AN EVALUATION FRAMEWORK FOR COMPLEX PALLIATIVE CARE PROJECTS

INTRODUCTION
Democratic governments that invest public funds increasingly mandate accountability from executing agencies through Program Evaluation processes. The goal is accountability for results and to demonstrate that citizens receive value for money in their capacity as taxpayers.

The Government of Canada’s, Primary Health Care Transition Fund (PHCTF) was a one-time, focused investment in Primary Health Care renewal of €525 million. A €2.9 million national investment for Hospice Palliative Care capacity was made through Pallium Project (Phase II).

The PHCTF required accountability for five common objectives and seven national project objectives. The study’s aim was to design and implement a robust evaluation framework applicable to demonstrating goal attainment across the Project’s diverse portfolio of 72 strategic activities, initiatives and subprojects.

METHODOLOGY
An external evaluator with past experience evaluating Government of Canada, Primary Health Care projects (i.e., Health Transition Fund) was retained early in the Phase II project. The evaluator worked in a collaborative and consultative relationship with the Project team to design an evaluation framework that balanced Phase II complexity with Health Canada reporting accountabilities.

Quantitative and qualitative methods were employed to validate Project objective attainment consistent with the Government of Canada’s accountability expectations. Analytic methods included work product and final deliverable analyses arising from strategic activities, initiatives and subprojects; descriptive variance analyses (i.e., account for variance between what was proposed/declared as intent and what was actually delivered); process evaluation and continuous improvement tracking as part of formative evaluation; observation and impact/outcome mapping guided by Health Canada’s, Participatory Evaluation Framework questions (see below). The Government of Canada’s, Results Based Management and Accountability Framework and The World Bank’s, LOGFRAME (Logical Framework) also informed project evaluation design.

EVALUATION QUESTIONS
1) How did we do this work?
2) Did we do what we said we would do?
3) What did we learn about what worked and what didn’t work?
4) What difference did it make that we did this work?
5) What could we do differently?
6) Were there any unintended outcomes?
7) How do we plan to use evaluation findings for continuous learning?

DISCUSSION/IMPLICATIONS
• It is possible to accountably evaluate a complex, multi-faceted capacity-building project with otherwise seemingly disparate operational and programmatic elements.
• Early engagement of independent/external evaluators, as well as facilitative rather than authoritative/controlling relationships (e.g., audit) can result in considerable value added from an evaluation investment.
• Many existing program evaluation models and methodologies proved unsuitable to the Project portfolio approach used for Phase II. A defensible hybrid framework and process had to be developed for project evaluation.
• Integration of impact/outcome mapping is a critical component in order to evaluate “ripple effect” impact (i.e., order removed/second/third, etc., generation changes resulting from strategic interventions).
• Emerging constructs for meaningful project evaluation of complex social change projects may have elements of a “social ecology.” Our team found the concept of a lush Boreal forest, rich with expansive biodiversity and great interdependence, a useful metaphor to discuss how Phase II operated and how it could be understood and reported back to stakeholders.

FIGURE 1
Project Evaluation Design Framework for Pallium Project (Phase II)

FIGURE 2
Tabular Representation of Inter-relationship of Key Evaluation Framework Elements

To improve access, enhance quality and build longer-term system capacity for hospice palliative care:
1) Enhancing the sustainability of the primary health care system by engaging stakeholders and the public in a dialogue on Primary Health Care renewal.
2) Educate the public about Primary Health Care renewal.
3) Maximize synergies and the use of common/collaborative approaches to renewal; providing for information sharing on Primary Health Care renewal experiences.
4) Improve availability and quality of information on Primary Health Care nationally.
5) Create common practical tools to address the challenges that will arise during the renewal process.
6) Facilitate collaboration among professionals involved in Primary Health Care.
7) Facilitate changes in practice patterns for Primary Health Care providers.
Thursday 7 June

CONNECTING DIVERSITY

10th Congress of the European Association for Palliative Care

10th Congress of the European Association for Palliative Care, Budapest, Hungary, 7-9 June 2007
905. Enabling Patients in Cancer clinics: a cross-sectional survey using the Patient Enablement Instrument (PEI)

Anne-Marie Carey1, Laura McGlave1, Jenny Freeman2, Karen Wilman1, Ikumi Okamoto2, Sam Ahmedzai3, Bill Noble1

