

protocol, documentation and research procedures. Areas that required acknowledgement and response during the trial included providing support to address issues of informed consent and eligibility, understanding the impact of the ‘wait’ allocation on participants, staff and volunteers, and integrating volunteer management and feedback into trial procedures. At subsequent feedback sessions, staff moved from being research naive to research active making recommendations about the design of future studies.

**Conclusions** For most this was the first time they had been involved in research yet they embraced this and developed research skills for future studies. The trial acted as a catalyst for training of staff who were able to contribute to running a rigorous and ethical wait-list trial. Funded by the UK Cabinet Office.

**P-71 MAKING CHILDREN’S HOSPICES RESEARCH-READY: A CRN WEST MIDLANDS’ INITIATIVE**

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Making children’s hospices research-ready: A CRN West Midlands’ initiative builds on the Payne Commission report in 2013 ‘Research in palliative care: can hospices afford not to be involved?’ and recognising the opportunity in the CRN: WM region to engender research in children’s hospices, engagement with the following hospices: Donna Louise Hospice, Acorns Hospice in Selly Oak and Hope House in Oswestry has started, in order to scope the needs for bringing research to this setting. Introductory and planning meetings with national key players were held and we also took part in initiatives eg Tweetfest to raise the profile of research in hospices, as well as gain advice and suggestions from key people nationally via Twitter. Next steps include expansion of GCP training, and providing paediatric communication and consent and PI masterclass courses to staff in children’s hospices, in order to give the staff the practical skills to run research studies in children’s hospices. CRN WM workforce development team will be involved in creating a bespoke training package for individual children’s hospices, tailored to their need to be research-ready. These initiatives firmly link the clinical research network with the hospice staff forging good working relationships and ensuring that the research skills are acquired in readiness for opening the first paediatric hospice study.

**P-72 BUILDING RESEARCH CAPACITY TO ADDRESS THE PUBLIC HEALTH NEED FOR PALLIATIVE CARE**

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**Background** The growing demand to address significant public health issues such as ageing populations, changing patterns of chronic diseases, individuals living longer with life-limiting conditions and so on increases the pressure on researchers to produce high quality, clinically relevant, innovative palliative care research so as to improve the quality of life for service users and carers.

**Aim** All Ireland Institute of Hospice and Palliative Care (AIHPC) believes that one way to meet this demand is through research

capacity building which is being taken forward via the Institute’s Palliative Care Research Network.

**Method** Capacity building is defined as a “process where individuals, groups, networks, organisation and the wider community are encouraged and facilitated in enhancing their knowledge and skills so as to increase their ability to perform innovative and high quality research” (Moley and Seale, 2009). It is a major component of large national and international funding that seek to enhance and develop research expertise and leadership in specific health areas, for example, Irish Health Research Board, Public Health Agency (Northern Ireland), Horizon 2020, Canadian Institutes of Health Research).

**Conclusion** AIHPC’s Palliative Care Research Network is taking forward a multi-tiered approach to research capacity building ranging from awareness-raising of research, to providing more extensive support to those who want to progress elements of palliative care research, to providing tailored support and leadership opportunities for more advanced researchers.

**P-73 INTERDISCIPLINARY RESEARCH IN PALLIATIVE CARE: WHEN ACTIONS SPEAK LOUDER THAN WORDS**

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Multidisciplinary research is characterised by two or more disciplines coming together to address the same issue or area of interest from their respective paradigms. Interdisciplinary research arguably moves several steps further to bring two or more distinct academic fields together, integrating theory, methodology, terminology and/or data to address critical and complex health issues (National Institutes of Health, 2007). A range of environmental, group and individual factors have been found to influence interdisciplinary working including organisational commitment, availability of resources, effective communication, strong leadership, mutual trust between partners, flexibility in addition to specific scholarly competencies (Aboelala *et al.*, 2007; Gebbie *et al.*, 2008). Porter *et al.*, (2012) describe the correlation between funded interdisciplinary networking and scholarly impact noting that research articles arising from interdisciplinary research are more likely to be published in high impact journals and be highly cited.

This paper aims to provide a high-level overview of the highlights and challenges to adopting an interdisciplinary research approach in palliative care drawing on Irish, European and international experiences.

