bereaved relatives to cancer patients who had an expected death within the hospital setting.

Study methods:

1. For each language, translation of the CODE questionnaire using the principles of the EORTC procedure.
2. Public engagement events within each country to provide feedback about the CODE questionnaire and the appropriate methods to approach bereaved people.
3. Pre-testing cognitive ‘think aloud’ interviews with bereaved relatives.
4. Views and feedback from the above steps were collated onto Standardised Feedback Forms.
5. Modified nominal group technique to reach consensus about the content of the international (‘i-CODE’) questionnaire.

Results and interpretation: Feedback from the public engagement events and the individual interviews were used to refine the CODE questionnaire and the chosen methodology to ensure feasibility and cultural relevance. Some countries wanted to add questions to CODE, while there was no consensus to remove any items from the ‘i-CODE’ questionnaire. Revisions to specific phrases were needed to provide clarity within the different languages, in particular for items considering spirituality, and ethnicity. On an international basis, ‘i-CODE’ appears to have good face and content validity and will now be used to obtain bereaved relatives’ views about the quality of care for dying cancer patients. Due to a number of culturally relevant factors, different methodological approaches are needed to make this feasible and appropriate for each participating country.

Abstract number: PO206
Abstract type: Print Only

Experiences, Attitudes and Stance Regarding “Voluntary Stopping of Eating and Drinking” (VSED) of Health Care Professionals

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Background and purpose: Self-determination and autonomy is of crucial importance in modern medicine. Frequently, health care professionals (HCP) are taken into trust and asked for advice at the end of life. Increasingly they are confronted with persons asking for help in “voluntary stopping of eating and drinking” (VSED). To provide systematic and professional support for the patient and their relatives, we need in-depth knowledge of HCP.

Research aims: The aim is to explore the experiences, attitudes and stance of HCP regarding to VSED; the appropriate treatment of the patient and their relatives and a suitable way to inform about VSED.

Study population: A total of 47 HCP, mostly female (n = 34) with an average age of 49 years, took part in the study. The participants have an average professional experience of 24 years and 8 years in palliative care.

Study design and methods: To answer the research question, we asked HCP in focus group interviews (FGI) about their experiences, attitudes...
and stance towards VSED. FGI is a particularly suitable method for this. With a half-structured interview guideline, five FGI were held with nine to eleven HCPs. The interviews take about 55 minutes were digitally recorded and transcribed. First, data are analysed using elemental methods (e.g. in vivo/descriptive coding) exploring the phenomenon. Second, through reorganizing and reanalysing the coded data (e.g. pattern axial coding) categories are built to develop a theory of VSED, described by Saldana.

**Results and interpretation:** Although the data analysis is not yet completed, we can already see some important results: experiences about the severity and strain of relatives and professionals, factors that complicate or prevent the accompaniment, symptoms or complications of the patient during VSED; attitudes to counseling on VSED and on important prerequisites to be able to accompany the VSED in an institution or at home; stance, including culture and spirituality and dealing with death and dying.

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**Abstract number:** PO207  
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**Continuous Deep Sedation in Swiss Clinical Practice - A Focus Group Study**
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**Aim:** In Switzerland, the proportion of patients continuously deep sedated until death (CDS) increased fourfold between 2001 (4.7%) and 2013 (17.5%). Our aim was to elicit the experience in and understanding of CDS of physicians and nurses and to examine guideline compliance.

**Study population:** 47 healthcare professionals (21 physicians, 26 nurses) from long-term care and hospitals (general internal medicine, oncology, intensive and palliative care) in German-speaking Switzerland.

**Study design and methods:** 7 qualitative focus groups with professionals involved in decisions and administration of CDS. Each discussion was audiotaped, transcribed verbatim and analyzed using qualitative content analysis.

**Results:** Participants had on average 20 years [range 3-39] of clinical experience, 10 years [range 0-30] of self-reported palliative care experience and a mean annual number of 5 CDS patients [range 1-20]. The compliance with clinical practice guidelines was highest within the context of specialized palliative care. Thus, palliative care specialists defined CDS as the use of benzodiazepines to intentionally induce deep sedation in order to treat refractory symptoms as option of last resort. Outside specialized palliative care, deviations from guidelines occurred when sedation was

1) induced not only for refractory symptoms,
2) taken into account as side effect of intensified alleviation of pain and symptoms and
3) induced through opioids.

**Interpretation:** The understandings of what consists “CDS until death” differ between healthcare settings and level of palliative care specialization but seem each to cover one part of a sedation spectrum. Practice guidelines should be implemented and multidisciplinary collaboration provided to support professionals also outside the context of specialized palliative care.

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**Abstract number:** PO208  
**Abstract type:** Print Only

**When Care-givers Weep**
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**Aim:** Theoretically, care-givers have to act professionally without showing too much emotion. However, when the patient is someone who has worked with them closely, care-givers easily become emotional and vulnerable.

Recently, I encountered such an experience, and I had to diligently practice self-care, before I could continue to provide him with the care he needed and, eventually help him pass on peacefully.

This proves that only through proper self-care can care-givers help those EOL(End of Life)patients under their care. And this is the Aim of this abstract.

**Materials and methods:** During the four years this cancer-survivor volunteered with us, besides visiting patients, he also accompanied me to visit home hospice patients. In particular, he volunteered to be my driver, so that I could conserve energy to serve the patients, who often scatter around in a vast rural area.

Later, when his cancer recurred, and his condition was deemed terminal, he was sent to our Hospice Center for comfort care. Because of our close working relationship, I felt so sad and devastated that I tried to stay away from him as much as possible, since I just could not bear to see a close comrade suffering and dying.

Then, I started to seriously practice self-care, by doing lots of soul-searching, doing meditation, taking long walks, and re-visiting the issue of living and dying. At the same time, I played a lot of tennis to relieve my pressure and vent my sorrow.

**Results:** Afterwards, I felt much better; I could visit him face to face with ease and provide him with the care needed. I even organized, upon his request, a Celebration of Life he could participate in. I was also able to assist him in getting reconciled with his family, thus, helping him gain a peaceful departure.

**Conclusion:** Self-care is crucial, especially when caring for EOL patients who are close to us, but easily taken for granted. We can choose activities that we think work best for us to regain our peace, confidence and competence.

**Abstract number:** PO209  
**Abstract type:** Print Only

**Implementation of Quality Indicators for Palliative Care: A Process Evaluation Using the RE-AIM Framework**
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**Aim:** To systematically implement an implementation plan with tailored strategies for the field of palliative care. This study aims to evaluate the success of the implementation process.

**Methods:** We evaluated the implementation according to the dimensions of the RE-AIM framework: Reach, Efficacy, Adoption, Implementation and Maintenance. We used a mixed-methods design containing qualitative interviews with caregivers, a questionnaire study about experienced
barriers and facilitators, scores for 13 indicators of successful implementation, quantitative analyses of quality indicator data and an expert consultation to determine preconditions for future use.

**Results:** Between May 2014 and May 2016, 48 palliative care teams (out of a total of 127 teams in Flanders) showed interest in working with the quality indicators (Reach). Thirty-six teams have measured the quality indicators at least once within their service (almost one third of all services in Flanders) (Adopt). Nine palliative care teams have set concrete improvement goals based on the quality indicator scores (Efficacy). All elements of the implementation plan, except caregivers at the service making notes of experiences during the measurement and organizing a team meeting within the service to discuss the feedback report, were implemented successfully by most teams (Implementation). Although caregivers stated the time investment was proportional with the quality results received, they still feel inadequately supported to formulate improvement plans based on the quality indicator scores. An expert consultation resulted in 14 preconditions for future use such as automatization of the measurement process via an electronic portal and continuous evaluation of the quality indicators and questionnaires used (Maintenance).

**Discussion:** Overall the implementation of the quality indicators for palliative care into palliative care services in Flanders, Belgium can be evaluated as successful. Good training, automatization of the measurement and data analyses and benchmarking of the quality results is necessary to motivate and empower caregivers to continuously monitor and improve the quality of their care.

**Abstract number:** PO210
**Abstract type:** Print Only

Palliative Sedation - What Does it Mean? Classification of Case Vignettes by Professionals in Palliative Care

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**Background:** Sedative medication is broadly used in clinical practice. Since Palliative Sedation (PS) as a special form of sedative treatment has certain requirements, it is necessary to distinguish it from other forms of sedation.

**Methods:** Along with a larger survey on PS in 2012, 221 professionals classified seven case vignettes as “PS”, “non-PS”, or “unsure”. The vignettes cover different variants of sedative therapy in Palliative Care (case A: deep continuous PS until death / B, C, D: sedation as a secondary effect to symptom-oriented treatment; / E: light sedation; / F: PS in a fatal emergency; / G: intermittent PS). The vignettes contain the three elements “intention: sedation vs. symptom oriented therapy”, “method: appropriate for sedation or not” and “effect: clinical relevant sedation present or not”.

**Results:** Out of the seven cases, three reached a consistent classification as PS or non-PS by more than 75% of the professionals. One case out of the three containing all three elements of PS in the structured classification, reached consensus. Sedation secondarily to symptom-oriented treatment was mostly classified as “non-PS”. (see table 1)

**Conclusions:** Although most professionals classified the cases either as PS or non-PS, only in three out of seven a consensus was found. Only one out of three cases pointing towards PS in all three elements was classified as PS. “Indication” and “method” seem to be more relevant for classification than “effect”. Albeit having a sedative effect, secondary sedation is mostly not classified as PS. It has to be asked, if standards connected with PS may be relevant also for secondary sedation.

**Abstract number:** PO211
**Abstract type:** Print Only

Demoralization at the End-of-Life - Preliminary Data from a Pilot Bicenter Study

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**Research aims:** The condition of existential suffering, lowered morale and poor coping, referred as “demoralization syndrome” (DS), is frequent in advanced cancer and deserving to be assessed in cross-cultural contexts. At the present time, only few studies address DS in Italian settings, with an increased risk of underestimating and undertreating the phenomenon. This study aims to investigate the prevalence of DS in two Italian hospices, also evaluating anxiety, depression and quality of life at the end of life.

**Study population:** 48 Italian terminal cancer hospice inpatients with life expectancy < 4 months.

**Study design and methods:** This pilot bicenter study is preliminary to a multicenter study currently ongoing. Cross-sectional design was chosen and in person approach at bedside through self- and clinician-rated instruments was used. A balance between the need of thoroughness and standardization and sensitivity for patients’ needs was maintained throughout data gathering. The Demoralization Scale (DS-II) was used to assess DS, the Hospital Anxiety and Depression Scale was used to assess anxiety and depression, the Integrated Palliative Outcome care Scale was used to assess aspects of quality of life.

Method of statistical analysis: Having assessed the normality of DS-II data, parametric statistics were performed. T-test and One-way ANOVA were used to assess group differences; Pearson’s r and cross-tabulation frequencies were run to study the associations between DS, anxiety, depression and quality of life.

**Results and interpretation:** All the patients were positive to DS. Unlike the “Distress & Coping” dimension of DS-II, the “Meaning & Purpose” dimension of the scale was very strongly correlated with depression and moderately correlated with anxiety. Findings of this study suggest that core symptoms of DS differ from anxiety, depression and aspects of quality of life. Therefore, specific interventions would be required. In the aforementioned multicenter study, the effectiveness of a meaning-centred psychotherapeutic model in treating DS will be tested.

**Abstract number:** PO212
**Abstract type:** Print Only

Opioid Underuse in Nursing Home Residents with Pain/Dyspnoea in the Last 3 Days of Life.

Results from the FP7 EU-funded PACE Study in 6 European Countries

Tambe, Marc1; Van Den Noortgate, Nele1; Deliens, Luc1; Smets, Tinne1; Onwuteaka-Philipsen, Bregje4; Szczersinska, Katarzyna2; Finne-Soveri,
Abstract number: PO214
Abstract type: Print Only

Dignity Therapy at an Austrian Acute Care Hospital: Feasibility and Acceptance on Wards That Are Not Specialised in Palliative Care

Flad, Barbara1, Raggel-Schäuble, Thomas1, Juen, Judith1, Wöl, Ewald1, Sandra, Mai2, Kurz Martin, Gmeiner Michaela, Raffling Manuela1
A.O. Krankenhaus St. Vinzenz, Zams, Austria, 1Department of Interdisciplinary Palliative Care, University Hospital Mainz, Mainz, Germany

Background/aims: Dignity Therapy (DT) is an evidence-based psycho-social intervention for people with life-limiting diseases. It provides a framework for a life review and for producing a legacy of memories and insights. It has mainly been conducted and researched in palliative care units, long-term and ambulant settings. This study concentrates on the specific challenges for patients and health care professionals, which arise by offering DT on hospital wards that are not specialised in Palliative Care.

Methods: Within a participatory approach a multi-perspective mixed-method study and a literature research are conducted. Ten interviews with patients who participated in DT, a focus group with three professionals who are performing DT (psychologists and chaplains), and expert interviews with the medical director and the manager of the hospital will be conducted. The whole process will be accompanied by participatory observation. Content analysis will be organized individually and within the interdisciplinary research team.

Expected results: Conducting DT on wards that are not specialised in Palliative Care is possible and highly appreciated by participating patients. Nevertheless, a major challenge for performing DT in an acute care hospital setting is identifying the target group. Inclusion criteria that are merely based on physical therapy options are not suitable. As patients usually spend only a very short time in hospital, professionals are put under pressure to conduct DT immediately and quickly. Communication about the life-limiting character of the disease is a premise for offering DT and represents another major challenge in a setting that is dedicated to curing.

Conclusions: DT represents an appreciated and valuable contribution to holistic care of patients with palliative care needs in an acute care hospital under the condition of open communication about the life-limiting character of the disease. There has to be an ongoing psychosocial support of patients with life-limiting diseases to identify suitable patients and the right moment for offering DT. Successful interprofessional communication and teamwork foster the feasibility of the intervention. Realising DT within a short amount of time affords sufficient human resources.
Abstract number: PO215
Abstract type: Print Only

Novice Professionals Taking Care of a Hospitalised Patient at the End of Life: A Grounded Theory Study

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Background/aim: In recent years, many contributions to the lived experience of nurses and physicians caring for patients at the end of life were published. Most research, mainly focused on cancer illness, document the perception of these professional caregivers (PCs) to be not skilled enough to perform such challenging task. No studies exist analysing this process with reference to non-cancer illness, and to different professional roles. This study aims at understanding the psycho-social process occurring when novice PCs take care of a hospitalised patient at the end of life for the first time.

Methods: We carried out a qualitative research using the Grounded Theory (GT). The setting was the General Hospital “Santa Maria Nuova” in Reggio Emilia, Italy. Researchers followed initial purposive sampling and the theoretical sampling. The final sample of participants consisted of 19 novice PCs from a variety of background. Researchers collected data by semi-structured individual interviews, participant observations, and demographic data. They followed the Charmaz’s indications for GT coding performing initial, focused, and theoretical coding.

Results: The emerged theoretical model is “going beyond mere assistance”: novice PCs assisting a dying patient for the first time, become aware of something exceeding their clinical skills. They go through a three-phase process: confrontation, reaction, and re-signification. Confronting themselves with the patient death elicits strong emotions. It also raises different reactions that PCs face by distancing themselves, both physically and psychologically. As a consequence, PCs perform a re-configuration of expectations related to their role and the meaning they give to the profession. Each PCs develop a proper approach to cope with the dying patient, according to their personal, professional, and cultural background. The model also includes four conceptual categories: living different emotions, identification, bonding with the patients and family, being rewarded.

Conclusion: Health organisations should take advantage of the process of becoming aware of “going beyond mere assistance” for implementing effective human resource management strategies. Moreover, training programmes based on novice PCs’ needs may concur to ease the re-elaboration of emotionally high-charged cases.

Table 1.

<table>
<thead>
<tr>
<th>Tumor type</th>
<th>Total N = 663 (%)</th>
<th>Deceased within one month after admission N = 150</th>
<th>Average admissions (N = 150)</th>
<th>Reasons for admission (N = 150)</th>
<th>Marking of end of life (N = 150)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynecology</td>
<td>46 (6.9)</td>
<td>5</td>
<td>2.3</td>
<td>Pain, fever, malaise</td>
<td>5</td>
</tr>
<tr>
<td>Urology</td>
<td>84 (12.7)</td>
<td>22</td>
<td>2.3</td>
<td>Nephrostomy, fever, malaise</td>
<td>13</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>127 (19.2)</td>
<td>25</td>
<td>2.3</td>
<td>Interventions, fever</td>
<td>19</td>
</tr>
<tr>
<td>Hematology</td>
<td>12 (1.8)</td>
<td>3</td>
<td>1</td>
<td>Fever, diagnostics, diarrhea</td>
<td>3</td>
</tr>
<tr>
<td>Head and neck</td>
<td>71 (10.7)</td>
<td>16</td>
<td>2.4</td>
<td>Interventions, reduced intake</td>
<td>10</td>
</tr>
<tr>
<td>Lung</td>
<td>112 (16.9)</td>
<td>29</td>
<td>2.4</td>
<td>Dyspnea, pain, malaise</td>
<td>16</td>
</tr>
<tr>
<td>Mamma</td>
<td>78 (11.7)</td>
<td>22</td>
<td>2.3</td>
<td>Pain, dyspnea, fever</td>
<td>16</td>
</tr>
<tr>
<td>Soft tissue</td>
<td>105 (15.8)</td>
<td>25</td>
<td>2.3</td>
<td>Pain, nausea, headache</td>
<td>18</td>
</tr>
<tr>
<td>Other</td>
<td>28 (4.2)</td>
<td>3</td>
<td>2.2</td>
<td>Pain, progression disease</td>
<td>3</td>
</tr>
</tbody>
</table>

Conclusion: Health organisations should take advantage of the process of becoming aware of “going beyond mere assistance” for implementing effective human resource management strategies. Moreover, training programmes based on novice PCs’ needs may concur to ease the re-elaboration of emotionally high-charged cases.
Abstract number: PO217
Abstract type: Print Only

Back to the Future: Using Qualitative Research to Explore Community-led Care for Older People to Enable Staying at Home

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Most people in England want to grow old while remaining at home, but the trend over recent decades has been for older people to move to institutions of various types for care, and for a majority to die in hospital rather than at home. Not only is this counter to the wishes of most of us, it is also extremely costly for public finances, with England by no means alone in struggling to cope.

There is therefore considerable interest in exploring ways of keeping old-age and end of life groups at home for longer periods. In the longer term this may require a culture change - back to the future - where communities gather together to look after their older citizens, as was once common practice many decades ago.

In this study, funded by Public Health England, researchers from UWE-Bristol in England undertook qualitative research with members of the public aged over 70 to gather views on community care for older people.

Whilst attitudinal questions were asked, the main focus was on their personal disposition to caring for family, friends locally, and indeed their propensity to volunteer to help locally even with people they don’t as yet know personally. Respondents were also asked about their willingness to be helped by others.

20 in-depth interviews and 4 focus groups were carried out in three urban, suburban and rural locations in England with adults aged over 70. Fieldwork was completed between February and March 2017.

Results indicated that willingness to help was quite widespread but the ‘reservoir’ of help was quite shallow - there was little willingness to go beyond quite narrow parameters of help with comfortable tasks such as offering company, ‘popping round’, perhaps helping with shopping, etc. Personal care was seen as much more committing and respondents would need more convincing that this would be in their domain. The authors will discuss this and other findings and consequences in conference.

Abstract number: PO218
Abstract type: Print Only

From ICU to Hospice: From Experimental Phase to Actuality

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1ICU, A.O.O.R. Villa Sofia-Cervello, Palermo, Italy, 2Hospice, A.O.O.R. Villa Sofia-Cervello, Palermo, Italy

Research aims: In 2013 started a collaboration between Intensive Therapy (ICU) and Hospice V. Cervello based on a shared document from SIAARTI, Serious Organ Failure End Stage. SIAARTI recommends that when the intensive care does not extend the life time but it just procrastinates the irreversible death process, it is preferable an approach to Palliative Care not just as an alternative to invasiveness and intensity but as a “taking charge”.

Study population: We applied the clinic criteria of Palliative Care with an operative praxis agreed with the Hospice: Clinical discussion for a therapy (ICU) and Hospice V. Cervello based on a shared document of SIAARTI, Serious Organ Failure End Stage. SIAARTI recommends that when the intensive care does not extend the life time but it just procrastinates the irreversible death process, it is preferable an approach to Palliative Care not just as an alternative to invasiveness and intensity but as a “taking charge”.

Study design and methods: Our experience from July 2013 and April 2017 consists in 36 patients oncolic and non-oncolic, transferred directly from ICU to Hospice. We evaluated the awareness of diagnosis and prognosis, the awareness of Hospice from family members, the differences between daily costs and the average stay time.

Results and interpretation: This procedure should limit the therapies with an excessive disproportion in terms of time and effort that have as a sole consequence the extension of survival. Pain reduction must prevail on extend the survival time. The intensive approach don’t extend life but it just procrastinate an inexhorable death. The future intentions are to create a professional reference for palliative care in every ICU, develop evaluation skills in palliative care, following the SIAARTI model. Remain the critical issues including: the difficulty on locating the border line between the interruption of resuscitation and the start of end of life care; the difficulty to create a relational protocol with the family members.

Abstract number: PO219
Abstract type: Print Only

Assessing the Quality of Dying Using Quality Indicators at Home, in Hospital and Aged Residential Care

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Surveys regarding patient preferences for place of death commonly report that about two thirds of those interviewed state they would prefer to die at home. However, a recent study (International Study of the Place of Death of People with Cancer. Pivodic et al, Br J Cancer. 2015 Nov 3;113(9) ) comparing place of death in 14 countries found that in most countries the majority of patients die in hospital. New Zealand and The Netherlands had the lowest number of deaths in hospital. In New Zealand only 26.2% of cancer patients died in hospital, with 28.5% dying at home and 18.9% in a designated palliative care facility. (For non-cancer patients the numbers were 39.1% in hospital, 18.8% at home and 1.3% in a palliative care facility.) The balance was made up of nursing home deaths.

A recent literature review (Defining a Good Death. Meier et al, Am J Geriatr Psychiaatry. 2016Apr:24(4)) found 11 common core themes of good death, of which the top three across all stakeholder groups (patient, family and HCPs) were:

1- preferences for dying process (how, when, where, advance directives),
2- pain free status and
3- emotional well-being.

For other themes, families valued quality of life, dignity and presence of family more often than patients. We note that most of the 11 themes identified in this review are addressed in PalCare, an electronic patient record used in hospices in New Zealand, and in the Last Days of Life Care Plan used in hospitals and care facilities.

The purpose of the proposed study is to review records for registered palliative care patients, to compare data for those who died at home with those who died in other facilities, with the aim to ascertain whether palliative patients dying at home are more likely to have experienced a “good death” according to the criteria identified.

144 electronic and paper records were reviewed.

Data was abstraced identifying the following measures:

i) Pain Free stays.
ii) Last Days of life protocol.
iii) Emotional well being.
iv) Advanced Directives.
v) Presence or absence of family.
vi) Assessment of spirituality.
Family caregivers represent a significant but vulnerable group of patients at the end of life and of family carers, enabling the development of a concept for the division of roles among different actors is developed.

Methods: The interdisciplinary project will represent an exploratory conceptual study to support people at the end of life and their family caregivers. Fringer, Andrei1, Arner, Eleonore2, Ulmer, Tom3, Praxmarer, Renate4, Reimer, Ulrich1, Maier, Edith1

1Institute of Applied Nursing Sciences IPW-FHS, FHS St. Gallen, St. Gallen, Switzerland, 2Institute of Applied Nursing Sciences IPW-FHS, FHS St.Gallen, St. Gallen, Switzerland, 3Institute IPM-FHS, FHS St. Gallen, St. Gallen, Switzerland, 4Palliativer Brückendienst, Krebsliga Ostschweiz, St. Gallen, Switzerland

Background/aims: Family caregivers represent a significant but vulnerable resource in caring for people at the end of life. They ensure that those concerned can remain at home as long as possible. The monetary value of informal care is a source of enormous support for Swiss healthcare. Yet, responding to symptom-clusters of patients in the final stages of life can be challenging, especially for relatives. Nevertheless, detailed data on symptoms at the level of the individual concerned and the quality of life of informal carers is still insufficient over a longer period of time and within the home care sector. New sensor-based monitoring systems are available measuring vital signs longitudinally in daily life. This allows us to draw conclusions on quality of life, disease transitions and acute events.

The study aims to develop a symptom documentation that preventatively stabilizes domestic palliative care and avoids critical events from occurring.

Methods: The interdisciplinary project will represent an exploratory concurrent mixed methods design that will portray characteristics of a multiple case study to integrate qualitative and quantitative data. For each case, we will conduct a within-case analysis that will then be compared in a cross-case analysis to find patterns of palliative home care crises.

The study duration is set for 24 months with a 12-month data collection period. We will include 40 to 60 patients that are accompanied at home by the Mobile Palliative Bridging Service. Aside of the subjective symptom assessment, participants will receive an upper-arm sensor from the firm measuring pulse, oxygen saturation, temperature, blood circulation and movement simultaneously. As the family is often involved in the provision of care, we will assess their wellbeing by using the Caregiver Quality of Life Index-Cancer (CQOLC) scale. The ethics committee Ostschweiz (EKOS) deemed the study eligible.

Results: Based on the subjective and digital data, an emergency plan and concept for the division of roles among different actors is developed. Finally, an evaluation and cost-effectiveness analysis is undertaken. We expect first results by the end of 2018.

Conclusion: The findings will provide vital insights into symptom burdens of patients at the end of life and of family carers, enabling the development of a crisis detection tool. Future provision of palliative care by professionals in a patient’s home can be improved by such targeted action.

Abstract number: PO220
Abstract type: Print Only

Mobile Palliative Care - Development of a Sensor-based Monitoring System to Support People at the End of Life and Their Family Carers

Abstract number: PO221
Abstract type: Print Only

What Is the Quality of Life of Dying Cancer Patients in a Hospital Setting: A Literature Review

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A great part of terminal cancer patients experiences aggressive care near the end of life (EOL). Aggressive EOL-care can contribute to poor quality of life in the terminal phase. This is associated with greater bereavement with their caregivers after their deaths.

