

P-155 IMPLEMENTING INTENTIONAL ROUNDING INTO A HOSPICE INPATIENT UNIT

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Background Intentional Rounding (the structured process whereby nurses carry out regular checks of patients using a standardised protocol to address issues of positioning, pain and personal needs) was introduced to NHS Hospitals in 2012 in response to the Francis Report (Francis, 2013). There are limited published examples of the benefits of implementing this in hospices. Pendleside Hospice wanted to explore the value of IR on its Inpatient Unit (IPU). It was clear that patients at high risk of falls and skin damage were being observed attentively but with limited evidence of how frequently this occurred. A quick and clear observation record was required.

Aims To ensure high quality, accurate records. To explore the use of Intentional Rounding (IR) in improving patient care.

Method The project followed the PDSA model with staff involvement throughout. The IR chart from the local NHS Trust was adapted for the hospice setting. The chart was trialled with feedback from nursing staff and regular amendments until they felt it was clear and easy to complete. The rationale for implementation was communicated with regular support to the team. Champions were identified early. The renamed 'Falls Prevention and Skin Check Chart' was incorporated into usual practice and aligned with hospice policies.

Results There is now clearer documentation to support incident investigations which in turn supports more individualised care plans for patients. Staff can easily see when patient cares are due. Reported falls are being examined to understand if the chart has contributed to a reduction in rates.

Conclusion Implementation of an adapted IR chart has improved evidence of care and enhanced management support. The use of the PDSA model has ensured a team approach and staff have embraced the change.

P-156 FALLS EARLY WARNING SCORE (FEWS CHART); THE IMPLEMENTATION OF A FALLS OBSERVATIONAL TOOL AND ITS CLINICAL EFFECTIVENESS OF REDUCING FALLS IN A PALLIATIVE CARE SETTING

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Background Falls management and prevention is a top priority in all healthcare settings (National Institute for Health and Care Excellence, 2019). Research suggests that some nursing staff lack confidence when making clinical decisions regarding the appropriate level of falls supervision. Observational assessment tools exist to support the assessment of patients in acute hospital trusts (Richardson, Dawson, Henderson, et al. *Age Ageing*. 2019; 48:(S2): ii1–ii10), but currently no falls observational tools exist for hospice settings.

Aims To develop an observational falls assessment tool, to support nurses' clinical decision making, for use in a hospice setting.

Methods Our multidisciplinary falls group was developed with an aim to reduce falls in the hospice setting. The group peer-reviewed an existing observational falls assessment tool which was designed for use in the acute setting to consider how the tool would translate into a hospice inpatient setting. We retrospectively reviewed contributing factors for reported inpatient falls at our hospice, and using this data we developed the FEWS (Falls Early Warning Score) chart; a more comprehensive assessment tool to assess palliative patients' risk of falls in a hospice setting. This tool considers important risk factors such as fatigue and breathlessness, environment, medical deterioration and patient compliance which our data showed to present significant risk of increasing falls amongst palliative patients.

Results Since the introduction of FEWS we have seen a significant decrease in the number of annual falls between 2021 (n=133) and 2022 (n=73). We now plan to carry out a project to further evaluate the adoption of FEWS in the hospice setting which we hope will create a change in the culture of how we think about falls in a hospice, shifting the focus to prevention rather than reaction.

Conclusions Developing a falls observation assessment tool to address the needs of patients with a life-limiting illness can reduce the incidence of falls. Further work will evaluate staff educational needs for better adoption of FEWS.

P-157 REDUCING PRESSURE INJURIES WITHIN A HOSPICE INPATIENT UNIT

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Background Over 700,000 patients are affected by pressure injuries in the UK every year (Wood, Brown, Bartley, et al. *BMJ Open Qual*. 2019 Aug 20;8(3):e000409), and it is estimated that the incidence of pressure injuries within palliative care is 11.7% (Ferris, Price, Harding. *Palliat Med*. 2019; 33(7): 770–782). There is evidence that education can reduce the incidence of new pressure injuries (Kim, Park, Kim. *Adv Skin Wound Care*. 2020;33(3):1–11), but improvements may only be temporary without cultural change (Yan, Dandan, Xiangli. *Int Wound J*. 2022; 19(2): 262–271). In 2014, we carried out training with all registered nurses and health care assistants, and encouraged all staff to be involved with pressure injury prevention and treatment. Over the following year, there was a significant reduction in the number of pressure injuries that developed in the hospice. This project, initiated in 2014, has continued over the past eight years, and with the results monitored regularly.

Aims To ensure that the initial reduction in pressure injuries was maintained, and identify the interventions required to make these improvements permanent. To demonstrate that involving health care assistants (HCAs) in all aspects of wound care is beneficial to patients, carers, and other health professionals, and that these improvements could be maintained over the longer-term.

