

communication regarding ReSPECT and shared resources e.g., Top tips newsletters. Future ongoing work focusses on improving the quality of ReSPECT forms and education surrounding the ongoing review of ReSPECT forms during acute admissions and at significant milestones in a patient's condition.

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#### UNDERSTANDING THE BENEFITS AND LIMITATIONS OF A BLENDED APPROACH (MIXING VIRTUAL AND FACE-TO-FACE CONSULTATIONS) TO MEDICAL OUTPATIENT PALLIATIVE CARE SERVICES: A MIXED-METHODS STUDY

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**Background** The Covid-19 pandemic led to a rapid increase in the use of virtual technologies (telephone; video) across healthcare. For palliative care patients, further evidence is required to inform integration of virtual technologies with traditional face-to-face consultations.

**Aim** To understand the benefits and limitations of a blended approach (mixing virtual and face-to-face consultations) to medical outpatient palliative care consultations.

**Methods** A mixed-methods study with a concurrent triangulation design was conducted. Phase 1 comprised an anonymous online survey of palliative medicine physicians in the UK. Survey questions were derived following a review of the literature and explored physicians' experiences and opinions of different consultation modalities. Phase 2 comprised qualitative semi-structured interviews with palliative medicine patients exploring their perspectives of virtual and face-to-face outpatient clinics. Patients were recruited from palliative medicine outpatient clinics and interviewed via Microsoft Teams. Results from both phases were integrated and recommendations for clinical practice developed.

**Results** The online survey received 48 responses from professionals, and eight semi-structured patient interviews were conducted. Patients and physicians felt face-to-face consultations were necessary for clinical assessments and improved communication and relationship building. The main challenge was the physical burden from travel. Telephone consultations were useful for simple and finite problems such as medication reviews, but the physical separation introduced communication barriers and prevented clinical assessment. Video technologies supported physically-limited patients to access clinics and allowed for some clinical assessment to occur. The most appropriate modality for breaking bad news and/or providing psychosocial support was felt to be patient and situation dependent.

**Conclusion** The use of a blended approach to palliative medicine outpatient clinics is acceptable to patients and physicians and has the potential to capitalise on the benefits of each modality to deliver an effective and efficient service.

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#### INTRODUCING WARD-BASED ACCESS TO SUBCUTANEOUS SYRINGE DRIVERS AT A TERTIARY CANCER HOSPITAL

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**Aims** To introduce a ward-based system for accessing and managing syringe drivers and to develop a tracking system to prevent syringe driver misplacement, improve timely availability and staff wellbeing through self-measured stress levels.

**Introduction:** Between September 2021-August 2022 ten clinical incidents were identified relating to syringe driver access across the trust, and inaccessibility had been cited as a significant source of stress for staff. This represents a large financial risk with the cumulative cost of syringe drivers in the trust reaching almost £100,000.

**Method** A pilot ward was given ownership of four syringe drivers to be kept on their ward. Ward staff kept a daily checklist of the location of the pumps and this was reviewed weekly, whilst also surveying how difficult access had been both in and out of hours and number of clinical incidents. Staff were also asked to self-report stress levels that they experienced while accessing syringe drivers. The outcomes each week were used to develop protocols for different scenarios, for example relocation of patients to hospices, or faulty pumps.

**Results** Compared to baseline figures after the first cycle there was a self-reported 66% reduction in both stress and difficulty levels accessing pumps for staff in-hours. Similarly, when reviewing out-of-hours data there was a 75% reduction. Comprehensive roll-out of the tracking system on the ward ensured that 100% of syringe driver locations were tracked through cycles 2-5 with no losses reported. Notably, after cycle 5 there was a significant increase in stress levels related to pumps being lent out to other wards not involved in the pilot, and the financial risk of this.

**Conclusion** A ward-based tracking system for syringe pumps can improve access, reduce stress and protect from financial loss. However, further adoption across the trust is awaited to ensure consistency and optimise ward-based tracking systems.

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#### IMPROVING END OF LIFE CARE DECISION MAKING ACROSS NORTH WALES

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10.1136/spcare-2023-PCC.117

**Background/Introduction** Treatment and care towards the end of life (EoL) often involve decisions that are clinically complex and emotionally distressing. Patients' decision-making needs to be supported by appropriate, individual, timely discussions with clinicians and those important to them. In North Wales, the support for end of life decision-making (EoLDM) is fragmented and uncoordinated.

**Aim** We undertook a detailed exploration of EoLDM in North Wales to inform a quality improvement (QI) strategy.

**Method(s):** We mapped components of EoLDM and examined those via individual and group interviews with stakeholders based on normalisation process theory constructs. We checked alignment with local and national guidance, contextualised findings utilising previous regional work, and prioritised QI topics.

