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TRANSFORMING MDT WORKING IN PALLIATIVE AND END OF LIFE CARE ACROSS ACUTE AND COMMUNITY SETTINGS

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As a forward thinking Integrated specialist Palliative and End of Life Care team working across community and acute settings within Walsall we are constantly appraising our service and looking to improve how we deliver the best possible care to our patients and carers.

Having an existing Palliative and End of Life Care MDT we wanted to refine the process and develop a more accessible platform for non specialist colleagues in a supportive environment to encourage open conversations with a more truly integrated pathway.

This process has involved the engagement of partner organisations such as our local Hospice St Giles Hospice Walsall, acute based teams, community specialist palliative care, GP's community matrons and district nursing teams, specialist services such as COPD HF, learning disabilities and mental health.

In the last couple of years the SPC has been critically appraised by its members and over the last twelve months we have trialled a rotational chair in order to promote the skills of clinicians outside the medical framework by introducing an innovative approach to the chairing of the MDT.

We also then focused on rotational locations for the meeting, a different time slot and the introduction of bringing cases for reflection. These focuses have promoted staff development, leadership skills, accessibility: bringing everyone to the table, revalidating interventions.

However most significantly the changes have increased engagement with attendee numbers rising significantly. A Survey Monkey demonstrate the value placed upon the SPC MDT both inside and outside the historical circles of palliative and end of life care.

This audit serves to appraise how these changes have affected the SPC creating a platform for further appraisal and improvement.

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A RETROSPECTIVE AUDIT OF THE PALLIATIVE CARE TEAM ELECTRONIC MDT PROFORMA AT THE ROYAL MARSDEN NHS FOUNDATION TRUST

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Background The Palliative Care (PC) Multidisciplinary Team (MDT) in a tertiary referral oncology hospital meets weekly across two sites. All new referrals and all inpatients under the PC team are discussed. In June 2016 an electronic MDT (eMDT) proforma was developed to record data including performance status, phase of illness, estimated prognosis, spiritual, psychological and welfare needs and Urgent Care Planning. A weekly MDT register is taken to establish core membership attendance and adherence to recommendations in the National Cancer Peer Review Programme (2012). A retrospective audit of the data was conducted.

Methods Weekly eMDT data (1 st June 2016 – 31 st March 2017) and PC inpatient lists were reviewed. All patient discussions were retrospectively analysed to determine whether we

were achieving departmental standards. Microsoft Excel was used for statistical analysis. An audit standard of 75% was set for core MDT attendance and for recording all data.

Results 803 individual patient discussions took place. 75% core attendance was achieved. Psychological needs were documented on the e-MDT form in only 38.5% and PPD in 25.7% overall. 67 (8.3%) of patients had an initial prognosis of 'hours to days' when first discussed. Of these 54 (81%) had a documented preferred place of care (PPC) and 52 (78%) had a documented preferred place of death (PPD).

Conclusions Electronic documentation of palliative care MDT discussions and decisions facilitates analysis and quality improvement. On the basis of this audit the operational policy has been updated. The psychology team have been invited to join the weekly MDT. The audit standards regarding PPD have been amended to only include patients who are identified as dying.

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DEFINING AND MANAGING THE COMPLEX PATIENT: STAFF PERCEPTIONS IN COMMUNITY SPECIALIST PALLIATIVE CARE

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Aim To evaluate factors perceived as contributing to patient complexity in a community specialist palliative care team (SPCT) and assess confidence of community staff in identifying and managing such patients.

Background Multiple co-morbidities, increased healthcare usage and psychosocial vulnerabilities feature broadly in descriptions of complexity and are prevalent within the palliative care demographic. Shared awareness of more-complex patients is necessary for cohesive care, effective handover and learning. Despite this, it is unclear how confidently SPCTs identify and manage such patients.

Methods 14 nurses, HCAs and AHPs in a mixed-experience community SPCT in North East England were surveyed. Participants scored different biopsychosocial-spiritual aspects on a scale of 1 to 5 according to perceived contribution to complexity (1=weak and 5=strong contribution). Scores for each aspect were totaled. Participants then self-rated agreement with statements around complex patient identification, management and team support. Percentages of respondents self-rating >6/10 were calculated.