1 University of Sheffield, Academic Unit of Supportive Care, Sheffield, United Kingdom
2 King’s College London, University of the Netherlands and Rotterdam, Netherlands
3 University of Sheffield, Consumer Research Unit, Sheffield, United Kingdom
4 University of Southampton, School of Nursing and Midwifery, Southampton, United Kingdom

**Aims:**
- to explore the use of the PEI in cancer care outpatient clinics
- to determine prerequisite factors associated with enablement as an outcome measure in cancer care consultations

**Method:**
Cross sectional postal questionnaire based survey in cancer outpatient clinic(s) in a UK Cancer Network. The Patient Enablement Instrument (PEI), EORTC QLQ-C30, HADS

**Results:**
Response rate 78% (96/120) (49% male, mean age 63, 46% cancer diagnosis). Mean PEI score 3.17. Enablement scores were higher if patients felt clinic staff knew them well (p<0.01), or intended to discuss their illness/treatment with their GP following clinic (p<0.001). PEI scores were lower (p<0.03) and anxiety scores higher (p<0.01) in females; however, there was no significant difference between PEI scores and HADS or EORTC QLQ-C30. Significant clinic variables associated with higher PEI were a review by a consultant surgeon/oncologist (p<0.001) and attendance at the clinic with communication training, clinic slot length >30mins.

**Conclusions:**
The PEI may be a useful tool for assessing cancer care consultations as it appears to be independent of psychological distress and quality of life. There was an association between high PEI score, patients feeling that staff knew them well or intent of discussions with their GP, pointing to a possible link between enablement and continuity of care. PEI is associated with clinic factors which could be expected to improve consultations.

906. Validation of a system to prioritize first visits to the Palliative Care Outpatients Clinic

Angela Durán, Jesús Gómez-Barbotteo, Jose Espinosa, Josep Porta-sales, Silvia Par, Xavier Goiméz-baite

Institut Català d’Oncologia, Palliative Care Service, Barcelona, Spain

A series of factors have been related to a higher risk for palliative care (PC) patients to fail outpatients follow up. These factors are: a Palliative Performance Status <50, age >60 years, cancer, anxiety, depression, reduction in social function, social support, and initial contact with a specialist (p<0.05). The PEI questionnaire was used to assess the methodology for prioritizing outpatients in the PC clinics. The PEI may be a useful tool for assessing cancer care consultations as it appears to be independent of psychological distress and quality of life. There was an association between high PEI score, patients feeling that staff knew them well or intent of discussions with their GP, pointing to a possible link between enablement and continuity of care. PEI is associated with clinic factors which could be expected to improve consultations.


Thomas Lynch1, David Clark1, Michael Wright1, Carlos Centeno1, Javier Espinosa2, Angel Duran2, Angela Duran2

1 Lancaster University, International Observatory on End of Life Care, Lancaster, United Kingdom
2 Universidad de Navarra, Pamplona, Spain

**Background:** The EAPC Task Force for the Development of Palliative Care in Europe: Eurobarometer Survey has produced information on the provision of palliative care across Europe. This study focuses on one part of the survey relating specifically to 22 countries in Central and Eastern Europe (CEE) and Commonwealth of Independent States (CIS).

**Aims:**
To identify barriers to the development of palliative care in CEE and CIS

**Method:**
A survey was undertaken amongst boards of national associations, eliciting opinions on opportunities and barriers to, palliative care development. By July 2006, 44/52 (85%) European countries had responded to the survey. We report here on the results from 22/27 (85%) countries in CEE and CIS Analysis:
Data from the Eurobarometer survey were analysed thematically by geographical region and by the degree of development in the region. From the varied data contained within the Eurobarometer, we identified four significant barriers to the development of palliative care in CEE and CIS: (i) lack of funding (ii) lack of opioid availability and choice (iii) lack of public awareness and government recognition of palliative care as a field of specialisation (iv) lack of palliative care education and training programmes

Despite huge variations in the levels of provision across many countries, data collected in the Eurobarometer survey revealed that barriers to development of palliative care in CEE and CIS:

