

A Lead Children's Cancer nurse, from a different region, heard about the module and approached me to see if the module could be delivered 'off campus' to meet her local need. ELearning has been used to offer education across regional and international boundaries but the lead nurse was very keen to encourage face to face networking of tertiary centre nurses, shared care hospital nurses and community nurses.

Contracts were negotiated between the Regional education commissioner and my university. I delivered the module at the Tertiary centre and attracted 14 students from the region. Specialist speakers from the Tertiary centre willingly contributed to the timetable as it was on their 'doorstep'.

The evaluation of the module was very positive e.g.

"Already taken knowledge gained from this course back to practice"

"Great to discuss all aspects of treatment and care from tertiary, acute, DGH and community perspectives"

This has been a worthwhile collaboration which has evaluated well and enabled appropriate education to be delivered 'closer to home'. Hopefully it will happen again next year!

### G211 BREAKING BAD NEWS: DIFFICULT UNDERTAKING FOR HEALTHCARE PROFESSIONALS

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**Aims** An evidence-based document<sup>1</sup> and journal article<sup>2</sup> are advocating effective strategies for nurses and doctors to utilise when supporting parents receiving 'bad news' as well as communication with children and young people during this difficult undertaking. Discussion outlines quality resources that will equip healthcare professionals in their practice. Nurses should aim to apply this guidance when undertaking this complex and challenging aspect of care.

**Methods** Delegates will be directed to communication frameworks, which are the product of a rigorous literature search of electronic databases and exhaustive consultation across four countries. Evidence suggests a variation in practice especially in the way in which parents are first given 'bad news' about their child's health. 'Bad news' may relate to a child's diagnosis or prognosis across a whole range of health and social care settings. Having significant or distressing news disclosed in a manner that lacks sensitivity or in an environment which is inappropriate may cause additional stress at what is likely to be a difficult time.

**Results** Developing the knowledge and skills of the pre-entrant student are important. A themed lecture with role-play outlining frameworks and communication of 'bad news' have their place in education. Ongoing evaluation within a University suggests that second year student nurses from within four fields of nursing have evaluated a timetabled teaching session very positively, commenting:

'that was one of those lectures that reminds you that you're in a privileged position as a nurse'

Also important to expose emerging healthcare professionals to inter-professional education and clinical areas where 'bad news' is given.

**Conclusions** Guidance assists nurses, midwives and health visitors to reflect upon their own experiences and to consider how their skills can improve<sup>1</sup>. This document has additional

guidelines on Child and Adolescent Mental Health services (CAMHS) and Emergency Care, as it was recognised that there were some very specific issues to address in these settings. The need for further research is highlighted and the requirement for supportive education and training opportunities to enhance both nurse's and doctor's skills in this important, challenging area of everyday practice.

### REFERENCES

- 1 RCN. Breaking bad news: supporting parents when they are told of their child's diagnosis. *RCN guidance for nurses, midwives and health visitors*. London; 2013
- 2 Crawford D, Corkin D, Coad J, Hollis R. Educating children's nurses for communicating bad news. *Nursing Children Young People* 2013;**25**(8):28–33

### G212(P) THE EXPERIENCES OF NURSES CARING FOR CHILDREN ON PAEDIATRIC INTENSIVE CARE (PIC) WHO TRANSITION FROM CURATIVE TO END OF LIFE CARE: A LITERATURE REVIEW

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**Background** The experiences of nurses caring for children in Paediatric Intensive Care (PIC) who transition from curative care to palliation and end of life care have the potential to be extremely varied and pose opportunities to be both a privilege and a challenge. A review of the literature was conducted to discover what may already be known about the experiences of nurses caring for children during this time of transition.

**Method** Medline, CINAHL, PsycINFO, Web of Science and ASSIA were searched. The databases were chosen to incorporate a variety of publications with differing disciplinary focus. MeSH and key search terms used included:

- Terminal care/Palliative care/end of life care
- Intensive care
- Paediatric/paediatric

Broad terms were used to capture as many articles as possible and were then checked visually for relevance.

**Results** 488 articles were identified, only 8 are included in the review. Reasons for exclusion included duplication focus on communication, education, interventions/change in practice, ethics or law.

Settings of the studies were adult intensive care and acute care, and paediatric oncology and acute care. From the 8 articles, the following themes arose:

- Making a diagnosis of dying and recognising the point of transition – knowing when the time is 'right' for a patient to transition to palliative or end of life care.
- Timing of transition and reaching a consensus
- Families – reaching a consensus, holding on to false hope
- Professional issues – emotional burden and crossing boundaries.

These all contribute to nurses experiencing frustration and increased levels of stress.

There are clear commonalities in these studies; however none specifically explore the experience of PIC nurses in the UK when caring for children transitioning to palliative or end of life care.

