

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.

#### P-124 PREFERRED PLACE OF CARE – ROOT CAUSE ANALYSIS

<sup>1</sup>Maria Debattista, <sup>1</sup>Andrew Fletcher, <sup>2</sup>Claire Capewell. <sup>1</sup>St Catherine's Hospice, Preston, UK; <sup>2</sup>Lancashire Teaching Hospitals Trust

10.1136/bmjspcare-2016-001245.147

**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 PPD. Preferred place of death was unknown in 4.2% (2/48) of patients. 8.3% (4/48) of patients died in hospital. In 50% (2/4) 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.

#### P-125 HOMEWARD BOUND: RAPID DISCHARGE OF PEOPLE TO THEIR PREFERRED PLACE OF CARE

Christina Ginsbu. *Earl Mountbatten Hospice, Newport, UK*

10.1136/bmjspcare-2016-001245.148

Following a period of sustained pressure on our local healthcare system, the gauntlet was thrown down from commissioners to the hospice to expedite discharges by providing care at home.

Our hospice, at the heart of the community, renowned for breaking barriers and a positive approach, rose to the challenge of this six-month pilot project.

We rapidly reorganised our community team to release their community support workers to form a team and recruited to expand the workforce.

This newly formed team received a week's robust training in preparation for our crusade to get people home from an inpatient setting.

We met with commissioners and local care providers to plan in partnership how we would work.

#### Aims of the project

- To respond to local need by developing a reactive workforce to deliver flexible, high quality personal and health care to support people at the end of their life
- Enable rapid response discharges by accepting fast track care requests from Continuing Healthcare within 1.5 hours and commencing care within four hours
- Preventing admissions and decreasing the need for use of acute care by providing and sustaining care at home
- Increase the number of people who choose to live and die in their own homes.

#### Results

- 100% of referrals were accepted within 1.5 hours
- 100% of these referrals received care within four hours
- 100% of these patients died in their preferred place of care
- We have met the needs of 56% of all fast track care requests.
- 18% were in partnership with local care providers.
- The evidence from the quality survey completed by families, has demonstrated nothing but positive feedback to the excellent responsiveness of the service delivery.

**Conclusion** It is the intention of the Hospice to continue and expand this service

#### P-126 AN AUDIT TO DETERMINE IF PEOPLE WITH A LEARNING DISABILITY (LD) AND KNOWN TO THE HOSPICE HAVE ACHIEVED THEIR PREFERRED PLACE OF DEATH (PPD) AND IF THE INITIAL DISCUSSION HAD TAKEN PLACE, WITH AN OUTCOME ESTABLISHED AND DOCUMENTED

Maria Stripe, Sue Spong. *St Francis Hospice, Romford, UK*

10.1136/bmjspcare-2016-001245.149

**Aims and objectives** To establish documented evidence of the preferred place of death (PPD) of people with a learning disability (LD) and establish if PPD was achieved and documented. Additionally; to establish where initial conversation took place with regards to PPD. To establish if an "easy read" Preferred