

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 25<sup>th</sup> 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.