**Conclusion** There is a clear gap in the research in this area. There is a qualitative study in a regional PICU being undertaken which will begin to address this.

### G213(P) END-OF-LIFE CARE DECISIONS: DIFFERING DECISION MAKING PROCESSES

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**Aim** Parents of children with life-limiting illnesses (LLI) are often required to make decisions regarding what type of life-sustaining treatment, if any, is to be provided and where care is to be delivered at the end of their child's life. This study aimed to explore the experiences of parents in making and revising end-of-life care decisions for their child with a LLI.

**Methods** Semi-structured interviews were conducted with three bereaved parents of children with LLI between April and July 2014. Data were analysed using Interpretative Phenomenological Analysis. Eligible families were invited to participate by the child's main consultant. Approval for the study was granted from the National Research Ethics Service and written informed consent was obtained prior to the interview.

**Results** Two parents in the study had received their child's diagnosis at least a year prior to their child's death, whereas the other parent had only received the diagnosis in the final weeks of the child's life. This parent, prior to receiving the diagnosis, had made decisions to treat her child aggressively on the presumption that the illness was curable. Upon receiving the diagnosis, she decided in conjunction with professionals to transition towards palliative care and ensuring comfort for her child. The other parents had been aware of their child's diagnoses for longer and deemed from the start that aggressive treatment would not be appropriate or in their child's best interests.

**Conclusion** The majority of the literature on the topic of decision making in children's palliative care includes children with both life-limiting and life-threatening illnesses (LTI). Although there may be some overlap in the decision making processes, this study although limited by its sample, has shown that decisions may differ for children with LLI as compared to children with LTI, suggesting that perhaps these populations should be researched separately. More research is needed in order to determine the differences in the decision making processes and whether specific support with decision making is needed between the two groups.

### G214(P) BLENDED FOOD FOR ENTERAL FEEDING VIA A GASTROSTOMY

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A blended diet for enteral nutrition is defined as home-made everyday food blended to a smooth "single cream" consistency. Currently blended food is not recommended by the British Dietetic Association as a first choice supporting guidance on enteral feeding from N. I. C. E. However in a UK children's hospice the policy is where possible to replicate the care received at home, respecting parents' wishes. Therefore guidelines needed to be created for its use in the hospice. Benefits in physical and emotional health needed to be balanced against risks in tube blockage, contamination and digestive upsets.

**Aim** was to gather information and risk assess the processes in order to formulate guidelines on the use of blended food for staff and parents.

The process involved searches for information on the internet and liaising with specialist groups of dieticians and tube manufacturers. For the process of syringing/plunging where there is very little information available a visual demonstration was developed using a plastic box and a gastrostomy button. For issues relating to contamination and food hygiene we used existing guidance on food preparation.

Guidelines were developed and presented to our clinical governance group for consideration and acceptance for use.

Working with local dieticians a package of information including all the considerations and risks were developed to give to parents.

Blended food is not recommended as a primary choice for enteral feed and may not be supported by all those involved in a child's care such as schools or respite unit. Blended diet is used by 10% of the tube fed children using our service. With careful consideration we have been able to develop practical guidelines that support and replicate care given at home whilst respecting the choices made by all our families on how their children are fed.

For the future one UK university has started research to look at the health, social benefits and implications of blended diet. In North America where there are prescription costs and strict insurance schemes many opt for blended food, for others this is simply their preferred method. Here a company has developed a shelf safe product for gastrostomy feeding from "real food" available on Amazon.com

### G215 SETTING AND MAINTAINING PROFESSIONAL BOUNDARIES IN PAEDITRIC CLINICAL PERSPECTIVES FROM AN INTERPROFESSIONAL PERSPECTIVE

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**Aim** This study explored the manner in which paediatric nurses and hospital play specialists set professional boundaries and the challenges they faced in maintaining a therapeutic relationship when caring for children and their families in hospital.

**Methods** A phenomenological approach was adopted, through a purposive sample of seven paediatric settings within one NHS Trust. Eight paediatric nurses and two hospital play specialists were interviewed. Thematic analysis, using field notes and transcribed tape recorded interviews, was used to identify emerging themes and generate a description of the respondents' experience.

**Results** The study revealed that paediatric nurses had difficulty in defining the concept of professional boundaries, therapeutic relationships and self disclosure. Although no clear definition was given for professional boundaries, respondents agreed that they were important. Paediatric nurses could recognise when boundaries were being broken but lacked the confidence to address boundary violations. Using self disclosure was seen as a balancing act which could lead to boundary crossing and boundary violation. Nurses felt unsupported by senior colleagues particularly when faced with "manipulative families" and found their code of conduct<sup>1</sup> helped guide their practice. Hospital play specialists had a greater understanding of therapeutic relationships than paediatric nurses.

**Conclusions** Health care professionals can recognise professional boundaries and boundary violations but they need support to