

Results The project is ongoing at the time of writing, however, initial results are positive, with an increase in individualised goals being documented at each visit from 65% to 90% in the first month of the project. This will continue to be monitored to ensure practice is embedded.

Conclusion This project, being driven by a team member passionate about goal-setting with patients, coupled with explaining why the practice is important from the perspective of the regulator, have helped to achieve buy-in from the team.

P-84 IMPROVING COMMUNICATION OF PATIENTS' PREFERENCES REGARDING HOSPITAL READMISSION – A QUALITY IMPROVEMENT PROJECT

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Background Hospital re-admissions often contribute to unnecessary suffering and decreased quality of life for palliative care patients and their family members, particularly those approaching the end of life. Discharge summaries provide vital information to support healthcare professionals when making decisions about care settings and whether patients should be re-admitted to hospital. A baseline audit of hospice discharge summaries conducted between October 2022 and March 2023 found only 15% of discharge summaries contained information regarding patients' preferences for hospice or hospital readmission.

Aim To improve communication between healthcare professionals regarding patients' preferences for place and ceilings of care.

Methods A quality improvement project was conducted. The hospice discharge summary template was updated to include a specific section on 'patient's preferences regarding hospital admission'. Medical staff were updated about the changes and teaching provided to key members of staff regularly involved in writing discharge letters. A review of discharge summaries between April 2023 and May 2023 evaluated the impact of these changes.

Results Documentation of patients' preferences for hospital admission improved 56% (15% (3/20) to 71% (5/7)) following the changes implemented. Information included in the most recent discharge summaries were that two patients would be for hospital admission, two were not for readmission and one patient had declined to discuss admission.

Conclusion We found an improvement in the documentation of patients' preferences for hospital admission following changes made to our discharge template document. Reviewing and changing template documents can have important effects of the quality of information provided between care settings. Further audit and quality improvement cycles are planned.

P-85 EVALUATING THE QUALITY AND EFFECTIVENESS OF GP UPDATE LETTERS BETWEEN A SPECIALIST COMMUNITY PALLIATIVE CARE SERVICE AND GENERAL PRACTITIONERS

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Background Accurate and timely communication between primary and secondary care is essential for delivering high-quality patient care (Dinsdale, Hannigan, O'Connor et al. *Fam Pract.* 2020; 37(1):63–68). Communication and collaboration between primary care and palliative care providers is needed to deliver complex care management and to coordinate care, and letters form an important modality for this (Professional Record Standards Body. *Outpatient letter v2.1.* [internet]). There is increasing evidence that GPs prefer to receive structured clinic letters from specialists, with clearly communicated problem lists and outcomes.

Aims To assess the effectiveness of GP update letters in communicating key messages and outcomes of a patient encounter with the specialist community palliative care team.

Methods To evaluate our template based GP update letters over a period of two months, assessing accuracy, timeliness, and clear conveyance of key messages including recording:

- Specific problem(s) for which the specialist team are offering advice.
- Investigations and change of management plan.
- Rationale for medication changes and prescription requests.
- Controlled medication requests given specific doses.
- Actions requested of General Practitioners in clear courteous manner, including urgency of action.

Results Interim data at two weeks: 37 letters sent. 86% sent same day. 100% recorded primary diagnoses. 37% recorded secondary diagnoses. 89% clearly outline relevant problems. 87% made a clear prescription request. 19% of letters requesting controlled medications did not specify doses.

Conclusion Interim analysis shows GP update letters were sent within 48 hours. Areas of improvement could include recording secondary diagnoses, further clarity around specific problems such as problem listing, and prescription requests, which for controlled drugs suggest doses. This ongoing audit is concurrent with further enquiry of the GP view via survey, and assessing an opportunity for letter writing training for the wider multi-disciplinary team, also by survey of confidence. Adding to the template format may assist these improvements.

Digital ways of working

P-86 DIGITAL LEGACY AND PALLIATIVE CARE: USING TECHNOLOGY, DESIGN AND HEALTHCARE PARTNERSHIPS TO RESEARCH HOW DIGITAL INFORMATION IS MANAGED AFTER DEATH

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Background Research, using design and digital methods, can potentially help patients and caregivers to manage their digital legacy (the digital information available about someone following their death – Coop, Marlow. *Palliat Med.* 2019;33(1):114–15). However, there is a lack of multi-disciplinary partnerships needed to conduct digital legacy research in palliative care (Nwosu, McGlinchey, Sanders, et al. *JMIR Aging.*