

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?

Erna Haraldsdottir, Kim Donaldson, Irene Barclay, Anna Lloyd, Brendan McCormac. *St. Columba's Hospice, Queen Margaret University*

10.1136/bmjspcare-2018-ASPabstracts.148

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

Cat Killin, Jillian Nicoll, Meriel Conn, Josaleen Connolly, Fiona Ewart, James Mack, Morag Thomson, Morag Cahir, Rachel Pugh, Shona Hynd. *The Ayrshire Hospice, The Biggart Hospital, NHS Ayrshire and Arran*

10.1136/bmjspcare-2018-ASPabstracts.149

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

Sarah Mollart, Emma Tregenna. *St. Nicholas Hospice Care*

10.1136/bmjspcare-2018-ASPabstracts.150

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

There are many eligible UK donors (50% of hospice deaths) and the British public are largely in favour of donation. However, most hospice staff are unaware or unwilling to raise the topic of cornea donation (CD). Fear of causing distress is known to be a factor. We conducted a service evaluation to explore the responses of patients offered CD.

Method The study was at an 8-bedded UK hospice. Previously, no hospice patients had donated their corneas. Staff education was undertaken first. For the study period (six weeks) all patients admitted were screened for CD eligibility. Those eligible were offered information, at an appropriate time. Exclusion criteria were being unable to engage in conversation, or distress during other discussions about dying. All patients were given anonymous questionnaires afterwards.

Data regarding the number of patient donating was also collected.

Results 15 of 29 inpatients were eligible for CD, and offered information. 11 questionnaires were returned. Patients were asked 'How did you feel about being informed?' 55% were 'glad' 45% had 'no strong feelings either way' (None 'didn't like it'.) They were also asked 'Was it upsetting to be informed?' 73% said 'No?'; 27% said 'Yes, but I'd still rather have had the conversation' (None said 'Yes, and I didn't like talking about it'.)

Of 15 patients offered information, 6 went on to donate. Patients are routinely offered CD information since. Over 20 months, 40 people donated, averaging 48 donated corneas/year.

Conclusions Staff fears of causing patients/families distress by discussing CD are unfounded. Failing to inform patients/families deprives them of their option. Routinely discussing CD leads to a significant rise in donations; this benefits those waiting for transplants.

(Project Highly Commended in the 2017 BMJ Awards)

124 IMPROVING MULTI-PROFESSIONAL HANDOVER IN A SPECIALIST PALLIATIVE CARE UNIT

Claire N MacDermott, Laura McTague, Hayley Evans, Eleanor M Smith. *Sheffield Teaching Hospitals NHS Foundation Trust*

10.1136/bmjspcare-2018-ASPabstracts.151

Background A new electronic whiteboard multi-professional handover (e-handover) was introduced to the in-patient unit. Handover is an excellent opportunity to share information, but is a potential source for errors, if not utilised correctly. There was no standard operating procedure (SOP) for the new e-handover, one was developed to ensure accuracy, a consistent approach and that addressed patients' specific palliative care needs.

Methods The e-handover was audited by two independent doctors against standards developed by The Academy of Medical Colleges, local nursing guidelines and against palliative care outcome measures. A multi-professional group of palliative care specialists including doctors, nurses, and allied health professionals then developed a SOP. The handover was then re-audited following its institution with staff training.

Results In March 2017, 16 patients' notes and e-handover summaries were audited. One hundred percent of patients had

an accurate primary diagnosis on their handover, although documented in a variety of different places. Thirty three percent had a documented preferred place of death (PPD), 56% had documented escalation status (ES), 50% had phase of illness (PoI) and 0% had modified Australian Karnofsky performance status (AKPS) documented on the e-handover. Sixty-nine percent of handovers were easy to read and 55% used trust approved acronyms. Following the SOP introduction, the second audit was performed in September 2017. One hundred percent had the primary diagnosis documented and all in the correct place. PPD was documented in 100% of patients. One hundred percent of patients had a documented ES, AKPS and PoI; however this was not always documented in the patients' notes. Ninety-two percent were easy to read and 92% used trust approved acronyms.

Conclusion Introduction of a SOP has improved documentation of diagnosis, escalation status, AKPS and PoI on the e-handover and enhanced ease of reading. Improvement is still required in documentation in patients' notes.

125 THE DIFFERENCE A MACHINE CAN MAKE: EXPERIENCES OF USING AN ULTRASOUND SCANNER IN A HOSPICE

Siwan Seaman. *Marie Curie Hospice Cardiff and Vale*

10.1136/bmjspcare-2018-ASPabstracts.152

Background Ultrasound imaging is increasingly being used by non-radiologists. The Focussed Abdominal Ultrasound in Palliative Care (FASP) course trains palliative care clinicians in the use of ultrasound to answer certain focussed clinical questions.

Method Analysis of an electronic database detailing all scans performed at the hospice between April and September 2017.

Results Over the 6 months 44 ultrasound scans were performed at the hospice on 35 patients. 25 scans were performed to confirm the presence of ascites or identify a safe site for paracentesis, 8 of these were for non-malignant ascites. 8 scans assessed for bladder enlargement or requirement for a catheter, 1 scan was to distinguish between intrahepatic and extrahepatic duct dilatation in a jaundice patient and 10 doppler ultrasounds were carried out to look for the presence of a proximal lower leg deep vein thrombosis. 24 of these ultrasound examinations would have otherwise required patient transfer to nearby hospital for the investigation. During the analysis period only 3 patients were transferred to hospital for ultrasound; one whilst author was on leave and two where further ultrasound assessments by a radiologist was deemed necessary. Using tariffs from the Welsh Ambulance Service and Health Board it is calculated, that in the 6 month period analysed, savings of £4435 were made through a reduction in return ambulance transfers and ultrasound scanning at the nearby DGH.

Conclusions The use of ultrasound as an additional real-time resource in clinical assessment at the hospice reduced unnecessary hospital transfers and needless urinary catheterisations. Positive feedback received from patients and relatives grateful for the rapid assessment and avoidance of what were described as exhausting and stressful transfers. Other members of the medical and nursing team at the hospice now plan to attend a FASP course.