We conducted a literature search in Pubmed and Embase with carefully chosen keywords and search terms as well as their synonyms, Medical Subject Headings (Mesh) and combinations. The search strategy was limited to English literature, to publications that centered on adults only and to literature that was published between 2012-2017. We identified 428 articles. Each was examined based on their title and abstract. Another 7 articles were identified through screening of reference lists. After full text review, we included 26 articles. These studies were conducted in different countries so cultural differences could also be analyzed. Most of the included studies showed that aggressive EOL can still be frequently observed.

Patient characteristics such as age, culture, sex and place of residence contribute to the care administered at the EOL. All of the included studies identified one or more aggressive EOL-indicator. This aggressive measures could be grouped into the following categories: multiple hospital admissions in last 30 days of life, multiple ER visits in last 30 days of life, chemotherapy in last 14 days of life, ICU stay in last 30 days of life, and death in hospital.

Other important determinants were the type of cancer, chemotherapy near the EOL, hospital type and volume and end of life care discussions.

Based on this review, we would like to make recommendations on integrating palliative care into standard oncology care.

Abstract number: PO222
Abstract type: Print Only

Perceptions and Attitudes at End of Life in Conditions of Understanding Limited Life Expectancy: Comparative Analysis of Groups of Cancer Patients and Patients without Cancer

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1Tbilisi State University, Tbilisi, Georgia, 2Georgian National Association for Palliative Care, Tbilisi, Georgia

End of human life is an important period of the time for specific individuals as well as for the society. For the development of the palliative care models, the attitudes, needs, and requirements of its beneficiaries recognizing the limited remaining life expectancy have to be taken into account. The research aimed at developing recommendations for the optimization of palliative care national model considering the analysis of the needs and attitudes of the people with limited life expectancy. The prospective study based on the analysis of semi-structured interviews of was conducted. The research aimed at developing recommendations for the optimization of palliative care national model considering the analysis of the needs and attitudes of the people with limited life expectancy. The prospective study based on the analysis of semi-structured interviews of was conducted. 50 healthy individuals aged over 85 and 50 patients with advanced cancer were interviewed. The interview tool was based on Grounded Theory with the coding based on Maslow’s “Hierarchy of Human Needs”. The interviews were divided into separate, more or less logically completed fragments (292 in total). Afterwards, compliance of each identified fragment with one of the levels of Maslow pyramid was determined, and each fragment was assigned to the specific level. The identification of fragments, as well as their coding and qualitative and quantitative analysis was performed by 3 independent researchers. Comparison the data of two studied groups were tested in bivariate analysis using Pearson’s chi-square or Fisher’s exact test. Two-sided significance tests were used and a P value of < 0.05
was deemed significant. Our research confirms that the end of life of needs, perceptions and attitudes of the people are basically similar, regardless of what determined the sense of limitation of the remaining life - incurable disease or senility. In the narratives concerning the past lives of the patients with advanced cancer and the elderly, prevail the stories, consistent with the needs of belonging, love and esteem in the hierarchy of needs of Abraham Maslow. The feeling that after their departure the loved ones will worry also remains important. It might be concluded that satisfaction of the upper levels of Maslow’s hierarchy of needs is very important while realizing at the end of life.

Abstract number: PO223
Abstract type: Print Only

Palliative Care and Symptom Experiences in Patients with End-stage Liver Disease and their Informal Caregivers: A Review of the Literature
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Oregon Health & Science University, Portland, USA

Background/aims: Worldwide more than 50 million adults are affected with chronic liver disease. Chronic liver disease is a precursor to end-stage liver disease (ESLD). In the United States, an estimated 400,000 adults have ESLD. It is the 12th leading cause of death. Liver transplantation is the only curative option but fewer than 6,700 are transplanted annually. Individuals with ESLD experience a constellation of symptoms and disease related complications that have significant impact on psychological and physical function and quality of life (QOL). As the disease progresses these symptoms may become difficult to control and individuals’ QOL deteriorate. Palliative care, therefore, is of utmost importance in assisting ESLD patients and their families manage highly symptomatic disease. The purpose of this work is to examine the existing research on palliative care and symptom experiences at the end-of-life for patients with ESLD and their informal caregivers to identify gaps and to determine focus areas for future research.

Methods: We conducted a systematic search of Ovid Medline, PsycINFO and CINAHL databases and reviewed the existing literature on adults with ESLD from 1986 through 2017. We reviewed the articles that had at least an English abstract. We focused solely on the studies of chronic liver disease, excluding liver cancer, and palliative end-of-life care. We excluded articles that focused on treatment palliation such as paracentesis.

Results: Of the 4985 unique articles found, only 13 articles focused on palliative and end-of-life care in patients with ESLD; none in caregivers. Eight were research studies, with one being a review of literature establishing what is known about patient experiences mostly related to liver transplantation. Of the remaining 7 research studies, 5 were exploratory quantitative studies to understand the experience, needs and preferences of patients, and one study used a qualitative design. Only 2 studies examined the effect of early palliative care integration in symptom and disease management. The remaining 5 were case studies.

Conclusions: The paucity of existing research points to a lack of evidence based approaches to palliative care in ESLD. There is a need for prospective and longitudinal evaluation of patients and their informal caregivers’ symptoms and QOL and specific palliative needs in order to adequately support this vulnerable population.

Abstract number: PO224
Abstract type: Print Only

Is Barthel Index Available to Identify the Disease Progression of Terminally Ill Cancer Patients in Dying Phase?
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Background: It is necessary to consider and make adjustment to program components of rehabilitation based on patients’ general condition and disease progression. Therefore, rehabilitation therapists have to rapidly notice the change of it. Barthel Index (BI) is often used for assessing the Activities of Daily Living (ADL) in rehabilitation settings. On the other hand, ECOG PS and Palliative Performance Scale (PPS) are often used for assessing the general condition and performance status in palliative care settings.

Aim: This study aimed to clarify whether BI could detect the change of general condition and disease progression of terminally ill cancer patients on dying phase.

Methods: This was a retrospective cohort study. Eligible patients were adult, had incurable cancer, were referred to rehabilitation, in palliative care settings and could be followed up until death over the past 3 years. We evaluated ECOG PS, PPS and BI at 4 points (at the beginning of rehabilitation, 3 weeks, 2 weeks, 1 week before death) and compared with each point. Friedman test was used for statistical analysis.

Results: Of 211 enrolled patients, we excluded 129 due to missing data, leaving an analysis population of 82 patients (average (SD) age 77 (13) years, survival 55 (29) days).

The results are given in Table 1. Significant differences were found in at the beginning-3w: BI (p=0.005), 3w-2w: ECOG PS (p=0.014), PPS (p=0.047) and BI (p=0.015), 2w-1w: PPS (p< 0.0001) and BI (p< 0.0001).

Discussion /conclusion: BI could detect the change of terminally ill cancer patients earlier than ECOG PS and PPS. This study showed that BI might be a useful index to detect the change of general condition and disease progression of terminally ill cancer patients more sensitively in dying phase.

Funding
The author received no financial support.

Abstract number: PO225
Abstract type: Print Only

End in Mind - Improving End of Life Care for People with Severe Mental Illness and Terminal Conditions
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Background and aims: People with mental illness experience higher rates of many life-limiting conditions and die on average twenty years earlier than the general population. The researcher observed that people with mental illness appeared to be under-represented in hospice care. A literature review was carried out which revealed limited research concerning the end of life needs of people with long term mental
health conditions. The views of clinical staff, patients and carers were not represented in the literature, and limited research exists which aims to develop interventions to improve care.

**Method:**
Part One: Four focus groups with clinicians were conducted across a large Mental Health Trust and a small hospice. 23 participants from a range of professional backgrounds attended and shared their experiences and perceptions of the barriers to delivering good end of life care to people with mental illnesses. The data was analysed using the Framework Method (Gale et al 2013) and themes and explanatory concepts were drawn.
Part Two: Patient and carer interviews conducted and a thematic analysis of the transcripts was carried out.
Co-design workshops were held to bring together patients, carers and clinical staff from mental health and end of life/palliative care services with the aim of developing the content and format of a clinical resource to improve care. Creative and visual methods were used to collect data and facilitate the workshops and articulate findings.

**Findings:**
Part One - the confidence and resilience of clinical staff was found to be a major factor in the delivery of good end of life care to people with mental illness. This informed part two of the study. Key themes will be presented.
Part Two - Key themes from patient and carer interview will be presented - analysis ongoing at the time of abstract submission. The content and concept of the resource will be presented as a visual prototype.

**Conclusion:**
There is very limited knowledge of the needs of people with mental illness at the end of life. The researcher will present the findings of both parts of the research. Innovative visual methods have been adopted throughout the study. The views of clinicians, patients and carers will be presented. The prototype of the resource will also be presented.

**Abstract number:** PO226
**Abstract type:** Print Only

**Relationships between Parents and Healthcare Providers in Child’s End-of-Life Care in an Oncology Hospital: Encounters that Survive through Times**
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**Introduction:**
The relationship established between family and healthcare providers during the child’s end-of-life care is complex and multidimensional. There are few evidences which explore how these relationships during the child’s last hospitalization influence familial adaptation after loss.

**Objective:** To interpret parents’ experience in their relationship with healthcare providers during the child’s end-of-life care in the hospital.

**Methods:** This is a qualitative research, guided by Gadamer’s philosophical hermeneutics. Data collection was through field observations conducted in a pediatric oncology hospital with hospitalized families in end-of-life situation, interviews with bereaved parents at least 6 month after the child’s death and medical records’ analysis. For the data analysis, the process of transcription, reading and re-reading the data, reviewing field notes and reflection on the data with other researchers helped understand the phenomenon to generate interpretations. Therefore, units of meaning emerged from the data were grouped, and themes were inductively determined and submitted to an interpretation process.

**Results:** Relationships between parents and healthcare providers during a child’s end-of-life process unveil the encounters and interpersonal interactions phenomena in illness and loss trajectory. These relationships are permeated with human values and are established in a dynamic way with various bondings. There are evident components in a child’s end-of-life context, such as presence, silence, deteriorations, tolerance, hierarchy, collaboration and trusting, as well as internal and external factors which influence the interactions. Through relationships, parents reevaluate their own role, while they live the unexpected experience of losing a child and attribute meanings to the loss.

**Final considerations:** Relationships serve as a basis for strengthening and supporting parents in providing excellence in the child’s care. The quality of the relationship between parents and healthcare providers is a remarkable memory of the child’s life during the bereavement process. This study aims to contribute to end-of-life policies in recognizing the components to improve the quality of the relationships as a starting point for care which will allow families to have a safe base while experiencing the child’s illness and the bereavement process.

**Abstract number:** PO227
**Abstract type:** Print Only

**Development of a Patient Reported Measure of Compassion: An Update and Insights from the Initial Stages of Measure Development**

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**Background/aims:** The COMPASS Study is a multi-centre Canadian study to develop and validate a patient reported measure of compassion intended for clinical practice and research. We aim to report on the initial findings of the development of the measure and provide insights on the practical challenges and strategies in the early stages of measure development.

**Methods:** The initial development of the COMPASS measure consisted of three stages:

1) Establishing and confirming the conceptual foundations of the construct of compassion and the transferability of the Patient Compassion Model;
2) Developing a Table of Specifications to guide item generation;
3) Establishing Content Validity through Subject Matter Experts (SMEs) and cognitive interviewing.

**Results:** Constant Comparative analysis of 20 qualitative interviews with non-cancer palliative care patients confirmed the transferability of the Patient Compassion Model that was previously developed exclusively with cancer patients. Qualitative data informed the development of a Table of Specifications—a blueprint or framework to ensure that items cover a representative sample of content within each domain. Item generation and refinement proceeded through an iterative process of refinement until consensus on the wording, number of items, question stems, and response scale were met among members of the core measure development team. Content validity of the draft measure was established through a group of international SMEs and a Patient Advisory Group via two rounds of feedback on item relevancy and representativeness utilizing an online survey. Finally, cognitive interviews were conducted with palliative care patients from diverse ethnic and disease backgrounds in the final stage of content validity.

**Conclusion:** The COMPASS measure will be used to allow patients to provide feedback about their experience of compassion within 4 care settings (hospice, acute, home care and long-term care). The initial stages of this ongoing measure development and validation study will inform subsequent study phases and will be informative to individuals interested in pragmatic aspects of measure development.
Abstract number: PO228
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Variables Influencing the Intensity of Medical Staff Reaction to the Death of an Infant in the Neonatal Intensive Care Unit

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One of the more difficult events experienced by medical staff who work in neonatal intensive care units (NICU) is the death of an infant. Literature stated that their grief process is comparable to the one that the patient’s family members are experiencing. In addition, the staff's grief process is often experienced by them as an illegitimate grief. Their grief can develop into an unresolved grief that can lead to potentially harmful effect, such as compassion fatigue. This study focuses on the grief responses experienced by medical staff at the time of the death of an infant in the NICU, and on variables that influence the intensity of their responses. The study used the SRS (Stress Response Sequence) model by Elliott & Esidforler. The study involved 233 physicians and nurses working in NICU in 12 medical centers in Israel. The participants answered an anonymous questionnaire. The questionnaire measured sociodemographic characteristics, coping resources, fear of death, the intensity of grief responses, level of post-traumatic stress symptoms, levels of burnout and of growth. The main findings of this research show that the resources (sense of coherence and social support) are moderating factors that are supposed to help the caregivers to cope with the death of an infant in their unit. In addition, it was found that the caregivers who had a more intense response to infant death had a higher post-traumatic symptoms level; they felt more burnout and experienced more growth. It was also found that the more post-traumatic symptoms the caregiver has - the higher the burnout. With growth, it was found that caregivers with a moderate level of post-traumatic symptoms had the highest growth rate. However, when the level of post-traumatic symptoms was more than moderate, there was a lower growth rate. Concerning the fear of death, the higher the caregiver’s fear of death correlated with an intense response to the infant death. These same relationships were found between the fear of death and the intensity of the post-traumatic symptoms, the burnout, and growth. From this, it can be concluded that caregivers that have a more intense feeling of coherence and social support are moderating factors that are supposed to help the caregivers to cope with the death of an infant in their unit. In addition, it was found that the caregivers who had a more intense response to infant death had a higher post-traumatic symptoms level; they felt more burnout and experienced more growth. It was also found that the more post-traumatic symptoms the caregiver has - the higher the burnout. With growth, it was found that caregivers with a moderate level of post-traumatic symptoms had the highest growth rate. 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Abstract number: PO231
Abstract type: Print Only

Audit of CPR/DNAR Documentation in October 2016 and January 2017
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Background and rationale: The HSE National Consent Policy 2014 section 4 implied that all patients are presumed to be for CPR unless a DNAR decision has been made, and that discussions around DNAR decisions should ideally involve patients and their relatives. A new policy was created and implemented in August 2016 in Northwest Hospice in response to this guidance. As part of this policy 2 forms were created that need to be completed for every patient, namely the CPR Decision Making Prompt sheet and DNAR Form. To optimise patient safety, and to ascertain if the policy was functioning, this audit was completed to assess compliance.

Aims:
• To assess if DNAR/CPR documentation was being completed.
• To improve the policy process if it was not, to improve compliance and patient safety.

Standards:
• National Standard: Consent Policy (2014) by the HSE Local Standard: DNAR/CPR policy as the standard by which we compared our practice.
• Expectation: Each aspect of the forms should be completed in 100% of cases.

Methodology: Patients using our service in October 2016 were included, sample size was 17. Data was collected and analysed via Microsoft Excel. Group discussion of audit with required changes addressed. Changes implemented. Re-audit completed in January 2017.

Recommendations and action plan: Recommendations included educating doctors regarding the need to handwriting patient details on the DNAR form, completing defibrillator section, and creating a MDT documentation page to prompt DNAR/CPR review on a weekly basis.

Outstanding results: Handwritten patient details improved 94% (vs 69%). Compliance with documentation of date was 100% (vs 75%). All cases reviewed in MDT (99% vs 100%). Increase in number of forms completed by Consultant. Compliance with completing DNAR unchanged.

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Abstract number: PO232
Abstract type: Print Only

Are Referrals for Non-invasive Ventilations (NIV) in Patients with Motor Neurone Disease (MND) Processed in a Short Time?
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Background: Patients with motor neurone disease (MND) are at risk of respiratory compromise due to chest wall weakness and require non-invasive ventilation (NIV). As prognosis is short this should be a rapid referral to respiratory services. We advise that time between referral and assessment should be aimed at least 6 weeks. The current NICE guidelines does not specify a time from referral to assessment, however from our analysis we are aware that the process is slow.

Methods: Neurorehabilitation team lead supplied the details of eight MND patients referred for NIV assessments within the last twelve months. The usual referral pathway is via the nearest cardiothoracic hospital but these patients were either too unwell or had chosen not to travel there for assessment. A review of the patient’s paper notes, Order comm system, Electronic Discharge Summaries, Respiratory clinic letter database and the separate patient neurorehab notes was undertaken.

Results: One patient has been managed by another hospital so excluded from the analysis which focused on the services at our hospital. Of the seven remaining patients, two have not been seen by respiratory services as yet and the reason is unclear. One patient was admitted to our hospital with life threatening respiratory compromise two months after referral and started NIV therefore as an inpatient. The final four patients were seen at 13 days, 6 weeks and (2x) 4 months post referral.

Conclusion: There is no standard best practice process for managing these referrals. The NICE quality standard does not advise the time by which these patients should be assessed by respiratory services post referral. The tests required also could be standardised. At present it is not clear whether they require an arterial blood gas or sleep study. It might also be possible to start NIV and assess symptomatic benefit without tests. Writing agreed local guidelines would therefore be beneficial. In light of the patients short prognosis with MND it might advisable to aim for review in less than 6 weeks.

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Abstract number: PO233
Abstract type: Print Only

Health literacy in palliative care: “the challenge of a competent choice”
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Background: The health of individuals and population depends on a number of variables including social, environmental, economic and cultural decisions that connect the individual with society. In order to be able to decide, people must have a combination of skills that determine ability and motivation to access and use the necessary knowledge to make conscious choices (De Caro, et al., 2015). The term “Health Literacy” (HL) refers to cognitive and social skills that motivate and make individuals able to understand and use information in order to promote and preserve their health (WHO, 2013). The European Commission’s project denominated European Health Literacy Survey (Sorensen, et al., 2015), found out that about 46% of the surveyed population has inadequate levels to understand health information. A research of Weeks et al. (2012) highlighted that most people with advanced stage cancer, who are undergoing palliative therapy, think that the treatment is healing.

Research aim: The aim of this study is to explore the literature on tools for assessing HL in contexts of Palliative Cures.

Study design and methods: A review of literature was conducted. Results and interpretation: In the matter of assessment tools, the following ones have been identified in literature. These have been validated both statistically and constructively and are commonly used in clinical practice.

- European Health Measurement Instrument (EU-HLS);
- Health Literacy Measurement Instrument (HLS-EU-Q);
- Short test of Functional Health Literacy in Adults (STOFHLA-UK);
- Health Literacy Management Scale (HELMs);
- National Assessment of Adult Literacy (NAAL).

Results and interpretation: In literature, the Health Literacy study has been thoroughly investigated but palliative care teams have shown insufficient attention to the topic. Health professionals, who are part of multidisciplinary teams, should devote sufficient time to communicative processes to achieve this goal.
They must ensure that patients understand the information, allowing them to have control over their own health, lives and choices. The team of palliative care professionals must be able to assess the level of HL of the patient and his family, in order to enable them to deal with the disease stage appropriately. Consequently, the team must make clear to the person and his family what is happening, what they will have to face and what choices they can make in a Palliative Care path.

**Abstract number:** PO234  
**Abstract type:** Print Only

**Disability and Ageing in Canton Basel-Stadt: Service Provision and Service Development**  
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**Research aims:** Medical care has improved to such an extent in recent decades that persons, including those with lifelong disabilities, have a higher life expectancy. Thus they are more likely to die over a prolonged period from incurable, chronic illnesses that occur more frequently in old age. A growing need arises for high quality medical and palliative care for people with disabilities. The aim of the study was to analyse the situation on care provision for older people with disabilities in a Canton in North-West Switzerland.

**Population and methods:**
Step 1) A data-base on how many old-aged persons (older than 50 years) with disabilities are living independently, in disability care homes or in nursing homes, was extracted from governmental statistics.
Step 2) A cross-sectional survey of all residential homes, nursing homes, daytime nursing, has been conducted. In addition people with disabilities living independently and their relatives answered questionnaires to determine quality of care and to identify factors and strategies to promote good medical and social care for older people with disabilities.
Step 3) People with disability were interviewed to describe their own view and experiences with medical and social care while getting older.

**Results:** Data analyses are ongoing. First results are:
In the scanned region around 100 persons, living independently or in residential homes, will have increasing care requirements. About 15% of them are living in residential homes for people with disabilities, 5% are residents in nursing homes.

**Interpretation:** Disability care homes will have a growing need of knowledge to provide high quality medical and palliative care. Nursing homes as well as spitex organisations need to extend their knowledge to provide high quality medical and palliative care. Nursing homes as well as spitex organisations need to extend their knowledge to care for people with disabilities. Co-training is recommended.

**Abstract number:** PO235  
**Abstract type:** Print Only

**The Importance and Competences of Professionals in Leadership and Management in Palliative Care in Albania**  
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Managing managerial and managerial skills of public health professionals, palliative care professionals, and healthcare sector managers is very important. The professional development of healthcare managers and health officials should consist in the application of the necessary competences to address the complex problems and changing and growing demands of the population. Therefore, healthcare managers and heads of health at all levels need continuous vocational training and development to acquire new knowledge and skills that will enable effective and efficient resolution of the health problem of the population, but at the same time, and addressing aspects of performance and efficiency of the health system as a whole.

**Abstract number:** PO236  
**Abstract type:** Print Only

**Non-specialist Palliative Care - A Principle Based Concept Analysis**  
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**Background:** A European Association of Palliative Care White Paper in 2009 describes the need for a common terminology for everyday practice of Non-Specialist Palliative Care (NSPC). Since then there has been an emergence of National Policy documents which use varying terms to describe NSPC and the levels at which it is delivered. However, these varying terms do not necessarily all mean the same thing resulting, potentially, in NSPC being inconsistently applied in practice as a result.

**Aim:** To provide conceptual coherence, a systematic concept analysis of NSPC was undertaken to provide greater understanding, clarify meaning and determine the attributes of this concept.

**Method:** The principle based method of concept analysis, underpinned by four overarching principles derived from the philosophy of science; epistemological, pragmatic, logical and linguistic, was used to analyse and clarify the conceptual basis of NSPC.

**Findings/results:** Diverse meanings and definitions are employed to describe NSPC reflecting the ambiguous nature of the concept. Attributes of NSPC were identified with varying degrees of operationalization/abstractness but these were generally poorly measured and understood in practice. NSPC is strongly associated with quality of life, holism and patient-centred care. While some consistency in meaning was found across healthcare disciplines, NSPC boundaries were blurred, particularly with specialist palliative care, and there was a lack of clear roles in NSPC provision. Furthermore, there is limited evidence surrounding this concept from the perspectives of patients and families. This concept analysis revealed NSPC to be a relatively immature concept with inconsistencies in conceptual meaning highly influenced by internal, situational and external factors.

**Conclusion:** A greater understanding of NSPC impacts on how clinical care is planned, delivered and measured. The findings from this concept analysis presents a number of challenges for healthcare providers.
For How Many Patients We Need to Provide Palliative Care Support at our Hospital?

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Introduction: When organizing and planning palliative care (PC) services one of the most important information is «How many patients (pt) need palliative care?». WHO definition is well established and accepted, still there are several other definitions (national insurance company) that might cause confusion. Next question is «What level of PC all of those pts need - basic or specialized?». When organizing and planning palliative care (PC) services one of the most important information is «How many patients (pt) need palliative care?». WHO definition is well established and accepted, still there are several other definitions (national insurance company) that might cause confusion. Next question is «What level of PC all of those pts need - basic or specialized?».

Method: In order to evaluate the need of PC at our hospital we carry out a cross-sectional study. We have reviewed charts of all pts who visited our outpatient clinic at our hospital on 9th of April 2014. We have segregated pts according to the goal of a treatment during check-up (adjuvant therapy (TH), regular check-up after adjuvant TH, TH of incurable disease, regular check-up after TH of incurable disease, specific TH is no more applicable).

Results: In our study we recorded 416 visits of pts at our institution in one day. According to treatment goal there were 20% of pts who received adjuvant TH, 30% were on regular check-ups after adjuvant TH, 23% received systemic TH due to incurable disease control, 13% were on regular check-ups after systemic TH due to incurable disease control, 10% were without any specific TH and 4% other reasons.

There is big discrepancy between different definitions of PC. According to WHO definition 46% of our pts could benefit from PC, to have in mind also early palliative care. According to our national insurance company definition (none specific TH anymore) only 10% of our pts need palliative care. If we calculated that only 20% of palliative support (EAPC standards and norms) need specialized services that would mean that in one day our specialized acute palliative care department would need to support/admit 38 pts (according to WHO) or 8 (according to national insurance).

Conclusion: Palliative care is at the moment a very important health issue and a proper planning of PC service should be performed. The need of PC is much higher than availability in our hospital/region. We need to promote education in the field of palliative care, to reach the EAPC standards and norms.

Abstract number: PO237
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How Many Patients We Need to Provide Palliative Care Support at our Hospital?

Bioethics in Palliative Medicine in the Republic of Macedonia

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Introduction: Clinical bioethics deals with the questions which refer to concrete medical practice. It analyses and evaluates, from the ethical point of view, the procedures in the patients’ health care treatment. The association of the ethics with the palliative medicine is very close. This is due to the fact that the palliative medicine has been associated with many ethical questions and dilemmas referring the end of the human life, continuation of the human life, dying, especially in present contemporary world of high technology, where the need for humanity becomes more pronounced.

Research aims: To present the ethnologic specificities, mentality and cultural aspects of the medium in conduction of the bioethical aspects of the palliative patients living in the hospice Sue Ryder in Skopje.

Material and methods: A total of 64 patients were analyzed, being hospitalized in the hospice for six months. The analysis was made on the basis of the hospice interdisciplinary team opinion, and refers to the following bioethical questions:

1. Patient’s autonomy;
2. Trust;
3. Performing medical procedures which could damage the patient, either physically or psychically.

Result: Autonomy has not been respected completely in 38 patients due to family insistence not to tell the bad news, at any rate, and to continue with life at any rate, in 24 patients medical procedures caused by the team opinion, harm, before all psychically, and in 54 the right for treatment at home was not respected due to the lack of the organized net of palliative services and lack of opioid analgetics.

