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.

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

Ross Chirgwin. St Helena Hospice, Colchester, UK

10.1136/spcare-2023-HUNC.64

**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.

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**P-44 HOSPITAL ADMISSIONS AVOIDANCE PROJECT**

Rachel Mills, Sarah Harries. Hospice of the Valleys, Ebbw Vale, UK

10.1136/spcare-2023-HUNC.65

**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.

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**P-45 THE DEVELOPMENT OF A PALLIATIVE CARE TRIAGE TOOL**

Jenny Warren, Louise Greenaway. Compton Care, Wolverhampton, UK

10.1136/spcare-2023-HUNC.66

**Background** It is common for care to be coordinated by a range of healthcare 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 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.