in the hospice for a short period of time it is vital that we know what matters to them and what is important to them not just their clinical condition. We are encouraging staff to discuss one page profiles with patients on admission so that staff can get to know their wishes right from the start. Patients can change their one page profiles at any time.

We are receiving very positive feedback from patients that have completed them. Comments include:

‘I feel much more relaxed now that you know what my likes and dislikes are’

‘Suddenly after completing the one page profile I feel I have the strength to talk to my daughter about my wishes’

‘I am happy that my wife will be involved with decisions about my care this means a lot to me’

‘I feel safe and secure that my wish not to be resuscitated has been listened to and everyone will know my wishes’

We have a working group who are undertaking evaluations and will audit this work.

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PREFERRED PLACE OF CARE – ROOT CAUSE ANALYSIS

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Introduction Surveys and research indicate that home is the preferred place of care at the end of life for many people (71%), whilst the most commonly recorded place of death remains hospital (53%).

Aim To identify barriers and enablers to the delivery of good end-of-life care for patients.

Methods The project was completed over a six-week period at a hospice in Northwest England. Each week at our multidisciplinary team meeting we discussed deaths of patients known to our community palliative care team and recorded our findings.

Results 48 patients known to the team died during the six-week period. Preferred place of death was achieved in 91% (30/33) of cases when this was home, and 85% (11/13) of cases when this was the hospice. None of our patients expressed hospital as their preferred place of death (PPD). Preferred place of death was unknown in 4.2% (2/48) of patients, a hospital admission was indicated due to acute unexpected deterioration. 77% (21/27) of patients dying in the community had face to face or telephone contact within three days of death. Identified barriers to good end-of-life care were: difficulties accessing oxygen at home for symptom management, one episode of difficulty accessing specialist care advice and challenges communicating directly with district nursing teams. Enablers were: appropriate use of DNACPR forms with no involvement of emergency services at the end-of-life as well as good team-working between specialist and generalist services.

Conclusions The majority of patients known to the team die in their preferred place of care, with a good quality of death as judged by the team. Lessons have been learned from after death analysis and action plans devised. This scoping exercise could be repeated on a periodic basis.