

an inequity between those supported at home and those admitted to the hospice IPU.

Aim We wanted to address this inequality in our service, ensuring our community patients receive a holistic MDT approach to their care. With intervention from the whole hospice MDT complementing the clinical nurse specialist service, resulting in improved patient wellbeing and end of life outcomes.

Methods We have introduced an electronic 'virtual ward' (Lewis, Vaithianathan, Wright, et al., 2013. *Int J Integr Care*. 13:1) where patients who have complex symptoms, social or emotional concerns, raising the question 'I am concerned because...' are admitted, highlighting the patient to the MDT. Patients are discharged once the concern has stabilised, which is identified by using the Integrated Palliative Care Outcome Scale (IPOS), Phase of Illness (POI) and Australian Karnofsky Performance Scale (AKPS).

Embedding a community physiotherapist in the team enables the delivery of appropriate and responsive physiotherapy plus close collaboration via daily 'alert' meetings with an Occupational Therapist, Social worker, Doctors, Carers' support and Spiritual care, all contributing their specialist expertise and knowledge.

Results An integrated community service allows for more responsive patient support from appropriate professionals and therefore better patient outcomes for those in the community setting, offering a more specialised and expert service (Seow & Bainbridge, 2018. *J Palliat Med*. 21: S37). The effectiveness of this integrated service will be measured through the IPOS, number of patients meeting their preferred place of death and patient and family feedback (Chang, Chung, Tam et al., 2021. *BMC Palliat Care*. 20(143)).

Conclusion Hospice community patients and their carers experience improved outcomes through the development of a 'virtual ward' and the introduction of an integrated community team, enabling access to the wider hospice MDT in the community setting.

P-115 THE MOUNTBATTEN AMBULANCE: ENABLING, PRIORITISING OF PATIENT WISHES

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Background The notion of a 'hospice ambulance' to transport patients has been thought about at various times when the demands on existing ambulance services results in delays for patients coming to, or from, the hospice. An opportunity arose and an ambulance was provided to the hospice.

Aim(s) To ensure we meet the needs of everyone who needs our care, and to support people to die in their preferred place of care in line with our strategic aims.

Method Staff attended a 5-day ambulance driver training programme provided by the local ambulance service. A small ambulance driving team was created. A policy and procedure was developed for use of the ambulance and CQC processes followed to register the new activity.

Results The addition of the hospice ambulance has meant patients have been supported to die in their place of choice. For example, a hospice patient asked to return home to die. A request for transportation was refused by the local ambulance service due to difficulty in transporting and accessing

the patient's home. Staff carried out a simulated test run, taking the hospice ambulance to the patient's home to plan and ensure a safe discharge home. The ambulance was prepared and the patient was transported home and their end-of-life wish fulfilled. Another patient wished to die at the hospice, but again was not viewed as a priority by the local ambulance service who stated they would be unable to provide transport for several hours. The hospice ambulance was utilised to bring the patient to the hospice. The patient arrived in time to die alongside family.

Conclusion Staff have demonstrated exceptional teamwork and innovation to ensure patients' wishes are met. The hospice ambulance has enabled more people to die in their preferred place, reducing stress and anguish for patients and their families.

P-116 IMPROVING PROVISION OF TIMELY ANTICIPATORY MEDICATIONS AT END-OF-LIFE FOR COMMUNITY PATIENTS; WHERE HAVE WE GOT TO?

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Background An ongoing challenge, both across our healthcare systems and for individual patients and families, remains regarding access to 'just-in-case' (JIC) medications to support symptom control at end-of-life (NICE. Guidance End of life care for adults. Quality standard [QS13]). Our community teams work across 5 CCGs, caring for approximately 1200 patients (own home or care home). Timing, assessment, procurement and administration of such medications, the governance and cost associated with this, particularly out-of-hours, needs further evaluation. Local community processes are not well established, with significant delays.

Aim This work builds on a previous service evaluation of JIC medications provided by the hospice to our community patients (Tran, Lee & Ross, 2021. *BMJ Support Palliat Care*. 11: A60).

Method Retrospective review of internal prescriptions for medications over 1 month including prescriber, medications given, with more detailed case-note review (of two-thirds) to identify themes/challenges and outcomes.

Results 159 prescriptions were written by doctors (45%) or NMPs over 1 month. 16% of patients required >1 prescription (range 2-7), with peak requests on a Friday. This cohort was elderly, half ≥ 85 years old; 49% had a primary cancer diagnosis (vs 51% non-malignant), a third also had a dementia diagnosis. Three months later, 85% had died (89% in their usual residence) median time to death 6 days. 20% of prescriptions were a new/urgent referral; 52% required urgent OOH visits. 94% included injectable medications (vs 3 transdermal analgesia; 3 PR paracetamol; 4 other). 73% received injectable opioids (Morphine 57%, Oxycodone 34%, Alfentanil 9%). We saw a 50% reduction in scripts for antiemetics, with reduction in haloperidol (79% to 35%) versus other antiemetics (levomepromazine 47%, cyclizine 14%, metoclopramide 3%) both of which were key outcomes to improve cost-effectiveness from our previous service evaluation. We documented administration of these injectable meds (stats or CSCI) in 55%. Themes/Challenges will also be presented.

