

Abstracts

A pre and post course self-assessment of knowledge skills and confidence

Post workshop evaluations

An end of programme questionnaire

This poster describes the analysis of these.

Results The programme met the needs and expectations of 100% of participants. 100% found the education clear and felt well supported by the EOlc facilitators. Evidence shows that each cohort improved in knowledge, skills and confidence across all topics when measured on a 5-point self-assessment scale. Qualitative analysis of feedback indicates that the care homes are working as a team to utilise end of life care tools and improve patient experience approaching end of life.

Conclusion The Six Steps to Success Programme has enabled care homes to bring about organisational change and develop frameworks to improve End of Life Care in their place of work. By working together, sharing experiences and ideas, supported by their facilitators and the local hospice (Queenscourt Hospice), care homes have developed comprehensive end of life care policies which have enhanced delivery of high quality care. By rolling out the programme to a large number of care homes over a 12 month period we are creating a ground swell of enthusiastic motivated care home staff with a desire to collaborate with those working in other health and social care settings to improve the experiences of their residents and relatives.

P7 RED ENVELOPE SCHEME

Shirley Young, Deb Hickey. *St Luke's Hospice, Basildon, UK*

10.1136/bmjspcare-2013-000591.29

Ambulance crews reported lack of information with regards to patient care & wishes, meaning their default position was Hospital admission as they could not 'waste time' looking for relevant documentation eg Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms, 'hidden' in copious patient records.

Aims To give crews readily accessible Patient information, enabling them to make decisions about best care, recognising patient choice.

To prevent unnecessary or unwanted hospital/hospice admissions for palliative patients. A form was designed which included Information regarding patients' Preferred Priority of Care, DNACPR, medications and contact details of relevant Health Professionals. This was agreed by the Ambulance Service.

An A5 Red envelope labelled 'FOR AMBULANCE CREW ONLY' held the completed form, to be The Scheme was piloted for 3 months from April – July 2012

During the trial 24 forms were completed and held by the patient and family

The checklist was described as 'Directional Documentation' by the Ambulance service. The contact numbers and information gave crews the opportunity to call and discuss the situation with other professionals.

Subsequent improved communication between services has resulted in Ambulance crews anecdotally describing a change in practice and increased confidence in making decisions to support patients to remain at home.

Discussion In the absence of Electronic Registers within our locality, the intermediate solution was to introduce the Red Envelope Scheme which gave Ambulance crews the right information at the right time. However despite the large catchment

area of the Hospice the Scheme reaches a small percentage of patients with palliative care needs.

Conclusion Crews now look for a red envelope in the patient's home. It gives support to crews to make the right clinical decisions and the opportunity to influence the patient journey in a more positive way.

P8 CARE ACROSS SETTINGS: EVALUATING AN INTEGRATED SPECIALIST NURSE-LED PALLIATIVE CARE CLINIC WITHIN A GENERAL PRACTICE SETTING

¹Emily Harrop, ¹Jessica Baillie, ^{1,2}Anthony Byrne, ³Karen Stephens, ¹Annmarie Nelson. ¹Marie Curie Palliative Care Research Centre, Cardiff University, Cardiff, Wales, ²Cardiff and Vale University Health Board, Cardiff, Wales, ³Marie Curie Hospice Cardiff and the Vale, Penarth Wales

10.1136/bmjspcare-2013-000591.30

Background A community nurse-led palliative care clinic was introduced at a UK General Practitioner's (GP) practice in April 2012. The clinic aimed to provide earlier identification of patients with cancer and non-malignant disease, initial patient assessment, education for GPs and other community professionals, and strengthen relationships with the local multi-disciplinary team. This provides a new model for engaging patients and ensuring that specialist palliative care is delivered across different clinical settings. Usually, clinical nurse specialists (CNS) support patients in the home. This new initiative brings a fortnightly clinic as a complementary resource to consolidate the joint primary/ palliative care approach.

Methods This study evaluates implementation processes and the impact of the clinic on patient experiences and professional practices. It assesses uptake of palliative services and the management and delivery of palliative care by GPs and CNS.

Baseline interviews with GPs (n = 5) and CNS (n = 4) were carried out in February 2012. Semi-structured interviews with patients (n = 6), GPs (n = 6) and CNS (n = 4) are being undertaken to assess perceptions of the clinic.

Patient interviews will be analysed using an Interpretive Phenomenological Analysis (IPA) approach. Interviews with GPs and CNS will be analysed using Framework Analysis.

Results Perceived aspirations for the clinic included: earlier referral; improved communication and continuity of care; psychological and practical benefits for patients/ carers; more targeted use of specialist nursing resources. Baseline interview data highlights the need for improved referral and communication practices, especially for non-cancer patients. Data from patient and follow-up interviews will be reported against these aspirations, with additional themes identified.

Conclusions and application Conclusions will be drawn on the effectiveness of the clinic and implications identified for palliative care provision in primary care settings, including the potential to roll out a similar model more widely.

P9 IS THERE ANYBODY THERE - TELEPHONE ADVICE LINES WHO NEEDS THEM?

