

followed by a supported transition to appropriate partner community services. A process evaluation was conducted to explore REACT team members' experiences of the establishment of the new service model.

Aims To evaluate the implementation of the REACT service – what has worked well and what could have been better.

Methods We conducted and thematically analysed eight semi-structured interviews with professionals who helped set up and deliver REACT.

Results The analysis identified the determination and passion of the REACT team and the culture of collaboration in Bradford as key enablers of the successful implementation of the service. Recruitment issues were highlighted as a major issue, particularly where night shifts were required. There were also recommendations made about the training requirements of the REACT team, because the evolving requirements when establishing a new service created a need for continuous learning.

Conclusions This evaluation of the REACT service demonstrated the importance of the confidence, commitment and drive of project staff to the establishment of a new service. It also identified the significance of a broader collaborative approach. Points for consideration were also identified when replicating similar service models in other areas.

P-43 ADMISSION AVOIDANCE – PREVENTING UNNECESSARY HOSPITAL ADMISSIONS IN THE LAST PHASE OF LIFE

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Background With the increased strain on healthcare nationally, all healthcare providers have a duty to prevent inappropriate admissions to an acute hospital (Local Government Association, 2021.). Hospices are in a unique position to support patients to remain in their preferred place of care (PPC) by utilising the skills and knowledge of the multidisciplinary team (Spencer. *Int J Palliat Nurs.* 2015, 21(5):245).

Aims To evaluate the role of the hospice in preventing inappropriate admissions to hospital. For the purpose of the audit, admission avoidance was defined as; preventing someone from being admitted to an acute hospital and allowing them to be supported and die within their PPC. The intervention taken place must prevent admission for at least 72 hours.

Method The audit took place within the hospice in the home multidisciplinary team over a two-week period. Clinicians informed the auditor if their intervention prevented an admission into hospital. The data was then collated and at the end of the two weeks each patient record was reviewed to confirm that the intervention prevented admission.

Results 19/19 patients reviewed were able to remain in their PPC and were prevented from being unnecessarily admitted to hospital. The hospice rapid response team prevented the most admissions, however, this was expected due to the nature of the role and 24/7 working pattern.

Common themes included:

- Rapid assessment, prescribing and symptom control.
- Initiating urgent care packages via the hospice virtual ward.
- Timely advance care planning allowing informed decisions about their future care.
- Urgent admission into the hospice or nursing home placement.

- Joint working with the ambulance service supporting patients to remain in their PPC.
- Provision of urgent equipment.

Conclusion The audit has provided evidence that the hospice is actively preventing admissions into the acute hospital. The interventions taken place have supported patients to remain in their PPC by providing timely person-centred care.

P-44 HOSPITAL ADMISSIONS AVOIDANCE PROJECT

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Background There are numbers of unnecessary hospital admissions whereby individuals have been admitted for social reasons and for treatment that could be given in their own home. Working in collaboration, we look to reduce the number of hospital admissions to promote better outcome for individuals and their family/carers.

Aims The Hospital Admissions Avoidance Project (HAAP) aims to prevent hospital admissions for patients who are acutely unwell and may require extra support whilst treatment options are administered at home. HAAP also supports carers who are in crisis, therefore preventing an admission.

Methods A team of Health Care Assistants will provide day/night care for a period of 5 -7 days. The team can provide personal care, encouragement with food and fluids, prompt medication and offer comfort and reassurance for the individual and carers. Referrals can be made by both medical professionals and social care professionals.

Results January 2022 – December 2022. Numbers of referrals: 83. Number of hospital admissions avoided: 78. Feedback received:

“Just to say the two Carers were amazing, not only for my dad, but for myself and my husband. We felt that we could face another day with hope. They were the kindest, patient, and loveliest of human being, I thank them both”.

“It was such a relief to have help, the overnight sits meant that, not only my dad had a night’s sleep (he was exhausted), but we all as a family slept better”.

Conclusion Our Hospital Avoidance Admissions Project has steadily grown since its introduction. It has provided support to those within our local community and allows individuals the chance to remain in their preferred place of care.

P-45 THE DEVELOPMENT OF A PALLIATIVE CARE TRIAGE TOOL

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Background It is common for care to be coordinated by a range of health care professionals and administration staff with varying backgrounds and experience. Many services rely on clinical judgement as their triage tool, potentially resulting in a variation in the type of service and response time offered. A triage tool was devised to enable a standardised response to improve patient experience.

Aims of the triage tool Categorise urgency and aid responsiveness. Equitable and fair access to services with a consistent

response for patients. Ensure the patient gets the right care, from the right team at the right time.