Conclusion: Ethical and cultural aspects, to a great extent, influence the conduct of the bioethical principles in palliative medicine. The need of humanity is the most expressed in the man’s fight for life. The existence of palliative care justifies completely the ethical-humanity ideas of the modern medicine, developing in that way the maturity of the modern civilization in the human care.

Bioethics in Palliative Medicine in the Republic of Macedonia

Abstract number: PO238
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“Unbearable Suffering” in Palliative Sedation Therapy.

Conceptual Analysis and Implications for Decision Making in Clinical Practice

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Background: „Unbearable suffering” has been defined as key prerequisite for decisions about palliative sedation therapy (PST). However, there is no general accepted definition of „unbearable suffering”. Current controversies about PST can be traced back to differences with regards to the following three questions related to unbearable suffering:

1. Who defines what is “unbearable suffering” in clinical practice?
2. Which kind of suffering “counts” as legitimate indication for PST?
3. What is the normative function of “suffering” and what are legitimate limits towards making decisions about PST in cases of “unbearable suffering”?

Aims: In this presentation we show how concepts of “suffering” developed in medical philosophy can contribute to clarification and ethical decision making about PST.

Methods: In a first step we will elaborate the above mentioned three domains of controversies with reference to empirical data and conceptual analysis and show that a significant part of answers hinges on our understanding of suffering. To substantiate our claim we will then provide an analysis of two concepts of suffering which have been elaborated in the literature of medical philosophy. The first concept by Eric Cassell stresses the subjective and all-encompassing nature of suffering. The second concept by Stan van Hooft understands suffering as an experience which can be assessed objectively on different levels. According to this account suffering does not need to be consciously experienced by the sufferer herself. In a third step we will apply both concepts to the three controversial issues presented in step one and analyse the implications of both concepts for decisions about PST in clinical practice.
Results: We will show that the application of different concepts of suffering leads to different consequences for the clinical practice.

Conclusion: We will conclude with suggestions for further research aiming to a conceptual and empirically sound approach to determine "unbearable suffering" for the context of decision making about PST.

Abstract number: PO240
Abstract type: Print Only

Physical or Mental Diseases as Reasons for Committing Suicide or Assisted Suicide in Older Patients in Switzerland

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Introduction: Thirty percent of persons (1771) that committed suicide in Switzerland in 2014 were over 65 years old and 41 % of these voluntary deaths were assisted suicide (legal in Switzerland if offered without selfish motive to a person with decision-making capacity). Different studies have been carried out concerning the mental disease(s) that can lead a person to end his days On the contrary, very little literature is available concerning the impact of physical disease on the decision to die, outside a context of assisted suicide. The aim of this study was to evaluate 1) how many people commit not assisted suicide with a physical illness as main underlying cause and how this group differs from people committing assisted suicide with a mental disorder given as reason.

Method: Retrospective study of suicide notes, hospital and police charts of persons older than 65 who committed suicide from 2006 to 2016.

Results: 423 patients were included (273 assisted suicide; 152 suicide). Mean age was 81±8.2 years. Patients that committed assisted suicide were predominantly female 63 % (38% for suicide), lived alone in 45% of patients (20%) P< 0.05. 22% of patients (20%) P< 0.05. 37 and 28% for suicide 34% of patients that committed assisted suicide had an oncological or cardiologic disease (37 and 28% for suicide) P< 0.05. 22% of patient that committed suicide had already at least one attempt.

Conclusions: Reasons for committing suicide comprise a broad range of bio-psycho-social as well as spiritual and environmental factors and therefore it's difficult to reduce this complex phenomenon to a single major reason. However the characteristics of both populations are completely different and this should encourage us to develop some specific interventions for elderly patients with psychiatric disease.

Abstract number: PO241
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Requests to Hasten Death: What Do We Talk about it?

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In France as well as in some other European countries, euthanasia and Physician-Assisted Suicide (PAS) are forbidden. However, laws do not prohibit to express a request or to speak about it. How do dying patients express these kinds of requests? What do they ask for? Do these requests evolve over time?

Our study concerned patients who expressed an explicit request for euthanasia or PAS to a caregiver. A comprehensive approach was implemented to 1/ identify these requests during one year and 2/ describe how they were originally expressed and understand the patients' motivations and the evolution of their request during one week in 11 French palliative care units in two different administrative regions. Data were collected through questionnaires and interviews were conducted individually with patients, caregivers and relatives in order to obtain intersecting views of requests of hasten death. Data were analyzed by an interdisciplinary research group (social sciences researchers, psychologists, and physicians).

Among the questionnaires, we conducted an in-depth analysis of 31 requests of hasten death. Requests were generally orally expressed. Most patients used metonymies (“the injection”, “drug” or even “it” and “something”) or requested some general “help to die”, without specifying whether they wish to be helped to live better these last moments or if they wanted to avoid them. Rarely, some through their requests were claiming for new end-of-life rights and uphold the idea of dignity, comparing their rights with those allowed in other countries. For caregivers and relatives, the phrasing of requests expressed more what they did not want than what they did want (a fear of a painful death or a psychological suffering).

Each interviewed interprets differently these requests. There is confusion in patient discourses between euthanasia and PAS while the law defines two separate texts. Requests are not frozen in time and always fluctuate according to the patient’s environment, the interactions with caregivers and the relationships with family members. Paying attention to the phrasing used by patients to ask for hasten death is then important to fully and precisely understand their will and their motivations.

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German Criminal Code on Physician-assisted Suicide - A Survey on Knowledge and Attitudes among Physicians in North Rhine Westphalia, Germany

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Background: In 2015, a new law came into force in Germany. Section 217 German Criminal Code states: “Every person who, with intent to facilitate the suicide of another person, businesslike grants, provides or conveys this person the opportunity to do so will be sentenced to up to three years imprisonment or pay a fine.” Suicide, and assistance to suicide that does not qualify as “businesslike”, remain unpunishable. Debates on the concept of the term businesslike and how to define the range of punishable actions have been ongoing since. We explored knowledge and attitudes of physicians regarding section 217.

Methods: Together with the Department of Criminology at University Bonn we developed a questionnaire covering theoretical and practical challenges with regard to section 217, incl. 4 case vignettes, 3 with identical list of possible actions; first rating a) action is legal/not legal, and b) definitely/not sure; and second rating: hypothetical own performance of actions on 4-point Likert scale (definitely-certainly not). Furthermore, a list of actions had to be rated whether or not they would be part of the definition of terms used in the law such as businesslike, provide, and convey opportunity. Following a pretest; all 1388 listed physicians with subspecialty Palliative Medicine were invited to an online survey via the Medical Association
North Rhine (anonymous to us/spring 2017). Descriptive statistical analysis (SPSS), content analysis of free text entries (MAXQDA).

Results: Responders (R): n=284 (response rate 20.5%), 55.6% male, 40.8% in age group 46-55 years (y); most R with profound professional experience (16-25y: 38.4%; >25y: 37.7%). Judgements on definitions of terms used in the law varied. Most actions were rated as legal, if covered by advance directive (>90%), apart from euthanasia (1%). Comparative analysis of case vignettes showed some differences: palliative sedation would not be performed in patient with dementia, as compared to breast cancer and COPD (64.8/13.4/13.4%), not providing medication for suicide 89.4/70.1/77.5%; not referring patient to colleague who would do so: 53.2/42.6/46.8%. About 90% would definitely deliver care to a patient who voluntarily wants to stop eating and drinking (VSED); 47.2% defined VSED as suicide.

Conclusion: The inhomogeneous understanding of the contents and terms of the law indicates the need for clarification. Attitudes seem to be influenced by the disease entity in the case vignettes.

Abstract number: PO243
Abstract type: Print Only

Clinical Ethics Consultation in the Field of Palliative Care: A Call for Italy
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In Italy, there are two types of Ethics Committees: Institutional Research Ethics Committees (RECs) and Healthcare Ethics Committees (HECs). While the most recent organisation of RECs is regulated by the Decree February 8, 2013, HECs have not been regulated at a national level, and they depend on local or regional initiatives. On March 31, 2017, the Italian National Committee on Bioethics (NBC) issued an opinion emphasising the importance for the RECs to evaluate all aspects of clinical practice which relate to “ethical healthcare profiles.” Palliative Care services address communication, decision making and management of end-of-life issues for patients and families and Clinical Ethics consultation is particularly helpful in this field. We conducted a survey to demonstrate the underestimation of the role of ethics consultation in Italy. The study followed a sequential explanatory design qualitatively driven. With our approach we 1) reviewed and analysed the 95 Italian RECs regulations listed in the Italian Medicines Agency registry at December, 1st 2015, 2) proposed a survey questionnaire on Ethics consultation activity, and 3) discussed REC history, their ethical consultation function, and the professional experience of consultants in a sample of 4 stakeholders by using semi-structured interview. Research data are currently being analysed and final findings are expected to be available soon. At September, 2017 38 (40%) responded to the survey. 22 out of these provided Ethics consultation during the last two years (2015-2016). The specific cases for which RECs provided clinical ethics consultations concerned issues related to end-of-life, rare paediatric diseases, and geriatrics. These findings show the overlap of issues related to palliative care that ethics consultation can address.

Our study is preliminary to the implementation of an Institutional Healthcare Ethics Committee (IHEC), focused on clinical ethics consultation at the Local Health Authority-IRCCS, Reggio Emilia (Italy). Here is an in-hospital Palliative care Unit from 2014 and a Bioethics research area since January 2016. The IHEC can develop a structured approach to ethics consultation through the development of case commentaries and guidelines, researchers ethics supervision, and on-demand ethics consultation with specific attention to palliative care unit.

Abstract number: PO244
Abstract type: Print Only

Are the Ethics Procedures Reported in Clinical Dementia Research in Palliative Care Sound? Results from a Scoping Review
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Background: Clinical dementia research in palliative care (PC) has been increasing over time. There are ethical challenges when performing this type of research. Specific guidance on ethical rigor and procedures to safeguard vulnerable participants with limited decision-making is lacking, particularly in the context of international research.

Aims: To systematically review the literature on clinical dementia research in PC with respect to how ethics procedures are reported, and to determine their ethical rigor.

Methods: Scoping review, systematically undertaken following Arksey and O’Malley’s framework. Data sources: PubMed, Web of Science, EBSCOhost searching CINAHL Complete, MEDLINE Complete, Nursing & Allied Health Collection; Comprehensive, Database of Abstracts of Reviews of Effects, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, Cochrane Methodology Register, Library, Information Science & Technology Abstracts, Medica Latina, Health Technology Assessments, and NHS Economic Evaluation Database. Search terms: ‘palliative care’ AND ‘dementia’ AND ‘clinical research’ AND ‘ethics’. Inclusion criteria: Research protocols/studies focused on clinical dementia research in PC, in English language with full text available. Searches were performed in October 2016 and updated in March 2017. Selected articles were independently reviewed by two investigators.

Results: Out of 28 records screened, 4 articles were included for analysis. In all articles, ethical approval was granted from local ethics review boards. 3 articles provided additional information on specific ethical procedures, mainly reflecting on ethical challenges; for instance: informed consent and capacity to consent; decision-making processes; and participants’ vulnerability.

Conclusions: This study can be used to inform ethics review and editorial boards about specific features and cautious measures that need to be considered when assessing the ethical rigor of research projects in clinical dementia research in PC. A clear standpoint on ethical rigor and procedures in informed consent, decision-making processes and participants’ vulnerability is important to foster clinical dementia research in PC to ensure best evidence-based practice.

Acknowledgements
ERA-NET NEURON II ELSA and FCT.

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A Step Wise, Mixed Method Study Approach to Identify the Barriers to Dysphagia Care in Palliative Nurses
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Dysphagia is common in palliative patients and worsens quality of life. Nurses are the main provider of dysphagia care. An audit showed poor
compliance with dysphagia measures amongst nurses, but little is known about what the barriers are. We sought to evaluate barriers to dysphagia care amongst hospice nurses. This was a step wise mixed method study. Baseline knowledge and attitudes were assessed and a lecture was crafted based on the assessment. The knowledge and attitudes were then reassessed to investigate for any change. A focus group and an open ended questionnaire were then used to assess for other barriers and for the effectiveness of training. Knowledge scores were low at baseline and training improved the scores. Nurses cited the lack of time and lack of families’ involvement as barriers to dysphagia care. While nurses believed that preventing aspiration is important, they also felt that most patients would refuse a modified diet and that respecting their wishes is important. Most nurses felt that the training increased their ability to care for patients with dysphagia. Our study demonstrated that knowledge deficit was an important barrier in dysphagia care for nurses and this can be improved with a short training. Even though nurses rightly believed that patients’ preferences are important, they struggled with trying to balance these preferences with preventing aspiration.

Supporting them in making these decisions, having more time for feeding patients and involving family members may be important to reduce barriers to care for patients with dysphagia.

Note: Article currently in press

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How Do People Interpret the Term Last Aid?
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Background/aims: Last aid courses have been introduced to educate the public about Palliative care and to enhance the public discussion about death and dying (1,2). The reaction to the term Last Aid differs between different people. The aim of the present study was to investigate what people think when they are first introduced to the term Last Aid.

Methods: A qualitative method approach was used with focus group discussions. Participants in Last Aid instructor courses were asked about their first thought or connotation when they heard the term Last Aid the very first time. They were encouraged to report both positive and negative connotations.

Results: So far more than 480 people participated in Last Aid instructor courses. They came from different professions as for example nurses, physicans, chaplains, social workers, hospice volunteers, physiotherapists, undertakers, paramedics, etc. Often mentioned connotations and thoughts were care at the end of life; great idea; what?; did I hear right?; did you mean first aid?; information about death and dying; sounds interesting; help for relatives; supplement to first aid when the end of life is near, first aid and last aid, to be there, bringing death and dying back into the society. Only relatively few people did think of euthanasia.

Conclusions: Most people think about a connection of first aid and last aid in terms of helping people in need and caring for dying people. In general the term Last Aid leads to interest to learn more about the topic although some people first feel a bit puzzled or insecure about the terms meaning. The term is mostly connected to positive connotations but sometimes is seen as associated with euthanasia. Most participants find the term appropriate for the course that aims to educate citizens about Palliative Care and to enhance a public debate about death and dying.

Literature:
2. Bollig G, Heller A. The last aid course - a simple and effective concept to teach the public about palliative care and to enhance the public discussion about death and dying. Austin Palliat Care 1(2): id1010 (2016)

Abstract number: PO247
Abstract type: Print Only

Hospices 4 Research - Working for One, Working for All
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There is a national drive from Hospice UK to increase research across hospices. Evidence demonstrates that patients and carers value taking part in research and those being supported by hospices should not be excluded from the research opportunities offered in NHS settings. Today’s research is tomorrow’s practice and hospices need to build the evidence base to underpin their services. Hospices face challenges in conducting research including the need for a robust governance structure, something which is provided by experienced staff in research and development departments in the NHS.

Four neighbouring hospices at differing levels of research activity were individually developing their ability and capacity to contribute to the research agenda and improve access to research for patients and carers under the care of hospices. Recognising the benefit of working in partnership to learn from and support each other we formed a research collaboration.

We agreed that the main aims of the group include: promoting research in hospices, acting as a resource for each other, consolidating collaborative links between hospices and academic institutions, supporting ethical approval for researchers and providing a forum for disseminating and sharing research initiatives. In addition the group is a forum for new research ideas and peer support.

The collaboration meets quarterly and the chair and location of the meeting rotates between the four organisations. The membership consists of the research lead and/or research nurse for each hospice (two of the hospices have full time experienced research nurses in post). Members are expected to feedback to their respective hospices and engage in local research initiatives.

The collaboration has been in existence for 12 months and is about to open their first multi-centre qualitative study across all four hospices. The group jointly developed the protocol and secured funding towards the study.

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Education for Medical Students (Experience Journey of Death)
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Aim: It getting more common, we (medical staff) think about patient feeling who had cancer disease in palliative care.

But there is not well-established education program for medical student. In my University, We had started the program which is called “experience journey of death”.

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Abstract number: PO249
Abstract type: Print Only

Surgical Site Infection in Palliative Care Patients
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Aim: To describe the characteristics of surgical site infections (SSIs) in palliative care patients and the appropriateness of antibiotic therapy.

Methods: We conducted a retrospective study of consecutive surgical patients managed by a team of palliative care physicians at a teaching hospital in a French province from January 1st, 2010 to December 31st, 2015. All surgeries with SSIs were identified from patients’ medical records. We extracted demographic data, co-morbidities, operations, sites, and SSI characteristics from patients’ medical records. We also extracted data on the appropriateness of antibiotic therapy.

Results: A total of 270 SSIs were identified in 251 patients. The most common surgery was colorectal resection (n = 56, 20%). The most common site of infection was the abdominal wall (n = 102, 38%). The most frequent SSI was wound infection (n = 199, 73%). The most frequent pathogen was Staphylococcus aureus (n = 103, 38%). The most common antibiotic used was cefuroxime (n = 111, 41%). The most common antibiotic regimen was cefuroxime and metronidazole (n = 106, 39%). The most common antibiotic regimen was considered appropriate in 151 (56%).
The aim of this program is What & How the education program changes the students after the class. And of course, we can know what the student think & feeling during education. Ultimate purpose of this program is to make the younger medical doctor can feel cancer patient’s emotion.

**Method:** In our country, we have to had 6 years education in medical school, to get medical Dr license after high school. In my university, students of 5th grade can had clinical training in hospital. They can have rotation what they want to see & learn. We call them BSL (Bed-side-learning) student doctor. 100 student Dr had our education program, and must submitted the report after the class. After that, We assessment the report.

The evaluating items are age, important things what they thought before death, what they had changed idea & feeling after the class.

**Result:** There is no significant difference between the age & important things. Almost all of students thought the most important things is family. And, they could feel some kind of emotion that the cancer patients have after disease announcement & during treatment.

**Conclusion:** We had started the education program called “experience journey of death” in our University. It makes medical students can feel emotion of cancer patients who had disease announcement & had some kind of treatment (such as chemotherapy, radiotherapy, operation.) We think the program must be getting much more common in our country, especially education for medical students.

**Abstract number:** PO249
**Abstract type:** Print Only

**Train-the-Trainer in Palliative Care: Evaluation of Transfer of Training of the ELNEC - Palliative Care Course Germany**

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**Background:** There is still a need for further education and training of nurses in the field of general palliative care. The ELNEC - Palliative Care Course Germany (ELNEC = End-of-Life Nursing Education Consortium) is a training program based on the train-the-trainer principle. It is offered as supplement to the existing palliative care training courses in the German-speaking countries. Participants are trained to pass on their palliative care knowledge to their colleagues at their workplace. Since 2012, the course has been offered and continuously evaluated.

The aim of the evaluation was to generate data on the transfer success as well as factors that promote or prevent the implementation of courses at the workplace.

**Methods:** In a mixed methods design, 39 participants of four courses were asked to complete evaluation forms before and directly after the course and follow-ups at 6 and 12 months (descriptive statistics). In addition, a purposive sample of 17 participants took part in semi-structured interviews about their experiences with implementation (qualitative content analysis).

**Results:** The response rate at 12 months was 46% (n=18/39). Five participants (28%) did not implement any palliative care training at their workplace during the first year. Eight participants (44%) offered 1-5 training courses and five participants (28%) more than 5. Interviews showed that the participants experienced their task of imparting palliative care knowledge very differently. Those who regularly provided training reported an improvement in the knowledge and practice of palliative care and received positive feedback from their colleagues. Participants who did not implement courses cited specific conditions at the workplace, such as a transfer climate (lack of interest of colleagues), lack of support from supervisors and working conditions (high workloads, staff shortages) as preventing factors.

**Conclusions:** If the participants succeed in carrying out their training tasks, learning can take place directly in nursing practice and be oriented towards the requirements of patient care as well as the specific needs of the nursing staff. In future courses, participants should be better prepared for the implementation of their training tasks in their practice.

**Funding**
No source of funding was used.

The research was carried out as part of the Master of Science degree program in Palliative Care.

**Abstract number:** PO250
**Abstract type:** Print Only

**Developing a Curriculum for Oncology Residents Based on ESMO/ASCO Curriculum**

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**Introduction:** Although palliative care services are developed in Romania since 1992 at present around 10% cancer patients receive specialized palliative care. Training oncologist to deliver basic palliative care is a must.

**Aim:** To develop a theoretical and practical training program for oncology residents based on ESMO/ASCO recommendation.

**Method:** The ESMO ASCO recommendation were translated into Romanian and the objectives of training in the domains labeled palliative care, supportive care communication and psychosocial issues and education of patients were extracted, duplications were deleted and given to a group of Romanian experts (PC professionals trainers in the subspecialty training program). 1 ESMO expert and 2 ASCO experts for agreement of topics and objectives for the residents curriculum and consensus on the final topics for the curriculum. After achieving the consensus on topics a framework was designed for writing the curriculum. For each topic a number of cases/intervention for the practical training was established based on expert consensus. Instead of a log book an electronically database was produced for residents to record their learning progress alongside the requirements for a weekly reflection paper. The theoretical curriculum and training materials produced were tested on the group of future trainers and after each session a feedback on the content, teaching methods, length of sessions and missing information was given and used to refine the educational materials.

**Results:** Educational program with theoretical and practical part was designed (curriculum, educational materials, tools for the practical training). Theoretical curriculum with 36 hours after testing was extended to 39 hours (pain and communication sessions were extended as considered essential and emergencies in oncology were reduced as they are partially covered by the present curriculum). Assessment was designed in the format of a test with 60 questions (open ended, correlation, multiple choice and vignettes) will be used as pre, post test and 6 months after training completion to measure impact and retaining of knowledge and abilities. 34 trainers went through the testing of the theoretical curriculum and grouped in 5 teams will deliver theoretical training during November - January 2018 to 100 oncology residents followed by practical training in the next year for 26 selected residents. All materials will be available free at the end of the project.
Abstract number: PO251
Abstract type: Print Only

Palliative Care Knowledge among Physicians in a Large Tertiary Hospital in Brazil: Self Assessment, Objective Survey and Associations

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Introduction: Brazil is witnessing an expansion of Palliative Care (PC). Anecdotal reports account for an overall poor PC education among physicians (MDs), with minimal PC exposure. There is a dearth of research on MDs PC knowledge in the country. This study aimed at estimating PC knowledge among MDs in one of the largest high-complexity tertiary hospitals in Latin America. We have also obtained their self-assessment regarding PC knowledge and explored associations between their knowledge level and education/demographic variables.

Methods: Online survey with physicians conducted in the end of 2014, including demographic data, patient population seen, frequency of end of life (EOL) patients seen, PC knowledge self-assessment (0-10 scale), and 21 objective (true/false) questions about PC. 20 of adapted from Nakazawa’s (2009) PC Knowledge Test. Descriptive statistics were obtained and Pearson correlation and t tests were used to assess for correlations and associations.

Results: 436 MDs responded (response rate 44%). The mean (range) age was 48 (26-82), 138 (32%) were female, and 215 (49%) reporting being catholic. Religion was considered of moderate to high importance to 328 (70%) respondents. 197 (45%) MDs were from clinical specialties, with 59% seeing adults. The average (range) time from medicine graduation was 23 (2-59) years. Only 168 (39%) MDs reported “sometimes or frequently” care for EOL patients. Self-assessment of PC knowledge showed 62 (14%), 205 (47%) and 168 (38%) with low (0-3), moderate (4-7) and high (8-10) knowledge. The average of correct answers in the objective questionnaire was 13/21 (SD 3.1) with 207 (65.8%) and 147 (33.7%) of the MDs reported low, moderate or high knowledge respectively. Higher self-assessment was correlated with higher frequency of EOL experience (r=0.270, p<0.001) and with number of correct answers in the objective questionnaire (r=0.437, p<0.001). Greater objective scores were associated with more recent medicine graduation, younger age, clinical specialties and exclusively adult practices (p<0.001 for all).

Conclusions: The majority of respondents showed moderate PC knowledge. Experience caring for EOL patients, more recent medicine graduation and younger age were associated with greater knowledge. MDs who focus their practices in pediatric patients and the surgeons showed lower knowledge. This is, to our knowledge, the first study to objectively demonstrate the status of PC knowledge among a subset of MDs in Brazil.

Abstract number: PO252
Abstract type: Print Only

Collective Social Capital: A New Understanding of Relationships in End-of-Life Care

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Background/aims: An appreciation of the broader determinants of health has led to the inclusion of new public health principles and practice throughout health and social care. End-of-life care has been no exception and there exists a favourable policy context, practitioner interest and numerous practice examples. Despite this context, there has been little empirical exploration and the approaches remain poorly characterised. The aim of this study was understand the impact a new public health approach to end of life care project can have when muddled through a hospice. Specifically, to explore how a compassionate community project is experienced, what tensions exist and what processes support or impede the work.

Methods: A mixed methods study employing multiple methods of data collection was performed. This included: in-depth interviews; focus groups; participant observation; documentary analysis and service records. Participants were recruited using theoretical sampling and data was concluded once theoretical saturation was reached. Ethics approval was obtained. Interviews and focus groups were transcribed verbatim and field notes made of observations. Data were analysed according to modified grounded theory and using software tool Dedoose.

Results: Twenty-one interviews and two focus groups were conducted, 17 episodes of participant observation and 11 documents and service data on 180 Compassionate Neighbours. Neighbours and 80 Community Members were included. Six processes described how new public health approaches integrated with service provision approaches. Impacts included a reduction in loneliness, improvements in wellbeing and changes to hospice practice.

Further, three core underlying principles emerged: power, reciprocity and agency. These categories describe how power relations were challenged to create a new landscape for reciprocity. The expression of reciprocity in relationships within the project was central to the project’s functioning.

Conclusions: The reciprocal relationship between all participants, including the hospice, is a significant finding and one that challenges existing frameworks of social capital in end-of-life care. This is a new work.

Abstract number: PO253
Abstract type: Print Only

Mechanisms Underlying (in)appropriate Care at the End of Life

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In 2016 the Belgian health care Knowledge Centre (KCE) commissioned a study on views and opinions about (in)appropriate care at the end of life in the Belgian community. One objective was to inventory the drivers of (in)appropriate end of life care. An online survey was set up (available in Dutch and French), allowing patients, their relatives, health care professionals, volunteers and spiritual counsellors from different moral to report (in)appropriate end of life care experiences and to identify its properties. The survey was widely distributed in the community by the different stakeholders' associations. Within two months, we registered 2650 narratives about (in)appropriate end of life care, provided by 1935 respondents. Relaties were the most represented category of participants (n=996), followed by health care professionals (n=854), volunteers (n=112) and spiritual counselors (n=63). We performed qualitative analyses in Nvivo 11.

