124

REVISITING POLYPHARMACY IN THE HOSPICE IN-PATIENT SETTING Shahlaa Walsh, Emily Sills. *Working and Sam Beare Hospices*

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Background Polypharmacy continues to be a concern in the palliative care population. Potentially Inappropriate Medications (PIMs), with no short-term benefit, contribute to pill burden, poor concordance and adverse drug events (ADEs). An initial study, carried out in two hospice in-patient units found that 40% of patients were discharged on 10 or more medications and 83% were prescribed at least one PIM. A deprescribing tool was implemented as part of a polypharmacy quality improvement project, based on Lindsey et al's guideline for deprescribing unnecessary medications in the palliative population.

Aim To identify whether the introduction of a deprescribing tool, to aid doctors in discussions about rationalising PIMs, reduces the number of unnecessary medications and total number of medications on discharge.

Method 63 inpatient notes (21 discharges, 42 deaths) were audited using the original audit proforma. For discharges; the number of medications pre and post admission were recorded. Additionally, the number of PIMs prescribed and the number of medications rationalised on admission were recorded.

Standards remained the same as the original study: 80% of medications with limited benefit to be stopped and 80% of patients to be discharged on 7 medications or less.

Results 71% of all patients were on at least one PIM pre-admission compared to 83% previously (pre-tool). 43% of patients were discharged on 7 or less medications, an increase from 38% in the initial audit. There was a 50% reduction in the total number of PIMs prescribed from admission to discharge. 65% patients had at least one drug rationalised on admission. Only 66% of patients went home on at least 1 PIM compared to nearly 80% in the initial audit.

Conclusion The deprescribing tool is beneficial in helping prescribers to recognise polypharmacy and consider rationalising medications, specifically PIMs, in hospice inpatients.

125

'BETTER THE LETTER' – IMPROVING HOSPITAL DISCHARGE COMMUNICATION FOR PALLIATIVE CARE PATIENTS: A SERVICE EVALUATION Sophie Hancock, Maria Debattista, Valerie O'Donnell. *Lancashire Teaching Hospitals NHS Foundation Trust*

10.1136/bmjspcare-2019-ASP.148

Background Communication between hospital and primary care at discharge is vital to ensure patients feel supported and prevent crisis readmissions. The hospital palliative care team (PCT) have developed comprehensive training for all doctors and produced 'better the letter' guidance to improve discharge letter content. The most recent innovation is the inclusion of a specific palliative care section on discharge letters with key information for GPs around advance care planning.

Methods A 'snapshot' service evaluation was conducted from October to November 2018. Discharge letters were examined for patients discharged from hospital who were on the hospital PCT caseload. Discharge letters were examined for presence of a completed palliative care section and relevant GP

actions. Electronic records were reviewed for suitable patients for the presence and content of an EPaCCS (electronic palliative care coordination system) record, created by the GP within two weeks of discharge.

Results 166 discharged patients were identified and 151 of these patients had discharge letters available for evaluation and were included in the study. 74% of included patients had an active palliative care section on their discharge letter. EPaCCS could not be assessed for 51 of the 151 patients due to patient death following discharge. 60% of patients with an active palliative care section on the discharge letter had an active EPaCCS record versus 38% of patients without an active palliative care section.

Conclusions There is some evidence that the presence of a specific palliative care section on discharge letters improves the creation of EPaCCS records in the community, which may improve the coordination of care for these patients. However, there was a proportion of missing data due to death soon after discharge. Further work is needed to improve communication of palliative care information on hospital discharge, and evaluation of the impact this has on patient care.

126

USING PALLIATIVE PERFORMANCE SCALE (PPS) AND PHASE OF ILLNESS TOOL (POI) TO FACILITATE IMPROVEMENT IN COMMUNICATION OF PALLIATIVE CARE NEEDS ACROSS HEALTH AND SOCIAL CARE Claire Howie, Marianne MacLeod, Monica Keenan, Kim Steel. *NHS Fife*

10.1136/bmjspcare-2019-ASP.149

Background In 2018, the NHS Fife Specialist Palliative Care team were awarded funding to spread the learning from the Macmillan funded TCAT 'Best Supportive Care in Lung Cancer' project. Communication barriers and imprecise language existed across our health care environments was one of the factors that had been identified within the Lung Cancer Best Supportive Care project, that needed improvement and this second phase of the project gave us this opportunity.

Methods

- Process map the 'hand-offs' in communication between professionals that occur from the bedside assessment in hospital to having a professional assessing again in normal place of residence;
- Teaching and feedback at all points identified in the process-map;
- Quantitative assessment of how many patients discharged by palliative care occupational therapy team were re-admitted within 14 days and how many died in normal place of residence;
- Qualitative interviews with professionals involved at the discrete points of the process map to describe the changes made to practice.

Results

- There was a change in response from the discharge assessment team;
- More patients were discharged home and died in their normal place of residences;
- There was an increase in the number of discharges home of patients known to the Specialist Palliative Care Occupational Team;

- The themes from qualitative analysis included the benefit of common language and sense of urgency that came across from describing the changes in PPS and POI over a period of time.

