

now be introduced into the second phase of LCP implementation. Further work is planned to ensure sustainability of the LCP following the use of this model.

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PE 1.F281

Exploration of needs and experiences of patients, families and medical staff to inform a palliative care service in Bangladesh

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Background: Needs assessment is crucial to development of palliative care services. WHO recognizes and strongly supports expansion of palliative care worldwide. However, it recommends that the services need to adapt to the special needs in resource poor settings. It also acknowledges the lack of research in those countries as one of the obstacles in providing an efficient service.

Aims and objectives: The aim of this study was to assist the palliative care movement in Bangladesh to identify success and failure in order to deliver a more effective care to patients, and plan future developments.

Study design: Cross-sectional qualitative interview study.

Methods: Service providers as well as service recipients were interviewed about their palliative care experience and needs. Semi-structured interviews were carried out using a local interpreter.

Data analysis: Content analysis was performed.

Transcripts were organized into general themes, and then categories of data were allocated to each theme.

Results: palliative care needs encompassed all the well known domains, physical, psychosocial and spiritual. However, pain control and need for morphine were the dominating feature in all interviews. Anger and mistrust towards health care system and health professionals were the unexpected findings in service recipients. Adequate information, but also compassionate and caring communication were regarded essential. Palliative care staff looked up specially to India as a role model. Lack of awareness in public and professionals was seen as the major barrier. Lack of availability of morphine was identified as the main barrier to pain control.

Conclusion: Palliative care needs in Bangladesh are in their content no different to developed countries, however, the magnitude and intensity of problems and their impact are overwhelming. Cancer experience is shadowed by poverty and low education/illiteracy, but also social injustice and inequality. International attention and collaboration with government of Bangladesh is needed to simplify narcotic regulations and make morphine available. For a wider coverage of palliative care and its expansion to rural area innovative ideas and strong advocates are required.

PE 1.F282

Palliative care social worker: A pilot post to establish the role

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Background: Historically the Palliative Care Service had not benefited from a dedicated social worker in either the inpatient unit, hospital or community team. The NICE guidance (2003) for Supportive and Palliative Care recommend that to provide specialist palliative care, teams require input from a social worker. A project was designed to pilot the role, within an established team.

Aims:

- To define the role of the social worker within the palliative care service.
- To determine the acceptability of the post to patients, carers, health and social care professionals.
- To establish the benefits of the role.

Methods: A steering group was formed with representation from social services, specialist palliative care service, primary care trust and acute hospital. A social worker was seconded to the post for one year. The pilot was evaluated with:

1. Focus groups with health and social care professionals, patients and carers.
2. A patient / carer satisfaction survey.
3. Activity data collection.

Results:

- Focus group themes:
 - Continuity care between social services and health funding and between care locations
 - Coordination of care
 - Advocate and support for carer
 - Signposting / resource for healthcare professionals
 - Involvement in rapid discharge planning and prevention of readmission.

Satisfaction survey: 100% respondents reported high (>8/10) level of benefit from social worker input. 50% wanted the social worker to have been involved earlier in their illness.

Activity data: 160 referrals in one year. Reasons for referral: discharge planning (26%), family / carer support (18%), financial advice (25%) and crisis intervention (31%).

Outcome of referrals: 21% helped prevent hospital admission, 19% facilitated discharge, 47% ongoing psychological support.

Conclusions: A post previously considered unnecessary has been shown to be valued by patients, carers, health and social care professionals.

PE 1.F283

Domiciliary palliative care service of a palliative care unit in Brazil

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Research aims: In the Palliative Care Unit of Instituto Nacional de Câncer (INCA), about 250 patients are taken care in the domiciliary service with de goal of reducing hospitalization and improving patients quality of life with their families when they require considerable assistance and frequent medical care.

Study design and methods: We will describe our service and define our patient profile after collecting dates during a period of 18 months. A team member collects information in their first visit using a specific framework and the results are analyzed every month with the whole team.

Results: This domiciliary care service is responsible for a multiprofessional assistance (physician, nurse, social worker, psychologist and physiotherapist) for these patients, embracing an area of 50 miles distant from the hospital divided in 5 regions, each one with a team of reference.

The service receives every month about 100 new patients, all of them with a performance status under 50%. Physicians are supposed to make their first visit into 5 days after they are referred to the service, when their needs and prevalent symptoms are defined and a therapeutic plan prepared.

