

the area covered is urban with good access to a variety of health and social care services.

In 2010 the hospice were asked to provide a similar service providing advice on palliative care/specialist palliative care to health care professionals across all geographical areas of North Wales acting as a triage centre for palliative medicine consultant advice, this service was not made available to patients and families due to concerns regarding potential volume of calls. This introduced a population located in large rural areas with more sporadic access to services.

Aim & Approach The purpose of the audit was to encourage discussions about the ethics of delivering a two tier service based purely on geography but also considers the context of the calls in terms of the services available to patients within each locality in terms of model of service provided and also the hours of operation/delivery

Outcomes This presentation details the findings of an audit of the advice call forms completed reviews and compares the data collected from both geographical areas covered by the advice line, considering the volume of calls from both areas, the time and duration of calls and also the reasons why people called.

Application to practice The audit recognises some limitations in the method by which data is currently collected and reviewed providing guidance for the future in terms of what do we need to know in order to measure the impact and outcome of the provision of this service to patients and their families.

The work also draws conclusions for practice in terms of identifying current need within our locality.

P10 HOSPICE RAPID RESPONSE SERVICE – A PROSPECTIVE ANALYSIS

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Background/context Following a retrospective analysis of urgent unplanned visits, evidence emerged that supported a new rapid response role for a clinical nurse specialist.

Main Aims

- To enable palliative care patients in the community, who have complex needs or whose condition is deteriorating, to access prompt specialist palliative care services.
- To assess whether more patients
- are enabled to exercise their preference about place of death

Approach used The service was available to new and existing patients for end of life care and support of urgent symptom control issues (N = 78). Referrals requiring urgent attention were passed onto the Rapid Response Nurse. The CNS worked flexible hours in order to support the needs of the patient. Data was collected prospectively over a six month period using survey monkey.

Outcomes Seventy Eight patients supported over 6 month period. 38% had a non - malignant diagnosis. 67% of patients were referred for terminal care with the remaining requiring symptom control. As a result of the rapid response visit 86% of patients remained in their own home. None were transferred into the acute sector. 75% of patients who died within the 6 month period achieved their preferred place of death with only 6% who wished for a home death unable to achieve this.

Application to hospice practice The service was timely, responsive and supported increasing numbers of patients to be cared for and to die in their preferred place of death. All visits responded to crisis therefore all patients had potential to be admitted to hospital. Patients in the Nursing homes were particularly vulnerable.

The service therefore prevented unnecessary admissions into the acute sector and supported Hospital Palliative Care Teams with rapid discharge home.

A Rapid Response Clinical Nurse specialist is effective – right skill, right intervention, right time.

P11 THE STARS THAT COME OUT AT NIGHT - PRESENTING THE HOSPICE '8 TO 8' NIGHT NURSING SERVICE

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Background/context Maximum impact in terms of achieving patients preferred place of care may be gained by focussing future service development on extending and improving care at home. This also ensures on-going collaboration between NHS and other providers of end of life care.

Since September 2011 the Hospice has been developing the '8 to 8' service which provides a night nursing service for existing Hospice patients and more recently, through partnership working with other healthcare providers for dying patients not known to the Hospice.

Main Aims

- To optimise the opportunity for patients requiring end of life care who wish to stay at home to remain in their preferred place of care
- To prevent unnecessary admissions to hospitals

Approach used The service is delivered by both bank and permanent members of staff and includes both registered nurses and senior health care assistants. All staff are inducted by the Hospice and given the requisite palliative care skills. The service is led by a clinical nurse specialist who supports and co-ordinates the allocation of staff according to clinical need. The nurses remain with the patient throughout the night.

Outcomes Evaluation demonstrates that the service has exceeded expectations. Most patients referred to the 8 to 8 service are for terminal care with 95% of patients achieving their preferred place of death. The service now delivers 50 nights per month across the catchment area.

Application to hospice practice The 8 to 8 service has been commissioned by two clinical commissioning groups since its inception and continues to expand and build on its success. It is delivered by specially trained nurses who are compassionate, efficient, caring and greatly improve the patient experience. Increasing numbers of complex patients are now able to be cared for in their preferred place of care.