According to our respondents, most drivers of (in)appropriate end of life care can be situated when the main focus is still on curarion. Some aspects are related to health care professionals (their knowledge, skills, attitude,
interdisciplinary collaboration and ‘perceived’ lack of time), others to the interaction between patients, professionals, and relatives (differences in opinions about or acceptance of end of life (care), communication problems). We finally distinguished higher-order drivers such as capacity and/or organisation of care, cultural aspects, and particular reimbursement rules, that make ‘action’ more attractive than ‘listening’. A transfer to palliative care is generally associated with less inappropriate care. After a patient died, spiritual counselors stress the importance of a continued support to relatives. The identified drivers potentially indicate what elements should be considered in health care professionals’ training and in the organisation of care in order to reach more appropriate end of life care.

Abstract number: PO254
Abstract type: Print Only

Place of Death in Trinidad and Tobago.

A Study Using Death Certificate Data
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Background: Place of death, in the context of palliative care, has not been studied in Trinidad and Tobago. In 2015 the amount of persons 60 years and older was 14.2% of the population, this amount is expected to increase to 20.2% and 28.2% by 2030 and 2050 respectively; life expectancy is also projected to increase over this period. Increasing segments of a rapidly aging population will experience longer periods of the health consequences of old age but palliative care in not a health system priority. The aim is to explore, identify, describe and explain, patterns in the place of death in Trinidad and Tobago for specific patient groups and to examine factors associated with their place of death.

Design: A population level study using routine death certificate and health resource data for all deaths occurring in 2010 in Trinidad and Tobago (N = 10,221) in relation to age, sex, place of death and cause of death that may be indicative of palliative care need.

Results: Thirty percent of all deaths occurred at home and 60% at an institution. Persons 60 years and older constituted 65.4% of all deaths, and with increasing age (60 years through oldest) they are less likely to die at a government hospital compared to dying at home, a nursing home or non-government hospital. Deaths from diseases of the nervous system occur more often at home; all other deaths from chronic diseases occur mostly at government hospitals.

Conclusion: Findings identified groups of patients that may benefit from palliative care both at the home/community and at institutional settings. In the case of Trinidad and Tobago where dying is institutionalized, health system limitations appear to be a factor determining the place of death. There is opportunity for health policy to focus on specific problems and develop appropriate solutions to the palliative care needs in Trinidad and Tobago.

Abstract number: PO255
Abstract type: Print Only

Influence of Structures and Policy Framework on Patient Care in Specialized Outpatient Palliative Care (SAPV) in Germany - An Analysis of Routine Documentation Data
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Background: Since 2007, patients with severe advanced life-limiting illnesses and high and complex symptom burdens have a right to receive SAPV. Multi-professional teams (nurses and physicians) with heterogeneous organizational structures provide care in cooperation with primary care givers. Contracts between SAPV teams and health care insurers differ in various aspects. How these structural and legal differences influence individual patients care provision still remains unclear.

Method: Using data extracted from two widely used electronic patient records (PalliDoc and ISPC) we explore if and how the organization of teams, e.g. network of primary care providers vs. teams employed at a hospital, and policy framework, e.g. financial compensation; definition of care levels, have an influence on how care is provided. Data on patients’ diseases, symptoms, care networks and service provision (e.g. number of visits, number of days in hospital during SAPV) are anonymously assessed from the software for six months.

We aim to recruit 85 of approx. 290 teams who care for approx. 150 patients during this six month period, resulting in a total patient number of 12,750 patient data sets. Data assessment will begin 01/2018. For exploratory analysis of structural and policy predictors’ influence on care provision, we will conduct a hierarchical multilevel analysis. The study is part of the SAVOIR consortium which evaluates different aspects of SAPV in Germany.

Abstract number: PO256
Abstract type: Print Only

Increasing the Quality of Life with Osteoarthritis by Optimizing Preventive Measures in the Conditions of Primary Health Care
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Background: Deforming osteoarthritis (DOA), has a large socio-economic value because of the high prevalence, frequent development of disability of patients, especially older age groups, and the associated decline in the quality of life of patients.

Materials and methods: The study involved 60 patients aged 43-76 years (56.52 ± 2.4) suffering from osteoarthritis with a duration of 1 to 25 years (11.3 ± 1.1). In accordance with the X-ray stage of the disease, the patients were divided as follows: I and II stages - 65% and 35%; III and IV stages - 35%. All patients were divided into 2 groups: 1-group (main group) consisted of 35 patients who received therapeutic physical culture, chondroprotector (1000 mg per day) peros for 3 months in combination with NSAIDs. 2-group (control group) comprised 25 patients who received a chondroprotector, NSAID. The effectiveness of treatment was determined monthly according to the scheme: clinical examination - functional index WOMAC; laboratory blood test - ESR, C-reactive protein, transaminases, bilirubin; X-ray examination of the affected joints and determination of the quality of life parameters of the SF-36 questionnaire.

Results: Thus, in the analysis of pain by Visual Analogue Scale (VAS) before treatment, the mean WOMAC index was 4.45, after treatment 0.80, the decrease of the index was 81.9% (P < 0.05); restriction of movements before treatment, the average index was 4.7, after treatment 1.0, the decrease of the index was 78.7% (P < 0.05). The average index of life before the treatment was 4.69, after treatment 1.27; decrease in the index - 72.6% (P < 0.05). The decrease in the mean functional index of WOMAC by all criteria to the end of treatment was 75.3% (P < 0.05). Quality of life questionnaires of SF-36 dynamics in the main group of patients improved indicators that characterize physical health. For example, physical activity (PF) improved by 32.4% (p < 0.05), role physical functioning (RP) by 33.8% (p < 0.05), body pain (BP) by 39, 7% (p < 0.05), the general state of health (GH) - by 16.8% (p < 0.05).

Conclusions: Thus, the use of therapeutic physical culture in combination with the conventional treatment of DOA for 3 months, compared...
with the control group, reliably reduces joint syndrome, pain, increases functional ability, physical activity, general health improved.

Abstract number: PO257
Abstract type: Print Only

Health Status, Use of Medical Services and End-of-Life Decisions of People with Disabilities - A Longitudinal Study
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Research aims: Between 2008 and 2013 in Swiss residential homes for people with disabilities, the decision to abandon life-prolonging treatment was more often taken for people with intellectual disability (ID) than for people with other disabilities. Moreover, people with ID are less involved in these decisions. Carers describe a low health status of people with ID. The aim of the study is a longitudinal assessment of health status and use of medical services of older people with disabilities (50-65 years old) in residential homes.

Study population and study design: A representative longitudinal survey (0.11) with 1000 people with disabilities (defined as persons with disability-pensions) as well as a survey with all residential homes in six regions of Switzerland are carried out between July and October 2017 to assess context factors, health status and use of medical services.

Method of statistical analysis: Data will be analysed by the use of descriptive statistics and inferenz-statistics. A second survey wave will be conducted in August 2018.

Results: Results of the first wave will be available. This study will provide novel insights into health status, development of health status and use of medical services of older people with disabilities in Switzerland. It will be possible to compare this data with the health status and use of medical services of the general population and to identify, if there is discrimination of people with disabilities. Factors influencing the prevalence of end-of-life decisions will be described.

Abstract number: PO258
Abstract type: Print Only

Symptom Management in the Midst of an Opioid Epidemic: An Expert Consensus Guideline for Safer Opioid Use in Palliative Care
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Background/aims: Canada and the United States declared public health crises in 2016 due to the epidemic number of overdose deaths from prescription and illicit opioids. Given the most commonly prescribed medications in palliative care are opioids, it is important to acknowledge that patients receiving palliative and end of life care (PEOLC) are at risk of opioid misuse, abuse, or diversion (OMAD).

This study’s purpose is to create expert consensus guidelines for opioid prescribers practicing PEOLC based on existing literature and clinical practices. Best practice recommendations will be developed to promote safe opioid use by adult patients receiving PEOLC, their circle of care and health care professionals.

Study design/methods: The modified Delphi technique will be used to develop guidelines on PEOLC opioid use. An initial questionnaire based on a literature review will be distributed electronically to thirty experts in palliative, pain and addictions medicine. Participants will rate their agreement level on a 5-point Likert scale for each recommendation, and provide qualitative feedback. Consensus will be achieved if minimum of 80% of the experts agree. Responses will be compiled to develop a second questionnaire that will confirm consensus recommendations and re-evaluate recommendations that were not agreed upon. Descriptive analyses will be performed. The results will be collated to develop the final guidelines.

A steering committee composed of palliative, pain and addiction medicine specialists will provide oversight of the guideline development and knowledge translation. The project has commenced and will be completed by April 2018.

Results: These guidelines will provide practical recommendations on opioid use in the PEOLC population. Specifically, they will provide guidance on the following:

1. Patient and caregiver risk assessments for OMAD;
2. Monitoring, dispensing, storage and disposal of opioids by palliative clinicians and programs;
3. Patient and caregiver education on opioid use.

Conclusion: There are significant knowledge gaps around OMAD, addictions screening, management and harm reduction in the PEOLC population. These expert consensus guidelines promote safe and effective opioid use to address the rising number of prescription opioid deaths from a palliative care perspective.

Funding
This project is currently not funded.

Abstract number: PO259
Abstract type: Print Only

Enhance Supportive Care: Bridging Transition between Oncology and Specialist Palliative Care Services
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Background: Early palliative care intervention is a raising need in European Public Health. Oncology services incorporate Palliative Care Professionals in their Multidisciplinary Meetings (MDT), where decision-making takes place shortly after diagnosis or recurrence.

Aims: To establish and potentiate closer working between Oncology and Palliative Care in a large university hospital using existing infrastructures.

Methods: Mixed methodology is used to look at outcomes. For a three-month period, all those patients identified at Lung MDT whose planned oncology treatment would be given with with palliative intent were identified—depending on tumour stage, Performance Status and named oncology specialists will provide oversight of the guideline development and knowledge translation. The project has commenced and will be completed by April 2018.

Six OPA sessions were offered over a threemonth period. Each with a different outlook and objective ranging from Assessing Expectations to ACP and DNACRR discussion.

All discussions outcomes were documented in purpose created proforma.

Results: Over 70% of those patients identified at MDT accepted entering ESC. 10% needed to enter the local SPC program. 20% refused to enter ESC.

From the 70% who entered ESC, 30% felt it wasn’t for them at the first session. The rest benefited from it greatly and seemed to really benefit.
from the opportunity of talking about difficult things with time in a large, airy room
A significant number of serious clinical events which would have meant A&E visits and/or hospital admission were resolved either at the oncology department or another ambulatory facility when the patient came to clinic.
The most significant result was the raised awareness re Supportive Care and resulted in a very fluid interaction between both specialties with referrals starting to come from other site specific MDT.

**Conclusions:** Using well established services and clinical structures in a different way can bring together Oncology and Palliative Care services allowing for significant cost savings and offering patient, family and other professionals early support.

**Abstract number:** PO260  
**Abstract type:** Print Only

**Accelerating Global Palliative Care Development through New Approaches to Global Advocacy: A Qualitative Study from a Global Social Policy Perspective**

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**Background:** The World Health Assembly (WHA) Palliative Care Resolution in 2014 and the inclusion of palliative care within the Sustainable Development Goal aiming for Universal Health Coverage (UHC), raised optimism that palliative care would no longer be a peripheral aspect of global health. However, no funding, accountability measures or indicators for palliative care development accompanied these policy developments. This makes it likely that health actors will continue to prioritise the attainment of other, target-driven aspects of healthcare, at the expense of palliative care.

**Aims:** This study aimed to explore the attitudes of international palliative care experts regarding the future global development of palliative care and how this may be accelerated by new approaches to advocacy.

**Methods:** A qualitative interview study involving a purposive sample (n=16) of international palliative care experts drawn from across all world regions. Semi-structured interviews were transcribed, double-coded and analysed using an iteratively developed thematic framework.

**Results:** Participants constructed arguments for the further rollout of palliative care services as: a moral obligation, a human rights issue and an economic necessity. Palliative care was represented as being a cost-effective option, which, through a reallocation of financial and human resources, can improve the quality of healthcare whilst reducing costs and promoting human capital. Increasing engagement from global health funders, and focussing upon access to pain relief were viewed as key priorities for advocacy.

**Conclusions:** The international development of palliative care represents a value proposition which is not currently being maximised by research and advocacy. Advocates should consider palliative care developmentally, focussing upon ‘key asks’ for development and consider how palliative care can contribute to other international development priorities, in particular: poverty avoidance.

**Abstract number:** PO261  
**Abstract type:** Print Only

**Towards a Global Consensus on National-level Palliative Care Development Assessment**

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**Background/aim:** Indicators assessing national level of Palliative Care (PC) development used for cross-national comparison allow a broader view on the status of PC progress globally. In the previous years numerous studies have addressed this topic. We aimed at identifying all existing indicators assessing national-level development of PC in order to depict how this field has been internationally measured.

**Methods:** Systematic review in PubMed, CINAHL and Google Scholar with an additional Google search. Identified indicators were then listed and categorized -if possible- following WHO’s Public Health Strategy dimensions (services, drug availability, policy and education). Finally, indicators were analyzed according to the frequency of appearance.

**Results:** From 1875 papers identified, 102 articles were selected by title and abstract. After removing duplicates, 63 articles were reviewed and 47 were included. 475 different alternatives to assess PC development were extracted, which corresponded to 70 indicators. The majority fell into the policy domain (n=13, 25%), from which national PC plans (n=34) and funding related indicators (n=32) represented the highest frequency. Following appeared the service dimension (n=6, 21%), highlighting PC service capacity indicators as the most frequent (n=76). Drug availability appeared next (n=13, 19%) with opioid consumption (n=23) and prescription regulations (n=18) leading. Lastly, education (n=9, 18%) with high frequencies in undergraduate schools teaching PC (n=22) and human resources for PC education (n=15). Of the identified indicators, 83% felt into WHO dimensions and 12% into other new domains: research (4%), contextual factors (2%), international cooperation (1%) and what some call vitality (5%). Within the research domain, volume of scientific publications (n=15) was the most frequently found, and in the vitality field the national PC association activity was the most frequently identified item (n=10). A remaining 5% indicators didn’t fit in any dimension.

**Conclusion:** While an 83% of the indicators matched WHO dimensions, reflecting the adequacy of WHO’s framework, the recognition of aforementioned domains can contribute to the strengthen PC assessment. The identification of indicators assessing PC development globally will serve to initiate a dialogue towards an assessment consensus. For instance, the results of this study will be part of Delphi expert-rounds programmed for the next European Atlas.

**Abstract number:** PO262  
**Abstract type:** Print Only

**Translation and Cognitive Testing of the Italian Integrated Palliative Outcome Scale (IPOS) among Patients and Healthcare Professionals**

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**Background:** Outcome measurement is fundamental to assess needs and priority of care in palliative care settings. The Integrated Palliative Care Outcome Scale (IPOS) developed from earlier versions of this tool. Its use is encouraged to ameliorate the assessment of individual outcomes in palliative care settings. The previous version, named POS (Palliative Care Outcome Scale) is now fully validated in Italian but needs to be updated to the IPOS version. This study aimed to translate and culturally adapt IPOS into Italian, and explore through cognitive testing its face and content validity.

**Methods:** After forward-backward translation, a qualitative study explored the views of and cognitive processes used by respondents. We
conducted individual semi-structured interviews with 21 patients admitted to two palliative care services from hospitals, hospices and the community, and focus groups with 12 professionals working in multidisciplinary palliative care teams. The data was analysed using a thematic analysis approach. The results were integrated in a final audit, including the project team and the original POS developer, to refine the final format of the tool.

Results: Patients and professionals felt content and format of IPOS appropriate and feasible, and not burdensome. Some layout problems were raised leading to adaptation. Main issues regarded: clarifying the meaning of choices and some cultural interpretation of some questions and response options and interpretation of some instructions. Some new terms were proposed since were felt as more appropriate and comprehensive in this cultural context, for example replacing the term “family” with beloved ones. The items that appeared unchanged from the Italian POS versions were left unmodified to maintain a coherence with the previously validated tool.

Conclusions: The Italian IPOS, in its four versions directed to patients or staff and with a recall period of 3 or 7 days has face and content validity for use in clinical settings and is ready for further psychometric and clinical validation.

Abstract number: PO263
Abstract type: Print Only

Self Evaluation and Test Scores (SETS): Does Post-course Self-evaluation Correlate with Knowledge Test Scores in an Advance Nurse Training Course? A Pilot Study
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Aim: We aim to find out if self-evaluated scores of self-confidence and satisfaction of a course can be used as a surrogate for post-course test marks.

Methods: GeriCare is a programme that provides training and tele-medicine consults to 8 nursing homes in Singapore. Selected registered nurses will enrol the TeleGeriCare Nurse Training Course (TNTC) in which they would be taught clinical skills that includes physical examinations, communication skills, geriatric assessments and management. A 50-MCQ knowledge test was administered at the end of the course. Participants also completed a confidence and a satisfaction survey. The confidence survey looked at both confidence in basic nursing skills (a control for confounder of baseline confidence) and in Tele-geriatric skills (TNTC knowledge-specific confidence). The group was divided into “high scorers” and “low scorers” based on the test results. Ratings of the confidence and satisfaction were entered into a simple linear regression analysis to evaluate their contribution to predicting test marks. Correlation analysis was also performed.

Results: 31 nurses completed the study. Demographic differences including years of nursing experience and seniority in nursing did not correlate with MCQ scores. Satisfaction levels reported were not significant predictors of the test scores. Confidence scores in basic nursing skills were not correlated with MCQ scores. However, confidence scores in Tele-geriatrics-specific skills correlated with MCQ scores (P 0.013).

Conclusion: Confidence in the correct domain (specific to TNTC’s learning objectives) were correlated with test marks. The absence of correlation in confidence in basic nursing skills to test marks shows that baseline confidence is not a confounder. Our results is contrasted with studies which did not show any correlation. Our pilot research showed that this research can be easily replicated on a larger scale and may yield positive results.

Our study showed that confidence surveying may be plausible as a surrogate for knowledge testing. Low scorers may be identified earlier in the course based on a confidence survey and early help could therefore be rendered to this group of learners. With more evidence, we may even be able to use confidence surveys to replace knowledge tests.

Abstract number: PO264
Abstract type: Print Only

Anyone Can Improve their Palliative Competence when Learning Interprofessionally
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Background: The impact of interprofessional education (IPE) has been studied extensively within disciplines such as medicine, nursing and healthcare. However, the impact on the interprofessional competence of the participants has been less researched. In this study, we aim to evaluate the effectiveness of an interprofessional course in the field of Palliative Care with respect to the participants’ self-efficacy.

Method: The interprofessional course “GeriCare” was developed by the authors in cooperation with participants from different healthcare professions, such as medicine, nursing, social work and psychology. The course aimed to improve the palliative knowledge and skills of the participants.

Results: Forty-two participants completed the course, representing a variety of healthcare professions. At baseline, there were significant differences between the groups in terms of age, gender, and previous experience in palliative care. After the course, there was a significant improvement in both basic and specific palliative knowledge, as well as in self-efficacy. The improvement was more pronounced in the minority groups (e.g., nurses from minority backgrounds).

Conclusion: The results of this study indicate that interprofessional courses in palliative care can be effective in improving the knowledge and skills of participants from different healthcare professions. Further research is needed to explore the long-term effects of such courses and to evaluate their impact on patient outcomes.

Abstract number: PO265
Abstract type: Print Only

Obtaining Ethical Approval for Palliative Medicine Masters Research - What Is the Reality?
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Background: In the field of palliative medicine, obtaining ethical approval for research can be a challenging process. The purpose of this study was to explore the reality of obtaining ethical approval for palliative medicine research projects.

Method: A qualitative research design was adopted, with semi-structured interviews conducted with key stakeholders involved in the ethical approval process. The interviews were focused on the barriers and facilitators to obtaining ethical approval.

Results: The study found that obtaining ethical approval for palliative medicine research projects can be a lengthy and complex process. There were significant variations in the ethical approval processes across different institutions, which can lead to delays and frustration for researchers. The study also identified the need for better communication and collaboration between different stakeholders involved in the ethical approval process.

Conclusion: The findings of this study highlight the importance of improving the ethical approval process for palliative medicine research. Further research is needed to explore strategies for streamlining the process and ensuring consistency across different institutions.
Results: Of the 129 alumni, 114 were contacted and 34 replied (32.5%).
73% (25/34) did a project requiring ethics approval. 56% (14/25) had an
initial response from the ethics committee in 4 weeks or less. 68% (17/25)
had an unconditional approval on first response. The median time for
ethical approval from candidates surveyed was 12 weeks.
Many students felt there was limited insight and awareness of the various
ethics committees in process of qualitative research. Other comments
included allowing sufficient time for the process and advised seeking
support from experienced mentors and colleagues. There were plenty of
encouraging comments and many felt they had benefited from the
experience.
Conclusions: This study has shown there is little information available
regarding the practicalities of obtaining ethical approval for research in
Palliative Medicine. In this cohort the majority of candidates obtained
ethical approval following their first submission and the average length
time for this process was 12 weeks. Further work examining the process
in more detail may allay some of the anxieties the students described
and could assist potential researchers within palliative care especially
those undertaking studies within particular time-constraints.
Reference
Casarrett, David J et al. Journal of Pain and Symptom Management. 20
(2): 130 – 139.

Abstract number: PO266
Abstract type: Print Only

Challenges in Research in Advanced Cancer - Lessons Learnt from the
Conduct of an Observational Trial on Prognostication in Pain
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India

Background: Research in advanced cancer is fraught with unforeseen
challenges at every step - beginning from conceptualization (formulation
of an ethical research question) to choosing relevant outcome measures
and barriers to successful recruitment. The completion of the designated
period of accrual may be followed by the emergence of a multitude of issues
pertaining to the methods employed, analysis of data and interpre-
tation of results.
Methods: This review focuses on enumerating the challenges involved in
research at various stages of conduct of a non randomized observational
trial which involved characterization of baseline Pain on Edmonton
Classification System for Cancer Pain with calculation of number of days
to achieve stable pain control, description of Acute exacerbation of
pain (AEP) on the Alberta breakthrough pain assessment tool and mainte-
nance of a Pain Education booklet for documentation of baseline Pain,
Acute exacerbation of Pain (AEP) on the Alberta breakthrough pain
assessment tool and maintenance of a Pain Education booklet for docu-
mantion of baseline Pain, number of daily episodes of AEP and Opioid related adverse effects by
the enrolled subject.
Results: The information which was available at the end of six months of
accrual was incomplete and lacked a definite direction. The planned target
of the number of follow up visits (two) was not met. This could be attrib-
uted to the unique problems inherent in the patient population, complex
ethical issues which could have been compounded by the paucity of an
effective communication process and collusion (inertia on the part of rela-
tives and researcher). This culminated in a higher than expected loss to
enrollment. This could be attributed to the number of patients with
advanced cancer and group training on the same skills. We asked:
How do oncologists and palliative care doctors evaluate an e-learning
course that aims to promote patient centered communication skills?

Aims: The educational program of PALLION (Palliative Care Integrated
in Oncology) consists of three elements; lectures, an e-learning course
focusing physicians’ communication skills in encounters with patients
with advanced cancer and group training on the same skills. We asked:
How do oncologists and palliative care doctors evaluate an e-learning
course that aims to promote patient centered communication skills?

Methods: The e-learning course, made up of ten 30-minute sessions, was
based on 4 films on consultations between doctors and a cancer patient from
start of last chemotherapy cycle until end of life. For each film questions
to be used in small group discussions were formulated. The groups consisted
of oncologists and palliative care doctors and were led by communication
trained doctors and psychologists. 18 communication skills were focused on
throughout the course. After course completion a structured, anonymous
web-based evaluation survey was distributed, focusing on:

1) a general evaluation of the course content and practicalities
   (range:1(quite good)-5(very poor)),
2) to what degree the course raised their awareness of communication
   skills (1(a very high degree)-5(not at all), and
3) the contributions (1(a very high degree)-5(not at all)) and participation
   (1(too active)-5(too passive)) of the teacher.

Results: Fifty of the 79 (63.3%) participating doctors responded (Mean age:
42; F: 65%). Between 63% and 86% reported that the course raised their
awareness of the communication skills in some, fairly or very high degree,
while 27% to 14% answered to a small degree or not at all. 67.2% reported
their general evaluation of the course content as fairly or quite good, 30.6% as
neither or good or poor, 2% as fairly or very poor. The practicalities were
rated by 55.1% as fairly or quite good, by 34.7% as neither or, by 10.2% as
either or good or poor, 2% as fairly or very poor. The practicalities were
rated by 55.1% as fairly or quite good, by 34.7% as neither or, by 10.2% as
fairly or very poor. 98% reported that the teacher provided useful contribu-
tions to the discussion and 92% teacher’s participation as appropriate.
Conclusion: Overall, the participants rated the e-learning course as fairly
good. The practicalities of the course have the greatest potential for
improvement. The course is to be followed by communication skills
training.

Abstract number: PO268
Abstract type: Print Only

A Delphi Study for the Development and Validation of an EPA
Framework for Palliative Care in Dutch Medical Undergraduate
Curricula
Pieters, Jolien1, Warmenhoven, F.C.1, Westen, J.H.1, Verstegen, D.M.L.1,
Courtois, A.M.2, van den Beek-van Eerdingen, M.H.J.2, Dolmans,
D.H.J.M.1

Abstract number: PO267
Abstract type: Print Only

Raising Awareness of Communication Skills by an E-learning Pro-
gram: Participants’ Evaluation
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2Department of Oncology, Oslo University Hospital and PRC, Oslo,
Norway, 3Department of Behavioral Sciences in Medicine, University of
Oslo, Oslo, Norway

Aims: The educational program of PALLION (Palliative Care Integrated
in Oncology) consists of three elements; lectures, an e-learning course
focusing physicians’ communication skills in encounters with patients
with advanced cancer and group training on the same skills. We asked:
How do oncologists and palliative care doctors evaluate an e-learning
course that aims to promote patient centered communication skills?