**Patient Care**

**P-74 HOW IMPLEMENTING THE FOUNDATION MODULES FOR PRODUCTIVE WARD HAS IMPROVED EFFICIENCY, SAFETY AND MORALE WITHIN THE INPATIENT UNIT**

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**Introduction** The inpatient unit has introduced the three foundation modules from the Productive Ward programme, Patient Status at a Glance, The Well Organised Ward and Knowing How we

are Doing. The project commenced in 2014 and continues to develop. There have been significant changes in the way the Unit operates alongside increased staff morale, enthusiasm, ownership and pride in the environment and maintaining and improving standards

**Aims** The ultimate aim of the Productive Ward foundation modules is to release time to care by ensuring efficient systems are in place in a well organised environment

**Methods** A project lead planned and trained three groups to lead each module. Each group nominated a group lead who reported back to the project manager quarterly. Quarterly reports were included in the annual audit plan for Dorothy House. A ward vision was produced and clearly displayed outlining out core values. A project board was introduced to demonstrate progress and maintain momentum. Before and after photographs were taken to demonstrate improvements. Once an area was completed standards were set and regular audits commenced to ensure compliance and sustainability.

**Conclusions** Patient Status at a Glance: An electronic whiteboard has been introduced that informs handovers and MDT meetings. This can be accessed via the desk top for all clinical teams connected with IPU. It records a variety of patient information and has the ability to aid in reporting and audit

**Well Organised Ward:** Each clinical area was assessed using the 5S tool involving to sort, set, shine, standardise and sustain. We worked with the three second rule where any item needed could be found within three seconds of entering the room.

**Knowing How we are Doing:** Friends and family feedback, suggestion boxes and safety crosses were introduced. The safety crosses monitor any incidences or near misses related to pressure ulcers, falls or medication errors

**P-75 DEVELOPMENT OF A PALLIATIVE CARE D.R.E.A.M. AIDE MEMOIRE TO HELP IN COMPLEX DECISION-MAKING AND ASSESSMENTS IN THE PALLIATIVE CARE ARENA**

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Specialist palliative care units are evolving. The ability to be more reactive in managing medical crises has enabled hospices to treat conditions such as pneumonia with intravenous antibiotics rather than transferring them to an acute trust.

With this greater ability comes greater responsibility. For these decisions to be made correctly and in conjunction with the patient and family, there is a need for highly coordinated and effective multidisciplinary team working.

With hospices becoming more involved with training of doctors, this brings huge benefits and also challenges to the units. Trainees in palliative medicine are at varying levels of training, and work closely with clinical assistants and specialty doctors.

This rich tapestry of the medical team means we need to have safe and effective handovers and medical decision making processes that are transparent and communicated properly.

Therefore, in an easy to remember format, I have devised the **D.R.E.A.M.** to act as a prompt for important palliative care issues that need to be considered.

It is a way of prompting both the clinician, and the multi-disciplinary team to consider the best care of the patient in a structured way.

The DREAM is completed on admission, and twice weekly within the wider MDT ward rounds.

**D Discharge planning and Discussions**

Careful and sensitive Discussions, Documented, Discharge planning.

**R Resuscitation Status**

Ensure this is considered on admission, unified/Hospice DNACPR documented.

**E Escalation of Care Decisions**

Decisions on level of treatment planned e.g. IV antibiotics, transfer out.

**A Anti-coagulation/Advance Care Planning (ACP)**

Prompt for medical decision making process. Evidence to support use of prophylactic heparin exists in the Palliative arena. Prompt to record and share ACP discussions.

**M Mental Capacity Act (MCA)**

Prompt to consider Capacity and all aspects of the Act, including DOLS, LPA and ADRTs.

**P-76 OFFERING AN ALCOHOL DRINK SERVICE IN A HOSPICE: ITS MEANING FOR PATIENTS**

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Offering an alcoholic drink to patients before their lunch and evening meal is an established service in many hospice in-patient and day service units. The appropriateness of this long-established service at Sobell House has recently been a point of discussion among staff. Concerns have been expressed about the appropriateness of promoting alcohol, and its potential for harm. These discussions prompted an evaluation of this service from the patients' perspective.

A patient experience survey was conducted during January 2016, which included several questions about this alcoholic drink service. Every patient attending day service was invited to complete an anonymous questionnaire on their experience of the care received. The same questionnaire was given to patients on the ward (or their family member if they were unable to complete it), and posted to a random sample of community patients. A total of 71 completed questionnaires were returned, giving a response rate of 33%.

The response to this survey has shown that the alcoholic drink service is valued by both users and non-users. 59% of respondents explicitly endorsed the value of the service. Of the remainder, all except one were equivocal or did not comment. Respondents describe it as a valued service, which provides social benefits and a sense of normality in an institutional environment. It is also seen to convey a sense of valuing the individual as a person rather than a patient.

This survey provides evidence for the value of an alcoholic drink service for patients. As a result, the hospice is clearer about its benefit and more aware of potential concerns. An action plan has been developed to respond to patients' concerns about its cost to the charity, and to ensure that quality non-alcoholic drinks are also available.