

## Abstracts

At St Mary's Hospice there was not a recognisable MDT meeting. Although in-patients were discussed weekly, it was called a "communication meeting", with little structure or outcome. On joining the organisation in 2012, I carried out a "snapshot" survey of the current MDT meeting and found that it lacked structure, outcomes, was very physically focussed, and did not include full MDT discussion. In October I wrote up my findings, stressing the positives as well as the challenges. This was shared with staff at one of these communication meetings. The response of all staff was very supportive.

I therefore devised an MDTM based on SBAR. This had been used in my previous place of work for MDT meetings but I further developed this into specific documentation, and planning paperwork (this will be shared at the conference). "Situation" covers patient information such as diagnosis, family tree, reason for referral and input; background includes relevant medical history, events leading up to referral, any other holistic issues; assessment includes what has been found / assessed since involvement, including advance care planning; recommendations include the plan of care.

The new format began trial in February and will continue until July 2013. It will then be audited: this will include staff surveys, audit of how the documentation has been utilised, and a full review. Details will be included at the conference, if this is accepted.

Early feedback shows increased attendance by the MDT, patients from all departments now being discussed, clearer documentation informing succinct relevant discussion, and clear being plans made each week for patients discussed.

### P80 APPLYING THE CLINICAL GOVERNANCE TOOLKIT IN THE HOSPICE SETTING; A POTENTIAL STRATEGY TO IMPROVE CARE THROUGH STAFF ENGAGEMENT IN CLINICAL GOVERNANCE

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**Introduction** Clinical governance is essential to the delivery of high quality safe and effective patient care. It provides a framework to continuously improve the quality of hospice services.

**Aims** To critically appraise the current clinical governance systems within our hospice and to re-design these to be efficient, transparent and encourage staff engagement.

**Methods** Workshops were held to examine existing governance structures and highlight areas of need and develop a solution which was both readily implementable and effective. The workshops reviewed current literature and examples of good practice surrounding clinical governance in hospices.

**Results** A consensus decision was reached to construct clinical governance under the 'three pillars' of patient safety, clinical effectiveness and patient experience as described by the Clinical Governance Toolbox (1). In order to enhance engagement with clinical governance three new groups were created for each 'pillar'. Each group consists of a multi-professional membership of clinical and non-clinical staff and is Chaired by a member of the senior management team. The group members will be responsible for disseminating information and educating staff and volunteers in their day-to-day work as well as in a monthly newsletter. The Clinical Governance board, drawing together the work of the three pillars, will provide organisational oversight. The Clinical Governance Board

is comprised of staff members, Trustees and an external scrutinizer.

**Conclusions** In adopting this clinical governance structure we believe we have developed a streamlined system that will promote best practice in all members of staff through clarity, communication, accessibility and inclusiveness. Importantly this process has also improved awareness of clinical governance throughout our team through the dynamic workshops responsible for re-designing our systems.

### P81 SIGNIFICANT EVENT ANALYSIS IN A HOSPICE SETTING

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Monthly significant event analysis (SEA) sessions, which all clinical staff are invited to attend, were introduced at an independent Hospice in 2010. SEA allows opportunity for a team to come together and reflect on a clinical event that has had a significant impact for them; in either a positive or negative way. The chair of the clinical quality (now clinical audit) group introduced SEA in recognition that it forms an important part of clinical governance. Guidance was developed outlining how a significant event may be identified, how the sessions would be structured (through use of a specific proforma) and facilitated, ground rules to be followed and including background information on the role of SEA in a clinical setting. Pathways for staff support are also outlined in the guidance. Dates of SEA sessions are issued in advance. The significant event to be discussed and session facilitator are decided at the organisations' "Implementing Clinical Governance Group (ICGG)". Since its introduction, the structure of SEA has been reviewed and adjusted to ensure it is robust from both a governance and learning perspective. This includes ensuring ground rules are set at the beginning of each session and that action points are followed up through ICGG. An aspect we are keen to further develop is the link between SEA learning outcomes and staff education. Examples of topics reflected on at SEA include management of terminal agitation, vulnerable adults, communication, boundaries, expectations, capacity and preferences. SEA is well attended and has received positive verbal, informal feedback with staff voicing they enjoy the sessions and are keen for them to continue. Recently a questionnaire has been developed and sent to all clinical staff to obtain formal feedback to support the development of future SEA sessions.

### P82 THE INTRODUCTION OF ELECTRONIC PATIENT RECORDS ON A HOSPICE IN-PATIENT UNIT (IPU)

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**Background/Context** Healthcare information systems have evolved to play a major role in healthcare in modern society and the introduction of the electronic patient record aims to improve patient safety and documentation quality. SystemOne is a centralised clinical system developed by TPP (The Phoenix Partnership) and its introduction at the Hospice was due to a need to introduce an updated medical activity system that incorporated patient records.