

**Outcomes** Success to date has been extremely positive with outcome measures exceeding expectation across all areas.

**Application into Hospice Practice** An action plan was developed and implementation commenced of the recommended actions. The new documentation was rolled out on the 30 November and is now being used for all patients who are admitted to the in-patient unit. Care plans were redesigned to encourage planning and documentation of personalised care. Records audit was then done every week, all patients records are audited without exception.

Feedback from issues found through audit is given directly to the staff member involved as soon as possible either face to face or by email and clinical supervision documentation is completed for evidence of feedback. Compliance of feedback is checked the following week whilst doing the weekly audit. The nurse coordinators' role defined to include monitoring of documentation following admission to ensure compliance sustaining improvements. There remained a need to continue weekly audits until staff have adapted and familiarised themselves with the documentation, by March 2017 following evidence of sustained compliance to the audit requirements, the audit was conducted fortnightly for three months and if remains stable will then be downscaled to monthly. Documentation is clearer and evidences patient and family engagement and consent in personalised care planning. Documentation compliance has improved.

**P-175 AN AUDIT OF DOCUMENTATION OF MENTAL CAPACITY ASSESSMENTS AT ST JOSEPH'S HOSPICE**

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**Introduction** Since the introduction of the Mental Capacity Act (MCA) in 2005, there has been much debate what constitutes an adequate MCA assessment. It is important to keep comprehensive documentation of MCA assessments as they can be challenged. Hospices (along with other healthcare services) need to ensure their staff are competent in conducting MCA assessments and that their documentation is clear and consistent.

**Aims** To evaluate the quality of MCA assessment and documentation for patients under the care of the hospice.

**Methods** All MCA assessments conducted in a 34-bed hospice over a six-month period were reviewed retrospectively using an audit tool developed by the British Psychological Society.

**Results and Recommendations** 44 assessments for 20 patients were analysed. Assessments were generally well documented: the rationale was clear (91%); the decision to be made was clearly stated (95%) and the diagnostic and functional tests were specifically addressed (91%). Areas where practice could be improved included: assessing capacity for one decision at a time; documenting any communication difficulties and how these are overcome; clearly documenting recommendations as a result of the assessment; and identifying the need for repeat assessments. As part of a multidisciplinary discussion, amendments have been made to the MCA assessment documentation template. Results have been disseminated and an education session held to increase awareness, and the hospice documentation template updated, prior to re-audit in August 2017.

**Conclusions** MCA assessment documentation was generally clear and appeared to show staff understood the basic

principles of the MCA. It is hoped that updating the documentation template, in addition to staff education, will address the areas requiring improvement.

## Service development, models and collaborative working

**P-176 I WANT TO DIE ALONE NURSE, I WANT TO DIE AT HOME**

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Supporting a patient with limited family and financial resource to die alone at home, when some people were profoundly uncomfortable with their end of life wishes proved a difficult, but not insurmountable, challenge.

**Background** The concept of a 'Good Death' (Ko et al., 2015) is widely accepted, dying alone is seen as an aspect of 'bad death'. The Mental Capacity Act (2005) makes it clear, people have a right to make informed choices; these choices should not be measured against those others might make. Patients who want to die alone are not always able to do so – well-meaning friends, neighbours and professionals can create barriers to prevent lone death including detailing safety, medicines and vulnerable adult concerns.

**Results** The patient died at home, alone, what did we do ?

- Enabled the patient to be explicit about their choices, and communicate them to friends, neighbours and professionals effectively
- Recognised that dying alone was a valid choice, made with capacity, and fully in tune with the context of this person's life
- Reflected on our insecurities, helped carers to do the same, recognising that our fear can create a barrier to patient choice
- Brought together the widest multidisciplinary team including social services, carers, neighbours, helping them to understand the patient's viewpoint, right to autonomy and self-determination
- Honestly addressed risks to patient safety, safeguarding, medicines management, access to patient's home – minimising those risks using technology, equipment adaptations and creative problem solving
- Rapid response hospice team involved.

**Conclusions** The biggest challenge was to overcome preconceptions of what is a good death to enable the patient to have their choices honoured. Creating common understanding with good communication, having a clear plan, and taking a degree of shared risk empowered real patient choice at end of life. An alone death is not necessarily a bad death.

**P-177 DISCHARGE BUDDIES – FEELING SAFE GOING HOME**

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**Background** When patients are discharged from a hospice inpatient unit many report feeling vulnerable and abandoned;