908. An evaluation framework for a complex palliative care project

Dorian Freer1, Jose Pereira1, Michael Ahern2

1 D. Freer & Associates, Red Deer, Canada
2 Pallium Project Canada, Calgary, Canada

**AIM:**
Governments investing public funds mandate accountability through evaluation. The goal is also accountability for beneficiaries and to demonstrate citizens receive value for money. The Government of Canada’s, Primary Health Care Transition Fund (PHCTF) invested 2.8 million in a palliative care capacity building project (Pallium Project) as part of its investment in primary health care renewal. The PHCTF required accountability for five common objectives. The study’s aim was to design and implement a robust evaluation framework applicable to demonstrating value added attainment across diverse subprojects. METE: An evolution team designed a multi-faceted evaluation framework. Quantitative and qualitative methods included document and product content analyses, descriptive variance analyses, process evaluation and continuous improvement, impact/outcome mapping and Participatory Evaluation from Health Canada’s, Participatory Evaluation Framework. The Government of Canada’s, Results Based Management and Accountability Framework and The World Bank’s LOGRAMI (Logical Framework) also informed design. RESULT: A comprehensive evaluation was produced with the necessary information to meet PHCTF requirements. A meaningful synthesis was produced for summative evaluation. The comprehensive project overview emerging from 70 subprojects and initiatives CONCIL: Large scale, complex palliative care as an exemplar of integrated program evaluation framework and supporting protocols to achieve accountability for large public investments

909. Methodological issues in the evaluation of educational initiatives

Jorge Eisenchutz1, Marisa Pérez1, Celina Berenger1, Gustavo De Simone1

1 Hospital B. Uadsno & Pallium Latinoamerica, Palliative Care Service, Buenos Aires, Argentina

**Background:** In evaluating educational initiatives (EI) pre-post designs are often used, which are prone to bias and decrease the validity of the results. To address these limitations, we piloted a pretest-posttest (response shift). Hence, pre-test evaluations have been implemented.

**Objective:** To evaluate an EI by using two different ways of time-series analysis (pre-post test vs. pre-then test). Method: In agreement with the objectives of a multidisciplinary palliative care course in Buenos Aires, knowledge, skills and attitudes (KSA) about end of life issues were evaluated through a structured questionnaire. Every student filled the questionnaire at the beginning (pre) and at the end (post) of the course, both about questionnaires and their GPA at the end of the course, although questioning about KSA at the course starting (pre) and comparing differences of pre versus post questionnaires were compared by non-parametric analysis. Results: All the students finishing the course filled the 3 questionnaires (n=1). There were improvements (p<0.05 in n=14) in KSA and post-then comparisons respectively. Mean difference for questions related to knowledge and skills was also significant (p<0.05).

**Discussion:**This study suggests that response shift might account for differences in the evaluation of EI. Those changes could impact on the results of the evaluation making necessary to adequately evaluate the methodology to use when planning this type of studies.

910. Development of a computer based questionnaire for assessment of physical function (PF) in palliative cancer patients

Line Olsdrev1, Jarun Holstbøll2, Mart Mjørdby3, Gerd Ringård1, Jon Loge1, Steen Kaas4

1 Norwegian University of Science and Technology Tromsø, institute for research and molecular medicine, Tromsø, Norway
2 Norwegian University of Science and Technology Tromsø, institute for research and molecular medicine, Tromsø, Norway
3 Norwegian University of Science and Technology Tromsø, institute for cancer research and molecular medicine, Tromsø, Norway
4 Norwegian University of Science and Technology Tromsø, institute for cancer research and molecular medicine, Tromsø, Norway

**Objectives:**
To develop a computer based questionnaire for assessment of physical function (PF) in palliative cancer patients.

**Method:**
A multidisciplinary palliative care course in Buenos Aires, knowledge, skills and attitudes (KSA) about end of life issues were evaluated through a structured questionnaire. Every student filled the questionnaire at the beginning (pre) and at the end (post) of the course, both about questionnaires and their GPA at the end of the course, although questioning about KSA at the course starting (pre) and comparing differences of pre versus post questionnaires were compared by non-parametric analysis. Results: All the students finishing the course filled the 3 questionnaires (n=1). There were improvements (p<0.05 in n=14) in KSA and post-then comparisons respectively. Mean difference for questions related to knowledge and skills was also significant (p<0.05).

