

Abstracts

resulting in avoidable admissions and prolonged hospital stays. They went on to describe how hospice at home services could have a significant impact in enabling patients to die in their own home. The existing night hospice at home service provided practical support to patients and carers between 10 pm and 8 am. Building on the 7 C's of the Gold Standards Framework (2005) the team promoted contingency planning and service co-ordination ensuring that they were already an integral and valued part of the community based services.

However, with an expected increase in the number of deaths from cancer and non-cancer deaths (Kings Fund 2011) and a local emphasis on preventing unnecessary admissions (Health and Well-being Board, 2012) a wide ranging review of the hospice at home service was undertaken in 2012. Service users and health care colleagues emphasised the importance of:

1. A 24/7 service
2. Rapid response
3. Not being reliant on external funding
4. Supporting carers via 'on the job training and support'
5. Being accessible
6. Highly skilled, consistent and compassionate staff

The review also identified several unmet needs which could be addressed by an expanded hospice at home team, these included:

- Crisis intervention, for example whilst acute symptoms were addressed, carer stress or ill health
- Rapid response and extended packages of care for changing needs
- Pre-admission to the hospice in-patient unit
- Supported discharge from the hospice in-patient unit
- Rapid discharge from the acute sector

Our service outcomes include:

- Provision of a hospice at home service tailored to meet local needs
- Increased integration of hospice services.
- Cost effective use of hospice resources
- Increasingly achieving preferred place of care/death

P13 EVENING CALL

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Introduction The End of Life Care (EoLC) Strategy (2008) and Preferred Priorities of Care (2011) documents support enabling people to remain in their own homes.

Prompted by the volume of calls into the in-patient unit, and workload of the district nurses in the early evening, the hospice piloted an extension to the Hospice@Home (H@H) working hours.

Aim To reduce unnecessary admission to hospital at the end of life by providing extended access to support and guidance for patients, carers and health care professionals.

Method Following a three month analysis of telephone advice calls received by the Inpatient Unit (IPU), outside of H@H working hours, the pilot took place over a 9 month period. This extended the accessibility of trained nurse contact from 4.30pm to 9pm on a daily basis.

Results Throughout the pilot phase, calls were recorded and outcomes summarised, paying particular attention to the purpose

of calls, caller identity, and the time the call was received. These statistics provided evidence that the service was not routinely accessed after 7pm.

During the pilot, five admissions to hospital were prevented, primarily due to the swift response and symptom management by H@H. Patients and carers benefitted from the flexibility and accessibility of a trained nurse to action changes, provide continuity and reassessment from 8.30am until 9pm.

There were a high proportion of calls requesting complex symptom advice, reporting family distress and requesting an increase in care.

Conclusion Staffing the extension to the service proved challenging however the pilot was positively evaluated by the district nursing team.

Guidance, reassurance and prompt response to need, undoubtedly contributed to the prevention of crisis admissions to the acute trust.

P14 THE IMPACT OF AUDIT ON CNS TEAM DEVELOPMENT

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In 2011 the Hospice Clinical Nurse Specialist (CNS) team were facing a significant increase in patient referrals numbers (approximately 70 per month). The demand for community based care, rather than acute hospital admission, was also resulting in increasingly complex and urgent referrals from all areas of the local healthcare economy. In addition, palliative and end-of-life care services traditionally available only to cancer patients were increasingly being accessed by patients with non-malignant diagnoses.

In response the CNS team undertook a month long audit of referrals to the community nurse specialist service. The audit revealed:

1. Low levels of referral information, resulting in delayed contact
2. Difficulties assessing levels of urgency
3. Lack of clarity regarding other services involved with the patient
4. Unnecessary home visits

As a result the CNS team has now introduced the following:

1. A new streamlined referral process
2. A full time specialist triage nurse who makes first contact with all referrals:

She:

- Responds to all referral agencies
 - Assesses level of urgency
 - Holds her own low-level caseload that she contacts by phone
3. Helpline established and available to patients and health care professionals: this service provides immediate access to a highly skilled CNS
 4. Accessing and completing the electronic notes systems to ensure comprehensive and up to date clinical information is readily available to the wider healthcare team.
 5. Enhanced patient documentation

Continuous development is key and plans are being developed for: