## P-110 IMPLEMENTING REHABILITATIVE PALLIATIVE CARE – A TEAM APPROACH

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10.1136/bmjspcare-2016-001245.133

**Background** Following the publication of Hospice UK's rehabilitative palliative care document (2015), it was highlighted that the hospice could challenge its current practice and welcome change with regards to rehabilitative palliative care. Whilst providing holistic, person-centred specialist services it was identified that the hospice could better tailor services for patients who were appropriate for this level of intervention.
**Aim** Develop the "Improving Care group in Rehabilitative Palliative Care" to identify and implement aspects of rehabilitative palliative care in and around the hospice.
**Method** A team of multidisciplinary staff from the in-patient unit, day therapy unit and the community led by the physiotherapist and including nursing staff, social work, allied health professionals and medics used the rehabilitative palliative care document and checklist to highlight all areas of concern or where further work would be beneficial and prioritise their actions accordingly
**Result** Monthly meetings were held and focus groups on separate topics were created.

Communication – Including handovers, leaflets for patients and relative, information boards, admission and discharge documentation

Goal Setting – Patient-focused goal setting documentation to be created, incorporated into weekly MDT and adapted in line with requirements

Rehabilitation care plans – care plan development with a focus on enabling patients facilitating independence and self-management
Environment – ensuring all hospice areas are enabling and facilitate independence and normality.

Education – Sharing information, knowledge and skills to support staff to change in practice.

Activities – Offer activities encouraging patients to access communal areas and interacting in activities

Admissions/Discharges – Ensuring information sharing with regards to admission and discharging patients is accurate and effective to ensure all aspects of care are appropriate

**Conclusion** Working as a team, the hospice staff have been able to successfully identify areas for change and work effectively to implement aspects of rehabilitative palliative care. This work is ongoing to make a difference to patients in our care.

## P-111 THE IMPORTANCE OF A DEDICATED FORWARD THINKING HOUSEKEEPING TEAM WORKING IN A CLINICAL ENVIRONMENT

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10.1136/bmjspcare-2016-001245.134

The housekeeping team worked daily to ensure the cleaning and standards of the hospice where completed to a high standard - but what standard? The cleaning team didn't have a choice on decision making or cleaning standards so we introduced a team leader who recognised the need for change to have a proactive approach to cleanliness, decontamination and infection prevention. We implemented change and for the first time the Housekeeping team leader sat on the infection prevention and cleanliness committee (IPCC) not only being an attendee but an active member to bring best practice and ideas forward. New policies and procedures where written, housekeeping staff re-trained and mentored. One positive improvement was to introduce Green "I am clean" stickers. These where easily recognisable by all; nursing staff, patients and families were confident knowing that the rooms where clean and the housekeeping team found this a positive communication skill.

We then needed to review that change to ensure this was an improvement. So we created cleanliness and operational reports approved by our IPCC. We based this on the PLACE model and tailored the areas of inspection to Cleanliness and Operation of patients' areas to ensure these are fit for use as well as clean. The report has 30 domains to score against which gives an overall rating of:

| | |
|---|---|
| Green | Control is sufficient |
| Amber | Further control needed for improvement |
| Red | Considerable need for improvement |

Once the report is complete, findings are reported to IPCC. In future it's hoped we can start to extract data which then can be used further to support training and best practice sharing. This forward thinking will certainly bring the housekeeping team to the forefront of the hospice rather than feeling undervalued and proves that collaborative working on this domain has been highly positive move.

## P-112 IS THE MANAGEMENT OF HEALTHCARE-ASSOCIATED INFECTIONS IN HOSPICES A MISNOMER?

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10.1136/bmjspcare-2016-001245.135

There is increasing evidence, albeit hospital based, that healthcare-associated infections (HCAIs) are amongst the leading communicable and preventable cause of morbidity and mortality (Tulchinsky and Varavikova, 2009, NICE, 2011). With the multifaceted delivery of healthcare, the risk of infection increases (Apisarnthanarak *et al*., 2012). Hospices are unique settings (with extremely vulnerable patient populations), but operate within wider healthcare contexts – so what is their role in managing HCAIs?

The aim of this study, using a critical literature review, was to identify and discuss the current knowledge available about the management of HCAIs in hospices. The study was triggered by a number of incidents where patients were due to be admitted to the hospice as part of a stepped discharge from hospital. In each case the patient was being treated for infections with multi-drug resistant organisms (MDROs), but their infection status was not handed over. Preliminary discussions with infection prevention and control practitioners in other hospices suggested inconsistencies in the management of the HCAI risk.

Five key themes emerged from the study – the availability of current empirical knowledge, risks associated with HCAIs, the impact HCAIs and of infection prevention and control strategies on the quality of life for patients in palliative care, the ethos of palliative care, and screening.