Conclusion The project demonstrates by empowering staff and building confidence, we have positively impacted on the choices available for patients and their families regarding the donation of tissues after death. Further education will be delivered to embed and ensure sustainability with this change in practice. A policy and procedure to standardise practice is being finalised.

In 1972, Stockwell published her controversial research (“The unpopular patient”) which described nurses’ relationships with patients who they perceived as “difficult”, and focussed on negative stereotyping. This was based around nurses giving preferential care to favoured patients.

Does this exist in palliative care, which prides itself on gold standard and person-centred care, across all care settings and particularly in specialist palliative care units and hospices?

During the author’s work in various palliative care settings and varying roles, it has been evident through a variety of approaches that even in palliative care patients can still be perceived as “unpopular”. This can, in turn, exacerbate that patient’s unpopular behaviour further (Goffman, 1963).

Dame Cicely Saunders stated, “You matter because you are you. We will do all we can to help you live until you die.” Equitable care access should prevent stereotyping, however the question is, do staff still label patients and families as unpopular? Is this simply an attitude and opinion? Does it affect the care they receive?

A brief literature review explores the concept of the unpopular patient in various care settings but not in palliative care. This work will complete a detailed literature review of “the unpopular patient”, the principles of palliative care and equitable access, and will be presented at the conference.

In future, research is required: initially this will be small scale through questionnaires to staff in a variety of palliative care settings and roles, using methodology similar to the original research. Following this, focus groups will be held to explore the emerging themes in more detail, and possibly individual interviews may be held with specific staff for richer data.

It is hoped that publishing and sharing this work will make staff working in palliative care self-aware about these attitudes.

P-83 FROM CRITICAL INCIDENT TO IMPROVED DOCUMENTATION; A MULTI-DISCIPLINARY APPROACH

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Background An inpatient developed a grade 4 pressure ulcer, however, inadequate documentation demonstrating the on-going management and escalation of the incident made it difficult to answer both the patient and their family’s questions. The incident was escalated to the relevant bodies and an internal investigation undertaken. The hospice and the patient’s family were keen to ensure lessons were learnt and that changes were made to improve documentation.

Aim To develop an effective process and training programme ensuring comprehensive documentation of patient care.

Methods Mandated documentation training focusing on clinical standards and the implications of poor record keeping was jointly developed with Her Majesty’s Coroner and delivered at the Coroner’s Court. A Clinical Documentation Management group was developed at the hospice to provide strategic direction and control.

A multi-disciplinary audit tool was developed to evaluate patient records and a six-monthly audit cycle established. Real time feedback highlighting positive practices and areas for improvement was provided to managers and clinicians. Results of the audit indicated changes were required within the documentation process; all paper assessment forms were reviewed and a