Improving the knowledge of staff around caring for patients who are diagnosed with dementia admitted to hospital
Increase the awareness of staff caring for these patients
Promote advance care planning for people with dementia
Support families of people suffering from dementia with decision making

Methods
A flow chart was designed and coloured to reflect the local End of Life Care Model. There was close liaison with trust staff about developments in dementia care within the acute setting and teaching materials were developed to train staff on caring for patients with dementia in their last days of life.

Results
The trust collated results from the dementia screening tool used to assess every patient over 75yrs; it demonstrated an increase in knowledge for staff in trust to recognise dementia as a terminal disease.

Discussion
The project aimed to support patients with dementia from diagnosis to bereavement. The work was a collaboration between the Acute Trust and local hospice services. Work streams were formed to develop care pathways, integrated working and shared learning. The trust adopted the butterfly scheme which the CNS team promoted when visiting patients with dementia and raise awareness of importance of advanced care planning for these patients.

Conclusion
Improving the knowledge of staff around caring for patients that are dying who have dementia improves their ability to effectively observe and manage symptoms, improves the quality of care and job satisfaction whilst improving outcomes and relieving distress for patients and families.

Respite care is currently disregarded as an essential component of palliative care despite interest on the part of Government and others to support home based end of life care and to increase access for people with chronic degenerative conditions.

During the last 2 years an East London hospice has delivered an updated model of respite care that recognises and responds to new emerging groups of users and seeks to enable more people to remain at home during their illness.

A new, nurse led service, headed by a nurse consultant, has been established which delivers planned respite care. The service proactively seeks to support people with non malignant conditions including young adults undergoing transition from children to adult services.

This shift results in time being given to a multi professional review of the patient and carer’s needs as a basis for establishing an updated care plan, designed to enrich the patient’s life and maintain their function and wellbeing. Access to other hospice services is also made available. It is particularly effective when the patient is admitted in a relatively stable state and can consider / negotiate different approaches to care in a safe environment. Seven beds are now open to provide this care.

Development of this new model has required a different culture of care, development of staff skills and new working relationships within and outwith the hospice.

The service has been well used (average occupancy 80%).

Review of activity data reveals a higher than average use of these beds by people with non cancer conditions (47%) and increasing utilization of young people undergoing transition (12 episodes). User satisfaction is high and the impact of care, measured through SKIPP is positive. Carer feedback, via focus groups...