traditional role of the specialist clinical pharmacist in palliative care.

This innovative role allows patients, carers and other healthcare professions to access the expertise of the clinical pharmacist in the patients home and is aimed specifically at complex patient groups moving towards end of life.

The aim of the role is to enable patients with more complex drug needs to remain in their preferred place of care, the role sits in a wider specialist community team comprising of physiotherapists, occupational therapists, dieticians, social worker and nurses.

Referrals include

- Complex symptom control i.e. unresponsive to or having experienced side effects and adverse drug reactions with conventional first and second line therapies
- Patients with multiple co-morbidities on complex regimes who require rationalisation of their medicines
- Patients requiring medication review/rationalisation including following discharge from secondary care
- Drug/dose choice for patients with impaired drug metabolism or clearance i.e. renal/liver impairment
- Advice on drug choice, route and formulation for patients with drug administration difficulties
- Issues around access to specialist palliative care medicines in the community setting
- Patients with a non-cancer diagnosis including those with end stage heart failure, renal failure, COPD, liver failure, motor neurone disease etc.
- Patients on palliative chemotherapy

In addition to working with the specialist palliative care team there are many external links these include GPs, district nurses, specialist clinical nurses (community and hospital), consultants, community pharmacists and hospice at home to provide seamless care for palliative patients across the interface. This involves joint professional visits, attendance of GSF meetings or hospital MDT meetings etc.

The Clinical Pharmacy team prescribe for their patients ensuring timely access to specialist medicines and prompt symptom control

P116 ANTICIPATORY MEDICATION 'AS STOCK' FOR RESIDENTS WHO ARE IN THE DYING PHASE: A PROJECT IN 3 NURSING CARE HOMES

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The Gold Standards Framework for Care Homes [GSFCH] and the Liverpool Care Pathway [LCP] guidance suggests the importance of obtaining anticipatory medication for the control of symptoms in the last days of life for nursing home (NH) residents. There is considerable wastage however as NH residents are dispensed anticipatory drugs on a named-patient basis. There is also evidence that when these drugs are not available residents are hospitalised inappropriately.

Aim The aims of the project were to explore the frequency of symptoms experienced in the dying phase and to explore whether there was a need for residents to have their own supply of drugs by examining wastage. The idea was to establish a process in order for homes to obtain anticipatory medication as 'stock' and to capture the benefits of doing this.

Process The managers of three NHs, who had shown interest in obtaining medication for the last days of life, met with a local GSFCH facilitator, specialist palliative care pharmacist and a pharmacist from the regulatory body. A proposal that included a list of necessary medication and how to acquire them was written. The NH staff developed the required Standard Operating Procedures. A prospective audit on medication used was commenced.

Results Significant improvements in the availability of anticipatory medication were found. 53% of residents were symptomatic highlighting the need to have anticipatory medication available. No medication other than "stock" was required by NHs. If all residents had their own supply of medication £4,506 worth of drugs would have been wasted. All staff involved perceived that this work had been beneficial.

Conclusion Anticipatory medication 'as stock' for people dying in NHs is an important step forward. There is less wastage of medication, less delay in controlling symptoms, reduced call out of GPs and less anxiety.

P117 THE IMPLEMENTATION OF A LOCALLY DEVELOPED ADVANCE CARE PLANNING DOCUMENT ACROSS FOUR DIVERSE HEALTH AND SOCIAL CARE SETTINGS

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Advance care planning (ACP) has seen its profile raised in recent years, with various UK government publications serving to drive forward the importance of identifying people's preferences, wishes and expectations for their future care.

Clear documentation is essential for effective sharing of information amongst the multi-disciplinary team, in a bid to ensure an individuals plan is communicated, respected and goals of care are achieved.

In the author's geographical area, it has been identified that there is no robust ACP document currently in use, particularly within the care home setting, therefore the author facilitated the production of a locally produced ACP document via the local palliative and end of life care strategy group.

This qualitative study used mixed methods including semi-structured interviews, questionnaires and a focus group to explore the introduction of this ACP document, highlighting both staff and patient's/residents perceptions of the process and the identified challenges and benefits. Four sites were chosen to pilot the document, (local nursing home, day hospice unit, memory service, supported living complex) representing a diverse range of health and social care services.

Key themes emerged from the analysis of the interviews and questionnaires: Staff confidence, timing of discussions, patient empowerment, patient diagnosis and apprehension regarding legally binding decisions. The perceived importance of having ACP discussions was the underlying similarity between the services; however the challenges varied depending upon the nature of the setting.

The results identified that 23 ACP documents were completed in the pilot phase, with 80% of patients/residents stating that they would recommend this process to others. Reduction of anxiety, peace of mind and control were frequently expressed by participants.

