

injectable medication for symptom control in the community impossible in time to allow him to die at home.

Discussion There is a striking lack of literature on managing patients prescribed diamorphine for addiction in a hospice. Our experience highlighted the need for close communication with the relevant Substance Misuse Team. Patient self-administration of intravenous diamorphine can continue, provided hospice inpatient policy criteria for self-administration of controlled drugs are satisfied. Where the indication for diamorphine use changes from addiction management to symptom control in the terminal phase, hospice doctors may take over prescribing [patient 2].

P-89

DEPRIVATION OF LIBERTY SAFEGUARDS: DEVELOPING A LEAFLET TO HELP FAMILIES UNDERSTAND DOLS AND IMPLICATIONS AT EOL

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10.1136/bmjspcare-2016-001245.112

Most hospices have supported people needing treatment and care who do not have capacity to consent to it, who need constant care and would not be allowed to leave should they try. DoLS legislation was introduced to safeguard such people from misuse of restrictions to their freedoms. Hospices have varied in their interpretation of/application of DoLS legislation, however what is widely shared is that the use of DoLS has caused distress to families, and delays to families in making arrangements after death. Our own experience of applying for DoLS for hospice inpatients is limited (4/374 admissions from April 2015-end March 16) but an increasing number of people we support in the community have a DoLS Standard Authorisation; usually care home residents with an illness affecting cognition (e.g. dementia; cancer affecting the brain). Death demands a Coroner's investigation and inquest because death under a DoLS = death in custody. We have been concerned to better support families whose relative requires a DoLS, and to better prepare them for obligatory processes after death.

We are developing a leaflet using the experiences of a relative whose late husband had a DoLS, a carer who was distressed by post-death processes, the Local Authority, police and coroner. All have commented that an explanatory leaflet which is easy to understand would be enormously helpful. Our aim is to develop something to really support carers both when a DoLS is authorised and when their loved one dies, towards a more supported care experience and smoother bereavement. It will explain simply the reason for and value of a DoLS, help support the maximising of freedoms for someone with a DoLS and prepare families for processes after death. Evaluation will be via our service users group, service users and colleagues from several local hospices who have shared similar experiences of finding the issues complex to explain.

P-90

IMPROVING ACCESS TO PALLIATIVE CARE SERVICES FOR DIVERSE COMMUNITIES OF CARDIFF AND THE VALE

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10.1136/bmjspcare-2016-001245.113

This presentation will describe a current development project based at the Marie Curie Hospice in Wales, which aims to build

relationships with the diverse communities of Cardiff and the Vale and in particular focusing on people with learning disabilities, people with dementia and people with a religious or no religious belief, to explore and address barriers that prevent access to palliative care services.

The project was funded in January 2016, for three years, by the Big Lottery Fund and aims to:

1. Develop links and improve communication with representative organisations in regards to dementia, learning disabilities and religion in the Cardiff and the Vale area to establish a better understanding of the end of life care needs and the gaps in service provision for these groups.
2. Identify specific barriers to service awareness and access for people with dementia, learning disabilities and of a religious background in the local community in Cardiff and the Vale.
3. Advise Marie Curie services in Cardiff and the Vale on learning.
4. Work directly with people with dementia, learning disabilities and of a religious background and their carers/families to provide support and advice on services.

This presentation will outline the project activity and outline barriers identified to date as well as discuss future project activity planned.

P-91

THE CONCEPT OF PREDICTING FUTURE RISK IN GUIDING REFERRAL TO SPECIALIST PALLIATIVE CARE SERVICES

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10.1136/bmjspcare-2016-001245.114

Identifying and responding to patient and carer need is fundamental in providing holistic end-of-life care. Numerous assessment tools are currently in use to facilitate this and whilst the advantage of these is recognised they only offer a snapshot assessment in what is often a long disease journey. It is the role of the specialist palliative care team to anticipate future needs that may be not immediately apparent but pose a risk to patients' or their loved ones in the future.

We propose the concept of risk factors for a negative death experience. These risks may not necessarily cause difficulty in the present but should alert health professionals that the patient is at risk of a turbulent disease trajectory. This is a new concept, with little supporting evidence at present.

Our review of the current literature base and local nominal group discussions have identified the following features as risk factors for a negative outcome for patients and their loved ones:

- Poor engagement with advance care planning
- Carer strain related to palliative illness
- Self-perceived burden
- Patient-carer mismatch
- High levels of service use
- Bereavement risk factors.

It is anticipated that earlier specialist palliative input in situations where these risk factors are present offers greater opportunity to intervene in order to ameliorate risk, resulting in better care for the patient and improved outcomes for those close to them.

We plan to use our findings to educate local GPs about the risk factors that should trigger early palliative care referral. A tool to aid the early recognition of risk is currently in development and will be integrated into Pilgrims Hospice referral forms in the future.