Methods: The e-learning course, made up of ten 30-minute sessions, was
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   (range:1(quite good)-5(very poor)),
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   skills (1(a very high degree)-5(not at all), and
3) the contributions (1(a very high degree)-5(not at all)) and participation
   (1(too active)-5(too passive)) of the teacher.

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42; F: 65%). Between 63% and 86% reported that the course raised their
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neither or good or poor, 2% as fairly or very poor. The practicalities were
rated by 55.1% as fairly or quite good, by 34.7% as neither or, by 10.2% as
fairly or very poor. 98% reported that the teacher provided useful contribu-
tions to the discussion and 92% teacher’s participation as appropriate.
Conclusion: Overall, the participants rated the e-learning course as fairly
good. The practicalities of the course have the greatest potential for
improvement. The course is to be followed by communication skills
training.
Methods: This Delphi-study started with a review of national and international literature. Two palliative care competency profiles appeared to be suitable for the Dutch situation: an educational framework developed in the Netherlands (VU, 2016) and the EAPC competencies described in a white paper (EAPC, 2013). These two documents were combined by experts in education and palliative care, resulting in one EPA list. To validate this list, a Delphi study was conducted.

Results: The original EPA list consisted of 46 items. The Delphi study included five different groups of stakeholders: palliative care experts, healthcare professionals, nurses, curriculum coordinators and junior doctors. They scored the required level for junior doctors of an EPA on a 6 point Likert scale. After the first round, descriptive analyses were conducted. The variation between and among the five groups was large. No consensus was reached on any of the EPA’s. Therefore, a second round was conducted. The results of the second round will be presented.

Discussion: The Delphi study results in a final EPA list that can be used as a basis for the development of educational materials.

References

Abstract number: PO269
Abstract type: Print Only

Good Practices of Palliative Medicine Teaching in Eight European Universities: A Case Study
García-Baquero Merino, Maria Teresa1, Perez de Oteyza, Coro2, Dominguez Cruz, Alfredo3, Tarrino Lozano, Alberto4, Ciardo, Antonio5, Ellershaw, Elinor, Frank6, Agnes, Csikos7, Filbet, Marilene8, Biasco, Guido9, Centeno, Carlos10
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Context: Palliative Medicine teaching (PMT) at the University has positively evolved in the last years in Europe but in a limited number of Universities.

Objective: The aim of this study is to show how PC medical education has emerged and is being taught in several European countries.

Method: Case study using a convenience sample of eight universities from different countries (Spain, France, UK, Sweden, Italy, Hungary, Germany and Poland) where experienced PC professors are teaching. Data were collected through face-to-face semi-structured interview exploring a) the model of PC medical education in each university, b) the professorship

c) an overview about the country including vision on barriers and opportunities to the develop of undergraduate palliative care education.

Results: The genesis of PMT in universities depends of a favorable social and political context in relation with palliative care, alongside pioneer’s initiative and students thrust. A Palliative Medicine curriculum frequently starts as an optional subject and becomes mandatory on a short period (around five years time). In the universities reported, PMT employs a wide variety of teaching methods as lectures, workshops, role-plays, and discussions. The PM assessment included tests, discussions, reflections, portfolios and research works. Lack of recognition, funding’s, and accredited teachers, along with competition with other curricula, are main barriers for PMT development at the university.

Conclusion: PMT has developed in European Universities with diverse paths and teaching tools. These samples may shed light on other medical schools to develop their PM curricula.

Abstract number: PO270
Abstract type: Print Only
e-ELCA Program as Innovation in Teaching for Spanish Professionals
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Background: Optimising end of life care is considered to be everybody’s job. Not only professionals but also society as a whole is involved in facilitating it. Teaching and training are very important. e-ELCA is a successful e-learning programme developed by Health Education England and APM to enhance training and education of workforce so that well-informed high quality care can be delivered.

Aims: To establish whether e-ELCA content and philosophy could be transferred to a different country with different language and where PC was not a medical speciality nor has a formalised training curriculum.

Methods: Health and social care professionals English speakers who an interest and experience in Palliative Care and in the subject. They were identified through the Regional database and a medical English teaching agency.

A course aimed to develop reflective practice and learning commentary was developed based on e-ELCA course contents, weekly reading list and with personalized tutorials and group -both online and classroom - discussions was designed

40 students used of their ELCA access, their personal work, comments around the group work and survey were analyzed with mixed methods.

Results: 40 professionals got on to the course

33 learners regularly worked on the course, usage report showed that there has been nearly 850 hours or learning, averaging 25 hours per learner and considered by eELCA team to be excellent usage over 10 months.

Seven completed all the course work. All of these had started to apply the newly learned tools to their daily job.

The survey showed that students preferred the calssroom sessions. Missed Spanish services information. Found difficulties having regular session online on the difficulty aspet. On benefits theywhere overwhelmingly positive: having been exposed to proper palliativecare teaching, improved communication skills, wideexposure to thearticles.

Conclusions: Our group benefited greatly from e ELCA. Our experience needs to be followed by a Spanish version of ELCA both reach further groups and compare the two courses delivered in two languages.
Abstract number: PO271
Abstract type: Print Only

Breaking Bad News: Analysis of Medical Residents’ Perception towards Communication Skills
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Objective: The study aimed to assess the medical residents perception about communication skills before and after a workshop.

Methods: It was developed a short workshop to teach communication skills to residents in internal medicine from a general hospital in Belém-Pará. They were submitted to an assessment before and after the workshop by means of questionnaire about their practice and about their learning communication skills by Communication Skills Attitude Scale. It’s a quantitative-qualitative study. The quantified data were dealt statistically thought Wilcoxon Test (CSAS score assessment) and Chi-Square and Adhesion G-Test (quantitative variables of the interview questionnaires about communication abilities). Qualitative assessment was done by the Content Analysis based on Bardin.

Results: Ten residents attended the workshop. They showed more positive attitudes towards learning communication skills after the workshop (Communication Skills Attitude Scale = 99.5 and 105, before and after the course respectively (p=0.0039)). Eighty percent of residents considered their communication skills improved with the workshop (p=0.0078). Most of participants became to consider the patient’s perspective and admitted changes in their emotional aspects after the course.

Conclusion: The intervention focused on the context of breaking bad news had a positive effect in the perception of participants regarding this type of learning skills in medical training. It is suggested that breaking bad news workshop should be included in teaching practice of medical residents and maybe reapplied to undergraduate curricula.

Table 1

<table>
<thead>
<tr>
<th>Each dosage form</th>
<th>CHs(n=22)</th>
<th>GHs(n=72)</th>
<th>p value</th>
<th>PCS(n=49)/No-PCS(n=45)</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>mean% (SD)</td>
<td>CHs(n=22)</td>
<td>GHs(n=72)</td>
<td></td>
<td>PCS(n=49)/No-PCS(n=45)</td>
<td></td>
</tr>
<tr>
<td>oral morphine (n=27)</td>
<td>32.0 (23.3)/15.4 (18.9)</td>
<td>p=0.07</td>
<td>23.4 (26.7)/14.9 (12.7)</td>
<td>p=0.13</td>
<td></td>
</tr>
<tr>
<td>morphine injection (n=5)</td>
<td>55.5 (38.2)/33.6 (31.9)</td>
<td>p=0.16</td>
<td>49.3 (40.0)/27.1 (26.5)</td>
<td>p=0.13</td>
<td></td>
</tr>
<tr>
<td>morphine suppository (n=3)</td>
<td>57.6 (25.0)/47.6 (26.4)</td>
<td>p=0.06</td>
<td>60.5 (29.7)/38.5 (21.5)</td>
<td>p=0.14</td>
<td></td>
</tr>
<tr>
<td>fentanyl injection (n=3)</td>
<td>53.0 (9.2)/36.5 (39.8)</td>
<td>p=0.22</td>
<td>48.9 (47.4)/31.1 (33.1)</td>
<td>p=0.28</td>
<td></td>
</tr>
</tbody>
</table>

Conclusion: In hospitals in Tokyo, CHs and PCS hospitals have more OAs available than GHs and non-PCS hospitals. When patients transition to community GHs or non-PCS hospitals, continuity of pain control could be challenging.

Abstract number: PO272
Abstract type: Print Only

A Survey on the Availability of Opioid Analgesics in Different Types of Japanese Hospitals
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Background: Opioid analgesics (OAs) are useful in clinical practice as they offer multiple routes of administration and have unique characteristics for pain control. They are not always broadly available in Japanese hospitals due to limitations in the variety of OAs that can be stocked.

Aim: To investigate the variety of OAs available in different types of Japanese hospitals and to examine pharmacists’ opinions on availability.

Methods: Questionnaires were sent to pharmacies in all cancer hospitals (CHs) and general hospitals (GHs) in Tokyo (n=214). We investigated the relationship between the availability of OAs (76 medications) and both the type of hospital (CH vs GH) and the availability of palliative care services (PCS) in the hospitals. We asked pharmacists in each hospital whether the variety of OAs was sufficient. Statistical analysis was done via t-test.

Results: Responses were received from 94 (42.7%) of the 214 hospitals. Of these, 22 (23%) were CHs, and 49 (52%) had PCS. The mean numbers of different OAs available were 10.3/22 (46.8%) and 18.3/72 (25.4%) in CHs and GHs, and 18.4/49 (37.6%) and 10.0/45 (22.2%), in PCS hospitals and non-PCS hospitals, respectively (p<.01). More OAs were available in CHs and PCS hospitals, but the differences were mostly statistically insignificant (Table 1). Fifty-nine percent of pharmacists in non-PCS hospitals felt that the variety of OAs available was sufficient, while 11% did not.

Objective: Understanding perception of cancer patient towards quality and satisfaction on palliative care in Central Hospital of Dr.Sardjito Yogyakarta.

Methods: A mixed methods study was performed with sequential explanatory design, from September to October 2016. We collected the quantitative data and then continued with the qualitative data. Forty eight patients with cancer involved in this study. The CES-P questionnaire was used to measure quality of care and the Famcare-P questionnaire was used to measured patients’ satisfaction. Semi-structure interview was performed and the data analysed using the content analysis. Integration of the results of quantitative and qualitative approach used the joint displays.

Results: This study found that 5 domains in the quality of palliative care were very high score namely: physical care by doctor (92,66), coordination and consistency (91,72), supported on making decision (90,94), environment (87,77), and physical care by nurse (86,10). Two domains were low score namely: psycho-existential care (70,03), and availability (62,22). Patients with cancer reported a high satisfaction on the subscale of support in decision-making with a mean (4,60±0,49), followed by a subscale of symptom management (3,96±0,42), communication and information (3,93±0,35), coordination and consistency (3,8±0,38) and accessibility (3,7±0,44). Based on semi structure interview, this study identified five themes:
1) quality of palliative care,
2) palliative care,
3) coordination of care,
4) satisfaction against palliative care and
5) accessibility of care.

Conclusion: Patients with cancer had perception that psycho-existential care and availability to access palliative care need more improvement. Further study is needed to explore more about patients satisfaction particularly regarding support in decision making on palliative care.

Abstract number: PO274
Abstract type: Print Only

Use of Technology within Palliative Care in Hospices, Nursing Homes and Home Care Organizations
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Introduction: The growing population of older adults in the Netherlands and increasing number of people with a chronic disease, leads to a greater need for palliative care. Technology may play an essential role in this increased demand for care. Therefore we studied the extent to which technological tools are currently used in palliative care in nursing homes (NH), homecare organizations (HO) and hospices (H) and the differences in use between these settings. This gives an understanding of the current state of the art, and may serve as a starting point for innovations.

Methods: A cross-sectional survey was conducted in 124 organizations: 17 H, 39 NH and 68 HO. All existing H in one region were approached, NH and HO were randomly selected. We designed a digital survey with 20 different technological tools based on the literature. This questionnaire was emailed, after a telephone-call, to the most appropriate person within each organization. Data has been analyzed using SPSS 25.0.

Results: At this moment, 79 settings (64%) responded: 12 H, 21 NH and 46 HO. Descriptive analyses shows that H use less technology tools than HO and NH (6, 9 and 10 tools are used by more than 50% of the organizations in these settings, respectively). Technological tools, such as personal alert, passive lifts, high-low beds, oxygen equipment and stand-up devices are used by more than 50% of the organizations in all settings. Sensors are specifically used in NH (74% compared to 42% H and 13% HO), electronic patient record in NH and HO (78% and 66% compared to 33% in H), and feeding pumps in HO (55% compared to 35% in NH and 17% in H). Video calling (0% of H, 13% of NH, 19% of HO), e-consultations (0% of H and NH, 11% of HO) and social robots (0% of H and HO, 9% of NH) are rarely used in all settings. Inferential statistics are available at time of conference.

Conclusion: There is a wide variety in use of technology tools in palliative care between the three settings. It is remarkable that technology is less used in hospices, in comparison to the other two settings. The technological tools that are used often, benefits mainly the work of the professional and not directly patients or informal caregivers. Further studies are needed to clarify our findings, and to improve the use of technology in palliative care.

Abstract number: PO275
Abstract type: Print Only

The Experience of Radiotherapy from the Perspective of Palliative Care Patients in an Academic Teaching Hospital in Germany - A Qualitative Study
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Introduction: If a tumor is well advanced and a cure is no longer possible, the ultimate goal in the care of terminally ill patients is ensuring the highest possible quality of life. If distressing symptoms occur, radiation therapy may be indicated with palliative intent. Despite a lower radiation dose and a short irradiation time, many patients suffer from physical and mental stress, during and after therapy. About the subjective experience of terminally ill patients during radiotherapy treatment, little is known.

Methods: Six patients with advanced and metastatic cancer participated in this study. Data were collected through participant observations and interviews with patients. Data were analysed using an interpretive phenomenological approach. The thematic analysis revealed five themes that were illustrated with paradigm cases and exemplars.

Results: Patients experienced radiation therapy depending on their previous experience and exposure to the symptoms as more or less challenging. Special aspects, such as the first irradiation, irradiation with face mask or lying on the irradiation table, were a challenge. The experience could be influenced by the extent of information about the therapy by the therapists or by their co-patients and their own way of dealing with their illness.

Conclusion: The results of the study can draw the attention of the professionals to the various aspects of radiotherapy from seriously ill patients in a hospital. For a good care of these patients, it is not only a certain attitude, but an extended expertise, following palliative care guidelines.

Abstract number: PO276
Abstract type: Print Only

Developing the All-Ireland Institute of Hospice and Palliative Care (AIHHPC) Palliative Care Research Network Strategic Plan 2017 - 2022
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Background: In 2012, AIHHPC established the Palliative Care Research Network (PCRN) to address the need for collaborative multidisciplinary palliative care research on the island of Ireland. The PCRN is governed by the Strategic Scientific Committee (SSC) whose membership includes representatives from the PCRN, people with life limiting conditions and their family/carers* and national funding bodies.

Aim: To develop a Strategic Plan to set out the main objectives of the PCRN and implementation actions required over next five years.

Method: Three phase development:
1) Identification of activity areas by SSC members via open agenda meeting and email review;
2) Refinement of plan created by SSC with support of AIHHPC via email/ phone review. Participants included: SSC; PCRN; Early Career Researcher Forum; AIHHPC’s Executive Committee; Voices4Care Research Panel;
3) Prioritisation to inform the actions required for implementation via stakeholder workshop. Participants (17) from: academic/clinical institutions; policymaking/funding organisations; Voices4Care research panel; AIHHPC.

Results: Five strategic objectives were identified:
1) Collaborative and coherent research environment and culture;
2) Deliver outstanding, innovative, internationally relevant research;
3) Develop research leaders and research capacity;
4) Advance knowledge and practice for hospice and palliative care through interdisciplinary collaborations and meaningful involvement of people with life limiting conditions and their carers;
Comprehending Complexity: The Palliative Care Situation as a Complex Adaptive System

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Background: A palliative care (PC) situation is characterized as a complex problem by reciprocal, non-linear relations and uncertainties. Dealing with complex problems necessitates problem-solving methods tailored to specific situations. The theory of complex adaptive systems (CAS) provides a framework for locating problems and solutions. A CAS consists of relatively autonomously acting agents which interact. It is part of a superordinated system and consists of interacting subsystems itself.

Aim: To describe criteria contributing to complexity of PC situations and develop a conceptual framework to promote the understanding of complexity of a PC situation by locating the complex problem in a CAS.

Method: Qualitative semi-structured expert (clinical/ economical/political) interviews. Audio-recorded interviews were transcribed verbatim. Data was analysed applying framework method. The thematic framework was developed inductively. Categories were reviewed, subsumed and connected considering CAS theory.

Results: 42 interviews from 6-10/2015. The CAS of a PC situation consists of 3 subsystems: system patient, social system, system team. Agents in the system patient are allocated to further subsystems on patient level: physical, psycho-spiritual, and socio-cultural. Social system and system team are composed of social agents which affect the CAS as carriers of characteristics (e.g. carer burden), roles (e.g. minor children) and relationships (e.g. cooperation with external service providers). Agents within subsystems and subsystems themselves interact on all hierarchical system levels and shape the system behaviour of a PC situation.

Discussion: All complexity factors described by experts could be translated into a CAS. System elements and their relations give insight into possible behaviour of the PC situation. Elements cannot be understood independently from the overall PC situation.

Funding
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Physical Burden of Nurses in the Palliative Care - An Underestimated Burden? Results of a Nationwide Study in Germany

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Statement of aims / research questions: The palliative care research focuses on psychological burden of nurses due to death and dying. Physical burdens aren’t hardly taken into account. Therefore, the aim of the study is to examine the physical burdens of nurses in all settings of the specialized palliative care in Germany (palliative ward, hospice, specialized outpatient palliative care (SAPV)).

Presentation of methods: The cross-sectional study is conducted from April to October 2017. The questionnaire contains one question regarding lifting and carrying of patients. The data were analysed by univariate and bivariate methods (contingency table p< 0.005).

Presentation of results: In the abstract the preliminary results of 491 nurses are presented. The physical burden because of lifting and carrying of patients is distributed as follows: no burden (13.6%), very weak burden (14.3%), rather weak burden (26.7%), rather strong burden (31.8%), very strong burden (12.4%). Nurses, who are burdened because of lifting and carrying of patients had more often chronic backpain in the last 12 months (p< 0.005). Lifting and carrying further denote a stronger burden in the palliative ward than in the SAPV.

Conclusion: The workload differences concerning the physical burden can be partly explained by structural differences. Nevertheless, physical nursing activities are perceived as a strong burden in the palliative care. The physical activity is related to back pain. As part of further research there should be greater focus on physical burdens. Training activities would be reasonable in view of specific physic activities, especially in the inpatient palliative care.

* The study “Work situation and Health of nurses working in palliative care in Germany” was conducted by the Institute of Occupational, Social and Environmental Medicine, University Medical Center of the Johannes Gutenberg University of Mainz in cooperation with the Institute for Health Care Research in Dermatology and Nursing, University Medical Center Hamburg-Eppendorf. The study was funded by the Employers’ Liability Insurance Association for Medical Services and Welfare Work (BGW).

Re igniting Compassion in Healthcare: Manaakitia Reflective Rounds

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Background: The reported levels of staff stress and burnout at all levels of training and disciplines is significant and recognised to impact on the care of patients and families. We present an initiative to support staff at an acute tertiary hospital based on the Schwartz Center Rounds.

Aim: To evaluate the efficacy of monthly case-based, staff support reflective rounds to discuss complex emotional and psychosocial issues that arise in caring for patients and families.

Methods: At an acute tertiary hospital, a pilot programme called Manaakitia Reflective Rounds was conducted between April 2014 and September 2015. These were facilitated 1 hour, monthly, case-based, staff support groups to discuss complex emotional and psychosocial issues in caring for patients. Staff evaluations and feedback were collated.
Results: A total of 12 rounds was conducted exploring a range of challenging issues, from difficulty in achieving a patient’s wish to die at home to coping with the ‘heart sink’ patient. There were 276 attendees in total, with an average attendance of 23 participants per round. A total of 218 evaluations was returned (79%) with rounds being rated as either exceptional or excellent by 87.5% of participants. Attendees reported positive benefits, such as gaining knowledge to help them care for patients (94%), working better with colleagues (87%) and gaining insight into how others think and feel in caring for patients (97%). Attendees reported a sense of having a ‘shared experience’ with better understanding of each other’s professional perspectives and acknowledgement of the limitations (practical and human) in caring for patients and families.

Conclusion: Evaluations of the rounds indicate a need for staff to have a safe and supportive space to explore the emotional aspects of their work. Staff particularly appeared to value having a ‘shared understanding’ with the recognition that they are ‘not alone’ when managing challenging situations.

Abstract number: PO280
Abstract type: Print Only

Prevalence and Characteristics of Reported Clinical Incidents with Opioids Experienced by Adult Cancer and Palliative Care Patients (2013-15) in NSW: A Quality Audit
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Introduction: Opioids are a high-risk medicine routinely used in cancer and palliative care services to manage pain. Cancer and palliative patients are at greater risk of exposure to and harm from medication errors due to advanced illness, multiple co-morbidities and polypharmacy. Despite the high volume of opioid use in cancer and palliative care services, few studies have examined the characteristics of opioid errors in these services. Despite the high volume of opioid use in cancer and palliative care services, few studies have examined the characteristics of opioid errors in these services.

Aim: To identify characteristics of clinical incidents with opioids reported in cancer and palliative care services in one Australian state.

Design: Retrospective review of incidents involving Schedule 8 opioids (hydromorphone, morphine, etc.), reported via cancer and palliative care services’ clinical incident reporting systems (2013-2015).

Results: 481 clinical incidents with opioids were analysed. The majority of incidents were reported in palliative care services (64%, n=309). Errors with hydromorphone (36%, n=172), morphine (21%, n=102) and oxycodone (21%, n=102) were the most frequently reported. Opioid administration errors accounted for 59% of incidents, primarily due to non-therapeutic dose omissions (29%, n=82), wrong dose (15%, n=42) and wrong route errors (13%, n=38). Prescribing error reporting (16%, n=76) was lower, and mainly involved medication charting errors (42%, n=32). In cancer services, half the opioid errors that reached the patient resulted in an overdose, whereas palliative care patients were more likely to receive an opioid under-dose (59%). For 23% of patients (n=44) clinical intervention was necessary to manage increased pain as a direct result of an opioid error. Non-compliance with medication management policy (47%, n=96) and poor clinical communication (43%) were the primary contributing factors to opioid errors.

Conclusion(s): Identifying characteristics and patient impact of opioid errors in cancer and palliative care services is essential to future patient safety initiatives targeting safe opioid delivery processes in these vulnerable patient groups.

Abstract number: PO281
Abstract type: Print Only

Palliative Care in a Society Emerging from Violent Conflict
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Background: Understanding the impact of the Northern Ireland ‘Troubles’/‘conflict’ on a particular area of health care - palliative care - which has received little, if any, previous research focus. The research was carried out for a dissertation submitted in partial fulfilment for the degree of Master of Philosophy.

Aim(s): To investigate how the legacy of the Northern Ireland conflict may be encountered by professionals providing palliative care - to those they are caring for who may have been directly/indirectly affected (victims/survivors) and those involved in inflicting damage, death and/or injury. To investigate how the distinct context of Northern Ireland has impacted on palliative care practice.

Method: Interviews were carried out with nine professionals with experience in the provision of support to people with palliative care needs. Participants reflected experience across a wide geography of Northern Ireland including the region’s two major cities, four of the region’s five health and social care trust areas, and four of the five inpatient hospice facilities. Participants included: three nurses; two doctors; a social worker; a chaplain; a complementary therapist and a welfare officer.

Results: This research opened up a dialogue between the disciplines of peacebuilding and palliative care. The language of legacy, narrative, life story and peacebuilding is one which the palliative care community understands.

The impact of the Troubles has had an effect on the delivery of palliative care, through the attitudes and influences on those who provide the care and those they care for.

Conclusion: The influences of the religious divide, the silencing, and the traumas of the past are not something that the care giver is apart from - they are very much influenced by them. The sensitivities around the Catholic/Protestant divide, the silencing, and restricting opportunities to talk about ‘Troubles’-related trauma, could prevent people from having appropriate palliative care.

Abstract number: PO282
Abstract type: Print Only

Towards Effective Palliative Care Knowledge Transfer and Exchange
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Background/aims: “Knowledge transfer and exchange” (KTE) in palliative care fills the gap between knowledge generated by research and its clinical use. Having found limited evidence for KTE in palliative care we set out to identify factors that influence KTE planning and implementation in two phases.

Methods (1): First, nine semi-structured interviews were performed with very experienced palliative care researchers across the Island of Ireland. Participants reflected experience across a wide geography of Northern Ireland including the region’s two major cities, four of the region’s five health and social care trust areas, and four of the five inpatient hospice facilities. Participants included: three nurses; two doctors; a social worker; a chaplain; a complementary therapist and a welfare officer. Attendees reported positive

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process and outcomes component of the MRC Guidance for Developing and Evaluating complex interventions (Craig et al. 2008), data were collected on the multiple perspectives arising from six cases studies utilising the EMTReK model.

Results (2): The eight main themes which arose during analysis of data arising from interviews of case study participants, corroborated by documentary evidence and researcher observations, were: Credibility of the Model; Model as Accessible; Applicability to Palliative Care; A Matter of Timing; Positive Role of Facilitation; Resources for KTE; Enhancing Research Quality; Limitations or Areas for Further Consideration.

Conclusions: A vital component of the EMTReK model appears to be the appropriate support and guidance to researchers to produce a KTE strategy, considerate of the complexity of disseminating new knowledge to and about vulnerable groups, such as those in receipt of, or requiring, palliative care services. Whilst EMTReK may have potential for broader application to health research, the exploratory case studies were all conducted within palliative care settings.

Abstract number: PO283
Abstract type: Print Only

History of Palliative Care in Spain.
The Vision of its Pioneers
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Background and aims: The history of Palliative Care (PC) in Spain dates back to the mid-eighties, and has been scarcely studied by few individuals based on their knowledge and some existing literature. This study was initiated four years ago and aims at building retrospectively a unique historical portrait through the vision of its pioneers, tinted by the testimony of original documents.

Method: Four methods in different stages:
1) Systematic review of the literature for identifying pioneers;
2) Two-round Delphi process for identified pioneers to select further pioneers;
3) Semi-structured interviews with all pioneers; and
4) Comparative narrative analysis of institutional and personal records against pioneers’ perceptions.

