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94A qualitative study to explore the experiences and roles of early adopters in the early implementation of magnolia house, a new facility for sharing life-altering information and bereavement care

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92 **ASSESSING THE QUALITY OF HOSPITAL DISCHARGE LETTERS FOR PATIENTS KNOWN TO THE PALLIATIVE CARE SERVICES AT A LARGE TERTIARY CARE CENTRE IN CENTRAL ENGLAND: A SERVICE EVALUATION**

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10.1136/spcare-2021-PCC.110

Background Patients approaching the end of life have complex care needs which are often addressed in a variety of health-care settings. Discharge letters are a critical means of communication between primary and secondary care, and play a fundamental role when patients are transferred out of hospital.

Aim To assess and optimise the written conveyance of significant information to GPs about hospital inpatients who had been reviewed by the palliative care team during their admission.

Methods We included all patients at the Queen Elizabeth Hospital Birmingham, over a one-month period, who had been reviewed by the Supportive and Palliative Care Team (SPCT) at least once and then later discharged from hospital. Their discharge letters were interrogated using a bespoke hospital letter assessment tool.

Results Thirty-seven patients were included. Involvement of the SPCT was reported in 54% of discharge letters. Medication changes were mentioned in 59% of discharge letters. Of the patients who were prescribed anticipatory medications during their inpatient stay (n=11), 73% had these mentioned in the discharge letter. None of the few patients discharged on a syringe driver had this reported in the discharge letter (n=3). Changes in resuscitation status were reported in 33% of relevant discharge letters (n=21). Of the patients referred to community palliative care (n=18), 66% had this referral noted in their discharge letter. Discussions about a patient's prognosis were reported in 58% of relevant discharge letters (n=12). The physical and emotional wellbeing of patients were rarely reported; functional status was mentioned in 19% of all letters, and emotional wellbeing in 3%.

Conclusions Relevant information is frequently omitted from the discharge letters of patients known to palliative care at our hospital. This includes information relevant to patient safety, care coordination, and end of life decision making. We have proposed an e-discharge bundle to address this issue.

93 **AN AUDIT OF A HOSPICE PARACENTESIS SERVICE BEFORE AND DURING COVID19**

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10.1136/spcare-2021-PCC.111

Background Our 18 bedded hospice, St Francis in Romford, Essex, sought to evaluate a new paracentesis admissions process, compliance of our inpatient paracentesis against safety guidelines and whether our service was affected by Covid19.

Methods A retrospective search of the patient electronic records database for patients who had a paracentesis between 8.4.19 and 30.6.20. Primary diagnosis was recorded and the

number of paracenteses performed before and after revision of our referrals pathway (8.10.19). Compliance against safety guidelines was reviewed against a check-sheet for all paracentesis from 8.10.19 to 30.6.20. This allowed comparison between the pre-Covid 19 crisis period and during the 'first wave', which began to affect local services, and our bed state, from 2.3.20.

Results Paracentesis rates increased from less than monthly to every 2 weeks after the pathway was revised. This improved rate was unaffected by the Covid19 pandemic, despite immediate reduction in beds to 10 (2.3.20), before normalising at 16 (from 20.4.20). Of eighteen paracenteses between 8.10.19 and 30.6.20, sixteen were 'elective' referrals. Elective referrals waited an average of 4.6 days. Their average length of stay was 5.9 days. No procedures fully complied with guidelines. 14/18 had an ultrasound pre-procedure. 16/18 had documented evidence of medications review. 16/18 had pre-procedure observations. 15/18 had aftercare instructions documented. 3/18 had no documentation of consideration for a permanent drain. Areas of particular concern were: poor documentation of the consent procedure (no documentation for 3/18; only 'verbal consent obtained' for 4/18), no documentation of blood testing/results for 8/18, and details of drain removal were missing for 9/18.

Conclusions Through streamlining the admissions process, the rates of paracentesis at our hospice improved from less than monthly to every 2 weeks and remained a component of care during Covid19. However, audit standards were not reached, and steps are being taken to address this.

94 **A QUALITATIVE STUDY TO EXPLORE THE EXPERIENCES AND ROLES OF EARLY ADOPTERS IN THE EARLY IMPLEMENTATION OF MAGNOLIA HOUSE, A NEW FACILITY FOR SHARING LIFE-ALTERING INFORMATION AND BEREAVEMENT CARE**

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Background Magnolia House (MH) is a new, innovative facility at an acute paediatric hospital. It was built to improve the quality of care for families and staff involved with sharing life-altering information and bereavement, through transforming the environment in which care is delivered. However, implementing healthcare innovations is known to be challenging. This study therefore aimed to understand the experiences of the early adopters of MH to understand factors that promote, inhibit or define new models of palliative care in acute settings.

Methods Semi-structured interviews were undertaken with hospital staff who used MH in its first 3-months of opening (i.e. early adopters). Data collection and analysis were guided by implementation theories, including the Normalisation Process Theory (NPT). Interviews were recorded and transcribed and then analysed using a two-step process involving inductive thematic analysis followed by an examination of the findings in relation to the NPT.