**Discussion:**This study suggests that response shift might account for differences in the evaluation of EI. Those changes could impact on the results of the evaluation making necessary to adequately evaluate the methodology to use when planning this type of studies.
855. Learning in Clinical Practice – An Innovative Palliative Care Open Learning Resource.

Stevens Stevens1, Carol Young1
1Royal College of Nursing, Palliative Nursing Forum, London, United Kingdom
2Endkure Hospital, Palliative Team, Erkine, United Kingdom

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

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

Paul Vogelaar, Anianne Brinkman, Marianne Karthaus, Wendy Pree de, El Prikker, Herlin Woldberg
NVVPZ, Nijmegen, Netherlands

In October 2005 the Dutch translation of the European Guideline appeared. Subsequently in 2004 the professional guidelines for Dutch palliative Care was developed and the Professional Nursing Educational Act was established. The NVVPZ has attempted to integrate these through three themes into the Dutch situation. The committee has developed a quality criteria for continuing education by describing the competences necessary for the diverse levels of expertise. By using this approach, the NVVPZ wants to give recognition for Palliative Care education for nurses in the Netherlands. In following the European Guideline, there are three course levels differentiated: basic, advanced and specialized. The basic level is for nurses in training and registered nurses. On the second level, there is a distinction made between the nurses who regular come in contact with palliative care and nurses who have specific team and organisational tasks. The tertiary level is especially for nurses who are engaged in policy making and innovative research in palliative care. On the poster, the NVVPZ will present its viewpoint and what it understands of the three described levels. The application of the European Guideline in the Dutch situation has led to a concrete plan of competences for every professional level. The guideline is an important condition for education. The poster will also cover the problems and queries the committee came across during their development.

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

Philip Larkin1, Sobhan Smyth1, Glodagh Coolery1, Kate Kelly1
1University College Galway, Nursing & Midwifery Studies, Galway, Ireland

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

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

A problem-based approach to shared learning is particularly suited to adult learners with considerable experience and helps them to use existing knowledge and skills in new situations. It enables participants to seek new ways of integrating their discipline into established main-stream health care.

861. Physicians view on competences and training in palliative care: a Dutch situation.

Bagt Van Oorschot1, Christine Schlesserman1, Ulrich Wedling2, Wim Basten3
1Julius-Maximilians-University, Klinik und Poliklinik für Innere Medizin, Würzburg, Germany
2Friedrich-Schiller-University, Klinik für Innere Medizin, Jena, Germany
3Friedrich-Schiller-University, Klinik für Anästhesie und Intensivmedizin, Jena, Germany

Training physicians in fundamental principles of palliative care is a priority in the care of patients with life-threatening illnesses in hospitals. We wanted to know more about hospital physicians’ interests in improving their palliative care and about their views on deficiencies in palliative medicine. In Germany, 141 questionnaires were sent to all clinical physicians working in the hospital of Friedrich-Schiller-University, Jena (24%). 131 questionnaires (92%) were sent back (28 %), mostly from younger physicians (78 years younger than 55). Physicians working in the hospital set the framework. They were mainly interested in training in non-surgical areas. 48 % expressed uninterest in palliative care. As difficult / very difficult were labelled: psychosocial aspects (57 %), lack of time (57 %), ethics (49 %), organisation and communication (48 %), financial aspects (52 %) and medical aspects. They desired training in pain therapy (87 %), communication skills (57 %), interdisciplinary cooperation (52 %) advanced direct impact (52 %). They agreed in general symptom control (30 %). The vast majority of the respondents anticipated the most benefit through better pain therapy (91 %) and better communication (78 %). We conclude that the conception of training programmes should take the high interest in bedsidework into account.

The results are presented from the qualitative data, the changes in OSCEs 3 was not significant, the effect size (d) was 1.67. Although the change in OSCEs 3 was not significant, the effect size was large (1.67). There were no significant improvements in knowledge levels (p = 0.35), practical impact (t= 2.9, p<0.01, d effect sizes 1.94 respectively). Although the change in OSCEs 3 was not significant, the effect size was large (1.67). There were no significant improvements in knowledge levels (p = 0.35), practical impact (t= 2.9, p<0.01, d effect sizes 1.94 respectively). Attitudes improved but did not reach significant levels, the effect size was acceptable (t=1.81, p=0.09, d=0.65). The internal reliability (Cronbach’s) of the knowledge, attitudes and comfort scales were 0.29, 0.68 and 0.92 respectively.