Nurses are supposed to visit them at least every 5 days to assure that required home assistance in been given, that caregivers are able to give adequate daily support, skin care and also to proceed specific non pharmacological therapeutically approach to prevalent symptoms.

Social worker helps to identify aim caregiver, gives orientation about their rights and legal responsibilities and is able to return to their houses always when identified their need by any other member of the team.

Conclusion: The aim of the domiciliary palliative care is to accurate the multiprofessional assistance in agreement with our patient profile for the adequate symptom control and improvement for the patient and family/ caregivers' quality of life minimizing bereavement problems.

PE 1.F284

Palliative care services: A proposal for Portugal

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Using as methodology, the protected referenced for Gomez-Batiste, Frank Ferris, Herrera, Rocafort, Clark, Stjernsward, Higginson, among other, we create for Portugal a proposal of net of palliative care services. This proposal has about guiding points: the estimate of patients that you/they would need palliative care, be oncologic or not oncologic, the number of beds, the number of you equip, of the several typologies, the number of doctors and of necessary nurses. This way, with base in the population of 2007 and died on that year, we need, for Portugal, in medium numbers:

- 62107 patients to need of palliative care
- 14492 patients oncologic to need of palliative care
- 9290 patients no oncologic
- 21738 complex palliative patients, as well as the same

number of no complex, and intermediate or agonic

- Need of 1062 beds • 319 beds in units of health for patients "sharp" or units for patients of larger complexity
- 531 beds in units for sick crónicos, or of intermediate complexity
- 239 beds in nursing homes
- 133 teams of community support
- 102 teams of hospital support
- 27 teams in units for acute patients or for patients of larger complexity
- 44 teams in units for chronic patients or of intermediate complexity

Medical:

- 265 in teams community support / domiciliary
- 204 in teams hospital support
- 93 in the units of acute patients

Nurses

- 465 in teams community support / domiciliary
- 357 in teams hospital support
- 239 in the units of acute patients a day.

PE 1.F285

Cross sectional study of acute hospital referrals to the palliative care service

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Hospital Palliative Care services are used with increasing frequency. We aimed to assess the distribution of referral sources to palliative care, identify the reasons for referral and the areas of need. Referral forms over a 3 month period were retrospectively analysed, looking at the source, the reason for referral, and the symptoms where relevant. 51.6% of referrals came from oncology, 26.9% from acute medicine, 10.8% surgical, 4.3% geriatrics, 4.3% haematology, 1.1% gynaecology, 1.1% paediatrics. 41.9% were referred for symptom control, 20.4% home care, 10.8% end of life care, 1.1% discharge planning, 8.6% home care follow up and symptom control, 3.2% discharge planning and symptom control, 6.5% other, 7.5% not documented. Symptom management accounted for 75% of Geriatric, 50% of Surgical and Haematology, 41.7% of Oncology, and 36% of medical referrals. End of life care accounted for 30% of surgical, 25% of Geriatric, 20% of medical and 2.1% of oncology referrals. Of 27 referrals involving a request for home care follow up, 21 came from oncology, 5 medicine, and 1 surgery. Among patients with malignancy the most common reason for referral was symptom control (43.2%), while among patients with non-malignant disease the most common reason for referral was for end of life care (41.7%). 50 referrals involved symptom control, 24 of which were for a single symptom, 11 for multiple symptoms. In 15 the symptoms were not specified. The most common symptom was pain. Oncology, who refer to the service most often, tend to refer more frequently for home care follow up than end of life care, suggesting they may involve palliative care at an earlier stage in the disease trajectory. It is encouraging that the most frequent reason for referral among 5 of 7 specialities was for symptom control. A large proportion of surgical referrals were for end of life care. Some teams refer infrequently, suggesting that there may be scope for further use of the palliative care service.

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Acute care palliative medicine and discharge planning

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Aims: We used electronic databases to report:

- 1) Patient characteristics in an acute palliative medicine inpatient unit
- 2) Post acute care (PAC) service utilization
- 3) Factors influencing discharge planning.

Methods: Retrospective electronic databases analysis of 2006 & 2007.

Results: 1634 admissions. 52% Female; Median age 62 (20-99); 56% Married, 19% Single, 14% Widowed, 10% Divorced; 27% African-American, 70% White. Length of stay (LOS): Median 8 (range 1-103 days). Admit source: Clinic Referral (62%), Emergency Room (21%), and Hospital Transfer (17%). Payor source: Commercial (38%), Medicaid (9%), Medicare (47%), and others (6%). Readmissions (13%). Discharge disposition: 21%