of the prescription of steroids. A sticker has been developed and after multi-disciplinary team discussion it was added to the admission documentation with the aim of improving practice at the time of admission. Work to evaluate this intervention is on-going.

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99

RE-AUDIT OF IMPROVEMENTS MADE TO THE MULTI-PROFESSIONAL ELECTRONIC HANDOVER IN A SPECIALIST PALLIATIVE CARE UNIT

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Background Sheffield Teaching Hospitals, including the Macmillan Palliative Care Unit (MPCU), is now using a system of handover via the electronic whiteboard (e-handover). Handover is essential for effective sharing of information but is a potential source for errors. The e-handover was initially audited and a standard operating procedure (SOP) was subsequently produced by a multi-professional team of allied health professionals, nursing and medical staff and the ward pharmacy team. This SOP was introduced in August 2017 with the intention to ensure accuracy and a consistent approach in sharing of information. Re-audit in September 2017 showed significant improvements in all domains and this further re-audit in September 2018 aimed to assess if these improvements had been sustained.

Methods 17 patients' notes and e-handovers were audited by two independent members of the MDT against standards developed by The Academy of Medical Colleges, local nursing guidelines and against palliative care outcome measures. Results were then directly compared to earlier audits in 2017.

Results One hundred percent of patients had an accurate primary diagnosis on their handover and all documented in the correct place. 66% of patients had a documented preferred place of death (PPD), 100% had a documented and accurate escalation status (ES), 71% had a documented phase of illness (PoI) and 82% had Australian Karnofsky performance status (AKPS) documented. 32% of handovers were easy to read and 92% used trust approved acronyms. This confirmed deterioration in some domains, particularly PPD, PoI and AKPS, all of which were recorded as 100% in September 2017.

Conclusion One year after implementation of the SOP there has been deterioration in some of the information on the e-handover. Further work is needed to identify factors involved, such as changeover of staff, and to then re-educate ward staff in the completion of the handover.

100

THE QUEST TO BE A RESEARCH ACTIVE HOSPICE

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Background In 2013, the Commission into the Future of Hospice Care published 'Research in palliative care: can hospices afford not to be involved?' It identified the importance of hospices becoming research active. St Margaret's Hospice in

Somerset includes inpatient and community services and has a history of participation in research. A potential was identified to develop the structure and focus of the research process and to widen participation further to increase research activity going forward.

Methods

- Identifying staff with a research interest and promoting GCP training.
- Developing links to facilitate involvement in collaborative projects.
- Forging links and seeking support from the NIHR locally.
- Developing a more robust research governance structure.

Results A Research group was created with quarterly meetings, involving core members from different disciplines. The aim being to increase awareness of research projects within the organisation, provide a forum for discussion of future projects and promote evidence based practice.

A Research booklet was created with a plan to update a paper copy yearly with continuous online updates. Participation in several portfolio studies including GAS, Hydration at the end of life, and presently STOIC; 32 patients recruited so far.

Conclusion It is feasible to become a research active hospice, even without the infrastructure of an R and D department and a local academic unit.

Key facilitators were the identification of staff members with the interest and enthusiasm to develop research further, seeking local support and collaboration where possible and choosing collaborative projects which the majority of staff felt looked at an important issue and were engaged with. Also with more staff GCP trained, the more opportunity there is for participation.

Next steps

- Forming a collaborative body with the local acute and community trusts.
- Looking at funding options for regular research nurse support.
- Development of in house research projects.

101

A REPORT ON THE BENEFIT AND ACCEPTABILITY OF A NEWS BASED ACUTE ILLNESS MANAGEMENT PLAN IN A HOSPICE INPATIENT UNIT

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Background Over recent years we have had increasing numbers of acute admissions, with potentially reversible conditions, as well as noticing increasing use of intravenous antibiotics, without any structured monitoring of progress. We have introduced an Acute Illness Management Plan (AIMP) including regular observations with triggers for medical review, based on the Royal College of Physicians National Early Warning Score (NEWS). This change was introduced alongside improving oxygen prescribing and administration, and an education programme, and is being followed with ongoing quality improvement work. It is important to ensure staff feel a change is worthwhile and important to ensure they are motivated to develop this further.

We aimed to assess acceptability of an acute illness management plan in a hospice setting.