

survey questions prompted participants to provide information on the types and number of resources (goods and services) they used, and to identify who paid for these resources and by what percentage. **Results:** The study provided a comprehensive picture of costs occurred by palliative care patients and their families in five Canadian regions, by specifying the cost sharing between the public health care system, the family and not-for-profit organizations. The most important cost component supported by the public health care system was inpatient hospital care, followed by home care. A large part of costs supported by the family was attributable to caregiving time. Almost all costs assumed by not-for profit organizations were for medical equipment or aids used by patients in their home. **Conclusion:** The study results allow us to draw a clear picture highlighting the extent to which, and the areas that, families need to be financially assisted in their efforts to care for their dying loved ones at home. The question should be addressed as to whether or not this burdening of the families is "socially" acceptable. The decision to dying at home when the context is favourable to do so should not have as a consequence an unfairly shift of the financial burden over the family.

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**Poster number:** P127

#### **A Ten Years Experience Following Cancer Patients in Home-care: Organisation of the Service**

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**Aim:** The drawing thought of the GRADO Association (Gruppo Ricerca Assistenza Domiciliare Oncologica) is that "home" should be the best place of treatment in the end-of-life period, considering that house is the natural container of persons' life which, with a convenient help, would prefer to spend the terminal phases of their life at home rather than in hospital. **Methods:** Patients were visited at home by an Oncologist with a Professional Nurse. The team is also composed of an Internist, a Physician for Pain Therapy, a Psychologist, a Physiotherapist. Assistance is completely free for the patients and their families. The professional team is also supported by a group of trained volunteers who are responsible for the social aspects of the patients' life. **Results:** From June 1998, 602 patients, which mean age was 66,9 yrs (16-90), have been followed; they requested 6534 oncological visits, 2235 medical visits, 3964 nurse interventions, 4179 supportive treatments, 392 paracentesis, 354 toracentesis, 1023 psychological supports. The mean/median follow up were 66,3/57 days (3-359). 498 patients (82,7%) died at home. **Conclusions:** The data showed us that this assistance permits education and adaptation of patients and their families with the disease and diminishes the hospitalizations of these pts, resulting in an improvement of their quality of life (better preserved in their family environment). We have distributed 38.651,00 days of medical services and it has certainly helped in saving the expenses of the welfare state. So considering the mean cost of a day in a general hospital approximately equivalent to 650,00€ and considering a day of a medical services = a day of non-hospitalization, our work allowed an economical benefit of 25.123.150,00€ for the public health resources. Home-Care models could be the successful instruments and strategies of treatment in advanced cancer care.

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#### **Ambulance Based Palliative Care in Northern Thuringia - 2 Years of Experiences**

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**Aim:** Since two years we offer an ambulance based palliative care concept for the region of Northern Thuringia. The experiences, difficulties and results should be summarized and analyzed. **Methods:** Our palliative care concept includes a 7/7 service for patients and their families. The multi-professional team has two physicians and three special trained nurses. Each service of our team is done on request of the family physician. For the presented analysis the files of all treated patients were reviewed regarding basic disease, type of palliative care, main symptoms, and place of death. **Results:** 162 patients were treated until July 2009. The leading diagnoses were cancer in 141/162 (87%), and neurologic disorders in 21/162. The localizations of cancer were ENT region in 68/pts (48%), GI tract in 28 pts (20%), breast in 13 pts (9%) uro-genital tract in 13 pts (9%), lungs in 7 pts (5%), brain in 4 pts (3%), lymphatic system 5 pts (3%), and skin in 3 pts (2%). Only 37/162 (22%) patients were able to visit our department. All other patients were visited by the team at home. Our patients suffered from pain in 40%, dysphagia in 45%, malnutrition in 31%, dyspnoea in 12%, exsiccosis in 9%, superinfected wounds in 9%. Further symptoms were dementia, abuse, different GI symptoms, bleeding, spontaneous fractures, brain pressure, pruritus, and lymph edema. 8% of all patients asked for palliative sedation, 4% needed spiritual support, and 2 patients (1%) the family situation was desolate. 92/162 patients (57%) were dead at time of analysis. 49/92 patients (53%) died at home, 5/92 (6%) at hospices, and 38/92 (41%) at hospital. **Conclusions:** Palliative care offers are important for patient's remaining and dying at home. Our patients are suffering from a variety of symptoms. As earlier palliative care starts, as more it represents all types of supportive medicine, including nutritional support and wound management.

