

together to report on the educational and financial value of education plans.

Results The work of the Clinical Support Analyst is enabling standardisation of the data collection. The CPF has collated four months of activity data, manipulating visual representations of the data to analyse his time allocation. Using an electronic booking system gives a streamlined process for the organisers and attendees, making more efficient use of administration time.

Conclusions The work is ongoing, initial conclusions are as follows. The Clinical Support Analyst prompted a formalisation of data requests and rigorous recording of the time work takes him to complete. It has also highlighted that the data from the electronic patient notes does not match the data collected locally. The CPF has found that the App has to be used with rigour to ensure full data capture. Not all members of staff are confident enough to book their own training and do not read their emails in a timely way.

P-55 DEVELOPMENT OF PERSON-CENTRED CARE AT A HOSPICE

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Background We have had an electronic patient record (SystemOne) at the hospice for the past five years. This is our tool for documenting the care that we provide, viewing and reviewing these notes and reporting on this data. Our patients and families have input from many members of the multi-disciplinary team to ensure that they receive person-centred holistic care. Our electronic patient record, SystemOne was structured so each discipline completed initial assessments within a communal template but ongoing care tended to be written as separate reviews and action plans. The result of this was silos of information and staff not reading each others notes and using the information obtained from patients and families to the optimum. We recognised that the crucial bits of information from patients that make a huge difference to their experience were not being captured and communicated well.

Aims To put people at the centre of their care and support and maximise their involvement through development of person-centred templates on SystemOne.

Methods Multidisciplinary team meetings explored the current methods of documentation. Using patient journeys, a gold standard method of documentation was designed within SystemOne. Generic nursing care plans were removed and replaced with a multi-disciplinary 'About me' Care plan.

Results An 'About me' care plan pops up as soon as an electronic record is opened. It is completed by all members of the MDT and tells us how to care for a patient. It is divided into seven domains of care. It includes phrases like 'Julie likes to have a Baileys in the early evening'. All other elements of care are documented in a person-centred care template by all disciplines.

Conclusions The new method of documentation puts the patient at the centre of their care and ensures their care and support is completely individualised.

P-56 DO ELECTRONIC PALLIATIVE CARE COORDINATION SYSTEMS (EPaCCS) INCREASE THE CHANCES OF A GOOD DEATH?

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Background People at the end of life frequently receive care from a variety of teams and organisations. Continuity of care is particularly important for patients at the end of life and a lack of information sharing is often cited as a barrier to the provision of good quality end of life care.

Nationally, the policy drive to address this has been the development of electronic palliative care coordination systems (EPaCCS). The purpose of EPaCCS are to provide a shared local record for health and social care professionals, with key information about an individual approaching the end of life, including their expressed preferences for care.

Quantitative studies have shown striking differences in place of death with EPaCCS, but are potentially biased and confounded. Technology in isolation is not guaranteed to bring benefit and the initiation of an EPaCCS relies on healthcare professionals opening conversations about death and dying. Whether EPaCCS facilitate such conversations is unclear.

We do not know if EPaCCS improve practice or simply document what is already taking place. Little research has been undertaken to understand how, and by whom, EPaCCS are being used and whether EPaCCS support patients' end of life wishes. Rigorous evaluation and research is needed to investigate to what extent EPaCCS influence services working together to support 'a good death'.

Aims Describe the socio-demographic characteristics of patients who die with an EPaCCS record, their cause and place of death and compare these with patients who die without an EPaCCS record. Explore the impact of an EPaCCS on the experience of receiving end of life care for patients and carers, and understand healthcare professionals' views and experiences of utilising an EPaCCS to provide coordinate care.

Methods This is a mixed-methods study, taking place in the Bristol, North Somerset and South Gloucestershire area, within a realist evaluation paradigm.

Results and conclusions Work in progress – data collection starting September 2018.

P-57 MOVING FROM PAPER TO ELECTRONIC RECORD KEEPING WITHIN A CHILDREN'S HOSPICE

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The aim of the work was to enhance patient safety in the following ways:

- Ability to remotely access a patient record enabling advice or queries to be addressed without finding a set of case notes
- Reduced amount of telephone traffic between the multi-disciplinary team and hospice staff around episodes of care – enabling more timely and appropriate interventions to be offered to the children and their families

- Enabling access to shared community records improving records on significant risks such as allergies and accuracy around what medication had been prescribed
- Saving of clinical time that could be reinvested in providing more time with children and an increased capacity to care for more children and their families
- Improve accuracy in record keeping.

