

understand whether the OMs captured the impact of SLT interventions.

**Methods** The Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) guidelines were used. 422 items were screened, 308 met the inclusion and exclusion criteria and seven papers were selected for review.

**Results** The papers described 296 patients. (range of 1 – 96 participants per study), aged 19 – 89 years, diagnosed with cancer (83), motor neurone disease (4), other/mixed (208), progressive neurological (1) and not further described (2). The heterogeneity of the study designs did not allow for further analysis. The studies were of poor quality.

Ten outcome measures were used in the studies. Assessment at two time points were described in 14 patients (two studies).

**Conclusion** OMs commonly used in palliative care do not address the main areas of clinical focus of SLTs; dysphagia and communication barriers. OMs used in SLT practice are rarely validated in palliative populations. Challenges are compounded by the reality of practice in the UK where SLTs offer consultation for palliative care patients but are infrequently employed within palliative care teams. Contact with patients may be a single assessment and advice session, reducing the opportunity to use OMs and demonstrate the efficacy of SLT colleagues. Evidence of change in response to SLT intervention is not yet demonstrated in the literature. Use of validated OMs by SLTs in palliative care appears to lag behind use of OMs in other areas of SLT work, and behind use of OMs by other professionals in palliative care. Development and use of validated OMs should consider flexibility as patient function changes and the need for both patient and proxy completion.

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### 'I ALWAYS ASSESS MY PATIENTS HOLISTICALLY I DON'T NEED A SCORING SYSTEM TO TELL ME HOW ILL THEY ARE'

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**Background** Measuring patient outcomes is necessary to assess the impact of care and identify areas for improvement (Etkind, Daveson, Kwok, et al., 2015; Marshall, Haywood, Fitzpatrick, 2006). It is therefore vital that staff are confident and comfortable using outcome measures. Hospice adopted three of the Outcome Assessment and Complexity Collaborative (OACC) (Witt, Murtagh, de Wolf-Linder, et al.) measures in July 2019: the Phase of Illness, Australia-modified Karnofsky Performance Status (AKPS) and Integrated Palliative care Outcome Scale (IPOS). In July 2020, Hospice investigated clinicians' perceptions of the measures.

**Aim** To understand clinicians use and views of the OACC measures, any problems and suggestions for improvement.

**Methods** A survey was distributed to clinicians (n=42). Descriptive statistics were calculated using the statistical packages R and RStudio (Version 4.1.0 for Windows). Qualitative data were analysed using a thematic analysis framework (Braun & Clarke, 2006).

**Results** Twenty-nine clinicians (response rate 69%) had used one of the three measures at least once. Twenty-five (93%), 22 (85%) and 24 (92%) stated that they use IPOS, AKPS and Phase of Illness some or all of the time, respectively.

Moreover, 24 (83%), 23 (79%) and 21 (72%) clinicians felt confident appropriately using IPOS, AKPS and Phase of Illness, respectively.

Respondents identified the measures as a helpful resource for person-centred assessment and monitoring. They can help open up dialogue and increase rapport between patient and clinician, and provide a 'common language' between clinicians. However, they felt the measures added little to a clinical assessment, particularly for Allied Health Professionals (AHPs), and an apparent focus on physical health limited holistic assessment.

Respondents recommended increased application of OACC measures at handover. For AHPs, other outcome measures might be considered. Some wanted feedback on outcomes and more training on use of the measures.

**Conclusions** In a palliative care setting, benefits were witnessed mainly in patient assessment but less in the application of outcomes. Further staff training and application of outcomes may be beneficial.

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### LEARNING FROM DEATHS IN HOSPICE CARE

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**Background** The NHS National Quality Board published its first edition of 'National Guidance on Learning from Deaths' in March 2017. Although a charitable hospice care provider, Phyllis Tuckwell Hospice Care (PTHC) followed NHS, Care Quality Commission (2016, 2018) and Royal College of Physicians (2016) guidance and established a pilot process for learning from deaths in 2018.

**Aims** This report outlines the approach taken to establish a new process and culture of learning from deaths in a UK hospice and shares our experience as a model of good practice.

**Methods** Terms of Reference (TOR) were established to guide the structure and the culture of the learning from deaths process. The TOR linked learning from deaths with PTHC's core values including keeping patient care at the heart of our practice, acting with honesty and integrity and fostering a culture of continuous learning.

**Results** The first Learning from Deaths review occurred in December 2018 following the death of a patient during transfer to hospital for acute treatment. An outcome of this meeting was to review the care of three further patients who were transferred to the acute sector. Learning translated directly into a change in clinical practice in August 2019 through the roll-out of the National Early Warning Score 2 (Royal College of Physicians, 2017; Frinton, Malia, Owen, et al., 2019) on the inpatient unit. The learning from deaths approach is now integrated into PTHC's clinical governance system and 19 cases have been reviewed between April 2019 and March 2021.

**Conclusions** Conducting formal reviews into the deaths of patients under hospice care offers an important opportunity for reflection and learning to improve services for future patients. Senior support and a constructive, positive culture are essential facilitators in establishing staff engagement with the process. A literature review did not identify any reports of existing models for learning from deaths in hospice care. This innovative approach is transferrable to other charitable units.