P-92 IMPROVING TIMELY ACCESS TO SPECIALIST PALLIATIVE CARE, USING QUALITY IMPROVEMENT (QI) METHODOLOGY

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10.1136/bmjspcare-2016-001245.115

The aim of the project is to enable more people who are triaged as appropriate for admission by the multi-disciplinary team, to be admitted and receive timely specialist in-patient palliative care.

Background

The rationale behind the project was that:

- Data indicated an increasing demand on specialist palliative care beds
- There was evidence of the impact of delayed discharges on achieving timely access
- There is need to educate society about the changing role of specialist palliative care.

Aim The aim is to increase the number of appropriate admissions from 70% to 75%.

Method The project uses Quality Improvement methodology as the mechanism for improving practice. The driver diagram below demonstrates how we structured our project.

Small change ideas are being used to slowly make improvements that are effective and sustainable. An example of one change was to review the referral form and admission documentation to ensure from the point of referral that patients understand the reason for their in-patient hospice care and the potential for discharge.

The project is based on the Model for Improvement tool.

Results We are using a measurement strategy to map and evaluate our progress. We are making significant progress as for the last

eight months we have surpassed our original target and reached 79%. There are further change ideas that we intend to explore to help with sustainability and spread. One of these is holding a round table discussion with external partners to look at ways they can support the discharge process.

Opportunities We are intending that this project will enable us to maximise available resources whilst at the same time improve access to specialist palliative care to more people in a more timely way.

P-93 REACHING OUT – IMPROVING CARE BEYOND OUR HOSPICE WALLS

Kathryn Hamling, Kenny Steele. *Highland Hospice, Inverness, UK*

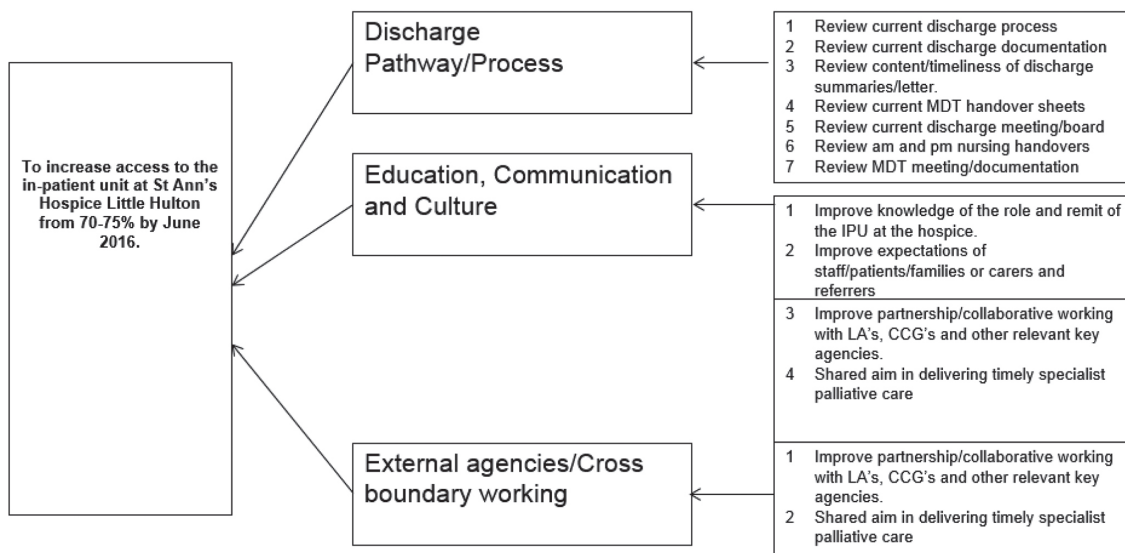
10.1136/bmjspcare-2016-001245.116

Highland Hospice has a proud history of delivering and promoting high quality palliative care for our community, geographically the size of Belgium with a population of just over 220 000.

The sphere of influence of the hospice is far greater than the direct care we provide to patients, families and carers. It is acknowledged that while direct care can (and does) provide the highest quality response for the individual it is resource intensive. Indirect support can however potentially support many more people especially those who live in the more remote areas of our wide geographical area. As a result we are currently piloting a number of innovative and creative responses to deal with these geographic and demographic challenges using digital communication. In this way we are supporting more people to a higher standard at home or in a care home environment, increasing our value to the wider health and social care system and providing better quality care for those in need.

This outreaching of care is being developed in a number of different ways:-

- Using ECHO Highland Hospice Scotland – a collaborative web-based model of education and care management that moves knowledge without moving people.
- HHeLP – Highland Hospice electronically Linking People – an interactive, secure internet portal developed to provide



Abs P-92 Table 1