

of EOLC tools rose dramatically. 140 staff received EOLC training.

Year 2 – Post-training, 19% of patients died in an acute setting and the ADAs suggested only 5% might have been avoided if end of life needs had been correctly identified. Uptake of EOLC tools increased with 90% of those who died having some form of ACP and nearly 80% having a valid DNACPR form. 157 staff received EOLC training

Discussion The uptake of EOLC tools was the most obvious achievement and qualitative data indicated increased staff confidence as a major factor. The ability to measure a reduction in inappropriate hospital admissions was more difficult due to interventions from other in-reach projects. The importance of good engagement with GP practices was identified early on, but was outside the scope of this project.

Conclusion This project demonstrated the value of EOLC training, tailored to care home staff needs. Hospices can increase opportunities for good end of life care in the community, without the need for specific patient intervention from specialist palliative care providers.

P4 VALE: VOLUNTEERS AT LIFE'S END, THE LOROS CARE HOMES PROJECT

Jo Kavanagh, Shani Faulkner, Christina Faull. *LOROS Hospice care for Leicester, Leicestershire and Rutland, UK, Leicester, UK*

10.1136/bmjspcare-2013-000591.26

Background Supporting people in the last hours of their life has a particular importance: a human presence may reduce fear, and agitation and promote a peaceful dying (1); provision of a 'sacred space' (2) performing rituals or an environment of valuing of the person's way of life and beliefs may be a consideration; and witnessing the passing from life to death.

Aim LOROS developed a novel pilot service recruiting and training volunteers to work with care homes to compliment their care of dying patients. The aim was to explore the feasibility and evaluate its added value.

Approach used A three day training programme was developed for 9 volunteers : learning hand massage; a focus on common features of dying; features of dementia; and discussing the role and potential impacts on the volunteer. Volunteers developed 'comfort packs' containing readings, music, massage oil and religious icons. A regular support structure was developed.

Four care homes developed operational frameworks for contacting and integrating volunteers in to their team. Leaflets provided information to service users and processes were developed to discuss the service with residents and relatives.

Outcomes Over seven months three of the four care homes utilised volunteers with 10 residents. Most residents who died did not need the additional support of a volunteer and some volunteers were not utilised. Where volunteers did provide support it was highly valued by staff and by relatives. Volunteers enjoyed the work and despite being needed infrequently there was no attrition.

Application to hospice practice Hospice trained and supported volunteers are welcomed by care homes as part of their care team for dying patients. The need for their service is infrequent and unpredictable and when it does occur it is immediate and intensive. These practical factors make it difficult service to provide.

P5 THE SOUTH EDINBURGH CARE HOMES PROJECT: A COMMUNITY NURSE SPECIALIST-LED INTERVENTION TO IMPROVE PALLIATIVE CARE

¹Hilary Gardner, ¹Anne Finucane, ¹Barbara Stevenson, ¹Lynn Muir, ¹David Oxenham, ¹Emily Montgomery, ¹Hilary Gibson, ²Scott A Murray. *¹Marie Curie Hospice Edinburgh, Edinburgh, UK, ²University of Edinburgh, UK*

10.1136/bmjspcare-2013-000591.27

Context Approximately 20% of people die in long term care settings. ⁽¹⁾ National and international policies call for care homes to provide reliably good end-of-life care. Hospices are well placed to support care homes to deliver palliative care to residents who would benefit. This project builds on two previous projects aimed at better meeting the needs of care home residents. ^(2,3)

Aim To improve the delivery of palliative care to care home residents using a hospice-led model of care home support.

Approach used Nineteen South Edinburgh care homes were approached by two Community Palliative Care Clinical Nurse Specialists (CNS) to take part in the project. All care homes agreed. Care homes were divided into two geographically defined clusters. The intervention is currently being delivered to the first cluster.

Key components of the intervention include: support from a dedicated Community Palliative Care CNS; identification of two palliative care lead nurses in each care home; a study day and three workshops based on the Macmillan Foundations in Palliative Care programme; implementation of key processes such as multidisciplinary palliative care review meetings, and support to use tools to help identify residents who may be approaching end of life.

Outcomes The primary outcome is the proportion of residents who die in the care home. Other outcomes include the proportion of deceased residents who had an anticipatory care plan in place; DNACPR documentation in place; appropriate anticipatory prescribing and who died on the Liverpool Care Pathway. Outcome data is being collected before, during and after the intervention period.

Application to hospice practice This project will show the extent to which a hospice based model of care home support enables care home staff to improve the delivery of palliative care to their residents. This would allow hospices to greatly extend their influence to reach non-malignant patients.

P6 ONE STEP AT A TIME: INTRODUCING AN END-OF-LIFE CARE PROGRAMME TO A CRITICAL MASS OF LOCAL CARE HOMES

Cathy Godfrey, Alex Stevenson, Bernie Barber, Baldry Cath, Karen Groves. *Queenscourt Hospice, Southport, UK*

10.1136/bmjspcare-2013-000591.28

Aims The Six Steps to Success programme was launched in the UK (North West) to support the delivery of end of life care in care homes. 36 (1162 beds) of the 109 nursing and residential homes (3,600 beds) in our locality (Southport, Formby and West Lancashire) have undertaken the programme and this poster demonstrates the impact of the programme upon the knowledge, skills and confidence of care home staff.

