

- Care staff were given tools to initiate a regular seated exercise group.
- Provision of targeted input to some residents which showed improved elements of function, mood and quality of life (this was evidenced by verbal feedback).
- Raised the profile of St Christopher's' rehabilitation service and built relationships with local care homes.
- Enhanced understanding of the experience of living in care home settings for residents and care staff.

On conclusion of the project, a resource was developed with the focus on Rehabilitation in Care Homes – for staff, families and residents allowing further opportunity for enabling and embedding a rehabilitative palliative care approach.

P-26 CLINICAL NURSE SPECIALISTS IN PARTNERSHIP WITH PRIMARY CARE AND CARE HOMES TO EMBED 'RESPECT' AND ACP

Tricia Evans, Louise Greenaway, Claire Evanson. *Compton Care, Wolverhampton, UK*

10.1136/spcare-2022-HUNC.48

Introduction Care home residents are conveyed to acute settings in more frequent episodes in the absence of a completed ReSPECT process or clear escalation plan. Resuscitation is required to commence in the absence of a clear do not attempt resuscitation decision. There is a large percentage of decisions to convey a resident in the absence of a ReSPECT document and/or an advance care plan to support wishes to remain in their usual place of residence.

The scope of this service is to ensure that all ReSPECT and Advance Care plan documentation was up to date and fully completed with residents/families and other professionals, working in partnership with primary care and the care home sector across Wolverhampton.

Methods The service initially commenced within 3-6 care homes with a population of 50-75 residents, identified by conveyance figures, GP and PCN leads. The aim to complete, per home, 75% of all identified residents ReSPECT document prior to engagement with other homes.

Compton Care Clinical Nurse Specialist engaging with care homes to proactively embed the ReSPECT process, support and role model advance care planning conversations increasing the confidence and skills of care home staff in identifying their residents' needs.

Results From the onset of the service February to April 2022 increased activity over timeline. Increased numbers of both care homes and residents engaging in the process of ReSPECT in support of dying within usual place of residence. Further results to follow on poster.

Discussion The implementation of this service will ensure that residents are able to have meaningful conversations in relation to their wishes and preferences for palliative and end of life care. From onset the feedback received from care home staff, PCN leads and GP who have been supportive toward the service, PCN ANPs and both residents and families has remained positive. The team have led on meaningful ACP discussions and facilitated ReSPECT process to support residents' choices. The increased demand and activity across Wolverhampton has enabled further expansion of the team by Compton Care; increasing the number of both CNS and paramedic

practitioners within the service, each now aligned with individual PCNs.

P-27 VOLUNTEER ADVANCE CARE PLANNING SERVICE PILOT

Elizabeth Brown. *Saint Michael's Hospice, Harrogate, UK*

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Background Advance care planning (ACP), with particular reference to care home residents, has been brought to the fore by the COVID-19 pandemic, with concern over residents' involvement in resuscitation decisions leading to a review by the Care Quality Commission (2021). Whilst recently published Universal Principles (NHS England. 2022) will be helpful, achieving high quality ACP consistently with impact and at scale has proved elusive. In response to this need we piloted an innovative ACP service for capacitous care home residents; delivered remotely by trained volunteers to include treatment escalation plans.

Aims To evaluate our ACP service with reference to: a) concordance between treatment escalation decisions made by residents when supported by a volunteer compared to a GP; b) time taken by volunteers and GPs; c) acceptability of remote ACP in this population; d) feedback on the service from GPs, residents and care home managers.

Methods Apr – June 2020: service set up with PCN leads' support, recruitment and training of volunteers (counsellors and medical students), partial funding from West Yorkshire & Harrogate Health Inequalities Fund. Residents completed an ACP with a volunteer which was then re-discussed with GP. July 2020: Pilot commencement with data collection on time taken, outcomes and feedback questionnaires to all involved. Service evaluation after 25 appropriate referrals.

Results 95% concordance in escalation plans created with volunteer compared to GP. Average time taken; volunteer 52 mins, GP 12 mins. 100% of residents found the service useful and would recommend to others, with 88% finding the remote platform acceptable. The GPs reported the service as being useful for 96% of referrals.

Conclusion An ACP service for capacitous care home residents delivered remotely by trained volunteers is feasible and acceptable. This has the potential to allow GPs, or clinicians within an ACP service, to reduce down the time taken by building on volunteer-led ACPs or concentrate on complex ACP decisions where clinical input is needed.

P-28 PARTNERSHIP WORKING TO ESTABLISH A VOLUNTEER COMPASSIONATE COMPANION SERVICE WITH AN ACUTE TRUST

¹Helen Meehan, ²Wendy Meilton. ¹Royal United Hospitals Bath NHS Trust Foundation Trust, Bath, UK; ²Dorothy House Hospice Care, Winsley, UK

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Background Not many of us express a wish for where we wish to die; a lot of us would hope to be at home, but for many it is hospital where they are cared for in the last days of life. For some patients and families there was a need for companionship support in the last days of life in hospital.

Aim To establish a volunteer service for patients nearing end of life to provide compassionate listening, comfort and companionship.