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

864. Schooling of children with severe life-limiting illness

Helene Poruch
University, Education, Lausanne, Switzerland

Aim: Investigate the school follow-up for severely ill children and identify their educational needs + identify the hospital teacher’s work, their role and competences

Method: Semi-structured interviews with 11 ill children- teachers working with children who face life-limiting illnesses; professional questionnaires of the parents- teachers- health and care. The hospital teacher's work, their role and competences

Results: Children were recognized, overlapping the 2 worlds of instruction and care. The hospital teacher should be competent to integrate and balance the needs of children, their developments, school programs, usual teacher and current hospital life.

Propositions: Create an individualized integration plan through networking - teachers- health and school professionals - hospital teacher. Hospital teachers working with children who face life-limiting diseases also need to develop new networks at a national and European level.

Conclusion: Challenges successfully a child to keep up with his schooling, according to Childrens’ rights, is a key element for his quality of life by giving him hope and meaning to his life.
Practical e-learning technologies are important tools to improve quality in palliative care services. Professionals so they may provide better access and flexibility in learning and decision support for busy learners. The Palliative Learning Commons, will be featured as an Interprofessional Learning System (ILS) to support individualized, self-directed learning. Results: Learners completed pre- & post-course evaluations that allowed flexible learning and decision support for busy professionals so they may provide better access and quality in palliative care services. Conclusion: Practical e-learning technologies are important tools transforming where, when and how practitioners learn to develop and maintain palliative care competence.

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

José Peresta 1, Terry Collin 1, Mone Palacios 1

1 University of Calgary, Centre for Distance Education in Palliative Care, Calgary and University of Lausanne, Service de Soins Palliatifs, Lausanne, Switzerland

Aim: The goals were to develop 3 long (each 20 min.) oncology clinical examination stations (OSCEs) and score sheets to assess a variety of PC competencies and establish their psychometric properties. Methods: Guidelines for developing OSCEs were followed. Actors/actresses followed scripts and used scenarios to simulate PC consultations. Each OSCE score sheet consists of an itemized checklist and a global scale of “fail”, “borderline” or “pass”. 20 rural family medicine registrars completed pre- and post- course OSCEs as part of a PC course. Surveys and focus groups were conducted post- course. Earlier testing of the OSCEs showed that most of the learners had revealed inter-rater reliability scores (0.87 to 0.92). Results: Face and content validity of the OSCEs were acceptable. Inter-rater reliability scores of the values scores ranged from 0.63 to 0.82 across the 3 stations. The correlations between the total course OSCEs scores were significant (rho = 0.47 to 0.77, p < 0.001 to p < 0.04). Inter-item coefficient correlations identified several items that appeared redundant and others that provided evidence for divergent and concurrent validity of the scales.

Conclusion: If validated, the OSCEs possess acceptable psychometric properties and are useful for evaluating skill-related competencies in formative and summative assessments. They also serve to support reflective learning. Potential limitations are recognized. A generic framework for a score sheet for palliative care OSCEs (Pal- OSCE) is proposed.

887. “Palliative Care: The Essentials” Evaluation of a multidisciplinary education program

Karen Quinn, Peter Hudson, Michael Ashby

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

The need for palliative care education, including knowledge of how to address needs of palliative care pts & their families. Australian Commonwealth funding was secured to educate clinicians from a range of settings. Aim: To develop, deliver & evaluate a multidisciplinary education program focusing on core elements of palliative care. A 2-day program was developed based on a literature review and input from an expert panel. Evaluation consisted of a pre & post-course questionnaire and each session and overall program assessment. Participants evaluated changes to perceived levels of knowledge, skills and confidence in eight different areas of the need for palliative care (2) team work, (3) patient & caregiver support (4) communication, (5) symptom management, (6) legal & ethical issues, (7) spiritual & cultural concerns and (8) grief & bereavement. The program was delivered 4 times in metropolitan & regional areas to a total of 537 participants incorporating a range of disciplines & care settings.

