and carer experience of the disease, particularly at times of significant physical change.

C12-B
End-of-Life Care for Stroke

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Stroke is a leading cause of disability and the third leading cause of death in Canada, according to the Heart and Stroke Association. Despite a high mortality rate, the experience of dying from a stroke has received limited attention from a palliative point of view. When attempting to make inferences from other specialties that have well researched methods of palliation, there was an obvious gap when considering the stroke population. Palliative stroke patients, at the Royal University Hospital, rarely have access to a bed on a specialized palliative care unit. It has therefore been a priority of the inter-professional staff of the acute stroke unit (ASU) to adopt a palliative care philosophy that can be effectively delivered.
The quality improvement initiative was led by the unit's palliative care nurse consultant to ensure that a palliative care approach was consistent regardless of the direct care provider initiating the palliative orders. This included developing a physician's order set, nursing care plan and pamphlet for family education. A retrospective chart review was completed to compare medication changes pre and post implementation of the newly formed palliative care tools. In total 32 charts were reviewed, from patients who became palliative between January 2016 and November 2017. The average number of days of palliation was 4.3 day (median was 3.5 days). The opportunity to complete a FamCare assessment was offered to families attending to their loved ones palliative period. The initiation of the palliative care package resulted in consistent and effective physician orders, a reduction in unnecessary nursing interventions and the opportunity for patients to be comfortably transferred to their home hospitals. The experience of implementing a stroke specific palliative care has been a valuable initiative on the acute stroke unit at the royal university hospital both for patients and the care team.

C12-C
Who Consults a New Neuropalliative Care Service?

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The Montreal Neurologic Hospital is a tertiary, university-affiliated institution which opened its doors in 1934 to care for patients with neurologic illness and to advance our understanding of neurologic diseases. It was physically connected to a general hospital, the Royal Victoria, and shared service with its palliative care team until it moved to a new site in 2015. With the general hospital moving and the nascent development of neuropalliative care as a subspecialty, a new model of service delivery was created in 2016.
A dedicated nurse specialist now coordinates supportive care on site. At the end of its inaugural year, spontaneous referrals to our program for inpatients have been analyzed to better understand the perceived needs of neuroscience patients and their families. To date, our experience shows that the majority of referrals are for the care of patients from neuro-oncology and cerebrovascular (stroke) populations. Lesser patterns of referrals were seen for patients with; pain, neuromuscular (amyotrophic lateral sclerosis), neuroinflammatory (multiple sclerosis) and neurodegenerative diseases (Parkinson's Disease and the dementias). Our hospital does not have inpatient services for pediatrics or neurotrauma.

This analysis displays the current pattern of referral for inpatients with neurological illnesses to a new neuro supportive care program. This data can be compared to a literature review regarding the burden of symptoms with various neurologic pathologies. Sources of referral bias will be examined. In this way, we hope to identify and support under-serviced populations and plan to deliver care where most appropriate (in-patient services, out-patient clinics, home-care etc.) in the next phase of our program development.

C13-B
Exploring Awareness of Spirituality in Physicians Working in an Inpatient Specialist Palliative Care Unit

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Objectives: Physicians are expected to be aware of and acknowledge the spiritual dimension of illness and pain as part of their overall assessment and care of patients in palliative care. This study aimed to examine how doctors in an inpatient specialist palliative care unit recognized and recorded the spirituality of patients in their care and then to assess the effectiveness of a teaching intervention in spiritual care.

Methods: A retrospective audit of medical documentation was performed to ascertain how and if doctors recorded spirituality as part of their assessment of patients. An interactive spirituality workshop intervention was provided with 100% attendance by doctors working in the unit. Following the workshop a repeat unannounced audit was conducted on all inpatient