HOSPICE CNS SEVEN-DAY SERVICE: 6/12 PILOT REVIEW

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Background The hospice community CNS team has piloted a 9–5 service at weekends and bank holidays in response to national guidance and the need for a continuous seven day service for patients with complex palliative care needs at home (NPEoLC Partnership, 2015–2020).

Aims To promote preferred place of care/death, avoid inappropriate hospital admission, promote appropriate hospice admission and provide continuity of care for hospice community patients.

Methods One CNS working on bank holidays and weekends received 52 urgent referrals from the hospice advice line for interventions associated with uncontrolled symptoms, rapid deterioration, emotional distress, and requests for hospice admission. 47/52 received the service of which 36/47 were visited at home.

Results

1. Promote PPC or PPD
   Most patients with complex needs who received this service achieved their preferred place of care, 27/32 or 84%.

2. Avoid inappropriate hospital admission
   This was achieved as hospital admission was appropriate for 5/5 or 100% who were assessed as requiring treatment from secondary care.

3. Access for appropriate hospice admission
   Appropriate admission to the hospice was achieved by 10/12 patients but two were not admitted due to lack of beds. Inappropriate hospice admission was avoided for a further seven patients where 5/7 were supported by this service to stay at home and 2/7 assessed as requiring hospice admission.

4. Provide continuous care in complexity
   CNSs strongly agreed or agreed that the aims of the referrals were met for 43/44 or 98% of patients and families who received this service.

Conclusions The results demonstrate positive outcomes of this service in the urgent management of complex symptoms, distress, deterioration and the promotion of PPC. The service criteria is being expanded to address the unmet need of patients who require proactive CNS interventions to sustain palliative care control and avoid crises.

REACHING OUT: VOLUNTEER OUTSIDE SERVICE

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Aim Volunteers ensure high quality experience for hospice attendees. Building on existing practice and promoting future excellence, a volunteer workforce was trained to support patients and families in end of life (EoL) choices, in own home/hospital, particularly if alone. Volunteers, aligned to hospice vision and values, complement and ‘fill gaps’ in existing services.

Approach A review of day/at home patients, revealed those ‘well enough’ for discharge from specialist palliative care (SPC) input, who would still benefit from regular hospice support for self/family. A willing, confident, flexible, health and social care experienced, volunteer team, able to respond to changing demand, recruited to work unsupervised in people’s homes. A bespoke training programme, addressed expressed anxieties, role clarity, boundaries and communication skills. Volunteer Outside Service (VOS) co-ordinated by Hospice at Home, ideally placed to promote initiative whilst identifying/assessing potential patients. Patients seamlessly allocated volunteer visits and SPC as condition dictates. Uniformed volunteers, with lone worker devices, start and finish from hospice, with current patient information to avoid ‘surprises’ on arrival at patients’ home, undertake light household duties; provide listening ear/read; make meals; not expected to undertake personal/clinical care; have clear guidelines to follow if encounter difficulties and appropriately debriefed on return.

Results 10–14 volunteers made 500 home/hospital VOS visits. Volunteers report feeling valued and fulfilled, privileged to be involved in lives of people at an important time and proud of making a difference. Hospice staff report, that despite required time and support, they have integrated well into existing team providing companionship and practical support.

Conclusion Volunteers, integral to package of care, meet complex and challenging patient and family needs. Younger volunteers are needed, due to the demographic profile of the current volunteer workforce. The plan is to support more people dying in hospital and we continue to communicate with secondary care colleagues to ensure professional boundaries are respected. Volunteer training and retention, ensures continuity of a reportedly worthwhile valuable service.

SUPPORTING PEOPLE AND FAMILIES AT END OF LIFE TO ENSURE THEY ARE CARED FOR IN THEIR PREFERRED PLACE OF CARE

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The hospice was approached by a Clinical Commissioning Group (CCG) to run a pilot project supporting people in their normal place of residence at end of life.

The CCG felt that too many people were being admitted to hospital and that there were delays in discharge due to lack of co-ordination and personal care.

The aim of this service was to enable people to: die in their preferred place of care; enable rapid discharge from acute care to preferred place of care; avoid unnecessary admission to acute care; provide support to carers/families.

This community service was developed to enhance services already available to support people at end of life.

Method A small team was recruited to deliver this service: one band 6 RN to assess, plan care and co-ordinate the service (Monday to Friday 9 am – 5 pm)

Availability of HCAs to deliver personal care from 8 am-8 pm, 7 days a week

Referrals were made via the hospice assessment and coordination team.

People were managed by this service for a maximum of 5 days, then discharged on to the most appropriate hospice/external service for ongoing support

Detailed results were kept and reported on.

