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

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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

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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.