Method We established a partnership steering group and secured a 3 year grant to set up a volunteer companion service for the Royal United Hospitals Bath, building on an existing companion model at Dorothy House Hospice. We agreed a volunteer role profile, recruited volunteers, provided specific training and supervision. We developed referral criteria and information resources for patients and their families, for hospital staff and for volunteers. We tested the model on three wards and then agreed a roll out plan to all wards.

Results Despite the COVID-19 pandemic the service has rolled out to 19 wards. We have recruited four cohorts of volunteers and currently have 25 active volunteers. The service has received 86 referrals and supported 71 patients. The volunteers have provided 319 support visits and 618 hours of companionship. The reasons for referral have included: no family support (n=7), limited family support (n=37), respite break for family (n=38) and support for family (n=3).

Conclusion The Compassionate Companion Service is making a huge difference to patients, their families and staff. Sometimes it is the little things, the small acts of kindness, the holding of a hand, the words of comfort and being present that give so much support to those nearing end of life and to their loved ones. We plan to roll out to all wards this summer and have service funding for a further three years.

P-29 IMPROVING PALLIATIVE CARE IN SCOTTISH ACUTE HOSPITALS – A THREE STRAND APPROACH

¹Caroline Sime, ²Kirsty Boyd, ³Deans Buchanan, ⁴Gordon McLean, ⁴Trisha Hatt, ¹Mark Hazelwood. ¹Scottish Partnership For Palliative Care, Edinburgh, UK; ²University of Edinburgh, Edinburgh, UK; ³NHS Tayside, Dundee, UK; ⁴Macmillan Cancer Support, London, UK

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Background Hospitals remain an important and necessary place of care for people nearing the end of their lives, and in Scotland nearly 1 in 3 hospital beds are occupied by someone who will die within the next 12 months (Clark, Armstrong, Allan, et al., 2014. *Palliat Med.* 28:474). Despite this, resources to support improvement activity across the country remain underdeveloped and ad hoc.

Aim Building on the Best (Phase 2) a three-year, Macmillan funded project aimed to improve the experiences and outcomes for patients and families in Scotland's hospitals.

Methods We:

1. Created a multidisciplinary national network for hospital specialist palliative care team (HSPCT) members.
2. Supported a range of quality improvement projects across the country.
3. Facilitated public engagement via the projects and other stakeholders.

Results The Scottish Network for Acute Palliative Care (SNAPC) was launched in Jan 2020. It facilitated the HSPCTs across Scotland to work very effectively and efficiently to collaborate and contribute to the development of COVID-19 specific palliative care guidelines; share local work nationally; and develop new collaborative connections.

9/12 QI projects successfully completed in six health boards showing local improvements to the care being offered to patients and their families specifically in planning ahead and bereavement care.

Public engagement activities included participation in focus groups to develop resources for introducing the ReSPECT document and feedback on bereavement follow up.

Conclusions The successes and limitations of this project were defined by the pandemic. While the SNAPC network flourished and developed as a need for information and sharing experiences with colleagues was required, barriers to engaging with the public restricted engagement activities. A sense of urgency amongst HSPCT to improve care, an infrastructure to support information sharing and collaboration and resource to support small projects has led to impactful change in the care experiences in several hospital settings across Scotland.

P-30 PALLIATIVE CARE EMERGENCY DEPARTMENT IN-REACH PROJECT

¹Emma Dawson, ²Harriet Preston, ¹Sarah Roberts. ¹Trinity Hospice, Blackpool, UK; ²Blackpool Teaching Hospitals Foundation Trust, Blackpool, UK

10.1136/spcare-2022-HUNC.52

Background and Aims Emergency admissions to hospital increase in the last year of life and can be avoidable (Barbera, Taylor &, Dudgeon, 2010. *CMAJ.* 182: 563). In 2016 there were over 1.6 million such admissions in the UK, at a cost of £2.5 billion (Marie Curie, 2016). Emergency Department attendance data can be used as a quality indicator for care at the end of life (Earle, Park, Lai, et al., 2003. *J Clin Oncol.* 21:1133) and early palliative care involvement can reduce length of stay (Jordan, Allsop, ElMokhallati, et al., 2020. *BMC Med.* 18:1; Zaborowski, Scheu, Glowacki, et al., 2022. *Am J Hosp Palliat Med.*). This project aimed to provide daily in-reach into ED at the local teaching hospital to reduce unnecessary admissions, provide responsive and timely palliative care support, and increase the number of patients achieving their preferred place of care/death.

Methods We introduced a dedicated bleep as the main point of contact for ED for support during normal working hours (7.30am - 5.30pm, 7 days). Daily visits and liaison with the nurse in charge identifies suitable patients and promotes the service. Data collected includes any evidence of advance care planning prior to admission e.g., EPaCCS, DNACPR.

Results During 1st Feb 21 - 31st Jan 22 a total of 69 patients were supported. Of those 19 (28%) were discharged back to their place of residence or the local hospice, avoiding admission and reducing length of stay by on average a day, saving 78 bed days. 38 (55%) did not have a completed EPaCCs in place prior to admission. 10 (14.5%) of the patients seen died the same day.

Conclusions A larger number of patients have been seen than anticipated, reflecting current pressures on local health care systems. A significant proportion of patients attending without a DNACPR or EPaCCs highlights the need for further work to promote anticipatory advance care planning. Early specialist palliative care in-reach into ED can prevent unnecessary admissions for patients in their last year of life as well as providing support and education to staff.