

(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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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),