

## 82 IMPROVING SPIRITUAL CARE IN HOSPICE – INTEGRATING THE ‘HOPE’ ASSESSMENT TOOL INTO THE MEDICAL ADMISSION DOCUMENT

Amy Taylor, Jim Armstrong, Clare White. *Northern Ireland Hospice*

10.1136/bmjspcare-2019-ASP.105

**Background** Junior doctors undertake holistic patient assessments on hospice admission. Although physical and psychosocial needs are frequently comprehensively evaluated, medical staff often lack confidence and training in the assessment and management of spiritual issues. This quality improvement project aimed to improve medical staff confidence in the assessment and documentation of patients’ spiritual needs upon hospice admission.

**Methods** An anonymous survey evaluated hospice medical staff opinion on spiritual care. A chart review examined the spiritual assessments documented at baseline and monthly (February to June 2018). Using the ‘HOPE’ tool, factors assessed were: identification of source of Hope; Organisation/spiritual community; spiritual Practices; desired Effects on healthcare. Interventions included dissemination of a spiritual care journal article, integration of ‘HOPE’, a spiritual assessment tool, into the admission proforma and junior doctor education by the hospice chaplain. Descriptive statistics were generated using Microsoft Excel.

**Results** Eight medical staff (junior doctors and consultants) completed the survey. Spiritual care was identified as important but often forgotten. 63% believed religious leaders should direct spiritual care, but that all staff should have relevant skills. Over 50% lacked confidence in spiritual aspects, particularly regarding religious minorities.

Completion of spiritual assessment improved from 83% to 94%. Identification of source of hope increased from 50% to 78%, which was sustained. Identification of a spiritual community improved from 6% to 67%, but this was not maintained. Identification of spiritual practices improved from 28% to 75% and discussing effects on healthcare rose from 17% to 67%. These were sustained.

**Conclusions** Introducing a spiritual assessment tool improves identification of spiritual needs on admission, particularly source of hope and spiritual practices. Ongoing targeted education would ensure continuous improvement. Use of this tool across inpatient and community palliative care settings could improve spiritual care by clinicians.

## 83 ASSESSING DEPRESSION ON ADMISSION TO HOSPICE: AN AUDIT

Felicity Wood, Emma Lowe. *Wakefield Hospice*

10.1136/bmjspcare-2019-ASP.106

**Background** Depression is prevalent but often undiagnosed and undertreated in hospice settings. The aim of this audit was to establish how well depression is assessed and managed on admission to hospice and during the course of admission.

**Method** All admissions to Wakefield hospice between April and June 2018 were examined. The electronic GP notes were accessed to determine if an established diagnosis of depression was recorded. Written hospice notes were then reviewed. Demographic information was collected as well as whether depression was assessed on admission, and whether it was

rated, as per the medical admission proforma. If mood was recorded as low, it was noted whether a plan was in place regarding this. The medical entries during admission were also read to see if depression was assessed during the course of admission.

**Results** There were 87 patients admitted to the hospice during the 3 month period. Data was available on 61 of those. Less than a third of depression diagnoses documented by GP were noted on admission. In 48% of cases depression was assessed on admission. When recorded as being low in mood, there was rarely a plan specified in managing this. In only 6% of all notes was a rating score recorded for depression. This is part of the admission proforma. In 10% of cases, there was some review of mood made during the course of admission.

**Conclusion** Despite depression being prevalent in a hospice setting, an assessment of this was recorded in less than half of cases on admission. Mood was infrequently documented during the course of admission. When depression was noted, there was not often a plan documented for managing or reviewing this. The plan is to update the admission proforma, educate staff on depression screening and re-audit in 6 months time.

## 84 EVOLVING HEALTH AWARENESS AND CARE EXPERIENCES INFLUENCE PREFERENCES FOLLOWING ACUTE ILLNESS: QUALITATIVE ANALYSIS FROM A MIXED-METHODS PROSPECTIVE COHORT STUDY OF FRAIL OLDER PEOPLE

Simon Noah Etkind, Natasha Lovell, Anna E Bone, Laura Cottrell, Fliiss EM Murtagh, Irene J Higginson. *King’s College London, Cicely Saunders Institute; Wolfson Palliative Care Research Centre, Hull York Medical School*

10.1136/bmjspcare-2019-ASP.107

**Background** Acute illness may catalyse changes in care preferences, but the influences on preferences are incompletely understood in frail older people following acute illness.

**Aim** To explore influences on the care preferences of frail older people following acute illness.

**Methods** Prospective cohort study utilising a concurrent dominant status (quan + QUAL) mixed-methods design with six month follow up. Inclusion criteria were: age  $\geq 65$ ; Rockwood clinical frailty score  $\geq 5$ ; recent acute illness requiring secondary care assessment or admission. Of a study sample of 90 participants, 18 purposively sampled participants contributed both survey responses about their preferred care outcomes and serial in-depth qualitative interviews with a topic guide exploring influences on preferences. Patterns of preference stability identified in the survey responses of these 18 participants were explored during thematic analysis of interviews.

**Results** Median patient age 84 (inter-quartile range (IQR) 81 – 87), 53% female. Median frailty score 6 (IQR 5 – 7). Evolving awareness of deteriorating or uncertain health trajectories tended to influence preferences away from ‘extending life’, towards ‘staying out of hospital’, ‘being comfortable’, or ‘improving quality of life’. Care experiences influenced preferences more prominently than time during the study, particularly affecting place-of-care preferences. Health status changes did influence preference stability, but those with close support from family reported that family considerations were more important than health status changes as an influence on preferences, as family gave them ‘something to live for’. The