Participants reported an improvement in each of the eight key areas, with some variability between and within settings. The results were successful in meeting the learning needs as identified by the majority of participants. The findings demonstrate multidisciplinary educational programs can be effective in the context of palliative care. The high demand to attend the program suggests the need for ongoing education in this area.

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

Penny Hansford, Vicky Robinson

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

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

889. A distance learning course in palliative medicine for General Practitioners

Jason Ward

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

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

Method to design the development of a six-month education programme for GPs. The RESSIS criteria for effective continuing education were used to develop the course contents. The course aimed to provide GPs with an understanding of the relevance, individualisation, self-assessment, interest, specification/systemic (Harden & Laidlow 1992). Course outcomes

1. Independent study modules with clear aims, objectives and competencies; 2) articles and case studies to be completed each month; 7 different topic areas: principles of palliative care, pain, GI symptoms, emotional and psychological symptoms, palliative care emergencies, and communication.

2. Monthly attendance at a half day ‘consultant teaching clinic’ based on SNAPPs model of learner-centred approaches.
439. Social care interventions for hospice referral in a university hospital without palliative care unit
Sabine Frange1,2, Ricarda Klein1, Maik De Wit1
1 University Clinic Hamburg Eppendorf, Internal Medicine & Movement Science, Hamburg, Germany
2 University Clinic Hamburg Eppendorf, Department of Social Work, Hamburg, Germany

The aim of this study was to evaluate the transfer rates to a hospice for palliative patients of all departments of our University Clinic Hamburg Eppendorf without palliative care unit or palliative care team. The data base of the social care department concerning the year 2005 and from January to October 2006 who were referred from hospital to hospice care was analyzed. In 2005 118 consultations concerning hospice care were performed. 20 patients received psychosocial and social judicial interventions concerning palliative care and information about the options of patient care outside the hospital. Overall, 96 consultations, the intention of the care givers was to discharge the patient to a hospice. 56 patients could be transferred to a hospice. 42 patients died prior to discharge or could be cared for in the family setting with the support of the social worker. In 2005 32 patients and in 2006 (10 mths) 39 patients from the Department of Medical Oncology were referred to a hospice. For 8 patients in 2005 and 12 patients in 2006 an alternative decision was made. From January to October 2006 the social worker received 23 requests for consultation and referred the hospice care, of these 18 cases psychosocial and judicial interventions were required and from 100 calls for referral to a hospice 61 patients could be transferred to hospice. Palliative care interventions for assistance transferring patients to a hospice increased from 2005 to 2006.

440. The problems of transition from voluntary hospice care to formalities to modern health care teams integrated into the existing health care system
Gordana Spoljar1, Jvana Bardoč Osegovac2, Anica Bucal3
1 Croatian Association of Hospice Friends, Palliative care Service, Zagreb, Croatia, Republic of
2 Croatian Association of Hospice Friends, Palliative care Service, Zagreb, Croatia, Republic of
3 Croatian Society for Hospice/Palliative Care, Palliative care Service, Zagreb, Croatia

The Croatian Association of Hospice Friends (CAHF) was founded in 1999 to provide logistic support, first of all to the educational and promotive activities of the Croatian Society for Hospice/Palliative Care. CAHF aims to provide practical palliative medical, psychosocial and spiritual care during hospice home visits by interdisciplinary teams in Zagreb and Zagreb region. As soon as a provision about palliative care was included in the Croatian Constitution in November 2003, CAHF started the administrative procedure necessary to establish an Institute for Palliative Care. - All efforts were blocked by changes in the Government and/or day-hospital or outpatient healthcare insurance. Without any specialized palliative care services, the region has had a hospice for palliative patients of all departments of our University Clinic since 1993. This hospice has been visited by interdisciplinary teams in Zagreb and Zagreb region. Since 1999, CAHF started the administrative procedure necessary to establish an Institute for Palliative Care. 56 patients were transferred from hospital to hospice. In 2006 an alternative decision was made.

441. Specialised palliative home care in Bonn - which factors lead to informal patient settings previous to death
Martina Kern, Elke Osthage, Heike Wessel, Eberhard Klakslch
University of Bonn, Department for Palliative Medicine, Bonn, Germany

Introduction: Specialised palliative home care services are not always available. It is well acknowledged that this is not achieved in all patients. This study analyses, which factors lead to referral to informal patient settings previous to death.