A need for further research in those diagnosed with early dementia is indicated. Collaboration across services may be needed to develop ACP trigger guidelines that fit the complex needs of diverse patient/client groups. Also the challenge of

maintaining training within rapidly changing workforces is acknowledged.

P118 ADVANCE CARE PLANNING IN CARE HOMES: AN EXPLORATION WITH STAFF, RESIDENTS AND FAMILIES

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Aims To explore staff, residents and families' experience of participating in advance care planning discussions.
Background/literature review: Within the UK, implementation of the Gold Standards Framework in Care Homes (GSFCH) programme is being promoted to develop the quality of end of life care for frail older people living/dying in care homes (DoH 2008). An integral part of this involves advance care planning (ACP) discussions. This study explored the experience of initiating and undertaking these discussions.
Methods A qualitative descriptive study was undertaken in three nursing homes implementing the GSFCH programme. Following an ACP discussion, semi-structured interviews were undertaken with the resident, their family member/s and the staff member undertaking ACP. Thematic analysis was used to identify the main categories and themes.
Results Twenty eight interviews were carried out. Five main categories arose: understanding ACP; undertaking ACP discussions; the impact of ACP discussions; use of documentation; and, relationship and rapport.

Staffs understanding of ACP varied and this affected the depth of their discussions with families and residents. The use of documentation either acted as a useful prompt or limited the discussion, blocked opportunistic cues and encouraged a 'tick-box' exercise. Staff had to face their fears around discussing death and dying. The assistance of a trained facilitator helped staff to develop knowledge, skills and confidence with end of life conversations. Residents were open to having ACP discussions, though the way it was introduced could impact on the result. Families found comfort that their loved ones future care had been considered.
Conclusions Care home staff need to develop the knowledge, skills and confidence to engage in discussions around end of life care. The assistance of a trained facilitator who role models this process would enable this.

P119 IMPROVING END OF LIFE CARE IN WORCESTERSHIRE: ADVANCE CARE PLANNING

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Advance care planning (ACP) is a process of reflection and communication in which a person with decision making capacity is able to express his/her wishes regarding preferences and wishes for their end of life care. The End of life strategy (2008) highlights the need for proactive guidance in exploring a person's preferences and wishes at an early stage within life limiting illness, resulting in the potential of unnecessary and unwanted crisis interventions being minimised. The newly formed, three clinical commissioning groups (CCG'S) for Worcestershire have acknowledged ACP as a priority and commissioned a countywide project, under the auspices of the End of Life and Palliative Care network for Worcestershire the role out and implementation of the new countywide ACP documents, this is seen as critical components of the quality improvement process in health and social care (Help the Hospices,2012).

A 12 month project overseen by an ACP Project Manager and hosted in collaboration with St Richard's Hospice will see the Implementation of a training and awareness programme across all health and social care providers being undertaken. This is to enable collaborative countywide working and embed the ACP documents in to practice. Training and awareness will be developed for the workforce to enable underpinning knowledge and skills required in supporting patients through ACP discussions.
Enabling:

- Patient choice regarding preference and wishes as end of life approaches
- Proactive guidance for preferred place of care
- Minimise crisis admission as end of life approaches

A skilled workforce across health and social care will enable a consistent approach to advance care planning countrywide ensuring a patient's wishes and preferences are elicited, documented and shared.

Integrated care at end of life within the changing health and social care policy landscape will be delivered in line with the recommendations from, Preparing for the future: key operating principles (Help the Hospice,2012).

P120 THE IMPACT OF ADVANCE CARE PLANNING OF PLACE OF DEATH, A HOSPICE RETROSPECTIVE COHORT STUDY

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10.1136/bmjspcare-2013-000591.142

Objectives There is limited evidence of the impact of advance care planning (ACP) on outcomes. We conducted a retrospective cohort study on deaths of all patients known to a hospice in a 2.5-year period to see if use of ACP affected actual place of death, hospital use and cost of hospital care in the last year.
Results 969 patients were included. 550 (57%) people completed ACP. 414 (75%) achieved their choice of place of death. For those who chose home, 34 (11.3%) died in hospital; a care home 2 (1.7%) died in hospital; a hospice 14 (11.2%) died in hospital and 6 (86%) who chose to die in hospital did so. 112 (26.5%) of people without ACP died in hospital. Mean number of days in hospital in the last year of life was 18.1 in the ACP group and 26.5 in the non-ACP group ($p < 0.001$). Mean cost of hospital treatment during the last year of life for those who died in hospital was £11,299, those dying outside of hospital £7,730 ($p < 0.001$). Mean number of emergency admissions for those who died in hospital was 2.2 and who died elsewhere was 1.7 ($p < 0.001$).
Conclusions ACP can be used routinely in a hospice setting. Those who used ACP spent less time in hospital in their last year. ACP is associated with a reduction in the number of days in hospital in the last year of life with less hospital costs, supporting the assumptions made in the End of Life Care Strategy 2008.