Results: Twelve pioneers of PC in Spain were identified: five through the literature review, five through the Delphi process; and two included by the research team. To date, eight interviews have been conducted. Pioneers explain the origins of PC as a response to seeing patients dying for whom they could do nothing, or patients in pain whose effects did not disappear when physical symptoms were treated. This led them to get in contact with inspiring models abroad; in UK, Italy or Canada; where they got to know PC for the first time. Some adopted PC as a personal humanizing approach at a clinical level, whereas others opted for allocating efforts in integrating PC at an organizational level. PC was spread all over Spain through a second-line pioneers’ bunch who participated in courses and meetings organized by the first ones, along with the contribution of their hosting institutions and organizations like the Spanish Association Against Cancer or the Hospital Order of San Juan de Dios. All pioneers shaped somehow the progressive sensitization (with the creation of the PC culture), institutionalization (with the establishment of the Spanish National Association for PC) and implementation of PC in Spain (by founding PC units and teams).

Conclusion: Pioneers’ stories leave us a comprehensive narration of the origins of PC in Spain. This historical approach may not only draw the most comprehensive picture of the history of PC in Spain, but also may capture the original values from those that initiated PC, and that realized the importance of a person-centered medicine. Documents will add factual data not biased by pioneers’ memories and perceptions, completing and nuancing the story of the pioneers.
Author Index

A
Aarts M. FC73
Aas N. P7, P272
Abas M. P7
Abboah-Offei M. P7
Abe K. PO272
Abetkoff S. FC116, P340
Abu-Saad Huijer H. PO18
Adams A. P385
Adang E.M.M. P347
Aebersold D.M. FC19
Aegerter P. P69
Agahi N. PO269
Agar M. P90, P165, P205
Aggarwal G. P7
Agnes C. PO115
Ahaddour C. P248
Ahmed A. P203
Ahn H.-Y. P240
Akagi T. PO30
Alabakovska L. PO238
Albert N. P357
Alberto A.B. P114
Albright D. PO126
Alburquerque E. P338
Aldridge M. P41, P154
Aleksandrova-Yankulovska S. P194
Alfallouji Y. P49
Allsop M.J. FC87
Almack K. PO69
Almansa-Gimeno M. PO77
Alonso A. PO86
Alonso-Babarro A. PO194
Alquati S. PO179
Alsirafy S. PO173
Alt-Epping B. P224
Althaus B. P223
Alvarado Gutiérrez R.E. PO148
Alvarenga A. P221
Alvarez-Moleiro M. PO148
Alvariza A. PO121
Ameloot R. P183, P184, PO137
Ameser J. PO179
Antunes B. P206
Antunes C.M.C. P36
Antunes L. P35
Aoun S. PO226
Aoyama M. PO226
Aparicio M. PO115
Apóstolo J. PO59
Appleton L. PO55
Aradilla-Herrero A. PO190
Araneda A. PO98
Arantxmanci M. P59, PO81
Arantezolbarrien M. PO82
Arantxu J. PO244
Arano J. P92, PO78
Archer S. FC55
Arend A.J. PO78
Areste K. FC39, FC53
Ariasa N. PO91
Arnes J. FC59
Armstrong M. PO77
Aronson-Segarra M. P194
Arts G. PO109
Ataera-Torrellas N. PO194
Atten R. PO109
Atoum S. PO107
Aubrey R. P356
Aujesky D. FC19
Auperin I. P74, P161, P162, PO133, PO253
Austin J. P336
Azevedo S. P079
Aznar Gallardo E. P096
Aznar A. FC51

B
Baade I. P346
Baccini M. P266
Bak C. P15
Bak J. P85
Bagaraga E. PO24
Bagchus C. PO18
Bagchus L. PO39
Bagci G. PO59
Baid D. PO281
Bailey C. P164
Bailey S. PB06
Bakitas M. PO33
Bakker E. P336
Balaguer A. P211, P213, P214, P378
Baldin Guarnieri T. PO162
Baldomá-Campos G. FC46, P184
Baliza M.F. FC51
Ballabeni P. P223
Ballester M. P319
Bally K. P316
<table>
<thead>
<tr>
<th>Authors</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balmer D.</td>
<td>FC16, FC81</td>
</tr>
<tr>
<td>Balstad T.R.</td>
<td>P192, P143</td>
</tr>
<tr>
<td>Bandert H.-R.</td>
<td>P316</td>
</tr>
<tr>
<td>Bannister S.</td>
<td>FC86</td>
</tr>
<tr>
<td>Basaj A.</td>
<td>P303</td>
</tr>
<tr>
<td>Baratiski A.</td>
<td>P294, P312</td>
</tr>
<tr>
<td>Barallat-Gimeno E.</td>
<td>FC46, P183, P184, PO137</td>
</tr>
<tr>
<td>Barns I.</td>
<td>P19</td>
</tr>
<tr>
<td>Barbarat C.</td>
<td>FC5, P359</td>
</tr>
<tr>
<td>Barbato M.</td>
<td>P278</td>
</tr>
<tr>
<td>Barclay G.</td>
<td>P278</td>
</tr>
<tr>
<td>Barclay I.</td>
<td>P051</td>
</tr>
<tr>
<td>Barclay S.</td>
<td>PO32, PO33</td>
</tr>
<tr>
<td>Bardallo-Porras M.D.</td>
<td>P97</td>
</tr>
<tr>
<td>Bargenda H.</td>
<td>PO130</td>
</tr>
<tr>
<td>Barnes A.</td>
<td>PO260</td>
</tr>
<tr>
<td>Barnes S.</td>
<td>P151</td>
</tr>
<tr>
<td>Barnfield J.</td>
<td>PO312</td>
</tr>
<tr>
<td>Baron A.</td>
<td>FC30</td>
</tr>
<tr>
<td>Batic B.</td>
<td>P318</td>
</tr>
<tr>
<td>Battaglia M.A.</td>
<td>P176</td>
</tr>
<tr>
<td>Bausewein C.</td>
<td>P102, P217, P218, P319, P348</td>
</tr>
<tr>
<td>Bay J.</td>
<td>P176</td>
</tr>
<tr>
<td>Bayes R.</td>
<td>P66, P68</td>
</tr>
<tr>
<td>Bazello</td>
<td>P0162</td>
</tr>
<tr>
<td>Beale G.</td>
<td>P0126</td>
</tr>
<tr>
<td>Beas E.</td>
<td>P0279</td>
</tr>
<tr>
<td>Becker G.</td>
<td>P036</td>
</tr>
<tr>
<td>Bective M.</td>
<td>P0217</td>
</tr>
<tr>
<td>Bedini G.</td>
<td>P306</td>
</tr>
<tr>
<td>Beye E.</td>
<td>P314</td>
</tr>
<tr>
<td>Becker A.</td>
<td>P134</td>
</tr>
<tr>
<td>B6</td>
<td>P315, P247, P276, PO123</td>
</tr>
<tr>
<td>Beguin</td>
<td>P317</td>
</tr>
<tr>
<td>Bega C.</td>
<td>P0102</td>
</tr>
<tr>
<td>Bega M.</td>
<td>P318</td>
</tr>
<tr>
<td>Belar A.</td>
<td>P131, P287</td>
</tr>
<tr>
<td>Belchamber C.</td>
<td>P288</td>
</tr>
<tr>
<td>Bell C.</td>
<td>P339</td>
</tr>
<tr>
<td>Bellamore F.</td>
<td>P340</td>
</tr>
<tr>
<td>Bellis G.</td>
<td>P099, P218</td>
</tr>
<tr>
<td>Benedik J.</td>
<td>P65, P237</td>
</tr>
<tr>
<td>Benkler I.</td>
<td>FC50</td>
</tr>
<tr>
<td>Bennett A.</td>
<td>FC126</td>
</tr>
<tr>
<td>Bennett M.</td>
<td>PL2, P80</td>
</tr>
<tr>
<td>Bennett M.I.</td>
<td>FC76, FC87, P308</td>
</tr>
<tr>
<td>Benoist C.</td>
<td>FC16, FC81</td>
</tr>
<tr>
<td>Bernau M.</td>
<td>P64, P66</td>
</tr>
<tr>
<td>Bernet M.</td>
<td>PO129</td>
</tr>
<tr>
<td>Bertocchi E.</td>
<td>P306</td>
</tr>
<tr>
<td>Betley A.</td>
<td>P327</td>
</tr>
<tr>
<td>Beenders A.J.M.</td>
<td>P270</td>
</tr>
<tr>
<td>Bhatzari F.</td>
<td>P216, P0115</td>
</tr>
<tr>
<td>Bianchi E.</td>
<td>P285</td>
</tr>
<tr>
<td>Bisco G.</td>
<td>FC48, P192, P0269</td>
</tr>
<tr>
<td>Bidstrup P.</td>
<td>FC49</td>
</tr>
<tr>
<td>Bignan M.</td>
<td>P319</td>
</tr>
<tr>
<td>Bijnardorph F.</td>
<td>P233</td>
</tr>
<tr>
<td>Bille H.</td>
<td>P387</td>
</tr>
<tr>
<td>Bilkekens P.</td>
<td>FC103, P0199</td>
</tr>
<tr>
<td>Bilsen J.</td>
<td>P229, P0159</td>
</tr>
<tr>
<td>Bird L.</td>
<td>P11</td>
</tr>
<tr>
<td>Birkeu R.</td>
<td>P067, P068</td>
</tr>
<tr>
<td>Birks C.</td>
<td>P178</td>
</tr>
<tr>
<td>Bissieux E.</td>
<td>P319</td>
</tr>
<tr>
<td>Bitsche S.</td>
<td>P39</td>
</tr>
<tr>
<td>Villard I.</td>
<td>P096</td>
</tr>
<tr>
<td>Bland J.M.</td>
<td>P208</td>
</tr>
<tr>
<td>Blikenkopp A.</td>
<td>P308</td>
</tr>
<tr>
<td>Bloch S.</td>
<td>P248</td>
</tr>
<tr>
<td>Bloom B.</td>
<td>P170</td>
</tr>
<tr>
<td>Bloom A.</td>
<td>P140</td>
</tr>
<tr>
<td>Bloomer M.</td>
<td>P33</td>
</tr>
<tr>
<td>Blot F.</td>
<td>P086</td>
</tr>
<tr>
<td>Bluebond-Langner M.</td>
<td>P134</td>
</tr>
<tr>
<td>Boesler H.B.</td>
<td>P250</td>
</tr>
<tr>
<td>Beeru A.</td>
<td>FC27</td>
</tr>
<tr>
<td>Beeru E.</td>
<td>P091</td>
</tr>
<tr>
<td>Bega C.</td>
<td>P2015</td>
</tr>
<tr>
<td>Bega E.</td>
<td>P091</td>
</tr>
<tr>
<td>Bega M.</td>
<td>P231</td>
</tr>
<tr>
<td>Bega M.</td>
<td>FC54, P290</td>
</tr>
<tr>
<td>Bega M.</td>
<td>P108</td>
</tr>
<tr>
<td>Beenam A.</td>
<td>P038</td>
</tr>
<tr>
<td>Bellenza A.</td>
<td>P147</td>
</tr>
<tr>
<td>B6langer E.</td>
<td>P0246</td>
</tr>
<tr>
<td>Bellenza D.</td>
<td>P305</td>
</tr>
<tr>
<td>Bellenza E.</td>
<td>P0269</td>
</tr>
<tr>
<td>Bellenza F.</td>
<td>P060</td>
</tr>
<tr>
<td>Bellenza A.</td>
<td>P220, P221</td>
</tr>
<tr>
<td>Bellenza B.</td>
<td>P318</td>
</tr>
<tr>
<td>Bellenza C.</td>
<td>FC36, P41</td>
</tr>
<tr>
<td>Bellenza D.</td>
<td>P29</td>
</tr>
<tr>
<td>Bellenza E.</td>
<td>P0102</td>
</tr>
<tr>
<td>Bellenza F.</td>
<td>P036</td>
</tr>
<tr>
<td>Bellenza G.</td>
<td>P216, P220, P221</td>
</tr>
<tr>
<td>Bellenza H.</td>
<td>P354, P0207</td>
</tr>
<tr>
<td>Bellenza I.</td>
<td>P215, P224, P271, P283, P310, P012, P0196, P0202</td>
</tr>
<tr>
<td>Bellenza J.</td>
<td>P271, P280, P305</td>
</tr>
<tr>
<td>Bellenza K.</td>
<td>P285</td>
</tr>
<tr>
<td>Bellenza L.</td>
<td>P0109, P0111, P0226</td>
</tr>
<tr>
<td>Bellenza M.</td>
<td>P271, P280, P305</td>
</tr>
<tr>
<td>Bellenza N.</td>
<td>P285</td>
</tr>
<tr>
<td>Bellenza O.</td>
<td>P354, P202, P207</td>
</tr>
<tr>
<td>Bellenza P.</td>
<td>FC87, P125, P132, P143, P350, P0116, P0217</td>
</tr>
<tr>
<td>Bellenza Q.</td>
<td>INV6</td>
</tr>
<tr>
<td>Bellenza R.</td>
<td>FC16, FC81</td>
</tr>
<tr>
<td>Bellenza S.</td>
<td>P0276</td>
</tr>
<tr>
<td>Bellenza T.</td>
<td>P188</td>
</tr>
</tbody>
</table>
Authors Index

Bozzaro C. PO239
Bradley S. P267
Braglia L. P306
Bramley L. PO199
Brand C. FC90
Brandio M. PO78
Brandeland M. P112
Brandt A. FC114
Brännström M. FC39
Brasil M. PO205
Brathäll C. P205
Brazil K. P15, P63, PO243, PO20, PO136
Breen L. FC164
Brenne A.T. P23
Brenne A.-T. P286
Breton C. FC70
Bricout-Chandemerle C. FC319
Brighton L. FC86
Brixiois A. PO233
Broeckaert B. P338
Broeders M. FC56
Broese J. FC90
Broese van Groenou M.I. FC78
Brophy N. PO100
Brosnan A. PO46
Brosse C. FC86
Brown A. FC78
Brown L. PO136
Brown M.J. PO282
Brown S. PO219
Bruera E. PO147
Brunelli C. FC93
Brungardt A. FC119
Brząkała J. PO139
Buchanan A.M. FC43
Bukk J. FC219
Bulli F. FC90
Bullich I. FC115
Bullo S. PO102
Buma S. PO126
Bundaleska O. FC44
Bunn F. PC78
Burckel J. FC83
Burse M. FC12
Burke M. FC2
Burke M. FC2
Burkhardt S. FC78
Burney S. PO199
Bush S. P205
Bush S.H. FC112
Bussy C. PO102
Butler D. PO105
Butola S. PC6
Buurman B.M. FC44
Buyzma N.
Buganová R.
Bye A. FC12
Byrne L.
C
Cabezon L.
Deck L. PO13 Downey L. PL5
De Forche B. PO123 Downing J. P133
Dekhuizen R. FC70 Downrick C. FC29, P0306
Dekker - van Doorn C. P33 Doyle S. P326
Del Fabbro E. FC104 Dressel G. P141, P356
Delage S. PO86 Dreyling M. P102
Delaney G. P79 Drier S. FC126
Delgado Guay M. PO154 Driller B. P1, P358
Delgado-Gay M. PO154 Drony J. FC6, FC32, FC55, P93
Deliens L. FC75, PO179, FC205, FC51 Duke S. P32
Demark-Wahnefried W. FC71, P245, PO126 Dumitrache M. P28
Demiris G. FC71 Dumitrescu M. P28
Demiris G. PO126 Eagar K. P386
Den Herder M. PO59 Eap M. FC22
Deodhar J. FC68, P88 Eastham R. P22
Derom E. PO95 Eds R. P383
Dev R. FC47 Edstein S. P22
Devreguele M. PO130 Edo-Gual M. P97
Dey P. PO76 Edwards B. PO269
Dhillonander N. P172, PO57, FC207, PO278 Eduardo G. P230
Di Cienzo V. PO185 Edwards H.L. FC63
Di Giovanni A. PO95 Edwards B. FC87
Di Gasio P. PO296 Edwards T. P205
Di Lee S. FC75, PO179, PO215 Eeuwals M. PO140
Di Noto D. PO10 Eeuwals M. P140
Dias G. PO73 Ebert Moltara M. P65, PO129, PO237
Dias L. M. PO271 Ebrel H. PO195
Diawara F. PO112 Eckstein S. P230
Diaz Crescitelli M.E. PO233 Edra N. PO146
Bibaja S. FC47 Edr D. P178
Dicker L.-M. FC54 Edra N. P217
Diehl E. P172, FC29, PO278 Eeckhout J. PO140
Dietz A. FC21 Edwards B. P140
Diederikin Rahm N. PO185 Edwards H.L. P140
Diederikin-Rahm N. PO240 Edwards T. P205
Diez L. PO151 Eeckhout J. P140
Dillen J. P152, PO341 Efendy C. P293, PO201
Di Giacomo M. PO185 Egger B. P293
Dijkstra B. PO99 Egger M. PO201
Dijkstra L. P140 Eicher S. FC63, FC58
Dillen L. PO61 Ekholm O. P338, PO190
Dinescu C. P128 Ekstrom M. INV12
Dijkland S. P218 Ellershaw J. P338, PO190
Dijkstra B. PO140 Ellis-Hill C. P114
Dijkstra B. PO59 Elger B.S. P316
Dolmans D.H.J.M. PO202 Eliz M. P262
Domalain J. PO202 Eliz M. PO205
Dome - Doron S. PO228 Ely W.Y. P205
Dombrech L. P135 Emmanuel B. P69
Donassens Benedetti F. P38, PO107, PO92 Engel M. P45, P71, P250, PO178
Domineguiz B. P338 Engelberg R. PL5
Dominguez Cruz A. PO270 Engels Y. ICN9, FC7, FC70, FC97, FC82, FC111, PO122
Dominicus W. PO61 Engers S. P314
Domke A. P39 Engstern M. P314
Donaldson G. P104 Enguidanos S. PO3
Donaldson K. PO51 Epper A. PO185
Donker G.A. FC37, P86 Ercolani G. P21
Donker G.A. PO98 Ercolani G. P21
Donker G.A. P79 Esher M. P260, PO31
Dos Santos B. P204 Esher M. P260, PO31
Douma G. P204 Esher M. P260, PO31
Douma J. FC73 Escoiaronen L.C. P172, PO357, PO278
Doveo S. PO86 Escobar Bravo M. P56
### Authors Index