Method In conjunction with our specialist palliative care teams, a tool was devised that considered the most common symptom issues. Categories were devised and a list of questions prompted our care co-ordination staff to enable a standardised triage process whilst detecting urgency. The tool was trialled over a 12-month period by clinical nurse specialists within the team. Following this trial a finalised version was rolled out for the whole team, training was provided and a standard approach to triage was adopted by all.

Results Patients were given the right response, at the right time from the right team. Increased confidence and reduced anxiety surrounding decisions made. Improved quality of information collected. Reduced the need for repetition for the patient.

Conclusion The triage tool has had several positive outcomes including, but not limited to:

- In line with National Ambitions for Palliative and End of Life Care.
- Patients and families are given the same advice and level of service at point of contact.
- Improved standard of documentation and communication between services.
- Improved patient and family experience.
- Improved history-taking skills.
- Improved confidence of staff.
- Dedicated triage team employed to support process.
- Improved symptom management for patients.

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HOSPICE AT HOME: INTEGRATED MODEL OF SPECIALIST END OF LIFE NURSING CARE AT HOME

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Background Douglas (BMJ. 1992, 304: 579) wrote about the hospice movement and innovative future care for the dying 30 years ago. Hospice at Home services have developed nationally in response to local demographics, resources and need. More people want to die at home (Ali, Capel, Jones, et al. BMJ. 2015, 9(1): 84–91), where care should be guided locally by our ambitions for palliative and end of life (Ambitions for Palliative and End of Life Care, 2021).

Aims On January 25th 2021, the Hospice at Home service began, with an aim to provide 24hour specialist end of life care to enable patients to die at home as their preferred place of care.

Methods The model is integrated within the health and social care deliveries and voluntary sectors, including Marie Curie, Urgent Care Response, and hospice volunteers. Referrals are received for end of life care (General Medical Council, 2010). There are 5.7 whole time equivalent (wte) specialist nurses (Band 6) including an advanced nurse practitioner (Band 7), and 2.4wte assistant practitioners (Band 4). The 24hour service works with 3-day shifts (08:00–20:00) and an on-call nurse specialist shift (20:00–08:00). This is crucial to service outcomes as providing specialist nurse visits 24/7 enables symptom management and support night and day. Service data for referrals, preferred and actual place of death, caseload,

discharge and disease, was collated. Funded by a local charity, quarterly board meetings direct service evaluation and development.

Results In two years, 198 patients died, 180 in preferred place of death (ppd) = 91%. 177 patients died at home or care home (ppd) = 98% avoided unwanted hospital admissions. Referrals and deaths increased by 50%. Overnight call-outs increased by 200%. Preventing admission = £755,333 yearly saving (average 10-day admission in final year of life). Average length on caseload = 96 days. Cost = £2,000 per patient.

Conclusion The Integrated Model for Specialist End of Life care is successful, and showcases future specialist end of life care at home.

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STREAMLINING THE HOSPICE AT HOME TEAM'S PROCESSES TO IMPROVE EFFICIENCY AND JOB SATISFACTION

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Background During the COVID-19 pandemic, the Hospice at Home (H@H) team were divided into three localities, resulting in an enlarged, but divided, team. Registered Nurses (RNs) within the team subsequently needed to co-ordinate the Health Care Assistant (HCA) workforce and assess patients for a prognosis of less than 12 weeks for funding purposes. Senior RNs in one team audited the processes, finding that six months into the new model, people in our care were not always being reviewed for health needs in a timely way; often received H@H care for longer than the commissioned 12 weeks; were difficult to assess remotely, and sometimes deteriorated whilst receiving only domiciliary care visits.

Aim To create a smooth pathway for managing the patients and the HCA workforce to greatest effect.

Methods

- Spreadsheet devised to track and monitor each patient through their time with H@H.
- Validated tools from the OACC suite of measures used to map people's condition and deterioration.
- Speed of decline (Watson, Armstrong, Back, et al. (2016) Palliative Adult Network Guidelines. 2016, 4th ed.) taught and used as an indicator of prognosis, to aid decisions about ongoing care.
- RN joint visits with HCAs to support, educate and facilitate performance of assessment during care visits to maximise input.
- HCAs taught to give complementary therapies during respite visits.

Results An increase in patients being discharged to Adult Social Care (ASC) if they stabilised, freeing up visits for those who were at end of life. Cross-charging to ASC when appropriate, saving money. Length of time of patients receiving H@H care reduced to the commissioned 12 weeks for the majority of patients, demonstrating the value of accurate identification of end of life. Better use of HCA time, increased job satisfaction and team bonding for the H@H team.

Conclusion HCAs felt supported and educated, whilst the patients benefited greatly from clearer identification of the end-of-life stage and more tailored care.