Conclusions Palliative Care Performance Status and Phase of Illness can be implemented across an acute hospital and can aid transitions to discharges. It improves communication of the patients needs, health and carer status. As communication underpins all we do the need for accurate, reproducible, evidence based descriptors is important to keep patients safe and to advocate for their needs.

127 IMPROVEMENT OF MDT MEETINGS IN A PALLIATIVE CARE INPATIENT SETTING – A SERVICE IMPROVEMENT PROJECT

Sarah Shipman, Constantina Pitsillides. *Sheffield Teaching Hospitals*

10.1136/bmjspcare-2019-ASP.150

Background Multidisciplinary team (MDT) meetings are central to the management of chronic disease and they have become widely established across the NHS (Department of Health, 2004). MDT meetings are believed to ensure higher quality decision-making and improved outcomes however the evidence to support this is limited.

Despite MDT care being found in many secondary care settings throughout the UK, there is no national standard for an MDT (NICE, 2017). NICE suggests that indeed some of the MDT's success may be in the flexibility to suit each particular clinical area; however, good planning and communication are common themes throughout.

The Macmillan Palliative Care Unit (MPCU) holds a weekly MDT to discuss all current inpatients. There is opportunity to review the effectiveness of documentation during these meetings to ensure they are fit for purpose.

Methods Data was collected retrospectively looking at various aspects of good record keeping prior to a MDT proforma being implemented. A proforma was then introduced and changes made each week on 3 separate weeks. Data was collected after each change to monitor if record keeping improved. Changes made were based on suggestions by members of the MDT.

Results Number of patients' notes reviewed ranged from 14–18 depending on the number of patients on the inpatient unit that week. A deterioration or poor documentation in specific areas prompted changes to be made to the proforma. As a result, the overall documentation of discussions and decisions greatly improved.

Conclusion Overall documentation of discussions and decisions made at MDT meetings has improved following the implementation of the proforma and ensures all MDT members are included in discussions about patients.

128 TRANSFORMING INTERPROFESSIONAL WORKING IN AN ACUTE PALLIATIVE CARE SERVICE

Kim Steel, Monica Keenan, Marianne MacLeod, Fran Stretton. *NHS Fife*

10.1136/bmjspcare-2019-ASP.151

Background Since 2016 NHS Fife acute palliative care team has been developing models of interprofessional working

within the acute hospital. The NHS Fife Specialist Palliative Care Service is a single NHS service which includes 2 hospice units, a community and acute team. Although the Specialist Palliative Care service provides medical and nursing input into the acute hospital, the hospital provides occupational therapy, dietetic, chaplaincy and pharmacy support. To ensure we were providing effective and efficient service we have undertaken multiple assurance measures about the service

Methods

1. Footprint of mortality across our hospital-this was to inform which areas we needed to focus opportunities to develop to benefit most patients;
2. Setting up a structured acute palliative care MDT with all groups that obligates commitment to the service defines the activities of the professionals that attend the group. The MDT also includes learning from complaints, comments and compliments;
3. Using Palliative Performance Score (PPS) and Phase of Illness (POI) to describe our patient group to provide re-assurance that we are seeing patients of appropriate complexity;
4. Developing governance reporting mechanisms from our MDT activity.

Results By understanding where the highest mortality is within our hospital we have been able to increase the focus of resource and education into that area. The MDT has resulted in increase in the confidence of the professionals to overcome organisational boundaries results in co-ordination and efficiency of our approach to patients. PPS and POI has shown that we see mostly unstable patients across the range of PPS and POI. We have annual audit activity that reports to the acute operating divisions governance structure.

Conclusions Sharing a structured MDT and using a system for discussing patients has resulted in sufficient improvements in co-ordination of our acute palliative care team. The change in interprofessional monitoring and reporting has raised the profile and impact of acute palliative care.

Supportive Care | Posters 129 – 139

129 EXPLORATION OF VOLUNTEERS AND SUPPORT WORKERS INITIATION OF QUALITY OF LIFE CONVERSATIONS IN HOSPICE PALLIATIVE DAY CARE

Sharan Watson, Alison Hembrow. *University of Derby, Treetops Hospice Care*

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Background Treetops Hospice, in partnership with University of Derby have commenced a research project exploring the outcomes of developing volunteers, in initiating conversations around quality of life. As a pilot site work for NHS England for Personal Health Budgets (PHB's), Treetops discovered that the 'conversations' around what's important right now to the patient/carer can be just as important, than the outcome of the PHB. This is a vital piece of work which directly could impact on improving individual's wellbeing, the new approach focuses around the mnemonic L.I.S.T.E.N (developed by Treetops Hospice). Policy drivers have acknowledged that there is a much greater need and demand for person centred care than professionals in health and social care can meet, the barriers around developing these conversations, possibly relate to lack of time and clarity to