**127** THAMES HOSPICE ADMISSIONS PROCESS PROJECT – TAPPING INTO OUR SERVICES. USING QUALITY IMPROVEMENT (QI) METHODOLOGY TO IMPROVE ACCESS TO THAMES HOSPICE (TH) INPATIENT UNIT (IPU) AND IMPROVE STAFF SATISFACTION WITH THE ADMISSIONS PROCESS

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**Background** Thames Hospice IPU is a 28-bedded unit providing specialist palliative care to East Berkshire and South Buckinghamshire. With very high demand for inpatient beds, we identified scope to improve the admissions process.

**Methods** QI methodology was used to implement and evaluate changes to the IPU admissions process. In cycle 1 a dedicated afternoon admissions meeting was introduced, with attendance of key hospice staff. In cycle 2, the hospice referral form was adapted to be more user-friendly and to better inform admissions decisions.

The changes were evaluated by collecting qualitative and quantitative data, including:
- Time between referral received and bed offered, T(referred-offered)
- Time between referral received and patient admitted, T(referred-admitted)
- Referrers’ perceptions of accessibility, timeliness, and satisfaction
- IPU staff’s perceptions of accessibility of information, process efficiency, and overall satisfaction

**Results** Average T(referred-offered) reduced by 30.3 hours in cycle 1 (n=28 pre-intervention, n=22 post-intervention, p=0.045), and 41.6 hours in cycle 2 (n=15 pre-intervention, n=12 post-intervention, p=0.104).

Average T(referred-admitted) also fell by 29.5 hours and 40.1 hours in cycles 1 and 2 respectively.

Referrers’ perception of timeliness of admissions improved. 72.7% of respondents expressed a wish to continue with the new admissions meeting structure after cycle 1, with nobody wishing to revert to the previous structure.

Satisfaction of IPU staff improved across both cycles, with 100% of respondents reporting that changes made in cycle 1 were positive, and staff also reporting increased efficiency following cycle 2 (42% respondents reported processes very efficient cf. 22% at start of QI project).

**Conclusions** This QI project involving simple changes to the Thames Hospice IPU admissions process has shown significantly improved staff satisfaction and admission efficiency (i.e. reduced time from referral to admission), therefore improving quality of care for TH patients and ability to access IPU services.

**128** INTENSIVE CARE PERCEPTIONS AND UNDERSTANDING OF PALLIATIVE CARE IN A TERTIARY TEACHING HOSPITAL IN THE UK

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**Background** Palliative and Intensive Care might seem like very unlikely co-operators in providing the best patient care, however, they are not as far apart as some think. Symptom burdens are high, not least because of the medical interventions, and these impact on the patient’s care and sometimes outcomes. Psychological distress is high among both patients and relatives/carer. The burden is not only on patients (and relatives), but also on the staff of the ICU, not least because ‘palliative’ or end of life care may not be ‘what they came into ICU for’.

**Methods** We carried out an online questionnaire of ICU staff within our hospital. We wanted to get results from all employee groups, not just doctors. The questionnaire was a mixture of multiple-choice options and free text boxes. We plan to follow up on at least one of the groups identified with a more in-depth interview to ascertain their perceptions of palliative care.

**Results** Responses came from Cardiac, Neuro and General ICU as well as Surgical high dependency and were from a variety of staff: nurses (40%), doctors (20%), however also included HCAs, Physiotherapists, Ward Clerks and Pharmacists. The majority (83%) had experience of working with palliative care and had referred patients. The experiences of palliative care were overwhelmingly positive and highlighted the support to patients, relatives and also staff. 82% of responders felt that palliative care was well integrated into ICU.

There was a wide range of views about who the palliative care team should see ranging from ‘any patient that has a diagnosis of progressive illness and requires support’, to ‘nurses and relatives’ to ‘those with symptom control issues’.

Themes arising showed that the staff recognised the need for more relative and staff support.

**Conclusions** Palliative Care and ICU are well integrated in our tertiary hospital however there still remains more we could do and more the ICU teams would like in terms of support for the patients but also for relatives, and themselves as staff.

**129** ACCESS TO HOSPICE CARE; EQUALITY, DIVERSITY AND INCLUSION

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**Background** In line with St Oswald’s Hospice values we offer palliative care to patients with malignant and non-malignant conditions, aiming to serve our local population ensuring inclusivity and diversity reflective of the local demographic.

Hospice UK guidance ‘Equality in Hospice and End of Life Care: challenges and change’, identified groups excluded from high-quality end of life care, this formed the basis for this audit, aiming to examine how we record information and whether our patient demographic reflects our local population.

**Methods** Clinical notes of the last 100 adult inpatients were reviewed in relation to:
- Postcode; entered in to the Index of multiple deprivation (IMD), which provided a decile; 1 most and 10 least socially deprived.
- Primary diagnosis (widening access beyond patients with malignancy)
- Religion (Newcastle population; Christian (56.4%); no religion or none stated (34.6%); Muslim (6.3%), Hindu (1.1%), Buddhist (0.6%), Sikh (0.4%), Other (0.3%), Jewish (0.2%)
- Ethnicity (10.7% of Newcastle population are from BAME population)