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#### **Palliative Home Care Teams in Portugal: How Many and where We Need**

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**Aim:** Describe how many and where are the palliative home care teams need in Portugal. **Methods:** Using as methodology, the protected referencied for Gómez-Batiste, Frank Ferris, Herrera, Rocafort, Clark, Stjernsward, Higginson, among other, we create for Portugal a proposal of number and location of palliative home care teams (PHCT). We stated by the point that we need 1-1.5 PHCT/100000 habitants. **Results:** This way, with base in the population of 2008 for Portugal, in medium numbers, we need these PCHT, by region:

1. **North: 37-56**
  - a. Minho-Lima: 3-4
  - b. Cávado: 4-6
  - c. Ave: 5-8
  - d. Great Oporto: 13-19

- e. Tâmega: 6-8
- f. Between Douro and Vouga: 3-4
- g. Douro: 2-3
- h. High "Trás-os Montes": 2-3

## 2. Center: 24-36

- a. Low Vouga: 4-6
- b. Low Mondego: 3-5
- c. "Pinhal Litoral": 3-4
- d. Inside North of Pinhal: 3-4
- e. Dão-Lafões: 3-4
- f. Inside South of Pinhal: 0-1
- g. Sierra Star: 0-1
- h. Inside north of "Beira": 1-2
- i. Inside south of "Beira": 1
- j. "Cova da Beira": 1
- k. West: 4-5

## 1. Midle Tagus: 2-3

## 3. Lisbon Region: 28-42

- a. Great Lisbon: 20-30
- b. Setubal's Pensinsula: 8-12

## 4. Alentejo: 8-11

- a. Alentejo Litoral: 1
- b. High Alentejo: 1-2
- c. Central Alentejo: 2-3
- d. Low Alentejo: 1-2
- e. Tagus's leziria: 2-4

## 5. Algarve: 4-6

## 6. Azores: 2-4

## 7. Madeira: 2-4

**Conclusion:** For one uniform and equal distribution we need 106-159 palliative care home teams by the country. The human resources for these teams should be trained and should be have specializing education.

**Abstract number:** 559

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**Poster number:** P130

### Transitions in the Last Year of Life to Access Health Care

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**Background:** Research is needed on the numbers, types, and impact of the relocations that occur during the last year of life. **Research objective:** A concurrent mixed-methods study to explore care setting transitions in the last year of life was undertaken in 2009. Study population: Nearly 20,000 persons die each year in Alberta, Canada; 20% are rural citizens. Study design and methods: Hospital data (2006-8) were explored to identify the frequency and types of care setting transitions in the last year of life, with an online survey and qualitative interviews undertaken for an in-depth understanding of the reasons for and impact of transitions. **Results:** This study found only half of all deaths in 2007 took place in a hospital bed, with 28.5% of decedents never admitted to a hospital in the last year of life. The average number of admissions to hospital over the last year of life was 1.6, with rural people admitted 50% more often to hospital and to emergency rooms. On average, decedents had 2.8 emergency room visits, 5.0 outpatient clinic visits, and 2.5 daysurgery clinic visits in the last year of life. Rural residents are burdened by the necessity to travel; as illustrated by the strong views and clear concerns voiced about difficult transitions and their direct and other impacts. This study shows it is possible for all diagnostic tests, treatments, palliative or end-of-life care, and death to occur without ever having been admitted to hospital for inpatient care. This ambulatory care shift is challenging terminally-ill persons and their families, with

rural residents significantly impacted by the need to travel more and travel more often to receive care.

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**Poster number:** P131

### What is the Scope of Information Available on Hospice Websites?

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**Aim:** The "End of Life Care Strategy" published by the UK government aims to provide people approaching the end of life with more choice about where they would like to live and die. The internet is a common source of information to aid decision making. The aim of this study is to describe the scope of information that is available on hospice websites, as hospices play a significant role in providing end of life care. **Methods:** The "Help the Hospices" directory was accessed online on 13 Oct 2009 to obtain a list of hospices for adults in England. A pilot study on 30 hospices (15 NHS and 15 voluntary) was done to draft a list of types of information available. This list was used to collect data from all hospice websites, which were accessed from 15-31 Oct 2009. **Results:** There were 197 entries in the directory for adult hospices in England, comprising 182 distinct websites due to duplicate entries. 4 hospice websites were not working, leaving 178 to study. The table shows the main results for information directed towards patients.

Type of information	Website itself only	Downloadable leaflet only	Both website and leaflet	Not available
Aims	134 (75%)	4 (2.2%)	5 (2.8%)	35 (20%)
History	107 (60%)	2 (1.1%)	2 (1.1%)	67 (38%)
Eligibility criteria	69 (39%)	15 (8.4%)	3 (1.7%)	91 (51%)
Referral procedure	101 (57%)	11 (6.2%)	4 (2.2%)	62 (35%)
Types of healthcare professionals	130 (73%)	15 (8.4%)	19 (11%)	14 (7.9%)
Facilities available	134 (75%)	10 (5.6%)	16 (9.0%)	18 (10%)
Description of activities	119 (67%)	12 (6.7%)	9 (5.1%)	38 (21%)
Smoking policy	23 (13%)	27 (15%)	0 (0%)	128 (72%)
Medical information	18 (10%)	17 (9.6%)	0 (0%)	143 (80%)

[Types of information available on hospice websites]

**Conclusion:** Although there was a wealth of information available, some areas such as eligibility criteria and medical information were less widely available. Details on medical aspects such as the use of a syringe driver and the process of dying would be valuable to patients. This study is a starting point for further work to improve access to information on the internet for patients and their carers, so that they can make informed choices about their care.