

documentation made by the case note reviewer was cross-checked by another reviewer to reduce bias as far as possible. All abbreviations were noted and used to develop an agreed specialist palliative care glossary that can be used by clinical staff in the organisation when documenting.

Results While full audit results are yet to be analysed, initial results suggest that abbreviations are commonplace and not universally understood by our workforce. Subjectivity is more likely to arise when documenting under pressure outside of direct clinical consultation, such as during multidisciplinary meetings.

Conclusions SARs are becoming more frequent in our organisation. Staff should be mindful that all documentation may be read by patients or family members. As digital abbreviations become more common in society, clinical teams need to agree upon accepted terms to ensure all language used is accessible to healthcare professional and the public alike.

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IN-PATIENT PRESCRIBING AT A HOSPICE: TRANSFERRING FROM PAPER COPY TO ELECTRONIC PRESCRIBING

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Introduction Drug prescribing is a potentially high-risk activity in palliative care as patients are commonly prescribed medication, including controlled drugs, for symptom management. Since the inception of our local hospice organisation, the in-patient unit has prescribed and administered medication using paper drug charts. All medication errors and near misses are reviewed through our clinical governance structure.

Aims Our clinical strategy identified a Quality Improvement Project (QIP) to investigate improving the quality of medicine documentation in the in-patient unit, improving patient safety.

Methods Research into solutions led to the setup of electronic prescribing medicines administration (ePMA) software within our existing electronic (SystemOne) electronic notes record. To support with implementation and best practice sharing, we connected with other UK hospices. The creation of a local formulary, system configuration, testing, guidance creation and contingency plans all formed part of the project prior to training all users and transitioning in April 2022.

Analysis and Results We anticipate initial increase in recording errors while the system embeds, before incidents reduce. We continue to seek feedback from users informally; remaining flexible, amending system settings to support effective and safe patient care. Pre-ePMA our prescribing and administration errors were 14 over 6 months. It is now reduced to 7 over 6 months. We will formally review our processes and errors after one month.

Conclusion This transition has been challenging, as is any process of change, particularly when including technology in the healthcare setting. We recognised the importance of allowing time for planning, testing and establishing clarity of processes prior to changing. Collaboration between the project leads and the medical and nursing teams was also important to ensure safe, high quality medication recording whilst remaining flexible, meeting our patients' complex needs. Despite staffing challenges, the change has been well received

and successful due to staff's determination to support the initiative and a positive attitude to change.

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INTEGRATION OF THE VIRTUAL CONSULTANT MODEL IN A HOSPICE SETTING

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Background The recruitment of senior doctors in palliative medicine remains challenging, particularly in remote and rural areas (Dixon, King, Matosevic, et al., 2015). A sustainable model that would facilitate expert support and guidance was sourced through the platform of telehealth. Telehealth refers to methods in which healthcare professionals communicate clinical information remotely via several different mediums (Hanlon, Daines, Campbell, et al., 2017. *J Med Internet Res.* 19: e172).

Aims The integration of a virtual consultant service into our hospice multidisciplinary team to provide senior medical support remotely, allowing our hospice in-patient beds to remain open.

Methods Using quality improvement principles, careful consideration of clinical governance and consultation at senior management level, the model was trialled with twice weekly multidisciplinary meetings using videoconferencing software and out of hours telephone support.

Results The model took time to embed with understandable apprehension from the team. Challenges were encountered with our technology and room acoustics. We found the new team moved through the normal stages of forming group dynamics (Tuckman, 1965. *Psychol Bull.* 65: 384) but perhaps more slowly than would be the case without the virtual aspect. Having the same Consultants each week for our meetings, and having a good baseline level of experience within the on-site medical team of Specialty Doctors and Advanced Nurse Practitioners were essential to the progress made. The addition of a routine 'trouble shooting' call from one of our Consultants on a Friday enhanced support going into the weekend. Over the last two years clinical confidence in the model has grown considerably and beds remain open for the local community.

Conclusion Telehealth is a growing solution to the challenges of modern healthcare (Asprey, Blinderman, Berlin, et al., 2021 *J Palliat Med.* 24: 1387). Advances have been driven forward by the current COVID-19 pandemic (Ahmed, Sanghvi & Yeo, 2020. *BMJ Innov.* 6: 253). Organisations' infrastructure needs to adapt to provide a progressive approach to the delivery of specialist palliative care (Dahlin, Coyne & Goldberg, 2019. *J Palliat Care.* 34: 21). More research is needed to support development of evidence-based practice in this area.

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A HOSPICE VIRTUAL WARD – PROVIDING COMPLEX PALLIATIVE CARE IN THE COMMUNITY

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Community palliative care has evolved in intensity and complexity, with more desire from patients and families to remain at home. We wanted to determine whether a virtual ward

model would be beneficial to our patients, and therefore set up a 6 month pilot. The aim was to provide a responsive, enhanced multidisciplinary specialist palliative care service to manage complex and acute needs in the community, for patients felt to be at high risk of in-patient admission.