Conclusion Projects to evaluate and change practice in this area can be effective; further integrated working to establish

and evaluate cost-effective pathways to access medications at end-of-life is essential.

P-117 **WHAT'S THE SCRIPT? NON-MEDICAL PRESCRIBING SUPPORTING PALLIATIVE CARE FOR COMMUNITY HOSPICE PATIENTS**

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Background Patients with life-limiting conditions often have rapidly changing symptoms and benefit from access to medication for symptomatic relief. However, access to prescribers out of hours is limited and can lead to delays (Webb & Gibson, 2011. *Int J Palliat Nurs.* 17:537; Latham & Nyatanga, 2018. *Br J Comm Nurs.* 23:94; Latham & Nyatanga, 2018. *Br J Comm Nurs.* 23:126).

Aims To test and implement procedures which enable hospice prescribers to prescribe medication in a timely manner for symptomatic relief for patients at home, supporting patients, families and primary care teams.

Methods A standard operating procedure (SOP) was developed to allow medical/non-medical prescribers access to hospital-based prescriber (HBP) pads (Hardman, Foot, Hillan et al., 2012). When hospice prescribers review a patient at home who requires medication, they can then prescribe via the HBP pad within their competency (Royal Pharmaceutical Society. Competency framework for all prescribers [Internet]; 2021 September [cited 2022 May 16]), which can be dispensed from a community pharmacy.

Evaluation of non-medical prescribing and SOP compliance was undertaken. Audit of carbonated copies of the HBP prescriptions measured documentation compliance, medication prescribed and rationale for the prescription. Reflective case note review, case studies and stakeholder feedback were used to determine user experience and whether access to hospice prescribers was beneficial for patients and primary care teams.

Results

- Positive feedback indicates a seamless, holistic approach describing benefits from prompt availability of medications that aid symptom control thereby reducing patient and family anxiety.
- All prescriptions were issued at weekends when access to primary care prescribers was limited. These were issued by the Community Advanced CNS, a non-medical prescriber, providing weekend cover for the seven day-a-week, hospice CNS service.
- Often the prescription issued was for Just in Case medication.
- Audit demonstrated good governance via high compliance with the SOP and documentation requirements.

Conclusions Patients benefitted from immediate review and issue of prescriptions from the hospice non-medical prescriber, thus ensuring patients were prescribed medications to relieve symptoms in a timely manner and reducing potential delays. Access to the hospice non-medical prescriber at weekends was beneficial, leading to the SOP being applied beyond this test of change.

P-118 **CREATING A BRIDGE BETWEEN COMMUNITIES AND HOSPICE SERVICES: DEVELOPMENT OF A NEW WAY OF WORKING TO REPLACE TRADITIONAL DAY CARE**

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Background Like many hospices throughout the UK (Swann, Easton, McGuinness et al., 2021. *BMJ Support Palliat Care.* Apr.29), our day service was forced to close due to COVID-19. We have developed a new way of working – ‘Live Your Life’. This is developing and evolving with ongoing evaluation.

Aim We aimed to:

- Put people at the heart of decisions and involvement in their care.
- Pilot a combination of Goal-Setting and Action-Planning (G-AP PC) (Boa, [PhD thesis], 2014) and Assets Based Community Development (ABCD) (Russell, 2022) alongside palliative support to enable people with life-limiting conditions to live well.
- Untether the service from our building, and open access, enabling more people to engage with support, including carers.

Methods We designed a model of working between hospice services and communities, in co-production with existing service users. Data collection includes:

- Referral routes.
- Outcome measures - Therapy Outcome Measures (TOMs) (Enderby, John & Petheram, 2013) and the Australia - modified Karnofsky Performance Status (AKPS) (Abernethy, Shelby-James, Fazekas, et al., 2005. *BMC Palliat Care.* 4:1).
- Anticipatory care planning.
- Goal achievement.
- Feedback from people and their families.

Results From 01/08/21- 19/04/22, 88 referrals were received from:

- Hospice CNS = 78%
- Other hospice professionals = 4%
- External professionals = 12%
- Self-referrals = 6%

15 carers and 88 people received support through a combination of phone, face-to-face and virtual connection, engaging in goal-setting conversations and connection with communities. Results so far show an average increase in participation, well-being, performance and anticipatory care planning conversations (before referral 65%, after referral 88%).

Conclusion Initial findings suggest that this way of working enables support for people in the way that suits them best, without them having to come into the building. Self-referral enables a shift in power from professional to person. Hospice services and communities are creating bridges, working together to empower people to drive care to meet their needs. Continued evaluation and data collection will provide further insight into this innovative and new way of working.