Results The 30 participants were from a wide range of specialties. They had used MH for wide-ranging activities

(treatment/prognosis discussions, advance care planning, treatment withdrawal, memory-making, bereavement care) and felt it improved care by providing privacy, removing distractions and facilitating the humanisation of care. However, issues were highlighted that influenced how MH was understood and used by staff, and have subsequently shaped the routine use of MH. These included issues relating to the practical management of MH, sense of ownership and shared understanding of purpose.

Conclusion The findings reveal important information about how palliative care can be improved in acute settings. They show how initial implementation strategies can influence staff engagement with innovations like MH and suggest factors that affect uptake and the quality of care. This work is informing the development of MH and has wider implications for how other acute settings can transform their care environments for the benefit of patients and families.

95 SERVICE EVALUATION: IDENTIFYING FACTORS CONTRIBUTING TO PROLONGED ADMISSIONS AT MARIE CURIE HOSPICE, NEWCASTLE

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Background The average hospice inpatient stay is 15 days [1]. Admissions can extend beyond this for a variety of reasons. We aimed to 1) measure how frequently length of stay (LoS) significantly exceeded this average at Marie Curie Hospice Newcastle, deemed internally as 25 days or longer, and 2) identify factors common to LoS. LoS is relevant to the limited, intensive resource a hospice provides, where a focus is on symptom control and end of life care.

Methods Hospice inpatients admitted for 25 days or more over a nine-month period (March–December 2019) were identified using SystmOne. Reasons for referral, discharge destinations, Phase of Illness (PoI) and Australian Karnofsky performance scores (AKPS) were recorded, and notes were reviewed to identify contributing factors to LoS.

Results Of 181 patients admitted over the 9-month period, 53 patients (29%) were admitted for 25 days or longer. The median duration of stay was 35 days. Referral reason was multifactorial including symptom control, end of life care, and social breakdown. PoI on admission was unstable (23) and deteriorating (30). AKPS during the admission deteriorated (36), remained static (11) or improved (6).

28 patients died during admission and 25 patients were discharged; the majority (88%) to a nursing or care home. The four most common themes contributing to prolonged stays were complex symptoms (28), gradual deterioration (23), acute medical deterioration (21) and awaiting input from other clinical specialties (14).

Conclusions A prolonged inpatient stay was unavoidable for most patients and related to the underlying patient condition, including complex symptom management and variable disease trajectories. This perhaps highlights the complexities and management challenges with this patient cohort. The hospice has implemented changes to reduce LoS including targets for completing fast-track applications, arranging discharge planning meetings, multi-disciplinary team discharge discussions and the documentation of preferred places.

96 ESTIMATION OF PALLIATIVE CARE NEEDS OF PEOPLE EXPERIENCING HOMELESSNESS USING MORTALITY DATA AND CAUSE-OF-DEATH

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Background People experiencing homelessness have higher standardised mortality rates and higher risk of death than the general population. In recent years, inclusion health services have developed internationally with the aim of addressing extreme health and social inequities. Much of the research exploring delivery of palliative care to people experiencing homelessness is qualitative. We are unaware of a study that has attempted to quantify the palliative care needs of people experiencing homelessness.

Aim To apply cause-of-death based methodology of estimating palliative care needs to deaths of people experiencing homelessness. To evaluate the appropriateness of this methodology to quantify the palliative care needs of this population.

Design Secondary data analysis of a previously reported observational study. Mortality data (2005–2015) of people experiencing homelessness was reviewed for illnesses (malignant and non-malignant) potentially requiring palliative care input, using specific International Classification of Diseases-10 codes. This method, developed by Murtagh et al, has been used widely internationally to calculate both the current and future palliative care needs of populations. Setting and participants: N=361 deaths of people experiencing homelessness in Dublin between 2005–2015.

Results A minimum of 25% of all deaths of people experiencing homelessness would have benefitted from palliative care. This percentage increases according to age-group with at least 64% of people experiencing homelessness over the age of 60 years dying of illnesses which would benefit from palliative care input.

Conclusions Estimating palliative care needs based on single underlying-cause of death has limitations when applying cause-of-death based methodology to a population of people experiencing homelessness. Incorporating multimorbidity would provide a more accurate estimate of need. In developing a palliative care response to inclusion health, older people in homelessness should be considered a priority group.

97 PROSPECTIVE AUDIT OF PATIENTS ADMITTED TO A NEWLY ESTABLISHED SUPPORTIVE CARE UNIT IN WIRRAL UNIVERSITY TEACHING HOSPITAL (WUTH)

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10.1136/spcare-2021-PCC.115

Background Following redesign of palliative care services, four specialist palliative care beds were opened in August 2019 on a ward shared with Haematology. An SOP was developed to guide admissions to the Supportive Care Unit (SCU),