The local General Practices and community services decided to move to one electronic patient system (EMIS web). The hospice was invited to piggy back on the move. Discussions were held with the providers of the system to make the system bespoke for use in the children's hospice. Analysis took place of existing systems enabling them to be transferred to an electronic format. At all stages training, engagement and communication with staff was a high priority to successfully engage them in a significant change to practice.

Findings The nursing team have access to real time information about care episodes for the children both within the hospice and community. The accuracy of recording key information such as allergies and medication histories has improved significantly reducing the risk to patients. The amount of time lost in making phone calls and verifying information in order to deliver care has reduced.

Conclusion Time spent on documentation is more productive enabling more time to be spent with the children and families. The ability to share records with other agencies facilitates collaborative working between agencies.

P-58

'TOO MUCH INFORMATION?' IMPROVING SPECIALIST PALLIATIVE CARE REFERRAL FORMS TO AID SUCCESSFUL TRIAGE

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Background Good referral forms should cover enough key areas to allow effective triage (Donaldson, Carter & Green, 2000) and elicit complete and clear information from referrers (Depasquale & Crockford, 2005). Feedback from current referrers to two neighbouring hospices covering the same NHS Trust suggested existing referral forms were complicated, time consuming, often necessitating further information gathering before they could be triaged.

Aims To assess the completeness of a sample of referrals to specialist palliative care and the proportion of these that could be effectively triaged given the information provided. To utilise the findings in redesigning the referral form.

Methods Retrospective analysis of all referral forms for new patients received by both hospices during August 2017. Internal/existing patient referrals were excluded. Analysis of completion rates of different sections was undertaken and subjective opinion given by one clinician per site as to whether the form could be effectively triaged. The findings influenced referral form redesign.

Results 205 completed referral forms were evaluated. Of 100 referrals to hospice A, the mean percentage of sections completed was 75% and 82% of referrals could be triaged based on form data alone. Of 105 referrals to hospice B, a mean of 73% of sections were completed and 89% could be triaged. Particular sections of the form were

repeatedly left blank. However, even at the lowest completion rates (23%) forms could be triaged, usually due to information provided in 'any other comments' section. Given these results, the forms were made more concise and included an 'open comments' section. Following stakeholder engagement, 'phase of illness' and 'Australian Karnofsky Performance Status' were added (National End of Life Care Intelligence Network, 2016; Abernethy, Shelby-James, Fazekas, Woods *et al.*, 2005).

Discussion The pilot of the new referral form is currently underway with initial positive feedback from referrers. Preliminary analysis from evaluation of the first pilot forms received, suggests a high proportion can be adequately triaged. Pending further results adoption throughout clinical community is planned.

P-59

IMPROVING CROSS-DISCIPLINARY INFORMATION SHARING

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Background We are a large service with a catchment across three Clinical Commissioning Groups, serving a population of 832, 350. We have a 27-bed NHS inpatient unit (IPU) seeing 604 patients/year, a community team (CSPCT) seeing 1642 patients/year and hospital team seeing 1788 patients/year. Our IT system PCS is used across the palliative care service, but is not accessible to GPs or hospital services. Patients travel between all parts of our service and beyond but holistic cross-disciplinary information sharing is limited.

Aim To improve weekly holistic multi-disciplinary assessments of hospice inpatients and share these within and outside the service.

Methods The CSPCT is organised into three teams but the IPU was organised into two teams. IPU teams were restructured to align with the three community teams, with three consultant ward rounds and three post-ward round MDTs each week. A Community Clinical Nurse Specialist now attends the relevant MDT. An electronic holistic assessment form was developed and is projected at MDTs, facilitating communication, capture and dissemination of information within meetings and beyond. The forms are uploaded to the patients' PCS record, accessible throughout the palliative care service.

Results An electronic survey was sent out to all members of the palliative care service. Themes arising include: improved participation from all disciplines; focussed care planning; improved access to and sharing of information; facilitation of better-informed clinical and discharge decision-making when patients moved across the service.

The future Dissemination of the Holistic Assessment Form to all:

- Palliative care service users: uploaded as an attachment on PCS – already happening
- Hospital users: will be uploaded as part of Trust Electronic Document Management System 2019 – to be evaluated
- GPs: to be sent on discharge with patient's Discharge Summary – to be evaluated
- Health and social care professionals e.g. paramedics, out of hours services: to upload to Future Planning Templates.