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

Lydia Sinclair, Oliver Hodge, Jennifer Skinner. Thames Hospice

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

Megan Davies, Jo Brown. St Oswald’s Hospice

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)
Results Postcode of the patients home address; the data showed a spread across the deciles with a mean in the centre of 5th decile with 1st, 2nd and 10th deciles having greatest numbers. Primary diagnosis was malignant in 70% of patients and non-malignant in 30% Religion 62% of patients were documented as having a religion, these were Christianity (57%), Hinduism (1%), Jewish (1%), Sikhism (2%) and others (1%). Ethnicity 68% were White British, 6% were from a BAME background. 26% did not have an ethnicity recorded.

Conclusions St Oswald’s is providing increased access to non-malignant conditions including; neurological, respiratory and cardiac conditions. The patient population served appears diverse in relation to socioeconomic status. Some ethnic groups and religions remain underrepresented, this has provided areas to consider for our equality, diversity and inclusion steering group.

REFERENCES

Abstracts

Mixed-Methods Study To Understand and Improve the Value of Digital Palliative Care Multi-Disciplinary Team Meetings (MDTMs) in a Tertiary Oncology Centre

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Background Despite minimal evidence regarding utility, and no national guidelines, MDTMs are embedded within palliative care. However they are costly so efficiency must be maximised (De Leso et al, 2013).2 The function of MDTMs includes coordinating care for complex patients (Borgstrom et al, 2021).1 This project aimed to review completeness of local electronic MDTM documentation and assess staff’s views of the meeting’s purpose and associated documentation.

Methods Mixed methods project 1) Retrospective data analysis of completeness of digital data entries in palliative care MDTMs over a 6-month period at a tertiary referral cancer centre. 2) Survey of MDTM members to understand what they felt the role of the MDTM was, what it should be, and how to best capture the data electronically.

Results MDTM entries from 329 patients were reviewed. While some domains were completed for the majority of patients eg. Phase of Illness and Performance Status (>95% of patients), other domains were poorly completed, eg. estimated prognosis (33%) and preferred place of death (24%).

The survey was completed by 27 MDTM members from 7 disciplines. Members felt that the sharing and receiving of information was the purpose of the MDT – both currently and ideally. However while members felt that allowing shared decision making was important in their ideal MDT, they didn’t feel the current MDT fulfilled that purpose as strongly. In addition while members reported feeling comfortable contributing to discussion, some members thought there should be more discussion from different disciplines.

Conclusions MDTM members felt that the main purpose of the meetings was to discuss complexity, and that meetings had a positive impact overall, with more of a positive impact on MDTM members than patients. MDTM members value the MDT but feel that there could be more discussion amongst members to avoid it feeling like a ‘box-ticking’ exercise.

Improving Advanced Care Planning in Severe Frailty

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