Results 23.7% of patients were rated more complex than average. Exhausting clinical management options and high symptom burden contributed most to complexity (aggregated score 65/70), followed by rapid condition changes (64/70) and requirement for frequent interventions/admissions (63/70). 57.1% of staff felt at least somewhat confident in identifying and managing complex patients, with only 35.7% aware of robust systems for flagging complex individuals. 78.6% agreed a formalised system (e.g. 'Virtual Ward') could improve complex patient care.

Discussion Self-perceived influencers of complexity are congruent with the literature, yet confidence in identifying and managing such patients is low. Subgroup analysis shows that although more-experienced staff have greater confidence in managing complexity, they perceive fewer opportunities to flag and discuss complex individuals, highlighting the need for a cross-sectional approach to enhancing complex patient care.

Findings will help develop criteria to objectively and proactively define complex patients and improve care through greater team collaboration.

121 PERSON CENTRED CULTURE IN A HOSPICE: MYTH OR REALITY?

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Background Person centred care is inherently integrated into palliative care as one of its cornerstones. Having developed from a pioneering grass route movement to an established organisational structure the culture of palliative care has become increasingly influenced by routine and the need for standardised practice. This has challenged the capacity to foster creative, flexible and dynamic approaches to care that put the person at the centre. McCormack and McCance's Person Centred Practice Framework (2017) is a theoretical framework that addresses such limitations. Using this framework as an underpinning theory in our research we aimed to assess and develop a person centred culture in a hospice.

Aim To evaluate and develop a person centred culture in a hospice setting.

Method Participatory action research using a cooperative inquiry approach involving key stakeholders within the hospice.

- Research Group established with staff members being co-researchers
- Values and beliefs exercise around the meaning of person centred care across the hospice.
- Baseline data collection including observations and interviews to identify the existing culture.
- Analysis of base line data and mapping against the Person Centred Practice Framework.
- Identifying key areas for further exploration and development.
- Development and implementation of an action plan.

Results

- Staff relationships and communication, identified as a key area needing further exploration.
- A fourth generation evaluation (Guba and Lincoln 1989) workshop with all teams in the hospice highlighted a lack of time for staff to reflect on practice and engage in meaningful relationships with each other and thus neglecting the positive impact of effective teamwork.
- Action plan, including development of stronger team relationships was implemented.

Conclusion McCormack and McCance (2017) consider the existence of 'healthful relationships' as central to a person-centred culture. This research highlights a practical approach for teams to explore their own micro level structures in order to develop healthful relationships in teams.

122 THE BIGGART PROJECT: COLLABORATION BETWEEN HOSPICE AND GERIATRIC COMMUNITY HOSPITAL TOWARDS SHARED LEARNING

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Background The increasing need for end of life care in older people meant Biggart Hospital admitting more terminally ill patients and the Ayrshire Hospice managing more complex co-morbidity. To deliver best palliative care, shared learning was needed.

Method Key personnel from both sites met bimonthly over an 18 month period. Challenges were identified and strategy determined, nurses' learning needs having been evaluated by survey. Senior nursing and medical staff visited the hospice as clinical observers. Palliative care ANP attended Biggart weekly. A bespoke teaching programme was delivered to Biggart with four different sessions provided for nursing staff. Teaching sessions were delivered by hospice speciality doctor to geriatrics trainees. Patients and carers/family were surveyed about their care on completion.

Results Before the teaching programme, 26/30 respondents (87%) wished for further palliative care education. Key concerns included pain and symptom management, and a need for a key point of regular contact for advice. After the programme a second staff survey was conducted. 13/17 respondents were keen for more palliative care education. Their main concerns were pain (10), end of life care (10), advance planning and DNACPR (6), care of relatives (1). Of note, this was not the same group that received education or who replied to the first survey. Programme attendees who gave feedback reported increased awareness of palliative care. Following the training programme, relatives (n=10) felt care in Biggart was 'always good' (10/10), pain/symptoms 'always' or 'usually' well managed (5/10; 5/10 respectively); sufficiently supportive both emotionally (8/10) and spiritually (4/10).

Conclusions Joint working improved relationships, skills and confidence. ANP visits consolidated this new approach. Education programme was valued by attendees albeit numbers were small.

Education programmes need learner and management commitment to support attendance. Pain, spiritual support and care of relatives remain key areas for ongoing education.

123 ADDRESSING PALLIATIVE CARE STAFF FEARS THAT DISCUSSING CORNEA DONATION IS DISTRESSING FOR PEOPLE

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Background Cornea disease causes blindness. Cornea transplants are highly successful, but limited by shortage of donated corneas. The UK annual shortfall is %£500 corneas.