Tracy Livingstone. *Nightingale House Hospice, Wrexham, UK*

10.1136/bmjspcare-2013-000591.31

Background and Context Nightingale House Hospice have offered a 24-hour telephone advice line to patients and their carers in North East Wales since the year 2000. Predominantly

the area covered is urban with good access to a variety of health and social care services.

In 2010 the hospice were asked to provide a similar service providing advice on palliative care/specialist palliative care to health care professionals across all geographical areas of North Wales acting as a triage centre for palliative medicine consultant advice, this service was not made available to patients and families due to concerns regarding potential volume of calls. This introduced a population located in large rural areas with more sporadic access to services.

Aim & Approach The purpose of the audit was to encourage discussions about the ethics of delivering a two tier service based purely on geography but also considers the context of the calls in terms of the services available to patients within each locality in terms of model of service provided and also the hours of operation/delivery

Outcomes This presentation details the findings of an audit of the advice call forms completed reviews and compares the data collected from both geographical areas covered by the advice line, considering the volume of calls from both areas, the time and duration of calls and also the reasons why people called.

Application to practice The audit recognises some limitations in the method by which data is currently collected and reviewed providing guidance for the future in terms of what do we need to know in order to measure the impact and outcome of the provision of this service to patients and their families.

The work also draws conclusions for practice in terms of identifying current need within our locality.

P10 HOSPICE RAPID RESPONSE SERVICE – A PROSPECTIVE ANALYSIS

Beverley Clayton, Lesley Spencer. *Princess Alice Hospice, Esher, UK*

10.1136/bmjspcare-2013-000591.32

Background/context Following a retrospective analysis of urgent unplanned visits, evidence emerged that supported a new rapid response role for a clinical nurse specialist.

Main Aims

- To enable palliative care patients in the community, who have complex needs or whose condition is deteriorating, to access prompt specialist palliative care services.
- To assess whether more patients
- are enabled to exercise their preference about place of death

Approach used The service was available to new and existing patients for end of life care and support of urgent symptom control issues (N = 78). Referrals requiring urgent attention were passed onto the Rapid Response Nurse. The CNS worked flexible hours in order to support the needs of the patient. Data was collected prospectively over a six month period using survey monkey.

Outcomes Seventy Eight patients supported over 6 month period. 38% had a non - malignant diagnosis. 67% of patients were referred for terminal care with the remaining requiring symptom control. As a result of the rapid response visit 86% of patients remained in their own home. None were transferred into the acute sector. 75% of patients who died within the 6 month period achieved their preferred place of death with only 6% who wished for a home death unable to achieve this.

Application to hospice practice The service was timely, responsive and supported increasing numbers of patients to be cared for and to die in their preferred place of death. All visits responded to crisis therefore all patients had potential to be admitted to hospital. Patients in the Nursing homes were particularly vulnerable.

The service therefore prevented unnecessary admissions into the acute sector and supported Hospital Palliative Care Teams with rapid discharge home.

A Rapid Response Clinical Nurse specialist is effective – right skill, right intervention, right time.

P11 THE STARS THAT COME OUT AT NIGHT - PRESENTING THE HOSPICE '8 TO 8' NIGHT NURSING SERVICE

Dawn Neil-Jones, Lesley Spencer. *Princess Alice Hospice, Esher, United Kingdom*

10.1136/bmjspcare-2013-000591.33

Background/context Maximum impact in terms of achieving patients preferred place of care may be gained by focussing future service development on extending and improving care at home. This also ensures on-going collaboration between NHS and other providers of end of life care.

Since September 2011 the Hospice has been developing the '8 to 8' service which provides a night nursing service for existing Hospice patients and more recently, through partnership working with other healthcare providers for dying patients not known to the Hospice.

Main Aims

- To optimise the opportunity for patients requiring end of life care who wish to stay at home to remain in their preferred place of care
- To prevent unnecessary admissions to hospitals

Approach used The service is delivered by both bank and permanent members of staff and includes both registered nurses and senior health care assistants. All staff are inducted by the Hospice and given the requisite palliative care skills. The service is led by a clinical nurse specialist who supports and co-ordinates the allocation of staff according to clinical need. The nurses remain with the patient throughout the night.

Outcomes Evaluation demonstrates that the service has exceeded expectations. Most patients referred to the 8 to 8 service are for terminal care with 95% of patients achieving their preferred place of death. The service now delivers 50 nights per month across the catchment area.

Application to hospice practice The 8 to 8 service has been commissioned by two clinical commissioning groups since its inception and continues to expand and build on its success. It is delivered by specially trained nurses who are compassionate, efficient, caring and greatly improve the patient experience. Increasing numbers of complex patients are now able to be cared for in their preferred place of care.

P12 HOSPICE AT HOME SERVICE LISTENING, RESPONDING, DEVELOPING

Vanessa Gibson, Liza McEvilly, Robert Standfield. *St Richards Hospice, Worcester, UK*

10.1136/bmjspcare-2013-000591.34

In 2008 the Department of Health (DH) identified increasing evidence that lack of co-ordinated community support was