

of clinical behaviours and practice, and identifying palliative patients.

Following initial scoping the IT enabler of choice, My Right-Care (MRC) was identified for the locality and was subsequently grant funded by the NHS England Nursing Technology Fund. Unlike other solutions MRC creates a patient-centric unified care plan, specifically being clinician friendly, with functionalities such as auto-population and flagging in your own system. Created care plans, are then shared (with consent) across all health care IT systems; primary and secondary care, including urgent care; ambulance and NHS 111 services. This coupled with developing a suite of tools to support GPs and provider colleagues to utilise as they choose, has supported, engaged, and empowered them to improve coordination of end of life care in the county and create a social movement on the frontline.

We would like to share the experience of a large rural county in achieving clinical engagement through bottom-up transformational change. With a small budget and little authority, but with innovative technology and a different approach we are implementing EPaCCS in our locality. And there are no project plans!

P-63 IMPLEMENTATION OF A PALLIATIVE CARE ELECTRONIC PATIENT RECORD SHARED WITH GPs, DNS AND THE OUT OF HOURS SERVICE

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Aims of the Project

1. To move to an electronic patient record across all clinical departments accessible to local community services enabling access to real time information about a patient's care and condition shared across the hospice, general practice, district nursing services and out-of-hours service
2. Enable hospice staff to remotely access a patient's up-to-date record enabling advice given and care delivered to be recorded without having to find a set of case notes or returning to base
3. Reduced amount of telephone and fax traffic between primary care and the hospice around clarifying care, medication and other key factors such as known allergies
4. Saving time on administration and record keeping to enable more clinical time.

Over a period of nine months using a change management approach an instance of the electronic patient record (EMIS) was developed for each clinical team, based on a common holistic assessment. At all stages staff engagement and communication was a high priority.

Roll out was staggered over a one month period with GO LIVE starting with the smaller day time services, to iron out any teething problems, using the lessons learnt in the bigger 24-hour services including both an adult and children's in-patient unit. (For patient confidentiality reasons the bereavement service was excluded from the whole process.)

Outcomes

1. Having completed level 2 of the information governance toolkit and compliance with information governance requirements locally all healthcare professionals in the community over 24hours are able to access real time

information about all patients known to the specialist palliative care service

2. The specialist palliative care service can access the records of patients referred to them and those where advice is requested
3. Accuracy of medication histories, compliance and allergy recording has improved
4. The amount of time lost by clinical staff making phone calls has reduced by a third.

P-64 THE CHALLENGES INVOLVED IN EMBEDDING THE PILOT PALLIATIVE CARE DATASET WITHIN AN ELECTRONIC PATIENT RECORD (SYSTEMONE)

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Background Our hospice was accepted as a pilot site for the Pilot Palliative Care Data set by Public Health England (PHE) in July 2015. The hospice was paper-lite using the electronic patient record system-SystemOne (S1).

Aim To embed any future dataset within S1 to ensure that data was captured within standard working practices enhance patient care as well as improve reporting of patient outcomes.

Methods There were three distinct elements to this pilot project:

1. Changing culture and the language used by staff
The pilot dataset included measures of performance status (Karnofsky), complexity (Phase of illness) and patient outcome measures. Champions identified within each staff discipline and education was provided on all measures.
2. Configuration of S1 for data collection
Extensive reconfiguration of S1 was required involving incorporation of the concept of "Spells of care", creation of templates and protocols
3. Creation of reporting tools
The granularity of data for the dataset required a different method of reporting to that used previously. This enabled access to a huge amount of raw data but has required an external data analyst company to produce the required reports

Results Seven months after commencing the pilot:

1. Changing the culture and language is taking time. This requires a stepwise approach but gradually these elements are becoming embedded across all sectors
2. SystemOne has now been configured to include all the data items required.
3. Reports were submitted to PHE but are now being fine-tuned to meet our needs.

Interpretation and conclusions To embed a new dataset within an EPR including all of the above elements takes longer than the six months anticipated. Although the palliative care dataset will not be taken forward, the elements of it are proving to be valuable resources that we feel will improve patient care and enable us to evidence the quality of care provided.

P-65 DEVELOPING DOCUMENTATION FOR END-OF-LIFE CARE

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