- A visiting 'rapid response' CNS
- A nurse led triage clinic
- Increased triage nurse hours

The CNS team have used audit to truly 'hear' what is happening in practice and as a result have used this knowledge to lead service redesign- a key aspect of the CNS role identified by National Cancer Action Team (2010)

P15 THE RIGHT WAY TO WRITE? DEVELOPMENT OF NEW DOCUMENTATION FOR COMMUNITY PALLIATIVE CARE

Hilary McPolin, Mary McMullan, Grainne McGinnity, Fiona Flynn. *Northern Ireland Hospice, Belfast, N. Ireland*

10.1136/bmjspcare-2013-000591.37

Background/Context Efficient, comprehensive documentation not only provides a record of care, but also reflects the quality of that care whilst reinforcing care standards. However, documentation in palliative care has often fallen short of these ideals (McEvoy, 2000). Following the development of a centralised triage system for new referrals to a community palliative care service, it was recognised that there was duplication of information being recorded by both the triage staff and the community nurses. There was also a general consensus that the triage documentation should be incorporated into the nursing assessment tool to reflect the patients' journey and promote continuity of care.
Aim To develop user friendly, time efficient documentation that provides a comprehensive holistic assessment of specialist palliative care patients and their families.
Approach Used A project team was formed with representatives from the triage team and the community nursing teams. Following a review of in-house documentation, Liverpool Care Pathway (LCP) and assessment tools from both hospital and community palliative care teams, a new tool was developed and piloted. Minor changes were made, based on the initial evaluations and subsequently, a second pilot was undertaken before the tool was finalised.
Outcomes The new tool was rolled out to all the community teams in January 2013. Feedback to date suggests a reduction in both the amount of duplication as well as the amount of time spent on recording the required information.
Application to Hospice Practice The new documentation tool reflects a holistic, comprehensive, specialist palliative care nursing assessment, in a user friendly, time efficient format. It has improved communication and accessibility of information and recognises the need to increase the capacity for recording the needs of carers. Better documentation can lead to better patient care.

P16 PLANNING YOUR WEEK: A NEW MODEL FOR RURAL WORKING

Derek Hart, Cathy Martin, Maggie Draper. *St Luke's Hospice Plymouth, Plymouth, United Kingdom*

10.1136/bmjspcare-2013-000591.38

An examination of caseload management is currently being undertaken by 2 community palliative care nurses who cover a large area, encompassing the environs of city to remote moor land. The remote areas have no mobile telephone access and poor infrastructure.

The caseload was analysed and divided into 7 geographical areas (zones). Visits were to be arranged to these zones on specific days to optimise efficiency, taking into account mdt commitments.
The aims were:

- To increase efficacy of visits, reduction of interruptions
- Reduce travelling time and mileage
- Improve response time from referral to first visit,
- Improve reliability and therefore develop stronger integrated working.
- Improve wellbeing and support of the CNS.
- Move from reactive "fire fighting" to proactive care where crises were predicted where possible.

The approach used was:

- A time table of areas and days was created.
- Two nurses covered the caseload of approx 60 patients.
- The timetable took into account mentorship needs of the new CNS. It promoted men- tee and mentor working in neighbouring zones. Meeting places in the field (literally!) were highlighted should support be required.
- 1 nurse per day was allocated to triage calls and trouble shoot.
- The administrative team were involved in planning and were aware of who to call.

Outcomes – to be measured / reviewed September 2013

- Supportive mentorship of new CNS in rural environment
- Reduced Mileage
- Reduced interruption from mobile phone calls.
- Reduced sickness
- Improved record keeping. The two nurses were reliant on each others records to provide continuity of care.
- A more efficient use of laptops reducing the need to return to base.
- Development of professional relationship between nurses encouraging peer review.
- Improved relationships with GPs and community nursing teams

P17 THE COMMUNITY AND HOSPICE HOME NURSING SERVICE

[1]Lesley Spencer, [2]Karen Masetti, [3]Gina Starnes. *[1]Princess Alice Hospice, Esher, England, [2]Central Surrey Health, Ewell, England, [3]St Catherine's Hospice, Crawley, England*

10.1136/bmjspcare-2013-000591.39

Background/ Context End of Life care support throughout Surrey had been fragmented and lacked an integrated approach. As a result three organisations came together to form the 'Community and Hospice Home Nursing Service'.

The service supports a multi-disciplinary partnership approach to delivering nursing care at home. Central Surrey Health (CSH), and two Independent Hospices; Princess Alice Hospice (PAH) and St Catherine's Hospice (StCH) are now delivering a seamless seven day, 24 hour service.
Main Aim To provide care that avoids inappropriate hospital admissions and enables more people to be cared for and die in their place of choice.