The model was based around a daily multidisciplinary team meeting consisting of palliative medicine doctors, nurses, allied health professionals and family support workers. A plan of care was made in the meeting and the patient assessed at home by the most appropriate member(s) of the team.

In the virtual ward pilot we had 36 patient admissions. At the initial review 26 of the patients were in the unstable phase of illness and 6 were deteriorating, highlighting that the virtual ward helped patients with complex acute needs. Preferred place of care was maintained in 31 patients (86%) and preferred place of death was maintained in 12 out of 14 patients who died (86%). Hospital or in-patient hospice stay was likely avoided in 14 patients. Supported therapies included bisphosphonate infusions, ascitic paracentesis, and non-invasive ventilation titration and withdrawal.

The virtual ward has enabled patients to have complex symptom management, therapy reviews and psychosocial support in the place of their choice, helping to support their preferred place of care and death as well as avoiding unnecessary admissions.

NHS England & Improvement has asked all Integrated Care Systems to extend or introduce virtual ward models (NHS E&I. Supporting information for ICS leads. Enablers for Success: virtual wards including hospital at home. April 2022. [Internet]). Our pilot has shown that virtual ward models can be used effectively and help manage the increasing demand on palliative care services.

P-66 THE DEVELOPMENT OF A PALLIATIVE VIRTUAL WARD

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Background The Warrington Integrated Palliative Care Hub (WIPCH) launched in March 2020 as a test concept and became an integral part of service delivery. Service review indicated the next phase would be development of a Palliative Virtual Ward (PVW) offering additional support to complex and other palliative patients and preventing hospital admission. Following review of experience and learning, a bid was submitted to develop a 10-bedded Palliative Virtual Ward offering additional support through a 14-day plan of care.

Aims By mobilising this model, multiple levels of monitoring are deployed dependent on patient need, with a variety of access points and escalation managed via a single digital platform. This proposal achieves against NHSE/I service priorities and is consistent with the national hospice @home model at level 4 and Cheshire & Merseyside's strategic intent.

Methods Evaluation will combine quantitative and qualitative data aligned to the Better Care impacts to improve experience, resource utilisation and outcomes. The data will include: patient experience, demographics and processes.

Results WIPCH launched the Palliative Virtual Ward on 25 April 2022. The pilot operating model clearly defines criteria for admission, discharge and plans of care to support patient flow. The development of the Palliative Virtual Ward will provide opportunity to deliver on five of the six 'Ambitions of

Palliative Care and End of Life Care, 2021-2026' and will be integral part of the strategy for Warrington 2022-2026.

Conclusion The 12 month pilot will provide the blueprint for development of a standardised operating model for further virtual wards across Warrington. This prototype model will inform the development of virtual wards in line with the national ambition for Integrated Care Systems to work towards the comprehensive development of 40 to 50 virtual ward 'beds' per 100,000 population by year end 2023.

P-67 ABSTRACT WITHDRAWN

P-68 VIEWS AND EXPERIENCES OF PALLIATIVE CARE HEALTHCARE PROFESSIONALS OF SUPPORTING PATIENTS TO MANAGE DIGITAL LEGACY AS PART OF ADVANCE CARE PLANNING

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Background The need for palliative care is increasing (World Health Organization, 2020) and it is essential to look at how emerging technologies can improve care for palliative patients and their carers in the future (Nwosu, Collins & Mason, 2018. *Palliat Med.* 32:164). With an increasing use of personal technology, many people are spending time creating their own online content (Office for National Statistics, 2020). This online content is often described as a digital legacy; the digital information that is available about someone following their death (Digital Legacy Association, 2021). There is limited evidence around the understanding of digital legacy amongst palliative care healthcare professionals and the benefits of supporting patients in managing their digital legacy.

Aim(s) To explore palliative care healthcare professionals understanding of digital legacy and how it could be included as part of advance care planning discussions.

Methods A qualitative single site study involving in depth interviews with ten palliative care healthcare professionals. Data analysis employed a constructivist grounded theory approach (Charmaz, 2006).

Results Data analysis is ongoing. Initial analysis shows a lack of understanding amongst palliative care healthcare professionals around digital legacy. Our results highlight the growing importance of digital legacy in various areas of palliative care. Participants described digital assets as important as physical belongings. The data highlights a concern around access to digital belongings following death, and the impact this could have on grief and bereavement.

Conclusions Exploration and understanding of views and experiences of healthcare professionals has relevance for policy and practice. A lack of understanding around digital legacy can create barriers to including digital legacy as part of advance care planning discussions and should be addressed through education and raising awareness around this developing topic. Results of this study will help us understand ways to create digital memories, to consider how to store them safely and