

Posters 19–28: End of life care

19 **A NIHR FUNDED CLINICAL RESEARCH NURSE SHARED BETWEEN FOUR UK HOSPICES HAS IMPROVED COLLABORATION AND RECRUITMENT TO PALLIATIVE CARE RESEARCH**

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Background Clinical research is essential to improve care and better target limited health resources. Clinically active research centres have better patient outcomes. Palliative care research is significantly underfunded and lacks capacity compared to other areas of health care. Additional challenges include isolation due to undertaking research in hospices outside of NHS structures, lack of experience and skills of many staff regarding research and a potentially vulnerable patient group. A clinical research nurse is an essential part of the research team, but hospices often do not have sufficient funding to employ a permanent research nurse.

Method(s) A multi-centred cluster randomised controlled trial is ongoing across hospices and other palliative care centres in the UK. Four hospices in the North-West of England applied to the National Institute for Health and Care Research (NIHR) Clinical Research Network for research nurse time to assist with this trial. A research nurse with a background in palliative care was asked to support the centres.

Results The trial is ongoing, but the centres have recruited: Trinity Hospice, Blackpool (11 out of 20 patients) St Catherine's Hospice, Preston (9/20) St John's Hospice, Wirral (9/20) and Willowbrook Hospice, St Helens (4/20) (enrolled later). We are on track for completing well within the recruitment window. Advantages included shared learning across sites, especially about study set up, logistics, and best recruitment practices. The research nurse reported patients were keen to take part and give something back. The clinical teams have gained confidence in research, and it has promoted a positive research culture in the hospices. Challenges included the research nurse's limited availability and wider issues regarding workload and clinical capacity.

Conclusion(s) We would recommend other hospices employ a similar approach to provide essential support for clinical research but also improve collaboration across sites and help build a positive research culture.

20 **IMPROVING DISCHARGE FROM HOSPITAL FOR PEOPLE AT THE END OF LIFE AND ASSESSING THE QUALITY OF HANDOVER TO PRIMARY CARE**

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Background Appropriate rapid discharge planning supports discharge to where the person wants to be cared for at EOL. This involves transfer of care over different settings. This evaluation assessed quality of handover and discharge processes from acute hospital setting for patients at EOL.

Methods Tri-methodology used.

1. Retrospective cross-sectional survey of electronic discharge summaries/notes for patients discharged for EOLC from acute setting (Aug-Oct 2022). Information included: local EOLC discharge guidance use, presence & quality of palliative care information on discharge, presence & quality of RESPECT form information, discharge Just in case (JIC) medications supplied and documentation of verbal handover if patient discharged to a hospice. Categories aligned to local guidance and NICE guidelines ([NG27] [NG142]). 2. Cross-sectional online survey of all junior doctors to identify experiences and barriers to effective handover. 3. Online Survey of local GP practices for views on handover/discharge information.

Results 1. 56 EOLC patients included. 19.6% patients had no palliative care information on discharge letter, 28.6% had minimal and 51.8% had good information. In 68% of cases the discharge letter mentioned the patient was discharged for EOLC. There was minimal information on the RESPECT form in 61%, good quality information in 34% and no RESPECT form in 5% of cases. Appropriate JIC medications were prescribed in 70%. 75% patients transferred to hospice had documented ward verbal handover. 2. Only 10% of junior doctors were aware of the local EOL discharge guidance. Main barriers identified to effective handover were time and job pressures, knowing how to contact GPs and information required. 3. No responses to GP survey received despite requests.

Conclusions There are challenges and areas for improvement in communication with primary care to improve discharge of patients at the EOL from hospital. Future work aims to address barriers and improve information provided.

21 **'COMFORT AT LAST' – USING DIGITAL COMFORT OBSERVATIONS TO IMPROVE CARE IN THE LAST DAYS OF LIFE IN THE ACUTE HOSPITAL SETTING**

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Background 37.5% of deaths in our area occur in hospital. There are known high unmet needs of adult patients dying in hospital, this unmet need can be reduced by using an individualised care plan and specialist palliative care review.

Intervention In 2022 UHSussex developed an electronic comfort observation chart and individualised care plan, with a centralised dashboard allowing Specialist Palliative Care Teams (SPCT) to view trends, target interventions, and a rolling prospective audit based on the SEECare criteria.

Results Since introduction one year ago, over 3000 patients have had their care supported with electronic comfort observations (e-comfort obs). Over 72% of all deaths in the Trust in the last 3 months have been on e-comfort obs, with 2/3 of all deaths in the first 12 months on e-comfort obs. The average length of time on e-comfort obs is 4 days resulting in 70 000 sets of e-comfort obs recorded since launch. Seven percent of e-comfort obs record moderate or severe symptoms. Our integrated rolling SEECare audit has prospectively audited care of 126 patients in the first 4 months and will ensure an annual prospective quality assurance audit of over 400 patients. We have identified benefits to people who are dying,