**Results** Examination of EoLDM components (discussions, documentation, acting on decisions and governance) revealed well-known barriers (e.g. time constraints, lack of universal

health care record) and key themes (e.g. need for clinician education & communication skills, executive leadership and dedicated people & systems resource). A targeted QI strategy includes coordinated communication ‘do not attempt resuscitate’ pathways between care settings, dedicated training resource for rolling clinician education, fit-for-purpose documentation of treatment escalation considerations and a public awareness campaign.

**Conclusion(s)** The detailed exploration of EoLDM across the region has resulted in a targeted QI strategy. It acts as a springboard for future work to normalise EoLDM. Our vision is that everyone in North Wales can have discussions to support their EoL decision-making at the right time supported by skilled clinicians. Fit-for-purpose pathways and documentation should ensure decisions and preferences are acted upon, within a robust governance framework. Only by learning from one another have we been able to grow together for the people of North Wales.

### 98 SAINT CATHERINE'S HOSPICE MORTALITY REVIEW; SERVICE DEVELOPMENT AND AUDIT

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**Background** Following on from the National Guidance on Learning from Deaths (NHS England 2017), and in preparation for the new medical examiner system, we have formalised our mortality review processes. We developed a death analysis template to be completed after each patient death alongside a monthly mortality review meeting (MRM) with multi-disciplinary team (MDT) and hospital input. The template is completed by a patient's key worker, reviewed in the weekly MDT meeting and those triggering certain criteria have an in-depth discussion at the monthly MRM. A random case is also always included.

**Methods** We performed a quarterly audit of numbers of patients with a completed death analysis template while the system was being embedded. We then performed a more in-depth audit of all patients discussed over the past year in the new MRM. This included both quantitative elements such as age and diagnosis and then also qualitative elements such as themes arising and actioned outcomes.

**Results** 93% of all patient deaths had a template completed and subsequent discussion at the relevant MDT meeting. 16% of those patients went on to be discussed in a MRM. Time of death to discussion at MRM was a mean of 39 days. Themes for improvement included missed opportunities for advance care planning, earlier referral to palliative care services and resources to improve overall patient wellbeing in the in-patient unit. Examples of actions taken forward include hospital-hospice handover work, positive feedback letters sent to carers and sourcing of an in-patient electronic audiobook library.

**Conclusions** We have put in place a robust structure to promote learning from deaths. Our work with the medical examiner service is about to begin to add breadth to this and will also importantly include family feedback. With ongoing refinement this new governance structure should continue to impact positively on patient care.

### 99 HOW ARE OUTCOMES OF SPECIALIST PALLIATIVE CARE MEASURED IN DIFFERENT PATIENT POPULATIONS AND SETTINGS?

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**Background** Outcome measurement is key to delivering effective, high quality, patient-centred care, as well as commissioning of services. The diversity of patient populations and service models in palliative care makes demonstrating efficacy and comparing services challenging.

**Aims** 1. To synthesise the evidence on how outcomes of specialist palliative care are currently measured in different populations and care settings.

2. To identify the evidence gaps where specialist palliative care services are under-evaluated.

**Design** A scoping systematic review of reviews.

**Data sources** Five databases (MEDLINE, EMBASE, CINAHL, Cochrane Library and Epistemonikos) were searched for reviews published between 2010–2021. Included reviews reported on outcomes of specialist palliative care in an adult population with life-limiting illness. Findings from the reviews were grouped, narratively summarised and compared.

**Results** 79 reviews met inclusion criteria. There was significant heterogeneity in the specialist palliative care services evaluated and the outcome measures and study designs used in the primary reviews. Health-related quality of life and symptom burden were the most frequently measured patient outcomes across care settings and populations. Health-system outcomes focussed predominantly on place of death and health service utilisation. There is a lack of evidence on outcomes of outpatient services, hospice care and telehealth services. The majority of evidence on population-specific outcomes is focussed on solid-organ malignancy. Evidence in populations with frailty, dementia, multiple long-term conditions and minority ethnic groups is lacking.

**Conclusion** Palliative care research is limited by a lack of cohesion in use of outcome measures and under-evaluated areas of practice. Expansion and adaptation of services should be driven by a co-ordinated approach to outcome measurement, as well as increased efforts to capture experiences across the breadth of community settings and in non-malignant disease.

### 100 MULTIMORBIDITY AND DISEASE-COUNT AS PREDICTORS OF HEALTHCARE USE AND MORTALITY IN EMERGENCY DEPARTMENT ATTENDERS: A CROSS-SECTIONAL SECONDARY ANALYSIS OF ROUTINELY-COLLECTED DATA

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**Background** Having 2 or more chronic conditions (multimorbidity) is associated with increased mortality and healthcare use in community-dwelling populations. In order to develop a nurse-led intervention for people with multimorbidity and