Methods: Data of every patient of the SPHCS at the University Clinic Munich Eppendorf documented in a computerised data base. For this study, the period from 1/2002 to 6/2006 was analysed. Patients who died in IS were compared to patients who died at home (DH) for testing differences (t-test) in symptom prevalence and availability of informal carers. Results: Data sets of 567 patients were included, of these 362 (64%) died at home and 205 (36%) did not die at home. High symptom prevalence was detected in IS patients for dyspnoea (27%, DH 19%; p=028) and nausea (13%, DH 7%; p=019). No differences were found for e.g. pain. Relatively as informal carers were less common in IS patients (62%, DH 86%, p<001).

Conclusion: This study has shown that certain factors have a significant influence on the place of death. Social preconditions like lack of family structures cannot be changed, and better qualification, coordination and better organisation, may increase the number of terminally ill patients in SPHCS in this area that can stay at home for dying. This can be a focus for further research.

442. Project for Safe Discharge and Home Care Service in Palliative Care by the Specialized Palliative Homecare Service (SPHCS) in the ONCOLOGICAL PROVINCIAL INTERCOMPANY DEPARTMENT of Lombardia (Italy)
Paola Castagnini1, Raffaella Speranza2, Gianstefano Gardi2
1 Azienda Ospedaliera Monza, Palliative care unit, Monza (Milano) Italy, Italy
2 Azienda Ospedaliera Monza, Palliative care unit, Monza (Milano) Italy, Italy

Project Purpose: Most of the home care oncological patients don’t need a hospital bed to receive any palliative care. It is therefore necessary to plan, set up and manage a service care program with the primary objective to enter into a national health insurance network with a territorial integration. The network will provide the following: The hospital as provider of a better discharge process The Local Health Unit as guarantee of different territorial social and health levels The Municipal Social Services Voluntary Service The project is for adult and paediatric patients with oncological and oncohematalogical diseases. The aim of the project is to promote a better relative integration between the hospital and the regions of the involved patients by a safe discharge process from the hospital and/or day-hospital or outpatient healthcare insurance. Method: The continuity model of health care consists of a computerized case report form. All the involved professionals in the assistence can communicate together easily and can be constantly updated. A specific training of all the involved professionals a pilot study for three years with a final inspection of the working system. Results: The Lombardia Region has approved and sponsored the project. Data processing systems have been implemented and training being performed. The communicative efficiency of the training will be evaluated after one year and also the case reporting will begin at that time.

443. Developing an early intervention supportive and palliative approach for adults with intellectual disabilities
Sally Stannard1, Linda McEnhill2
1 St. Christopher’s Hospice, Community and Hospice Nursing, London, United Kingdom
2 ST CHRISTOPHER HOSPICE, Education, London, United Kingdom

Despite policy/legislation the healthcare needs of British intellectually disabled people are poorly met and will detail work undertaken within a London hospice to develop accessible and appropriate supportive and palliative care. This pilot study has shown a clear need for Spiritual Care, 12 other national education resources and multiple innovations in e-learning and e-health to develop appropriate palliative care for intellectually disabled people. Adherence requires a personal rapport and trust between the IMNs and PCNs. Developing this requires time. Frequent meetings, ongoing training, and a review of the IMNs will view the consultation at times as an intrusion by the PCN and feel that they are providing palliative care for intellectually disabled patients. Explicit recognition by the PCNs of the personal distress that IMN experience when caring for palliative patients enhances the rapport. A focus on supporting the IMNs rather than focusing only on the patient enhances adherence. Improved communication between the IMNs and PCNs in turn reduces the sense of isolation and the sense of inferiority during the consultation process. Conclusions: Our PCN team needs to review its model of consultation, possibly adapting its model of consultation and referring the IMNs on to the PCNs on supporting the primary team. Formal and informal strategies to improve the rapport with IMN will be sought. Awareness by the PCN of the inferiority felt by the IMNs may enhance rapport building.

444. Clinical Audit in a Home Palliative Care Service: Auditing the audit
Maria Duad, Jorge Erschenich, Gustavo De Simone
Hospital B. Udallón & Pallium Latinoamerica, Palliative Care Service, Buenos Aires, Argentina

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