

push for deaths at home, it concentrates on out-of-hospital cardiac arrests (OHCA).

Methods: A literature review considered OHCA survival rates in terminally and chronically ill patients, with a special focus on high burden clinical conditions. The potential effects of patient age and functional status were also considered.

Results: Although there is relatively little published evidence, older, sicker and frailer patients have very low survival levels after CPR. OHCA survival is especially low for patients with advanced cancer, or advanced liver disease, or with dementia. Contradictory results for patients with multiple co-morbidities, or with other specific conditions, are partly explained by methodological issues. Importantly, the low CPR survival rates in the terminally and chronically ill are artificially inflated: resuscitation preferences change as clinical status worsens, and more of the sicker patients choose to avoid CPR.

Conclusions: Although the methodological issues make individual estimates impossible, patients and doctors need to know about the low survival rates following OHCA in patients with terminal and chronic illnesses. Discussions about resuscitation preferences may need to be revisited as patients get sicker, frailer and older. The forthcoming UK national approach considering decisions about CPR within overall goals of care and focusing on what treatments will be given rather than specifically on withholding CPR, may help here.

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Changes in Place of Death of Patients who Die of Pelvic Cancers in England, a Population Based Study

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Background: Research says more than 70% of people would like to die at their residence. 28% of all deaths have an underlying cause of cancer (England, 2004 to 2013). Of all the cancer deaths, 18.6% of death is due to pelvic cancer. Pelvic (gynaecological, urological and colorectal) cancer accounts for 5% (n= 23,993) of all deaths in England. Patients who die of pelvic cancer have similar complications which may lead to multiple hospital admissions.

Aim: To find out what percentage of patients with pelvic cancer die in their preferred place of death and the changes made after implementation of end of life care strategy in 2008.

Method: A population based study using data extracted from Office of National Statistics (ONS) mortality database. The study is restricted to residents of England with

death registered from January 2004 to December 2013. Since the data is obtained in an anonymised format no individual patients can be traced back, hence ethical approval was not required. Two sided t test is used to determine difference in proportions.

Data definition: ONS data is coded using ICD version 10.

Result: The proportion of deaths from pelvic cancers (underlying) that occur in hospital has declined from 46% (2004) to 34% (2013); deaths occurring at home/care home have increased from 33% to 46%. Three quarters of studied deaths were more than 70 years of age. 71% of people who are resident of a care home died in a care home. Among those who lived at home about 26% died at home.

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Defining Comfort: A Concept Analysis Research

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Background: Comfort is an important phenomenon to patients, relatives and healthcare practitioners. There is a need to clarify, to provide completeness and adequacy to the concept in order to provide indicators as an important outcome in quality of care and patients' well-being. Despite all the knowledge and research about comfort and comforting, it is still a very complex area, difficult to define, implement and evaluate, particularly in palliative care.

Aim: To provide a conceptually adequate definition of comfort.

Methods: Rodger's (2000) method of evolutionary concept analysis was used. A search with the terms comfort* and concept, was conducted in electronic databases PubMed, EBSCO (all databases), SciELO, Bireme, PsycINFO, Cochrane Database of Systematic Reviews and JBI Library of Systematic Reviews. Portuguese, Spanish, French and English papers, published in peer-reviewed journals until December 31st 2014 were included.

Results/discussion: Forty studies were included. Antecedents include inward factors (imbalances, information, practitioner-client relationship, previous experiences) and outward factors (social support, skills/ beliefs of practitioners, institution's model of care, environment). Comfort is a desired state of satisfaction and happiness, expressed as a pleasant experience, as something positive/ good related to feeling strength and safe. It's a holistic experience related to satisfaction of needs and sensitive to individual's

perception and ability of adaptation. Comforting is a process which comprise consequences to both patients and carers (attributes). Quality of life, spirituality, suffering and happiness are related concepts. Pain relief and palliative/ supporting measures are surrogate terms.

Conclusions: The study provides a new proposal of a clear and evidence-based definition. Studies are needed to examine the use of this concept and to continue its refinement and effectiveness.

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Do Not Wash your Dirty Linen in Public? Satisfaction Data and Quality of Volunteering in Hospice and Palliative Care

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Aim: Many aspects of volunteering have been discussed in literature, but not quality. No studies were found that address assessment methods for quality of volunteering in hospice and palliative care. This contribution presents data on satisfaction of hospice clients' family members. Step-wise we reflect on the value of such data to assess quality and share a (conceptual) search of how quality of volunteering in care focused roles in palliative care can be measured better.

Methods/results: Satisfaction data were gathered by VPTZ Nederland (national organisation). The inventory exists of 32 questions on 8 scales: information, communication, autonomy, competence, medical care, emotional and spiritual care, organisation. A pilot with this list resulted in 165 questionnaires, filled in by surviving relatives, found through 13 hospice organisations. Data show extreme satisfaction on psychosocial and spiritual care, privacy and communication. Medical care was scored a little lower.

Reflection: We reflect on the usability of satisfaction data to evaluate quality of volunteering in palliative care. To come to a specific set of instruments and a strategy for monitoring quality of volunteer contributions in hospice and palliative care, we continued with:

- a) literature research, performed to choose a theoretical perspective to grasp the essence of volunteering conceptually,
- b) development of a vision document with a clear operationalisation of quality of volunteering,
- c) feedback meetings in five different geographic areas of the Netherlands with audiences consisting of hospice coordinators and board members,

- d) feedback meetings with stakeholders like e.g. insurance companies, policy agents, patient organisations and professionals and their organisations,
- e) identification of criteria that evaluate volunteering and
- f) choosing instruments that measure and monitor quality in hospice and palliative care volunteering.

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"Palliative Sedation"? Use of Continuous Sedatives within the Last Seven Days of Life on a German Palliative Care Unit

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Background: Although guidelines for palliative sedation (PS) exist, it is still controversial when to call the use of sedatives "PS". The lack of a common definition has been suggested as one of the reasons for the wide range of reported PS prevalence.

Aims: To describe frequency, indications, duration and dose of continuous sedatives (benzodiazepines, levomepromazin, haloperidol, propofol; given continuously or intermittently according to duration of action) and the use of the term "PS" in the last 7 days of life on a palliative care unit (PCU).

Methods: Retrospective analysis of medical records of patients who died on a German PCU between 8/2014 and 7/2015. Descriptive statistics with SPSS 23.

Results: 152/192 patients (79%) received continuous sedatives within the last 7 days of life. Midazolam (n=145/95%) was most frequently used, followed by haloperidol (n=25/16%) and levomepromazin (n=4/3%). For 21 patients (14%), the therapy was called "sedation", for n=2 (1%) the term "PS" was documented.

Most frequent indications for continuous sedatives were agitation (n=51/34%) and anxiety (n=40/26%), median duration of use was 2.3 days (range 0.5 hours-16.2 days). For 85 patients (56%), continuous sedatives were started in the last 72 hours of life. Median midazolam doses increased towards death: The median total dose on the day of death was 14 (range 2-240) mg.

The maximum total daily midazolam doses of the 2 patients whose therapy was called "PS" were 135 and 58 mg. 11 other patients also had maximum total daily midazolam doses over 50 mg, for 3 of those the term "sedation" was documented. Depth of sedation was not consistently documented.