Method Annual mandatory training days and induction days, focusing on preventative care and early signs of skin breakdown. Strong engagement with team in discussion of new products and pilot trials. Emphasis on using prophylactic dressings. Tissue viability leads spend time every week working with staff. Feedback and reflection about the results

achieved. Questionnaire to patients, carers, and health care professionals to ascertain views about HCAs carrying out skin and wound assessments and applying dressings. Regular interviews with patients and carers to elicit feedback on services, including skin and wound care.

Results Initial and subsequent questionnaires and interviews have shown strong support for HCAs' involvement in wound care.

Conclusions Involving unregistered staff in pressure wound assessment and treatment is an important part of an effective pressure injury prevention programme. Regular training and support can maintain good results over the long-term. Feedback suggests that patients, carers, and health professionals see the benefit of this approach, and job satisfaction and morale among HCAs has increased. Our results demonstrate that this project has brought about significant and permanent improvements in the prevention of pressure injuries.

P-158 **STAND UP AND BE COUNTED: WORKING TOGETHER TO IMPROVE SYSTEMS FOLLOWING MEDICINE DISCREPANCIES**

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Background Routine IPU audits (November 2022) identified medication issues and numerous complicated management systems. In addition, there was an increase in process-related medicine incidents reported. A similar situation in 2018 resulted in increased governance for Zopiclone and communication of concerns resulting in increased staff anxiety. Our learning from Psychological Safety (Edmondson. The fearless organization: creating psychological safety in the workplace for learning, innovation and growth. 2019) encouraged a different approach to the same issue.

Aims To use a systems-based approach (Healthcare Improvement Scotland. Safe management and use of controlled drugs report. 2014; Komashie, Ward, Bashford, et al. *BMJ Open*. 2021; 11: e037667) to encourage engagement with IPU staff to raise concerns, be part of the decision making and integral to the solution to improve the safety of medicines processes.

Methods Nov. 2022 – Multidisciplinary group formed (all IPU registered nurses invited). Dec. 2022 – Three key workflows identified: schedule 3–5 medication governance arrangements, use of patients' own medicines and induction support. Jan. 2023 – Sub-group proposals considered. Feb. and Mar. 2023 – Planning and implementation of new processes and initial audit work. May 2023 onwards – Evaluation and feedback.

Results Governance arrangements: process now covers all schedule 3–5 medicines (Healthcare Improvement Scotland, 2014). Audit (April 2023) identified need for improved recording in registers for additional details within registers – repeat audit (May 2023) provided assurance of safe process in place. Feedback from staff continues and staff have openly discussed trust within medicine management processes (Edmondson, 2019; Jackson. *J Adv Nurs*. 2023 May 10).

Using patients' own medicines: the benefits outweighed any disadvantages (Crowther, Wanklyn, Johnson, et al. *BMJ Support Palliat Care*. 2013; 3:A50) and supported the

organisation's environmental sustainability ambitions. Pharmacy team role developed to include medicines reconciliation process, supporting consistency. Improved induction and support: staff feedback identified the need for enhanced pharmacy support and a clear and extended mentorship structure to ensure consistent messaging to all new staff.

Conclusion Current indications from audit and incident reporting suggests improvement. Opportunities have continued to engage with staff. A systems-based approach 'not hindered by fear' (Edmondson, 2019) has supported joint working between clinical, quality assurance and leadership teams to achieve safer practices.

P-159 **BETTER TOGETHER. PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK (PSIRF) THROUGH A COLLABORATIVE APPROACH**

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Background Ensuring patient safety is vital (Vincent. The essentials of patient safety. Notes on introduction. 2011). The PSIRF (Patient Safety Incident Response Framework) was launched by NHS England (August 2022) and sets out a new approach to developing and maintaining effective systems and processes in response to patient safety incidents. The value of collaboration to implement PSIRF was agreed at a hospice regional leader meeting. The importance of collaboration is highlighted in the national Ambitions Framework (Ambitions for Palliative and End of Life Care, 2021).

Aims Link with local hospices to achieve:

- Feedback on materials shared.
- Share thoughts and ideas on implementation plans.
- Highlight issues and barriers to implementation.
- Shared incident response plan and policy.
- Shared learning and networking.

Method In October 2022, the Quality Leads of local hospices were invited to join our patient safety specialist hospice forum. Initially, four hospices responded, and we held our first meeting in February 2023. Challenges of PSIRF were discussed for smaller providers and a joint proportionate approach agreed. A further three hospices joined and collectively we examined three years of safety incidents and complaints which resulted in common safety themes identified. A patient safety lead from an ICB attended one meeting and one hospice shared an explanatory presentation for their Board of Trustees, so that we were all delivering the same message.

Results The group identified: Key stakeholders; Key lead roles; Training needs and providers. And developed: PSIRF implementation project plan; Hospice incident profile; Incident response plan.

Conclusion The group has been an example of open collaboration to problem solve, learn and work together to achieve a united goal. We have been breaking down each task so that it is a series of smaller challenges rather than one large overwhelming one. Our next challenge will be how hospices can involve patient safety partners and engaging families and staff. We are planning to continue working together post PSIRF implementation to improve learning opportunities.