Design The programme, delivered from the Hospice Hub by end of life care facilitators, includes:

A pre and post course self-assessment of knowledge skills and confidence

Post workshop evaluations

An end of programme questionnaire

This poster describes the analysis of these.

Results The programme met the needs and expectations of 100% of participants. 100% found the education clear and felt well supported by the EOlc facilitators. Evidence shows that each cohort improved in knowledge, skills and confidence across all topics when measured on a 5-point self-assessment scale. Qualitative analysis of feedback indicates that the care homes are working as a team to utilise end of life care tools and improve patient experience approaching end of life.

Conclusion The Six Steps to Success Programme has enabled care homes to bring about organisational change and develop frameworks to improve End of Life Care in their place of work. By working together, sharing experiences and ideas, supported by their facilitators and the local hospice (Queenscourt Hospice), care homes have developed comprehensive end of life care policies which have enhanced delivery of high quality care. By rolling out the programme to a large number of care homes over a 12 month period we are creating a ground swell of enthusiastic motivated care home staff with a desire to collaborate with those working in other health and social care settings to improve the experiences of their residents and relatives.

P7 RED ENVELOPE SCHEME

Shirley Young, Deb Hickey. *St Luke's Hospice, Basildon, UK*

10.1136/bmjspcare-2013-000591.29

Ambulance crews reported lack of information with regards to patient care & wishes, meaning their default position was Hospital admission as they could not 'waste time' looking for relevant documentation eg Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms, 'hidden' in copious patient records.

Aims To give crews readily accessible Patient information, enabling them to make decisions about best care, recognising patient choice.

To prevent unnecessary or unwanted hospital/hospice admissions for palliative patients. A form was designed which included Information regarding patients' Preferred Priority of Care, DNACPR, medications and contact details of relevant Health Professionals. This was agreed by the Ambulance Service.

An A5 Red envelope labelled 'FOR AMBULANCE CREW ONLY' held the completed form, to be The Scheme was piloted for 3 months from April – July 2012

During the trial 24 forms were completed and held by the patient and family

The checklist was described as 'Directional Documentation' by the Ambulance service. The contact numbers and information gave crews the opportunity to call and discuss the situation with other professionals.

Subsequent improved communication between services has resulted in Ambulance crews anecdotally describing a change in practice and increased confidence in making decisions to support patients to remain at home.

Discussion In the absence of Electronic Registers within our locality, the intermediate solution was to introduce the Red Envelope Scheme which gave Ambulance crews the right information at the right time. However despite the large catchment

area of the Hospice the Scheme reaches a small percentage of patients with palliative care needs.

Conclusion Crews now look for a red envelope in the patient's home. It gives support to crews to make the right clinical decisions and the opportunity to influence the patient journey in a more positive way.

P8 CARE ACROSS SETTINGS: EVALUATING AN INTEGRATED SPECIALIST NURSE-LED PALLIATIVE CARE CLINIC WITHIN A GENERAL PRACTICE SETTING

¹Emily Harrop, ¹Jessica Baillie, ^{1,2}Anthony Byrne, ³Karen Stephens, ¹Annmarie Nelson. ¹Marie Curie Palliative Care Research Centre, Cardiff University, Cardiff, Wales, ²Cardiff and Vale University Health Board, Cardiff, Wales, ³Marie Curie Hospice Cardiff and the Vale, Penarth Wales

10.1136/bmjspcare-2013-000591.30

Background A community nurse-led palliative care clinic was introduced at a UK General Practitioner's (GP) practice in April 2012. The clinic aimed to provide earlier identification of patients with cancer and non-malignant disease, initial patient assessment, education for GPs and other community professionals, and strengthen relationships with the local multi-disciplinary team. This provides a new model for engaging patients and ensuring that specialist palliative care is delivered across different clinical settings. Usually, clinical nurse specialists (CNS) support patients in the home. This new initiative brings a fortnightly clinic as a complementary resource to consolidate the joint primary/ palliative care approach.

Methods This study evaluates implementation processes and the impact of the clinic on patient experiences and professional practices. It assesses uptake of palliative services and the management and delivery of palliative care by GPs and CNS.

Baseline interviews with GPs (n = 5) and CNS (n = 4) were carried out in February 2012. Semi-structured interviews with patients (n = 6), GPs (n = 6) and CNS (n = 4) are being undertaken to assess perceptions of the clinic.

Patient interviews will be analysed using an Interpretive Phenomenological Analysis (IPA) approach. Interviews with GPs and CNS will be analysed using Framework Analysis.

Results Perceived aspirations for the clinic included: earlier referral; improved communication and continuity of care; psychological and practical benefits for patients/ carers; more targeted use of specialist nursing resources. Baseline interview data highlights the need for improved referral and communication practices, especially for non-cancer patients. Data from patient and follow-up interviews will be reported against these aspirations, with additional themes identified.

Conclusions and application Conclusions will be drawn on the effectiveness of the clinic and implications identified for palliative care provision in primary care settings, including the potential to roll out a similar model more widely.

P9 IS THERE ANYBODY THERE - TELEPHONE ADVICE LINES WHO NEEDS THEM?

Tracy Livingstone. *Nightingale House Hospice, Wrexham, UK*

10.1136/bmjspcare-2013-000591.31

Background and Context Nightingale House Hospice have offered a 24-hour telephone advice line to patients and their carers in North East Wales since the year 2000. Predominantly