recorded for 143 (71.5%) patients, religion for 82 (41%), and nationality for 136 (68.0%). Where it was documented, 88.1% were white and 98.5% were British. Discussions were only documented in 34 (17.0%) cases. If specialist palliative care input was sought, cultural preferences were more likely to be discussed (p<0.001). When discussions were documented, patients were more likely to be referred to chaplaincy (p<0.001).

Conclusion/Discussion In this service evaluation, cultural preferences at the end-of-life were often not documented and possibly not being discussed with patients and families. Education is needed on the importance of assessing and addressing these needs.

Poster Nos 90–144: Service Development

90 EYE DONATION IN THE HOSPICE SETTING: PERSONAL AND SYSTEM-BASED BARRIERS TO DISCUSSING THIS END OF LIFE OPTION WITH PATIENTS AND FAMILY MEMBERS: AN EXPLORATORY QUALITATIVE STUDY

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Background In the UK there is a national shortage of corneas available for transplantation. Up to 50% of patients within a palliative care setting may be eligible to donate corneas, yet donation rates from this environment are low. Studies have indicated that healthcare professionals are reluctant to initiate conversations. Doctors views on donation are poorly represented in the literature.

Aim To identify and explore barriers to clinicians initiating conversations about the option of eye donation as part of end of life care planning in a hospice setting.

Methods An exploratory qualitative design was adopted using focus groups. The study was based from palliative care services in the South of England and was conducted between 15th and 22nd February 2017. Participants included 14 doctors holding registrar, specialty doctor or consultant posts.

Qualitative content analysis was the data analysis method chosen.

Results Despite holding positive views towards corneal donation, doctors are unlikely to initial conversations. Barriers identified included 1) lack of knowledge around eye donation, principally involving eligibility 2) attitudes, influenced by personal beliefs but also clinical experiences and the perception of patient and public views on donation in a hospice setting 3) professional concerns about workload and the prioritisation of significant conversations, and 4) a lack of confidence in the process of eye donation which directly impacted on an individual initiating a discussion. Findings indicate that level of clinical experience does not influence the likelihood of initiating conversations, but individual experiences do shape attitudes. The hospice was viewed as a unique entity with specific challenges to implementing corneal donation services.

Conclusions Despite positive views toward eye donation, many barriers contribute to a lack of confidence in the system and low donation rates. Improvements could be made by education and support for staff members and appointing a designated lead staff member.
healthcare funding, the Fast Track pathway, to facilitate discharge. This audit has led to a sticker which is added to the notes when Fast Track is invoked, as a reminder of the important aspects of discharge summaries for these patients. It has also led us to deliver education to foundation doctors about discharging patients at the end of their lives. Here, we present a re-audit evaluating the impact of these interventions.

**Method** The content of 181 discharge summaries written about patients receiving Fast Track funding produced at Royal Derby Hospital between 31/05/21 and 03/09/21 were reviewed against set criteria. Findings were compared to previous audits to identify trends and areas for improvement.

**Results** This re-audit had positive and negative findings. We found an increase in documented instructions to GP (62% from 46%), and in anticipatory medications prescribed on discharge (94% from 80%). However, we also found ongoing poor documentation of preferred place of care/death (36% from 38%) and fewer discharge summaries detailing a clear follow-up plan (47% from 61%). This may account for the increase in readmissions in this patient group (9% from 16%).

**Conclusion** The quality of discharge summaries written about patients who are approaching the end of their life remains variable. Disruptions to service provision and education due to COVID have led to a lack of guidance provided for writing discharge summaries. We recommend reinstating early teaching for junior doctors on this important topic. Re-audit following this is advised.

**REFERENCES**


93 Innovating Thinking - Collaborative Working: A Novel Approach to Prioritising Inpatient Referrals by Changing Communication Methods

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**Background** Hospice referrals for inpatient unit (IPU) admissions are discussed daily by the hospice medical and nursing teams, with decisions to admit based on the referral information and multidisciplinary team decision-making. The referring teams were previously not directly involved in these decisions. Our recent development was the introduction of virtual meetings, aiming to involve the referring teams and up-to-date information about the referred patients.

**Aims** To evaluate if the new model of meetings integrating the community and hospital SPC teams would change perception of fairness and equitable use of beds in our hospice IPU.

**Methods** A short evaluation questionnaire was sent to the participating teams with a combination of open/closed questions and opportunity for comments.

**Results** The respondents said the service has improved the admission process, the patients are discussed in enough detail to enable prioritisation, decisions about admissions are fair and consistent, the meetings are extremely beneficial, the view of each team is always respected and all teams work well together to ensure the most appropriate patient is admitted.

**Conclusion** This new model of collaborative working has proven beneficial for prioritisation of hospice referrals in real time and has also contributed to an improvement in communication and team work.

94 Implementing Respect During the Pandemic – Our Experience and Lessons Learnt

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10.1136/spcare-2023-PCC.114

**Introduction** ReSPECT was implemented in The Royal Wolverhampton NHS Trust and across the wider Wolverhampton health economy on 1st September 2021. This was the culmination of a year’s planning and preparations during the first and second waves of the COVID pandemic.

**Methods** A ReSPECT implementation group was established across the organisation in September 2020 which focused on areas including writing a revised resuscitation policy, agreement for and design of one-off mandatory modules for awareness and authorship training and development of a trust wide communications campaign. Amendments to the policy have allowed expansion of authorship to selected groups of non-medical staff including senior specialist nurses and ACPs with appropriate expertise.

The group liaised with partners to ensure a successful city-wide launch including primary care and hospice colleagues. An organisation wide roll out was supported by ward ‘ResPECT Champions’ in each area.

**Results and Lessons Since Launch** Mandatory training modules for ReSPECT authorship and awareness training were developed for approximately 7000 clinically facing staff with a target of 75% training compliance prior to launch. Training compliance was monitored weekly in preparation for launch and then subsequently, monitored monthly once target compliance was achieved. Over the last year ReSPECT has become embedded within the organisation and across the city. This has included a change in culture from the previously used DNACPR forms. Developments following launch include an addition to e-discharge document to include whether a ReSPECT form is in place and from this a monthly quantitative audit has begun across inpatient areas. Collaborative working has continued across the city to enable clear