P12 HOSPICE AT HOME SERVICE LISTENING, RESPONDING, DEVELOPING

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In 2008 the Department of Health (DH) identified increasing evidence that lack of co-ordinated community support was

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resulting in avoidable admissions and prolonged hospital stays. They went on to describe how hospice at home services could have a significant impact in enabling patients to die in their own home. The existing night hospice at home service provided practical support to patients and carers between 10 pm and 8 am. Building on the 7 C's of the Gold Standards Framework (2005) the team promoted contingency planning and service co-ordination ensuring that they were already an integral and valued part of the community based services.

However, with an expected increase in the number of deaths from cancer and non-cancer deaths (Kings Fund 2011) and a local emphasis on preventing unnecessary admissions (Health and Well-being Board, 2012) a wide ranging review of the hospice at home service was undertaken in 2012. Service users and health care colleagues emphasised the importance of:

1. A 24/7 service
2. Rapid response
3. Not being reliant on external funding
4. Supporting carers via 'on the job training and support'
5. Being accessible
6. Highly skilled, consistent and compassionate staff

The review also identified several unmet needs which could be addressed by an expanded hospice at home team, these included:

- Crisis intervention, for example whilst acute symptoms were addressed, carer stress or ill health
- Rapid response and extended packages of care for changing needs
- Pre-admission to the hospice in-patient unit
- Supported discharge from the hospice in-patient unit
- Rapid discharge from the acute sector

Our service outcomes include:

- Provision of a hospice at home service tailored to meet local needs
- Increased integration of hospice services.
- Cost effective use of hospice resources
- Increasingly achieving preferred place of care/death

P13 EVENING CALL

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Introduction The End of Life Care (EoLC) Strategy (2008) and Preferred Priorities of Care (2011) documents support enabling people to remain in their own homes.

Prompted by the volume of calls into the in-patient unit, and workload of the district nurses in the early evening, the hospice piloted an extension to the Hospice@Home (H@H) working hours.

Aim To reduce unnecessary admission to hospital at the end of life by providing extended access to support and guidance for patients, carers and health care professionals.

Method Following a three month analysis of telephone advice calls received by the Inpatient Unit (IPU), outside of H@H working hours, the pilot took place over a 9 month period. This extended the accessibility of trained nurse contact from 4.30pm to 9pm on a daily basis.

Results Throughout the pilot phase, calls were recorded and outcomes summarised, paying particular attention to the purpose

of calls, caller identity, and the time the call was received. These statistics provided evidence that the service was not routinely accessed after 7pm.

During the pilot, five admissions to hospital were prevented, primarily due to the swift response and symptom management by H@H. Patients and carers benefitted from the flexibility and accessibility of a trained nurse to action changes, provide continuity and reassessment from 8.30am until 9pm.

There were a high proportion of calls requesting complex symptom advice, reporting family distress and requesting an increase in care.

Conclusion Staffing the extension to the service proved challenging however the pilot was positively evaluated by the district nursing team.

Guidance, reassurance and prompt response to need, undoubtedly contributed to the prevention of crisis admissions to the acute trust.

P14 THE IMPACT OF AUDIT ON CNS TEAM DEVELOPMENT

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In 2011 the Hospice Clinical Nurse Specialist (CNS) team were facing a significant increase in patient referrals numbers (approximately 70 per month). The demand for community based care, rather than acute hospital admission, was also resulting in increasingly complex and urgent referrals from all areas of the local healthcare economy. In addition, palliative and end-of-life care services traditionally available only to cancer patients were increasingly being accessed by patients with non-malignant diagnoses.

In response the CNS team undertook a month long audit of referrals to the community nurse specialist service. The audit revealed:

1. Low levels of referral information, resulting in delayed contact
2. Difficulties assessing levels of urgency
3. Lack of clarity regarding other services involved with the patient
4. Unnecessary home visits

As a result the CNS team has now introduced the following:

1. A new streamlined referral process
2. A full time specialist triage nurse who makes first contact with all referrals:

She:

- Responds to all referral agencies
 - Assesses level of urgency
 - Holds her own low-level caseload that she contacts by phone
3. Helpline established and available to patients and health care professionals: this service provides immediate access to a highly skilled CNS
 4. Accessing and completing the electronic notes systems to ensure comprehensive and up to date clinical information is readily available to the wider healthcare team.
 5. Enhanced patient documentation

Continuous development is key and plans are being developed for: