

more patients to be cared for in their place of choice. However, for a very small number of complex patients, the lack of inpatient facilities had proved problematic. To avoid this consequence during the second wave, a new plan to open a virtual ward, staffed by some of the inpatient team, was devised. **Aim** To ensure that dying patients with complex needs were given equitable and appropriate care whilst the inpatient unit was closed.

**Method** Clinical staff were once more re-located to the community teams, but this time with 24-hour provision of nursing care, rather than the usual four times daily visits. Medications were administered in a more timely way, and delivery of personal care was given at the patient's convenience, rather than set times, with increased support for families. Closer liaison with the multi-disciplinary team (MDT) also improved the patient experience, with daily MDT discussion.

**Results** Eight patients who required complex medical intervention, were admitted to other local hospices. However, 47 patients were admitted to the virtual ward, averaging 8.6 admissions per month. Identification of the last weeks of life was greatly improved by the internal referral process, reflected in an average length of stay of 7 days (range 3-13 days).

**Conclusion** By offering complex care to people at end of life in their own homes, this approach fulfilled the ideal criteria of 'providing everyone the right care, from the right person at the right time' and reduced prior inequality of care provision (Thomas, 2021).

#### 0-15 WORKING COLLABORATIVELY TO IMPROVE END OF LIFE DOMICILIARY CARE

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10.1136/spcare-2021-Hospice.14

**Background** Audits and Care Quality Commission intelligence revealed a knowledge and skills gap for domiciliary carers giving end-of-life care. This resulted in end-of-life patients in Essex not always dying in the place of their choice, with frequent inappropriate 999 calls and transfer to hospital.

**Aim** This project was devised to offer unified end-of-life care teaching to domiciliary care providers across Essex, to upskill carers and create supportive links with council and local hospices. This ultimately would improve the care given to those at end-of-life, reduce unnecessary hospital admissions and support the confidence and comfort of carers.

**Methods** A three-day course was created by the three main hospices in the area working collaboratively with the local council. Funding was sourced by the council, so that participants could attend free-of-charge. The course was delivered in all three areas, covering the same end-of-life care material and addressing all six Ambitions for end of life care (National Palliative and End of Life Care Partnership, 2015; National Palliative and End of Life Care Partnership, 2021). The course also addressed the Care Quality Commission's inspection Key Lines of Enquiry and fulfilled requirements of latest national guidance (Thomas, 2021).

**Results** The teaching has reached approximately 650 carers over the last two years, through a cascade method of teaching. Pre- and post-learning questionnaires demonstrated increased knowledge and confidence for all participants. Furthermore, 80% of attendees reported cascading the knowledge acquired to colleagues, with 60% reporting a marked improvement in attitude of staff toward giving end-of-life care. Telephone calls to local hospice helplines increased, with a parallel reduction in 999 calls, meaning that those patients received more appropriate care at home. Links to local hospices have been strengthened, and participating care agencies have received recognition for their improved work, with one agency gaining 'Outstanding' in their inspection, and a care sector award for their end-of-life care.

**Conclusion** This joint teaching project has improved end-of-life care given to people across a whole county, and also offers a model for others to replicate.

#### 0-16 SUPPORTING CARERS TO ADMINISTER END OF LIFE SUBCUTANEOUS MEDICATION IN THE COMMUNITY

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10.1136/spcare-2021-Hospice.15

The aim of this initiative was to facilitate timely symptom relief at the end of life for patients in their own homes (Healy, Israel, Charles et al., 2018). By safely training family carers to administer subcutaneous medications, patients receive symptom relief without delay and family members report feeling able to support their loved one in their moment of need (Anderson & Kralik, 2008). This change not only enables effective, responsive symptom control, but also patient choice, carer involvement and preferred place of death. A registered nurse or doctor is responsible for ensuring this is carried out safely with training, reviews and monitoring (Healy, Israel, Charles, 2013).

Quality improvement methodology was used to provide a structure in which to safely roll out the initiative. During the early phases Plan Do Study Act (PDSA) cycles were used to evaluate success and identify opportunity for improvement after each new referral to the service. This included reviewing carer feedback at every stage to inform the evolution of the initiative, as part of the PDSA process.

This initiative is becoming well-embedded at Prospect Hospice and we have had fantastic feedback from those involved. We are now keen to support the roll out of this approach to the wider local Integrated Care System (ICS). Not only does it bring benefit to patients and family carers, it also releases valuable time and resource for the Hospice to direct elsewhere.

For example, thanks to this initiative one patient supported over a total of 13 days was able to remain at home, with support from her family, and died peacefully with appropriate medication administration. We calculated that the total number of community visits saved was 39, equating to approximately 3.5hrs of nursing time per day, including travel. Training was provided to the family carers when the patient was an inpatient at the Hospice, and the family had access to a 24hr helpline to use as needed. This is just one of many examples.