we will increase our reach to unique children by offering Outreach as a core service.

Methods Reinstating outreach, a team of qualified nurses, in July 2021, re-engaging with families who had little or no contact with Acorns through the pandemic through reassurance that we kept children safe through effective use of immunisation, testing and PPE.

Results Capturing the changes in development and care needs of those who had not engaged with us in 18 months, other than by having regular virtual contact from the family team, we were able to reassure families that re-attending the hospice would be safe for children and give families the much needed break from the intensity of caring. Some families chose not to come in-house, but appreciated the outreach model.

Model to be rolled out to families newly referred to Acorns to build relationships with Clinical Services.

P-130 'HE HAD TOO MUCH LIVING TO DO TO TALK ABOUT DYING': AUDITING ADVANCE CARE PLANNING IN A YOUNG ADULT POPULATION

Sheonad Laidlaw. *The Prince and Princess of Wales Hospice (PPWH), Glasgow, UK*

10.1136/spcare-2022-HUNC.147

Background Advance care planning (ACP) is a process and encourages individuals to have timely conversations regarding their future care needs with those they wish to have involved. Such discussions and planning require a whole 'community' approach – family, health, and social care - with the overall aim of improving the individuals' quality of life and ensuring that their wishes are known.

Unfortunately, discussions around a young adult's (YA) deteriorating health, their wishes, their preferences around escalation of treatment, their preferred place of care and preferred place of death rarely happen in practice as they are thought to be difficult to have or not appropriate during times of wellness.

Aims To access the documentation of ACP documents within electronic case notes at the hospice, and the completion of the ACP summary held on the regional health board clinical portal.

Objective To ensure that the YA's ACP, specifically their wishes and preferences, is completed and communicates effectively between their health care givers.

Results Despite developing solid therapeutic relationships with the YAs and their families on the caseload at PPWH, and often discussing worries about the future, ACP documentation is not consistently captured within the hospice; the shared clinical ACP on clinical portal is not being completed, and Key Information Summaries (KIS) are incomplete and out of date.

Discussion There is a lack of patient-centred end of life and ACP discussion and little evidence of effective sharing of information for this population: this is concerning in a group of YAs who are clinically exceptionally vulnerable and at risk of sudden deterioration. These discussions are best had throughout the individual's journey from diagnosis, incorporating regular, honest, and open communication initiated by those involved in the YA's care, allowing them to be documented and communicated quickly and succinctly to ensure if something does change quickly, the YA's wishes are known, respected, and heard.

P-131 IMPROVING A HOSPICE ADMISSION PROCESS WITH THE RESPONDING TO URGENCY OF NEED IN PALLIATIVE CARE (RUN-PC) TRIAGE TOOL

[1,2]Lucy Pain, [1]Katrina Welch. *[1]North London Hospice, London, UK; [2]North Middlesex University Hospital, London, UK*

10.1136/spcare-2022-HUNC.148

The North London Hospice is an 18-bedded hospice in North London, also providing community specialist palliative care to three local boroughs. Patients are admitted either for management of complex needs or for care in the last days of life, with an average length of stay of approximately two weeks.

The RUN-PC triage tool was developed in Melbourne, Australia and published in 2019 (Russell, Philip, Wawryk, et al., 2021. Palliat Med. 35:759). It was originally implemented at the North London Hospice in 2020 following staff and service user feedback expressing dissatisfaction with the length of time between referral and admission, particularly when patients did not achieve their preferred place of death.

Use of the tool was reviewed in 2021 as part of ongoing quality improvement work. Initially a period of observation was undertaken in order to first describe the current triage process, then to identify opportunities for improvement. Baseline data included; average waiting time, compliance with recommended response times as per the RUN-PC manual, and inter-rater reliability. The main areas identified for potential improvement were; frequent absence of a RUN-PC score when patients were initially prioritised at the daily bed meeting, lack of application of the recommended response times, and variation between scorers.

Interventions to date have included using the recommended response time to establish the order in which patients should be admitted, and the development of additional scoring guidance to reduce variability and minimise the impact of pressure from referrers, patients, and family members. Currently referrer satisfaction has improved with evidence of a reduced average waiting time. Efficiency of bed meetings has also improved with more reliable scoring providing confidence in the triage process.

P-132 IMPLEMENTATION OF A NURSE MANAGED BEDS SERVICE FOR END OF LIFE CARE AND AN AUDIT OF THE LAST SIX MONTHS' PRACTICE

Alison Chatten, Samantha Brook, Janice Edgar. *Sue Ryder, Leeds, UK*

10.1136/spcare-2022-HUNC.149

Background The Health Needs Assessment for end of life care in the city has clearly identified the need for hospice care for those in the last few days/weeks of life. Part of the hospice's five year strategy highlighted the intention to implement nurse-managed end of life care beds within the inpatient unit (IPU), offering end of life care to dying patients with