<table>
<thead>
<tr>
<th>Authors</th>
<th>Page Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Espejo Salamanca P.</td>
<td>P907</td>
</tr>
<tr>
<td>Espin A.</td>
<td>P022</td>
</tr>
<tr>
<td>Espino M.</td>
<td>P51</td>
</tr>
<tr>
<td>Etzkind S.N.</td>
<td>FC36, P41, P127, P160, P206</td>
</tr>
<tr>
<td>Eva Maria S.P.</td>
<td>P114</td>
</tr>
<tr>
<td>Evangelos D.</td>
<td>P0238</td>
</tr>
<tr>
<td>Evans C.</td>
<td>P032, P033</td>
</tr>
<tr>
<td>Evans C.J.</td>
<td>FC15, FC59, P41, P164, P375, P386, P3177</td>
</tr>
<tr>
<td>Evans N.</td>
<td>P333</td>
</tr>
<tr>
<td>Evenblij K.</td>
<td>P175, P177</td>
</tr>
<tr>
<td>Ewertowski H.</td>
<td>P08</td>
</tr>
<tr>
<td>Ewing G.</td>
<td>P14, P119, P122, P152, P153, P325, P345</td>
</tr>
<tr>
<td>Eyckmiller S.</td>
<td>FC19, FC167, P4, P171, P367, P01, P0188</td>
</tr>
<tr>
<td>F</td>
<td>FC94</td>
</tr>
<tr>
<td>Fachner J.</td>
<td>PC108, P120, P276</td>
</tr>
<tr>
<td>Faes K.</td>
<td>P92</td>
</tr>
<tr>
<td>Fahey J.C.</td>
<td>P086</td>
</tr>
<tr>
<td>Fahn J.</td>
<td>FC30, P129</td>
</tr>
<tr>
<td>Faohiti J.</td>
<td>P0195</td>
</tr>
<tr>
<td>Farquhar M.</td>
<td>P210</td>
</tr>
<tr>
<td>Farrar G.S.</td>
<td>P0149</td>
</tr>
<tr>
<td>Fase L.</td>
<td>FC119, P122, P216</td>
</tr>
<tr>
<td>Fasthomb John</td>
<td>P323</td>
</tr>
<tr>
<td>Faul C.</td>
<td>FC91, P92</td>
</tr>
<tr>
<td>Fayers P.</td>
<td>P064</td>
</tr>
<tr>
<td>Fazekas B.</td>
<td>FC19, FC100, P073, P074, P075, P0416</td>
</tr>
<tr>
<td>Featherstone I.</td>
<td>FC74</td>
</tr>
<tr>
<td>Fell S.</td>
<td>FC74</td>
</tr>
<tr>
<td>Feio M.</td>
<td>FC74</td>
</tr>
<tr>
<td>Fanning S.</td>
<td>P326</td>
</tr>
<tr>
<td>Ferguson B.</td>
<td>P350</td>
</tr>
<tr>
<td>Ferguson C.</td>
<td>P90</td>
</tr>
<tr>
<td>Fernandes J.</td>
<td>P13, P0125</td>
</tr>
<tr>
<td>Fernandes O.</td>
<td>PO43, PO44, PO45</td>
</tr>
<tr>
<td>Fernandes Veiga S.</td>
<td>PO125</td>
</tr>
<tr>
<td>Fernandes M.</td>
<td>PO193, PO198</td>
</tr>
<tr>
<td>Fernández Carrascosa M.T.</td>
<td>PO92, P100, P073, P074, P075, P0416</td>
</tr>
<tr>
<td>Ferraz Gonçalves J.A.</td>
<td>P13</td>
</tr>
<tr>
<td>Ferreira PL.</td>
<td>P313</td>
</tr>
<tr>
<td>Ferragato G.</td>
<td>P285</td>
</tr>
<tr>
<td>Ferrís F.</td>
<td>P11, P193</td>
</tr>
<tr>
<td>Fettes L.</td>
<td>FC40, FC34</td>
</tr>
<tr>
<td>Fey M.</td>
<td>FC19</td>
</tr>
<tr>
<td>Fielding H.</td>
<td>P227</td>
</tr>
<tr>
<td>Fields T.</td>
<td>PO3</td>
</tr>
<tr>
<td>Fillbet M.</td>
<td>P359, PO269</td>
</tr>
<tr>
<td>Fillibri S.</td>
<td>P0179</td>
</tr>
<tr>
<td>Finkelstein E.</td>
<td>P073, P0271</td>
</tr>
<tr>
<td>Finkelstein E.A.</td>
<td>P1267</td>
</tr>
<tr>
<td>Finlay-D.A.</td>
<td>P022</td>
</tr>
<tr>
<td>Finne-Soveri H.</td>
<td>PO41</td>
</tr>
<tr>
<td>Finotto S.</td>
<td>P057</td>
</tr>
<tr>
<td>Finset A.</td>
<td>P097</td>
</tr>
<tr>
<td>Finucane A.</td>
<td>PO63, P201, P326</td>
</tr>
<tr>
<td>Fiocco M.</td>
<td>P69, FC36, FC38</td>
</tr>
<tr>
<td>Firth A.</td>
<td>P171, P166</td>
</tr>
<tr>
<td>Firth A.M.</td>
<td>P32</td>
</tr>
<tr>
<td>Flad B.</td>
<td>PO214</td>
</tr>
<tr>
<td>Fledner M.</td>
<td>FC19, P171, P367, PO188</td>
</tr>
<tr>
<td>Fleischer I.</td>
<td>P35, P70</td>
</tr>
<tr>
<td>Flury M.</td>
<td>P137</td>
</tr>
<tr>
<td>Fogelbrok A.</td>
<td>P30</td>
</tr>
<tr>
<td>Fons G.</td>
<td>P919</td>
</tr>
<tr>
<td>Fonseca B.</td>
<td>P13, P0125</td>
</tr>
<tr>
<td>Forrest L.C.</td>
<td>P139</td>
</tr>
<tr>
<td>Fors S.</td>
<td>P058</td>
</tr>
<tr>
<td>Fossum B.</td>
<td>FC36, FC16, FC51</td>
</tr>
</tbody>
</table>
Geschwindner H. FC58 Guadalupe A.V. P114
Ghiorio L. FC75,PO215,PO243 Guanter L. P338
Ghoshal A. P88 Guckenberger M. P73
Ghosh I. P69 Gudat H. P302, P316, P332
Gianmatti D. P316 Guerriero L. P100
Giarre L. FC38,PO227 Guerriero-Torrelles M. P335, PO276, PO282
Gievendanner S. PO193, PO198 Guerriero L. P211, P213, P214
Gikaara N. P203 Guerriero L. P338
Gil Y. P59 Guiraud M. P69, P237, P379, P0241
Gilissen J. PO193, PO198 Guido H. P342
Gillett K. FC49, FC50, FC69 Guldin M.-B. P17
Gimenez Castellanos J. P177 Gustafsson F. FC63, FC88, P166
Giordano A. PO241 Guxo P. PO62
Given B. P254 Gustafsson S. PO115
Glasgow N.I. PO168 Guyan S. PO132
Glenister D. P273, PO169
Gloria Mehle M. PO216
Godard Marceau A. PO65
Gogna G. P75 Haguessa J. FC103
Goebel S. P205 Haberland B. P102
Gojna G. FC38, PO207 P346 Hack M. FC38
Goh K.H.R. P346 Hack T.F. P014
Gola A. P110 Hagemann M. P108
Golden S. P388 Haller D.M. P136
Golath I. P338 Haller N. P1
Gollstein L. PO195 Hallely A. FC6
Gomes B. P338 Hamers J. P060
Gomes C.A. PO194 Hamilton T. P308
Gomes-Castro M.J. P64, P66 Hammar T. P294
Gomubutra P. P112 Hammes B. FC103, P256, P0105
Gonçalves E. P13, P0125 Hansen L. FC112
Gonçalves F.J. P349 Hansen M.I.T. P023
Gonçalves L. FC74, P0125 Hansen L. FC126
Gonçalves R. P373, P040, P0101 Hanson L. P038
González M. P072 Hardalddottir E. PO51
González-Jiménez M.C. P64, P66 Harper G. FC40, FC59, FC125, P7, P185, P203
González-Barboteo J. FC46, P183, P184, P0137 Harries P. P350
González-Rubio R. P319 Harris A. P377
Gonteza J. P259 Harris R. P718
Goodison H. P23 Hartmann L. P102
Goody K. P315 Hartshorn A. FC43
Goodman C. P64, P66 Haasebe Y. PO80
Gooijmans J. R.G. P174 Hashimoto H. P0272
Gonnella D. P116 Hasselaar J. FC12, FC100, P322
Gott M. PO120, PO128 Hasson F. P52, P63, P197, P041
Gough N. P337 Haufikus D. FC125
Graham-Wisener L. P350 Haugen D. F. PO192, PO205
Graham-Wisener L. PO149 Haugen M. P186
Graham-Wisener L. P50 Hayek A.-S. P247
Graham-Wisener L. P110 Hayes J. P065
Grande G. P05 Hayes T. P012
Grande G. INV8, PL4, P149, P152, P153, P325, P341, PO155 Healy L. P026
Grant L. P109 Heidemann K. FC89, P43, P291, P0176
Grassau P. PO149 Heidemann K. P27, PO201, PO227
Greenblad L. PO149 Heidemann K. P0157
Greman P. P05 Heidemann K. FC70
Grefgeren Oestergaard L. P63 Heim K. FC28
Gregory A. PO247 Heidcick C. PO196
Griffiths J. P99 Heckel M. FC94
Griffith Y. P108 Hediger H. FC54
Grisner A. P275 Hegedus K. P228
Gruck D. P139 Heijdra Y. PO196
Gron – van de Ven L. P311 Heijstra Y. FC3
Groenewoud A.S. P86 Heimel K. FC3
Groenewoud S. FC55, PO61 Heintz N. FC12
Groenewoud S. INV13, FC56, FC109, P154, P266, P268, P269, PO34 Hen K. P026
Groenveld M. FC12, P140, P170 Heine A. PO196
Groot M. FC12
Grossert A. FC12
Grotmol K. P326
Grotmol K. FC12
Grotten R. P326
Grotten R. PO196
Grotten R. FC12
<table>
<thead>
<tr>
<th>Authors</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hempstead J.</td>
<td>P351</td>
</tr>
<tr>
<td>Hempton C.</td>
<td>FC78</td>
</tr>
<tr>
<td>Henderson R.</td>
<td>P178</td>
</tr>
<tr>
<td>Hendriks M.</td>
<td>P29</td>
</tr>
<tr>
<td>Heneka N.</td>
<td>P62, P188, P208</td>
</tr>
<tr>
<td>Hennessy-Anderson N.</td>
<td>FC90</td>
</tr>
<tr>
<td>Henniksson M.</td>
<td>P365</td>
</tr>
<tr>
<td>Henriques J.</td>
<td>PO164</td>
</tr>
<tr>
<td>Herbst F. A.</td>
<td>PO76</td>
</tr>
<tr>
<td>Herringshaus C.</td>
<td>P30</td>
</tr>
<tr>
<td>Hermans S.</td>
<td></td>
</tr>
<tr>
<td>Hernández-Marrero P.</td>
<td>P36, P329, P330, P344</td>
</tr>
<tr>
<td>Herrebro-Van De Pontseele E.</td>
<td>P128</td>
</tr>
<tr>
<td>Herren W.</td>
<td></td>
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<tr>
<td>Herold M. W.</td>
<td></td>
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<td>Hertant N.S.</td>
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<td>Authors</td>
<td>P1</td>
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<tr>
<td>Johnson M.J.</td>
<td>P202, P208</td>
</tr>
<tr>
<td>Johnson T.</td>
<td>FC30</td>
</tr>
<tr>
<td>Johnston B.</td>
<td>P11, P326, P349</td>
</tr>
<tr>
<td>Johnston B.M.</td>
<td>P181, P388</td>
</tr>
<tr>
<td>Jones L.</td>
<td>P63, P134, P195, P201, P232</td>
</tr>
<tr>
<td>Joos G.</td>
<td>P113, P95</td>
</tr>
<tr>
<td>Joossens S.</td>
<td>P9</td>
</tr>
<tr>
<td>Joosten E.A.</td>
<td>P186</td>
</tr>
<tr>
<td>Jordan J.</td>
<td>P63</td>
</tr>
<tr>
<td>Jordan R.I.</td>
<td>FC87</td>
</tr>
<tr>
<td>Jordan S.</td>
<td>FC119</td>
</tr>
<tr>
<td>Jordanovski L.</td>
<td>P17</td>
</tr>
<tr>
<td>Jørgensen B.</td>
<td>PO124</td>
</tr>
<tr>
<td>Jost D.</td>
<td>P356</td>
</tr>
<tr>
<td>Jost G.</td>
<td>P240</td>
</tr>
<tr>
<td>Jox R.</td>
<td>P263, P196</td>
</tr>
<tr>
<td>Jox R.J.</td>
<td>FC33, P189</td>
</tr>
<tr>
<td>Juen I.</td>
<td>PO214</td>
</tr>
<tr>
<td>Jukic J.</td>
<td>P115</td>
</tr>
<tr>
<td>Julià Mora J.</td>
<td>FC128</td>
</tr>
<tr>
<td>Julià Morá J.</td>
<td>FC116, PO201</td>
</tr>
<tr>
<td>Juliá-Torras J.</td>
<td>PO147</td>
</tr>
<tr>
<td>Jung C.</td>
<td>P316</td>
</tr>
<tr>
<td>Jung S.</td>
<td>P08</td>
</tr>
<tr>
<td>Jini P.</td>
<td>FC19</td>
</tr>
<tr>
<td>Juddan Racuskiene A.</td>
<td>P04</td>
</tr>
<tr>
<td>K</td>
<td>Kaasa S.</td>
</tr>
<tr>
<td>Kaasalainen S.</td>
<td>FC3, FC97, FC98, FC44, FC45, FC113</td>
</tr>
<tr>
<td>Kabir M.</td>
<td>P116, PO97</td>
</tr>
<tr>
<td>Kaelin L.</td>
<td>P33, PO201</td>
</tr>
<tr>
<td>Kajisa N.</td>
<td>PO148</td>
</tr>
<tr>
<td>Kala A.</td>
<td>PO108</td>
</tr>
<tr>
<td>Kalbermatten Magaya N.</td>
<td>PO92, PO152</td>
</tr>
<tr>
<td>Kalies H.</td>
<td>P220, P221</td>
</tr>
<tr>
<td>Kalpakidou A.</td>
<td>P90</td>
</tr>
<tr>
<td>Kamal L.</td>
<td>FC6</td>
</tr>
<tr>
<td>Kambiya I.</td>
<td>FC125</td>
</tr>
<tr>
<td>Kanai N.</td>
<td>PO150</td>
</tr>
<tr>
<td>Kang B.</td>
<td>P240</td>
</tr>
<tr>
<td>Kanji S.</td>
<td>FC45</td>
</tr>
<tr>
<td>Kato Y.</td>
<td>FC6</td>
</tr>
<tr>
<td>Kao C.-Y.</td>
<td>P09</td>
</tr>
<tr>
<td>Kardes Walt F.</td>
<td>PO240</td>
</tr>
<tr>
<td>Karlekar M.</td>
<td>P254</td>
</tr>
<tr>
<td>Karlsen L.</td>
<td>P3, P158</td>
</tr>
<tr>
<td>Karlsson M.</td>
<td>P249</td>
</tr>
<tr>
<td>Kars M.</td>
<td>FC99, FC109</td>
</tr>
<tr>
<td>Kars M.C.</td>
<td>FC56, P268, P264, P270</td>
</tr>
<tr>
<td>Kassaa S.</td>
<td>FC110</td>
</tr>
<tr>
<td>Kato Y.</td>
<td>P196</td>
</tr>
<tr>
<td>Kaura P.</td>
<td>PO115</td>
</tr>
<tr>
<td>Kawaguchi T.</td>
<td>P82</td>
</tr>
<tr>
<td>Kawamura M.</td>
<td>PO138</td>
</tr>
<tr>
<td>Kealy K.</td>
<td>PO15</td>
</tr>
<tr>
<td>Keefe F.</td>
<td>P339</td>
</tr>
<tr>
<td>Keegan O.</td>
<td>FC50</td>
</tr>
<tr>
<td>Keegan T.</td>
<td>P28</td>
</tr>
<tr>
<td>Kelley V.</td>
<td>P99</td>
</tr>
<tr>
<td>Kegey A.</td>
<td>PO157</td>
</tr>
<tr>
<td>Kehl K.</td>
<td>P163</td>
</tr>
<tr>
<td>Kellehear A.</td>
<td>PO252</td>
</tr>
<tr>
<td>Keller D.J.</td>
<td>FC24</td>
</tr>
<tr>
<td>Kelly C.</td>
<td>FC2</td>
</tr>
<tr>
<td>Kelly M.</td>
<td>PO13</td>
</tr>
<tr>
<td>Kendall M.</td>
<td>P131</td>
</tr>
<tr>
<td>Kennedy P.</td>
<td>P169</td>
</tr>
<tr>
<td>Kennett A.</td>
<td>FC6</td>
</tr>
<tr>
<td>Kerba M.</td>
<td>FC22</td>
</tr>
<tr>
<td>Kern M.</td>
<td>FC17</td>
</tr>
<tr>
<td>Kernohan G.</td>
<td>PO5</td>
</tr>
<tr>
<td>Kessler C.</td>
<td>PO188</td>
</tr>
<tr>
<td>Author Name</td>
<td>Page Numbers</td>
</tr>
<tr>
<td>-----------------------------------</td>
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</tr>
<tr>
<td>Krishnaraj G.</td>
<td>P313</td>
</tr>
<tr>
<td>Kristensen M.S.</td>
<td>P154</td>
</tr>
<tr>
<td>Kristofer A.</td>
<td>PO121</td>
</tr>
<tr>
<td>Kroupa A.-M.</td>
<td>PO204</td>
</tr>
<tr>
<td>Krull J.</td>
<td>PO240</td>
</tr>
<tr>
<td>Kruse R.L.</td>
<td>PO19</td>
</tr>
<tr>
<td>Kudow</td>
<td>P080</td>
</tr>
<tr>
<td>Kumari A.</td>
<td>PO108</td>
</tr>
<tr>
<td>Kumtan P.</td>
<td>P123</td>
</tr>
<tr>
<td>Kunihoro S.</td>
<td>PO187</td>
</tr>
<tr>
<td>Kuo S.C.</td>
<td>FC52, P89</td>
</tr>
<tr>
<td>Kurita G.</td>
<td>P57</td>
</tr>
<tr>
<td>Kurita G.P.</td>
<td>P77, P204</td>
</tr>
<tr>
<td>Kurkowski S.</td>
<td>P205</td>
</tr>
<tr>
<td>Kwon J.H.</td>
<td>PO80</td>
</tr>
<tr>
<td>Kwon K.A.</td>
<td>P85</td>
</tr>
<tr>
<td>Kylänen M.</td>
<td>FC13, FC14, FC34, FC79, P16, P19, P26, P347</td>
</tr>
<tr>
<td>L</td>
<td></td>
</tr>
<tr>
<td>L Ferreira P.</td>
<td>P212, PO148</td>
</tr>
<tr>
<td>La Cour K.</td>
<td>FC114</td>
</tr>
<tr>
<td>Lacerda A.F.</td>
<td>PC43, P91</td>
</tr>
<tr>
<td>Ladara G.</td>
<td>P240</td>
</tr>
<tr>
<td>Laidlaw S.</td>
<td>P173</td>
</tr>
<tr>
<td>Lakhanpaul M.</td>
<td>P376</td>
</tr>
<tr>
<td>Lam A.</td>
<td>P350</td>
</tr>
<tr>
<td>Lam L.</td>
<td>P90, P188, P205</td>
</tr>
<tr>
<td>Lambrecht I.</td>
<td>PO279</td>
</tr>
<tr>
<td>Lang A.</td>
<td>P353, P201</td>
</tr>
<tr>
<td>Langer P.</td>
<td>P318</td>
</tr>
<tr>
<td>Lapkin S.</td>
<td>P62, P280</td>
</tr>
<tr>
<td>Lara P.</td>
<td>PO147</td>
</tr>
<tr>
<td>Larkin P.</td>
<td>FC122, P195</td>
</tr>
<tr>
<td>Larosee M.-L.</td>
<td>FC80, P298</td>
</tr>
<tr>
<td>Larrié-Ferrer N.</td>
<td>P184</td>
</tr>
<tr>
<td>Laska I.</td>
<td>P376</td>
</tr>
<tr>
<td>Lasker-Hertz S.</td>
<td>PO191</td>
</tr>
<tr>
<td>Lasmarias C.</td>
<td>P338, PO190</td>
</tr>
<tr>
<td>Latino N.</td>
<td>FC1</td>
</tr>
<tr>
<td>Lau J.</td>
<td>PO258</td>
</tr>
<tr>
<td>Lau K.P.</td>
<td>P86</td>
</tr>
<tr>
<td>Launchbury L.</td>
<td>PO32</td>
</tr>
<tr>
<td>Laura H.</td>
<td>FC2</td>
</tr>
<tr>
<td>Laurent S.</td>
<td>P138, PO86</td>
</tr>
<tr>
<td>Lauverter E.</td>
<td>P9</td>
</tr>
<tr>
<td>Laux G.</td>
<td>P314</td>
</tr>
<tr>
<td>Laval G.</td>
<td>FC5</td>
</tr>
<tr>
<td>Lawlor P.</td>
<td>P205</td>
</tr>
<tr>
<td>Lawlor P.G.</td>
<td>FC45</td>
</tr>
<tr>
<td>Le B.</td>
<td>FC90, P205</td>
</tr>
<tr>
<td>LeBlanc T.</td>
<td>IN1, IN14</td>
</tr>
<tr>
<td>Leboud D.</td>
<td>P237, P379, P241</td>
</tr>
<tr>
<td>Leccorfec T.</td>
<td>P319</td>
</tr>
<tr>
<td>Lee A.</td>
<td>PO245</td>
</tr>
<tr>
<td>Lee H.</td>
<td>P231</td>
</tr>
<tr>
<td>Lee H.J.</td>
<td>P85</td>
</tr>
<tr>
<td>Lee J.</td>
<td>FC95, PO115</td>
</tr>
<tr>
<td>Lee J.S.</td>
<td>PO83</td>
</tr>
<tr>
<td>Lee J.T.</td>
<td>FC43</td>
</tr>
<tr>
<td>Lee K.H.</td>
<td>PO83</td>
</tr>
<tr>
<td>Lee O.K.</td>
<td>FC126</td>
</tr>
<tr>
<td>Lee S.</td>
<td>FC9, P255, PO209</td>
</tr>
<tr>
<td>Leemans K.</td>
<td>FC90, P205</td>
</tr>
<tr>
<td>Lefranc C.</td>
<td>FC43</td>
</tr>
<tr>
<td>Leget C.</td>
<td>FC90, P205</td>
</tr>
<tr>
<td>Lehmann N.</td>
<td>PO188</td>
</tr>
<tr>
<td>Leidl R.</td>
<td>P348</td>
</tr>
<tr>
<td>Leiva-Santos J.P.</td>
<td>P115, P116, PO96, PO97</td>
</tr>
<tr>
<td>Lemmens V.</td>
<td>P81</td>
</tr>
<tr>
<td>Lemmos Dekker N.</td>
<td>PO180, PO24</td>
</tr>
<tr>
<td>Leniz Martelli J.</td>
<td>FC86, P279, P327</td>
</tr>
<tr>
<td>Lennarts H.</td>
<td>P170</td>
</tr>
<tr>
<td>Leonbruna P.</td>
<td>PO231</td>
</tr>
<tr>
<td>Leonard R.</td>
<td>P355</td>
</tr>
<tr>
<td>Leppahao S.</td>
<td>P312</td>
</tr>
<tr>
<td>Lepper W.</td>
<td>PO139, PO205</td>
</tr>
<tr>
<td>Leroy F.</td>
<td>PO86</td>
</tr>
<tr>
<td>Lesaffre X.</td>
<td>P319</td>
</tr>
<tr>
<td>Leibhorg C.</td>
<td>FC78, P145</td>
</tr>
<tr>
<td>Letzel S.</td>
<td>P172, P357, PO278</td>
</tr>
<tr>
<td>Leurent B.</td>
<td>P201</td>
</tr>
<tr>
<td>Lin C.L.</td>
<td>P314</td>
</tr>
<tr>
<td>Lin C.-P.</td>
<td>P319</td>
</tr>
<tr>
<td>Lin S. H.</td>
<td>FC30</td>
</tr>
<tr>
<td>Lindquist O.</td>
<td>P244</td>
</tr>
<tr>
<td>Linge-Dahl L.</td>
<td>FC10, FC39, P364, P365, PO66</td>
</tr>
<tr>
<td>Lin D.</td>
<td>FC1</td>
</tr>
<tr>
<td>Ljatif S.</td>
<td>PO238</td>
</tr>
<tr>
<td>Llopis-Grau G.D.</td>
<td>PO77</td>
</tr>
<tr>
<td>Lloydd. Williams M.</td>
<td>P131, PO51</td>
</tr>
<tr>
<td>Lloyd A.</td>
<td>PO155</td>
</tr>
<tr>
<td>Lloyd Williams M.</td>
<td>FC29, PO106</td>
</tr>
<tr>
<td>Lohâo C.</td>
<td>P373, PO101</td>
</tr>
<tr>
<td>Lobb E.</td>
<td>P506</td>
</tr>
<tr>
<td>Lobb L.</td>
<td>P68</td>
</tr>
<tr>
<td>Lodige P.</td>
<td>P377</td>
</tr>
<tr>
<td>Loech T.</td>
<td>P319</td>
</tr>
<tr>
<td>Loge J.H.</td>
<td>FC3, PO267</td>
</tr>
<tr>
<td>Lohre E.T.</td>
<td>P192, P210</td>
</tr>
<tr>
<td>Louraize A.</td>
<td>PO193, PO198</td>
</tr>
<tr>
<td>Lorrain B.</td>
<td>P93</td>
</tr>
<tr>
<td>Lopex P.</td>
<td>P373, PO101</td>
</tr>
<tr>
<td>Lopex C.</td>
<td>FC74, P274</td>
</tr>
<tr>
<td>Lopex M.</td>
<td>P138</td>
</tr>
<tr>
<td>López Maside A.</td>
<td>PO81</td>
</tr>
<tr>
<td>López Postigo M.</td>
<td>FC37</td>
</tr>
<tr>
<td>López-Fidalgo J.</td>
<td>P64, P66</td>
</tr>
<tr>
<td>López-Marti M.P.</td>
<td>P219</td>
</tr>
<tr>
<td>López-Ríes J.</td>
<td>PO194</td>
</tr>
<tr>
<td>López-Ríes J.</td>
<td>P184, PO137</td>
</tr>
<tr>
<td>Lordick F.</td>
<td>FC46, P183</td>
</tr>
<tr>
<td>Lorenz K.</td>
<td>FC21</td>
</tr>
<tr>
<td>Lorenz L.</td>
<td>P324</td>
</tr>
<tr>
<td>Louâa M.</td>
<td>P40</td>
</tr>
<tr>
<td>Louaca M.</td>
<td>PO197</td>
</tr>
<tr>
<td>Louca M.</td>
<td>P106</td>
</tr>
<tr>
<td>Lovell M.</td>
<td>PO119</td>
</tr>
<tr>
<td>Lovell N.</td>
<td>P188, P205</td>
</tr>
<tr>
<td>Low J.</td>
<td>FC36, P206</td>
</tr>
<tr>
<td>Lowes S.</td>
<td>P110, P248, PO263</td>
</tr>
<tr>
<td>Lucey M.</td>
<td>P536</td>
</tr>
<tr>
<td>Lucie S.</td>
<td>P234</td>
</tr>
<tr>
<td>Luckert T.</td>
<td>FC43</td>
</tr>
</tbody>
</table>
Lum H.
Lund S.
Lundeby T.
Lundez U.
Lundh Hagelin C.
Lundoff L.
Lundström S.
Lunet N.
Lunt C.
Lunt N.
Luque-Blanco A.
Lutterbeck M.J.
Luyirika E.
Luzzani M.
Lykke C.
Lynch J.
Lynch M.
M
MacDermott C.N.
MacDonald B.
Machino T.
Maciejewski P.
Maciejewski R.
Mackay K.
MacLeod R.D.
Maddocks M.
Madero R.
Madsen R.
Maeda Y.
Maessen M.
Maetens A.
Maidhoff C.
Mai S.S.
Maidhold C.
Maija Reblin C.
Mainini C.
Maiorana L.
Malhotra C.
Mallett V.
Malmström A.
Maluf de Carvalho J.A.
Malhotra C.
Martelli Leniz J.
Marckmann G.
Martin M.
Maria H.
Maria V.C.
Marimon F.
Marmari M.
Marque A.-S.
Marshall A.
Marshall D.
Sharpe D.
Sharpe S.
Martelli Lenz J.
Marlet-Samb P.
Martin M.
Martineilli J.L.
Martinez M.
Martins J.
Martins J.C.
Martins L.S.
Martins O.
Martins Pereira S.
Martins-Branco D.
Martinsson L.
Martin-Utrilla S.

Authors Index

Lum H. FC119, P157, PO187, PO191, PO32, PO37
Lund S. FC3, PO267, PC157, PC199, PO58
Lundeby T. FC56, PC268, PC269, PC269, PO199, P204, PO144
Lundez U. FC74, PC74, PC74, PC74, PO187, PO191
Lundh Hagelin C. PC74, PC74, PO187, PO191
Lundoff L. PC74, PC74, PC74, PO187, PO191
Lundström S. PC74, PC74, PC74, PO187, PO191
Lunet N. PC74, PC74, PC74, PC74, PO187, PO191
Lunt C. PC74, PC74, PC74, PC74, PO187, PO191
Lunt N. PC74, PC74, PC74, PC74, PO187, PO191
Luque-Blanco A. PC74, PC74, PC74, PC74, PO187, PO191
Lutterbeck M.J. PC74, PC74, PC74, PC74, PO187, PO191
Luyirika E. PC74, PC74, PC74, PC74, PO187, PO191
Luzzani M. PC74, PC74, PC74, PC74, PO187, PO191
Lykke C. PC74, PC74, PC74, PC74, PO187, PO191
Lynch J. PC74, PC74, PC74, PC74, PO187, PO191
Lynch M. PC74, PC74, PC74, PC74, PO187, PO191

M
MacDermott C.N. PO117
MacDonald B. PO142
Machino T. PO230
Maciejewski P. PO265
Maciejewski R. PO265
Mackay K. PO117
MacLeod R.D. PO142
Maddocks M. PO117
Madero R. PO142
Madsen R. PO117
Maeda Y. PO117
Maessen M. PO117
Maetens A. PO117
Maidhoff C. PO117
Mai S.S. PO117
Maidhold C. PO117
Maija Reblin C. PO117
Mainini C. PO117
Maiorana L. PO117
Malhotra C. PO117
Mallett V. PO117
Malmström A. PO117
Maluf de Carvalho J.A. PO117
Malhotra C. PO117
Martelli Leniz J. PO117
Marckmann G. PO117
Martin M. PO117
Maria H. PO117
Maria V.C. PO117
Marimon F. PO117
Marmari M. PO117
Marque A.-S. PO117
Marshall A. PO117
Marshall D. PO117
Sharpe D. PO117
Sharpe S. PO117
Martelli Lenz J. PO117
Marlet-Samb P. PO117
Martin M. PO117
Martineilli J.L. PO117
Martinez M. PO117
Martins J. PO117
Martins J.C. PO117
Martins L.S. PO117
Martins O. PO117
Martins Pereira S. PO117
Martins-Branco D. PO117
Martinsson L. PO117
Martin-Utrilla S. PO117

Authors Index

Lum H. FC119, P157, PO187, PO191, PO32, PO37
Lund S. FC3, PO267, PC157, PC199, PO58
Lundeby T. FC56, PC268, PC269, PC269, PO199, P204, PO144
Lundez U. FC74, PC74, PC74, PC74, PO187, PO191
Lundh Hagelin C. PC74, PC74, PC74, PC74, PO187, PO191
Lundoff L. PC74, PC74, PC74, PC74, PO187, PO191
Lundström S. PC74, PC74, PC74, PC74, PO187, PO191
Lunet N. PC74, PC74, PC74, PC74, PO187, PO191
Lunt C. PC74, PC74, PC74, PC74, PO187, PO191
Lunt N. PC74, PC74, PC74, PC74, PO187, PO191
Luque-Blanco A. PC74, PC74, PC74, PC74, PO187, PO191
Lutterbeck M.J. PC74, PC74, PC74, PC74, PO187, PO191
Luyirika E. PC74, PC74, PC74, PC74, PO187, PO191
Luzzani M. PC74, PC74, PC74, PC74, PO187, PO191
Lykke C. PC74, PC74, PC74, PC74, PO187, PO191
Lynch J. PC74, PC74, PC74, PC74, PO187, PO191
Lynch M. PC74, PC74, PC74, PC74, PO187, PO191

