

P121 HOW IMPLEMENTING DECIDING RIGHT IN CUMBRIA SUPPORTS GOOD PRACTICE IN ADVANCED CARE PLANNING (ACP): A CASE STUDY

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Introduction Deciding Right (DR) is an integrated approach to making decisions about future care. It draws together statute and good practice for ACP with children, young people and adults across all sectors of health and social care, and embeds this through shared documentation. It starts with a conversation between the professional and patient about their right to make care decisions in advance. The project is jointly hosted by three of the independent hospices in Cumbria, and is strategically linked with the 1% GP palliative care registers campaign.

Case Study We will present a case study of Betty, 76yrs, with end stage COPD and multiple co-morbidities. This is a complex case featuring repeated hospital admissions and fluctuating capacity around end of life care. Through exploring this case history we will show how DR made a real difference to choice, control and sense of self for Betty, and to the health and social care management of her care. We will demonstrate how DR was important in facilitating multi-disciplinary working and critically, cross agency information sharing at end of life.

Discussion Establishing DR shared documentation across the whole of health and social care has been crucial in rolling out ACP conversations and this approach is effecting change in organisational culture. Training and education for professionals builds capacity within the existing workforce to change current practice, and engagement with students helps to future-proof the principles of DR in Cumbria.

Learning points 1. Making ACP conversations the responsibility of all professionals is key to ensuring that conversations happen early enough in people's journey for them to be well thought through and meaningful.

2. Agreeing and adopting shared documentation for Health, Social Care and 3rd Sector organizations is fundamental to ensuring that ACP conversations held are recorded appropriately and in a meaningful format for all concerned.

P122 DEATH, DYING AND DEMENTIA: DIMINISHING DILEMMAS AND DISTRESS

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Background/context There are currently 750,000 patients living with dementia in United Kingdom (Alzheimer's Society, 2011) with evidence of inappropriate hospital admission of patients with advanced dementia (Pace, *et al*, 2011). NICE, (2013) suggest a palliative care approach from diagnosis till death. Following a critical reflection relating to the end-of-life care of patient with dementia, the local hospice collaborated with local advanced dementia unit to hold bi-monthly meetings to improve planning care.

Aim As a result of this collaboration patients are supported to receive their end-of-life care in familiar surroundings resulting in equality of care to those who are cognitively intact.

Approach used Bi-monthly meetings assess newly admitted patients and identify patients approaching end-of-life. Discussions are documented in case notes with particular significance to DNACPR, preferred place of care/death and communication with relatives.

Outcomes As a result of this collaboration the outcomes are fourfold

- Patients can expect an agreed care plan at end of life, with coordination of specialist dementia and palliative care services.
- Carers can expect increased support, are involved in advanced care planning, have access to newly formed carers group and access to bereavement care.
- Dementia unit staff have increased expertise, improved their uptake of education on end of life issues, have received bespoke communication training and have rapid access to specialist palliative care advice.
- Hospice staff have improved recognition of needs of advanced dementia patients and allows them an opportunity to seek advice on control of symptoms of other dementia patients

Application to hospice practice This collaboration allows both units to transfer their skills to benefit an increasingly ageing population. It allows the hospice to plan ahead for the increase in future referrals of dementia patients in line with predictions.

P123 IMPROVING END OF LIFE CARE ON INPATIENT DEMENTIA WARDS

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Introduction This audit and service review looks at a collaborative approach to improving the end of life care for people with dementia on inpatient wards in Cornwall. It has prevented many inpatients resident on the inpatient dementia ward being transferred to the acute hospital for symptom control or terminal care.

Background People with dementia over 65 years of age are using up to one quarter of hospital beds at any one time and it is estimated that that the majority of the 100,000 people who die with dementia are in hospital. Multiple initiatives have set out to improve the end of life care of these patients. Despite this, there is evidence that suggests that end of life care for people with dementia is significantly poorer than for people without dementia.

Methods An inreach service to the dementia wards was provided by the hospice nursing and medical staff. The three key aspects were:

- Guidance - specific end of life care guidelines were written collaboratively, taking into account the complexities of setting, staffing and patient group.
- Confidence building - Dementia unit staff were educated in palliative care principles & skills, with hospice nursing staff & doctors providing peer education and support.
- Support - the dementia units were given 24/7 access to the hospice advice line with availability of consultant review withing 24 hours when needed.

Results Transfers of patients to the acute trust were reduced and end of life transfers eliminated in patients with contact with the inreach service. Staff confidence and expertise was developed to