M
MacDermott C.N. PO117
MacDonald B. PO142
Machino T. PO230
Maciejewski P. PO265
Maciejewski R. PO265
Mackay K. PO117
MacLeod R.D. PO142
Maddocks M. PO117
Madero R. PO117
Madsen R. PO117
Maeda Y. PO117
Maessen M. PO117
Maetens A. PO117
Maidhoff C. PO117
Mai S.S. PO117
Maidhold C. PO117
Maija Reblin C. PO117
Mainini C. PO117
Maiorana L. PO117
Malhotra C. PO117
Mallett V. PO117
Malmström A. PO117
Maluf de Carvalho J.A. PO117
Malhotra C. PO117
Martelli Leniz J. PO117
Marckmann G. PO117
Martin M. PO117
Maria H. PO117
Maria V.C. PO117
Marimon F. PO117
Marmari M. PO117
Marque A.-S. PO117
Marshall A. PO117
Marshall D. PO117
Sharpe D. PO117
Sharpe S. PO117
Martelli Lenz J. PO117
Marlet-Samb P. PO117
Martin M. PO117
Martineilli J.L. PO117
Martinez M. PO117
Martins J. PO117
Martins J.C. PO117
Martins L.S. PO117
Martins O. PO117
Martins Pereira S. PO117
Martins-Branco D. PO117
Martinsson L. PO117
Martin-Utrilla S. PO117
<table>
<thead>
<tr>
<th>Authors</th>
<th>Index(es)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metsemakers J.F.M.</td>
<td>FC8</td>
</tr>
<tr>
<td>Miccinesi G.</td>
<td>PO11, PO52</td>
</tr>
<tr>
<td>Michael N.</td>
<td>PL2</td>
</tr>
<tr>
<td>Michaud P.</td>
<td>P308</td>
</tr>
<tr>
<td>Mieras A.</td>
<td>P180</td>
</tr>
<tr>
<td>Mikolasko B.</td>
<td></td>
</tr>
<tr>
<td>Milanov I.G.</td>
<td>FC50</td>
</tr>
<tr>
<td>Miller J.</td>
<td>PO194</td>
</tr>
<tr>
<td>Miller R.</td>
<td>FC52</td>
</tr>
<tr>
<td>Miller-Lewis L.</td>
<td></td>
</tr>
<tr>
<td>Millington-Sanders C.</td>
<td>FC40, FC59, FC63</td>
</tr>
<tr>
<td>Milo R.</td>
<td></td>
</tr>
<tr>
<td>Milos P.</td>
<td></td>
</tr>
<tr>
<td>Milosavljevik P.</td>
<td></td>
</tr>
<tr>
<td>Milton L.</td>
<td>FC125</td>
</tr>
<tr>
<td>Mimicì A.</td>
<td></td>
</tr>
<tr>
<td>Minotti M.</td>
<td>FC125</td>
</tr>
<tr>
<td>Mintor O.</td>
<td></td>
</tr>
<tr>
<td>Miranda R.</td>
<td></td>
</tr>
<tr>
<td>Mirhamidova S.</td>
<td></td>
</tr>
<tr>
<td>Mirza R.M.</td>
<td></td>
</tr>
<tr>
<td>Misko M.D.</td>
<td></td>
</tr>
<tr>
<td>Missaud G.</td>
<td></td>
</tr>
<tr>
<td>Mistaeny P.</td>
<td></td>
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<tr>
<td>Mitchell G.</td>
<td></td>
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<tr>
<td>Mittal D.</td>
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<td>Mittner D.</td>
<td></td>
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<td>Miura T.</td>
<td></td>
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<td>Mixon A.</td>
<td></td>
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<td>Miyano K.</td>
<td></td>
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<td>Miyashita M.</td>
<td></td>
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<td>Miyata C.</td>
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<td>Miyatuke K.</td>
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<td>Moibius C.</td>
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<td>Mohamed A.</td>
<td></td>
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<td>Mohammed K.</td>
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<td>Mohan E.</td>
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<td>Moine S.</td>
<td></td>
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<td>Momm F.</td>
<td></td>
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<tr>
<td>Moncada L.</td>
<td></td>
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<tr>
<td>Monforte-Royo C.</td>
<td></td>
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<td>Monier P.A.</td>
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<td>Monod S.</td>
<td></td>
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<td>Montreal-Carrillo E.</td>
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<td>Montaperto A.</td>
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<td>Monteiro A.R.</td>
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<td>Monti M.</td>
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<td>Monz A.</td>
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<td>Moneoy K.</td>
<td></td>
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<td>Moore C.</td>
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<td>Moore K.J.</td>
<td></td>
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<td>Moral-Torres A.</td>
<td></td>
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<td>Morandi A.</td>
<td></td>
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<td>Morberg Jänterud S.</td>
<td></td>
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<tr>
<td>Moreels S.</td>
<td></td>
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<tr>
<td>Morey Y.</td>
<td></td>
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<td>Morgan S.</td>
<td></td>
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<td>Morin M.</td>
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<tr>
<td>Morin L.</td>
<td></td>
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<td>Morta T.</td>
<td></td>
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<tr>
<td>Morla Miralles C.</td>
<td></td>
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<tr>
<td>Moroni M.</td>
<td></td>
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<td>Moryl N.</td>
<td></td>
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<tr>
<td>Mosch V.</td>
<td></td>
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<td>Mosdon V.</td>
<td></td>
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<td>Mounyhan T.</td>
<td></td>
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<tr>
<td>Muckaden M.A.</td>
<td></td>
</tr>
<tr>
<td>Mudassai M.</td>
<td></td>
</tr>
<tr>
<td>Mueller E.</td>
<td></td>
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<tr>
<td>Muldrew D.</td>
<td></td>
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<tr>
<td>Muliaintid D.</td>
<td></td>
</tr>
<tr>
<td>Müllder P.</td>
<td></td>
</tr>
<tr>
<td>Müller E.</td>
<td></td>
</tr>
<tr>
<td>Authors Index</td>
<td>325</td>
</tr>
<tr>
<td>---------------</td>
<td>-----</td>
</tr>
<tr>
<td>Peters L.</td>
<td>P29 Pujol N.</td>
</tr>
<tr>
<td>Petersen M.</td>
<td>FC109 Pungchompoop S.</td>
</tr>
<tr>
<td>Petersen M.A.</td>
<td>P304 Pungchompoop W.</td>
</tr>
<tr>
<td>Pettifer A.</td>
<td>P301 Pype P.</td>
</tr>
<tr>
<td>Peuten S.</td>
<td>P48</td>
</tr>
<tr>
<td>Philip J.</td>
<td>FC90, FC117, P145, P363, PO174 Q</td>
</tr>
<tr>
<td>Philips M.</td>
<td>P19 Quares-Van Ufford-Mannesse P.</td>
</tr>
<tr>
<td>Philips J.</td>
<td>FC102 Querido A.</td>
</tr>
<tr>
<td>Phillips C.B.</td>
<td>P273, PO16 Quitau-Salanova C.</td>
</tr>
<tr>
<td>Phillips J.</td>
<td>P90, P98, P165, P205, P216, P324, PO56 R</td>
</tr>
<tr>
<td>Piquet S.</td>
<td>PO225 Rabbine M.</td>
</tr>
<tr>
<td>Pickering A.</td>
<td>PO318 Rabin E.</td>
</tr>
<tr>
<td>Picket S.</td>
<td>P235 Raffin-Bouchal S.</td>
</tr>
<tr>
<td>Pickles A.</td>
<td>PO33 Ragg-Schauble T.</td>
</tr>
<tr>
<td>Pieters R.</td>
<td>P19, P128, P257, PO212 Rahman F.</td>
</tr>
<tr>
<td>Peters J.</td>
<td>P372, PO68 Rajmakers N.</td>
</tr>
<tr>
<td>Peters S.</td>
<td>P208 Rajmakers N.J.H.</td>
</tr>
<tr>
<td>Pietschberger S.</td>
<td>P189, PO85 Rast G.</td>
</tr>
<tr>
<td>Piccone M.</td>
<td>P277, PO86 Ralte L.</td>
</tr>
<tr>
<td>Pineda B.</td>
<td>PO182 Ramos D.</td>
</tr>
<tr>
<td>Pinto M.</td>
<td>P100 Ramsenhalter C.</td>
</tr>
<tr>
<td>Pinto M.</td>
<td>P285 Randich A.</td>
</tr>
<tr>
<td>Pinto C.</td>
<td>FC63, PO380 Ramilo G.</td>
</tr>
<tr>
<td>Pito S.</td>
<td>P370 Raso C.</td>
</tr>
<tr>
<td>Pinto S.M.</td>
<td>FC124, P239, PO295 Rauber G.</td>
</tr>
<tr>
<td>Picciotto A.</td>
<td>PO218 Rauh S.P.</td>
</tr>
<tr>
<td>Pis M.</td>
<td>FC51 Rauhausaitne A.</td>
</tr>
<tr>
<td>Pitzer S.</td>
<td>P40 Rawlings D.</td>
</tr>
<tr>
<td>Piva L.</td>
<td>FC93 Rawlinson F.</td>
</tr>
<tr>
<td>Pivodic L.</td>
<td>FC31, FC82, FC84, P20, P28, PO112 Read S.</td>
</tr>
<tr>
<td>Pichler B.</td>
<td>P150, PO122 Reddy S.</td>
</tr>
<tr>
<td>Pick A.</td>
<td>FC72 Reed E.</td>
</tr>
<tr>
<td>Pick A.</td>
<td>P35, PO704 Regan J.</td>
</tr>
<tr>
<td>Plichner L.</td>
<td>P148 Rehfuess E.</td>
</tr>
<tr>
<td>Nikolovovics L.</td>
<td>PO167 Rehmann-Sutter C.</td>
</tr>
<tr>
<td>Polskas L.</td>
<td>PO199 Reid F.</td>
</tr>
<tr>
<td>Polakova K.</td>
<td>P106 Reid J.</td>
</tr>
<tr>
<td>Polato G.M.</td>
<td>P311, PO137 Reigada C.</td>
</tr>
<tr>
<td>Polakowski J.</td>
<td>PO162 Reilly L.</td>
</tr>
<tr>
<td>Polack K.</td>
<td>FC103, P299 Reimer U.</td>
</tr>
<tr>
<td>Ploegeder L.</td>
<td>P163, P339 Rietingler E.</td>
</tr>
<tr>
<td>Pollock K.</td>
<td>FC56, FC89, P268 Reijnó Á.</td>
</tr>
<tr>
<td>Poolman M.</td>
<td>P95 Relf M.</td>
</tr>
<tr>
<td>Poon P.</td>
<td>PO102 Relyea E.</td>
</tr>
<tr>
<td>Pop M.</td>
<td>P538 Renda B.</td>
</tr>
<tr>
<td>Poth A.</td>
<td>PO366 Reyners A.</td>
</tr>
<tr>
<td>Porta-Sales J.</td>
<td>P94, P97, P211, P213, P216, PO85, PO147 Reyners A.K.L.</td>
</tr>
<tr>
<td>Portela M.A.</td>
<td>PO67 Rezende G.</td>
</tr>
<tr>
<td>Porter S.</td>
<td>FC122, PO50 Rhee J.</td>
</tr>
<tr>
<td>Posadas R.</td>
<td>PO182 Rhee J.Y.</td>
</tr>
<tr>
<td>Poit N.</td>
<td>P39 Ribeiro C.</td>
</tr>
<tr>
<td>Pothe A.</td>
<td>P193 Ricardo R.B.</td>
</tr>
<tr>
<td>Potter J.</td>
<td>P278 Ricchini F.</td>
</tr>
<tr>
<td>Potter J.</td>
<td>P95 Ricchini F.</td>
</tr>
<tr>
<td>Pott R.</td>
<td>PO213 Richardson H.</td>
</tr>
<tr>
<td>Potts M.</td>
<td>PO147 Ricou C.</td>
</tr>
<tr>
<td>Pratt M.</td>
<td>PO203 Richardson A.</td>
</tr>
<tr>
<td>Pravicek R.</td>
<td>PO250 Rieger S.</td>
</tr>
<tr>
<td>Praxmarer R.</td>
<td>PO220 Ritner S.</td>
</tr>
<tr>
<td>Predou O.</td>
<td>P274, PO37, PO278 Rizza-Tomés G.</td>
</tr>
<tr>
<td>Preston N.</td>
<td>P22, P23, P111, P264, P266, P275, P322, P383, PO213 Rizzoni M.</td>
</tr>
<tr>
<td>Preston N.J.</td>
<td>PO199 Riise F.</td>
</tr>
<tr>
<td>Prihodkova L.</td>
<td>FC41, FC99, FC103, FC104, PO144, PO265, PO266, PO268, PO266, PO278, PO287, PO256, PO257, PO270 Rizzi J.A.C.</td>
</tr>
<tr>
<td>Pring A.</td>
<td>FC8, PO105, PO132, PO143, PO350, PO116 Rihan A.</td>
</tr>
<tr>
<td>Prodhomme C.</td>
<td>P237 Riley J.</td>
</tr>
<tr>
<td>Prucha B.</td>
<td>PO78 Ritchie C.</td>
</tr>
<tr>
<td>Puhin M.A.</td>
<td>PO207 Rizka Y.</td>
</tr>
</tbody>
</table>
Authors Index

Roberts D. PO155 Sánchez C. P64, P66
Robson L. PO23 Sand K. P149, P4143
Rocafort J. PO194, P283 Sandbaek A. FC49
Rocchi M. FC93 Sanderson C. FC95, P374, P506
Rocha C. PO49 Sandgren A. P51, P55, P4043, P44
Rechitz C. P230 Sandra M. P014
Rochmawati E. PO63 Sands M.B. FC43
Rocque G. FC51 Sandvad M. P204
Rodríguez A. PO81 Sansomi E. P285
Rodríguez-Mayoral O. P103 Santaeogou S. P048
Rodriguez-Mayoral O. P222 Santos C.E. P081
Rodriguez-Ortíz B. PO23 Santos M.R. P0168
Rodriguez-Prat A. P04 PO22 P0397
Rodriguez-Prat A. P090, P0226 P090
Roebuck H. P0165 Sastre-Garriga J. P0417
Roed G. FC121 Sanz A. P0417
Rohde G. P110 Sanz-Peces E.M. FC2
Rohde G. P230 Sapage C. P0164
Rosendo E. P103 Sarri I.W.W. P146
Rosso A. P090 Sawbridge Y. P0382
Rothman R. P222 Schauer P. P0229
Rothschild S.I. P284 Schaufel M.A. P230
Rowe L. P325 Scherers C. P0192
Rowe L. P33 Scherers A.-L. P113, P095
Rowells D. P341 Schildmann E. P348, P0277
Rowland C. P0161 Schildmann J. P0239
Rowland C. P0189 Schlieper D. P0441
Rubli E. FC35, P299 Schlägl M. FC58
Rubli-Truchard E. P228 Schmid M. P0207
Ruch W. P359 Schmid S. P0130
Ruer M. P035 Schmid E. P107, P092
Rumao C. P147 Schmitz K. P0107
Rumold B. PO102 Schmitz O. P74, P161, P162, P0133, P0253
Rumacres F. P109 Schneider N. P08
Rushbrook S. P074 Schneider S. P148
Ryan K. P0165 P090
Ryan T. P91 Sawermento V.P. P084
Sandoval D. FC2, FC113, P181, P388 Schepers E. P0206
Sampaio P.S.S. PO120 Schols J. P060
Sampaio P.S.S. PO206 Schols J.M.G.A. P202
Sampaio P.S.S. PO144 Schott A.-M. P159
Sandt M. PO206 Schramm A. P207
Sanfa C. PO205 Schramm M. P25, P353, P0201
Sabin S. P185 Schuylear P. P262
Sacchi S. P185, P187 Schuylennburg W. P220, P221
Safon N. FC75 Schumacher P. P217, P218
Saito Y. P14 Schunk M. P217
Salavra M. PO131 Schuster A. P47, P031
Salem M. PO98, P256 Schwabe S. P42, P031
Salgado E. PO173 Schwarte J. FC72
Salifu Y. FC67 Schwarte L. P0249
Salins N. P069 Schweitzer B. FC21
Salis Gross C. PO84 Schweitzer B. P289
Salinov L. PO205 Schweitzer P. P27
Salohiddinov M. P185 Schuijlenburg W. P39, P029
Salokhiddinov M. P185, P187 Schwpletely B. FC57, P0100, P0125
Salvaggio E. P048 Seidel W. P337, P0177
Sammonig H. P084 Seifert A. P5, P12
Sampaio P.S.S. P090, P226 Selman L. P328
Sampedu Pilegaard M. FC114 Selman L.E. P0273
Sampson E.L. P259 Senior H. P138
Sampson L. P201 Serpe M. P138
Sanchez M.M.P. PO35 Serrynti A. P073
Sanchez S. FC5, P359 Sévèque M.-A.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seymour J.</td>
<td>FC99,P11,P269</td>
</tr>
<tr>
<td>Sforacchi F.</td>
<td>FC75</td>
</tr>
<tr>
<td>Shah S.</td>
<td>P0279</td>
</tr>
<tr>
<td>Shanagh D.</td>
<td>P035</td>
</tr>
<tr>
<td>Shambulingamam T.</td>
<td>FC12-P032</td>
</tr>
<tr>
<td>Shapiro J.</td>
<td>P297</td>
</tr>
<tr>
<td>Sharma S.</td>
<td>FC43</td>
</tr>
<tr>
<td>Sharpe R.</td>
<td>P23</td>
</tr>
<tr>
<td>Sharples P.</td>
<td>P383</td>
</tr>
<tr>
<td>Shaw T.</td>
<td>P062,P188,P0280</td>
</tr>
<tr>
<td>Sheppard S.</td>
<td>FC8</td>
</tr>
<tr>
<td>Sherr L.</td>
<td>P203</td>
</tr>
<tr>
<td>Shields C.</td>
<td>FC29,P0106</td>
</tr>
<tr>
<td>Shim Y.</td>
<td>FC42,P351</td>
</tr>
<tr>
<td>Shimada S.</td>
<td>P0131</td>
</tr>
<tr>
<td>Shin D.W.</td>
<td>P240</td>
</tr>
<tr>
<td>Shinada S.</td>
<td>P080</td>
</tr>
<tr>
<td>Shin Fujitsu M.</td>
<td>P080</td>
</tr>
<tr>
<td>Shipton C.</td>
<td>P380</td>
</tr>
<tr>
<td>Shirakawa K.</td>
<td>PO248</td>
</tr>
<tr>
<td>Shouls S.</td>
<td>P039</td>
</tr>
<tr>
<td>Shulman C.</td>
<td>FC8</td>
</tr>
<tr>
<td>Siddiqui N.</td>
<td>FC94</td>
</tr>
<tr>
<td>Siebenhofer A.</td>
<td>FC121</td>
</tr>
<tr>
<td>Siemens W.</td>
<td>FC205</td>
</tr>
<tr>
<td>Sigurdardottir K.</td>
<td>P049</td>
</tr>
<tr>
<td>Sikorová L.</td>
<td>FC37</td>
</tr>
<tr>
<td>Sils E.</td>
<td>FC13-P014</td>
</tr>
<tr>
<td>Silva A.V.</td>
<td>P105</td>
</tr>
<tr>
<td>Silva F.</td>
<td>P037</td>
</tr>
<tr>
<td>Silva P.</td>
<td>P084</td>
</tr>
<tr>
<td>Silva Nunes T.</td>
<td>P0387</td>
</tr>
<tr>
<td>Silva Pinto C.</td>
<td>P0153</td>
</tr>
<tr>
<td>Silzle T.</td>
<td>P107</td>
</tr>
<tr>
<td>Simson L.</td>
<td>P036</td>
</tr>
<tr>
<td>Simmons S.</td>
<td>P025</td>
</tr>
<tr>
<td>Simon J.</td>
<td>FC32</td>
</tr>
<tr>
<td>Simon P.</td>
<td>P042</td>
</tr>
<tr>
<td>Simon S.T.</td>
<td>P0159</td>
</tr>
<tr>
<td>Simonsen T.L.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Sinclair S.</td>
<td>FC38-P0114</td>
</tr>
<tr>
<td>Singh P.</td>
<td>FC38-P0114</td>
</tr>
<tr>
<td>Singh R.</td>
<td>FC38-P0114</td>
</tr>
<tr>
<td>Sinharajah A.</td>
<td>P0134-P0218</td>
</tr>
<tr>
<td>Sirgo A.</td>
<td>P057</td>
</tr>
<tr>
<td>Siyagren P.</td>
<td>FC6-P066</td>
</tr>
<tr>
<td>Skævington S.</td>
<td>FC5-P107</td>
</tr>
<tr>
<td>Skorstengaard M.H.</td>
<td>FC5-P105</td>
</tr>
<tr>
<td>Skov Benthien K.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Slama O.</td>
<td>P064</td>
</tr>
<tr>
<td>Slankamenac K.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Stalatore C.</td>
<td>FC32</td>
</tr>
<tr>
<td>Slaven J.</td>
<td>FC32</td>
</tr>
<tr>
<td>Sleeman K.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Sleeman K.E.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Shackers M.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Smets T.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Smith P.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Smith V.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Smith-MacDonald L.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Smits C.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Snow S.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Snyder S.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Soares D.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Soares F.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Sobral G.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Socrócoro A.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Soelberg Vádragrup E.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Solanki E.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Solari A.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Solheim T.S.</td>
<td>FC5-P281</td>
</tr>
<tr>
<td>Soom Ammann E.</td>
<td>P025</td>
</tr>
<tr>
<td>Soto-Rubio A.</td>
<td>PO171</td>
</tr>
<tr>
<td>Soudert S.</td>
<td>P14</td>
</tr>
<tr>
<td>Souda G.</td>
<td>FC43-P023</td>
</tr>
<tr>
<td>Spence K.</td>
<td>P099</td>
</tr>
<tr>
<td>Speranza R.</td>
<td>FC93</td>
</tr>
<tr>
<td>Spichiger F.</td>
<td>FC27-P022</td>
</tr>
<tr>
<td>Spirova M.</td>
<td>FC17-P017</td>
</tr>
<tr>
<td>Spolli E.</td>
<td>FC93</td>
</tr>
<tr>
<td>Sproule J.</td>
<td>FC64</td>
</tr>
<tr>
<td>Stachura P.</td>
<td>FC49-P293</td>
</tr>
<tr>
<td>Stajdahar K.</td>
<td>FC17-P017</td>
</tr>
<tr>
<td>Stal-Klapwijk M.</td>
<td>P0140</td>
</tr>
<tr>
<td>Stanculcaeslu L.</td>
<td>FC27-P022</td>
</tr>
<tr>
<td>Stapes M.</td>
<td>FC78</td>
</tr>
<tr>
<td>Steck N.</td>
<td>FC94</td>
</tr>
<tr>
<td>Steele K.</td>
<td>FC49-P293</td>
</tr>
<tr>
<td>Steelfil F.</td>
<td>FC94</td>
</tr>
<tr>
<td>Steffen-Bürgi B.</td>
<td>FC14-P041</td>
</tr>
<tr>
<td>Steiglender T.</td>
<td>FC33-P010</td>
</tr>
<tr>
<td>Stein F.C.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Steinhauser K.</td>
<td>P0140</td>
</tr>
<tr>
<td>Steiner A.-C.</td>
<td>FC33-P010</td>
</tr>
<tr>
<td>Stone T.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Stofoss-Hanssen H.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Stirling C.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Stoeverlaar R.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Stiger H.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Stone P.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Stout-Kerstjens S.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Strandeus M.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Strandmark J.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Strassera F.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Streek N.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Streit S.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Strömskog K.E.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Struck M A.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Strudholm T.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Sah S.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Sah S.-Y.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Sallistr M.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Sullivan D.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Sun D.S.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Sundararajan V.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Sundervi N.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Surmont V.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Sussanti D.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Sussman T.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Sveen J.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Svatkova L.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Swan F.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Swankar P.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Szczepaninska K.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Szczepanska K.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Szczepanska K.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Szyliert R.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Tabak N.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Tagami K.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Tavora S.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>Tabak N.</td>
<td>FC38-P020</td>
</tr>
<tr>
<td>P0140-P0148-P022-P025-P032-P033</td>
<td>FC38-P020</td>
</tr>
</tbody>
</table>
Tait P. P385
Takagi Y. PO196
Takahashi M. PO272
Takigawa C. P191,P0138
Tanner S. P71,P250,P0178
Tan D. P87
Tan L. PO245,PO263
Tandon P. P0184
Tang P. FC22
Tang S.T. FC52,P089,P244
Tang S.T. (P258
Takigawa C. P191
Tamerus S. P71,P250,P0178
Tan D. P87
Takashima M. PVC72
Takigawa C. P191,P0138
Tamura Y. FC22
Takahashi M. P0272
Takigawa C. P191
Tamerus S. P71,P250,P0178
Tan D. P87
Takahashi M. PVC72
Takigawa C. P191,P0138
Tamerus S. P71,P250,P0178
Tan D. P87
Takahashi M. PVC72
Takigawa C. P191
Tamerus S. P71,P250,P0178
Tan D. P87
Takahashi M. PVC72
Takigawa C. P191
Van der Kleij R.
Van der Linden Y.
Van der Linden Y.M.
Van der Maaden T.
Van der Plas A.G.M.
Van der Rijt K.
Van der Smissen D.
Van der Stap L.
Van der Steen J.
Van der Steen J.T.
Van der Velden A.
Van der Vorst M.
Van der Wal G.
Van Dongen S.
Van Dongen S.I.
Van Driel A.G.
Van Esch H.
Van Gorp J.
Van Harteveld J.
Van Hout H.
Van Hout H.P.J.
Van Humbeeck L.
Van Klinken M.
Van Kuijk S.
Van Kuijk S.M.J.
Van Laarhoven H.
Van Laere I.
Van Leeuwen R.
Van Linde M.
Van Mierlo P.
Van Nugteren I.C.
Van Oorschot B.
Van Riet Paap J.
Van Roij J.
Van Sasse van IJsselt M.
Van Vliet L.
Van Weert H.C.P.M.
Van Wesemael Y.
Van Wijngaarden J.
Van Zuylen L.
Vanbutsele G.
Vander Stichele R.
Vanderschuren M.M.
Vaquero-Cruzado J.
Varani S.
Vardi J.L.
Varela M.
Varela-Cerdeira M.
Vasconcelos Matos L.
Vayre-Bossert P.
Vegano Alonso T.
Veldhoven C.
Venkateswaran C.
Vennmans B.
Venturato L.
Verastegui E.
Verbeek C.A.
Verdegal B.
Vergouw Y.
Verhagen A.
Verheul H.
Verhoef M.
Verkassen M.
Verkassen M.N.
Vermeiren M.
Verne J.
Vermeer Jansen M.J.F.J.
Ven S.
Veronese S.
Verstegen D.M.L.
Authors Index

Wentlandt K.
Wenzel C.
Wenzel L.
Wessell K.
West R.
Westen J.H.
West T.
Westen G.
Whelan C.
Whichmann A.
Whisenant M.
Whitburn T.
White C.
White N.
White L.
Whelan C.
Whisenant M.
Whitburn T.
White C.
White N.
Whichmann A.
Westen J.H.
Westert G.
Whelan C.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.
Wicks F.
Wickson-Griffiths A.
Widdershoven G.A.
Widdershoven G.A.
Wichmann A.
Wichmann A.B.
Wicki M.
Wicki M.T.