Results

- 99 people were supported in nine months
- 31 died under the care of the service
- 12 were admitted into the hospice
Abstracts

- 56 hospital admissions were avoided
- 53 were referred on to the hospice Community Clinical Nurse Specialist Team
- two were admitted to hospital
- only three people needed personal care.

Conclusion The project supported people to die where they wished to be cared for. It prevented a number of hospital admissions due to the rapid and skilled support of trained staff. The care component was not needed as the present provider was able to support within an appropriate timeframe. Feedback from families and carers was overwhelmingly positive.

**P-196** MOTOR NEURONE DISEASE: SUPPORTING PEOPLE TO DIE AT HOME IN LANCASHIRE AND SOUTH CUMBRIA

Simon Edgecombe, Sue Muller, St John’s Hospice, Lancaster, UK; Motor Neurone Disease Association, Lancashire and Cumbria, UK

In 2016, twenty people with Motor Neurone Disease (MND) in the Lancashire and South Cumbria region were admitted and died in hospital. Following a meeting in early 2016 with the MND Association, the local hospices were approached to consider how the MND ice bucket challenge money could be utilised for future MND patient support. From this, local MND Association staff met with St John’s Hospice staff to look at how the hospice could support MND patients through our already existing services.

The group looked at the gaps in services and staff knowledge, what caused a crisis leading to hospital admission, and what skills are required to keep people with MND at home, if that is their preferred place of care and death. The main issues often leading to admission were documenting and managing advance care planning; supporting cognitive impairment difficulties; and supporting family carers using practical skills such as taking blood gases, managing non-invasive ventilation (NIV) and using cough assist devices.

For family support and education, the day services team set up a ‘STAR’ group (Support, Time-out, Advice, Recovery: named by the attendees) for people with MND and their main carer. This addressed advance care planning; hospice services and what they can provide; support to carers; nutrition, and speech and language advice. This would run weekly, following on from the quarterly MND clinics, for four weeks. The team also set up a successful MND study day for professionals, which was well evaluated and covered diagnosis, prognosis, and symptom management. The Hospice at Home and ward teams are presently being developed in the practical skills listed above, in order to support people to stay in their own homes when near end of life. An update on this work will be included in the poster.

**P-197** REVIEW OF ST CHRISTOPHER’S HOSPICE ‘NIGHT TIME’ OUT OF HOURS SUPPORT FOR COMMUNITY

Anne Nash, St Christopher’s Hospice, London, UK

Aim The aim of this 18 month service review was to reflect on the number of calls/contacts to the night co-coordinator triaging service were processing, to review on the number of emergency visits, their purpose, and if there was an increased usage of the medical on call support.

**Background** Since 11 January 2016, the emergency St Christopher’s community team out of hours service has been supported by the inpatient nursing service. This is managed by the night co-coordinator triaging out of hours calls and if an emergency visit is required, (after 10 pm to approximately 6.30–7 am), then a Band 6 night co-coordinator or Band 5 ward-based RN and HCA from the night team will visit the patient, using a wait and return cab service. There remains the on call support from the medical team. The St Christopher’s community service supports 5 CCGs and, over night, four of the CCGs fund a community over-night district nursing service.

**Methods** For the first six months there was a small working group, (Medical Consultant, CNS Nurse Manager and Inpatient Matron), undertook an initial review of the service, with a focus of evaluating support from the medical team. This has continued with a three-monthly review by the Matron of the in-patient service. Each telephone contact from the patient or family member was recorded and any nurse visits by the inpatient nursing team. The out of hours visit was then reviewed retrospectively and themes analysed.

**Findings and Conclusions** On average per month there were 156 calls made to the night service triage service and eight nursing visits.

Of the 140 visits by the inpatient nursing team:
- 92 were primarily to administer medication for pain or end of life care
- 8 were for assistance with catheterisation issues
- 40 visits were for various other issues ranging from assessment of new symptoms, fixing O2 tubing, other hygiene issues and general nursing and repositioning issues.

All visits were assessed as appropriate use of this emergency support service, with the aim of supporting community patients at home and avoiding hospital admissions. The new service did not impact on medical on call support.

**P-198** I’M DYING – GET ME OUT OF HERE!

Rachel Whiting, Helen Meehan, Wayne de Leeuw, Dorothy House Hospice Care, Wiltshire, UK

**Background** Responding to an identified need to reduce length of stay for patients at the end of life in hospital and funded through the Better Care Fund, our hospice, in partnership with the Specialist Palliative Care Team at the acute hospital, created an Enhanced Discharge Service to facilitate discharge to preferred place of care.

**Aims**
- Reduce inappropriate delay in discharge to preferred place of care at end of life
- Provide up to 24 hour care at home dependant on need
- Develop and implement a ‘supportive care model’ using end of life care stages of decline to support decision making.

**Method** We used a partnership approach working with the Local Authority, Clinical Commissioning Group and acute hospital.

Appropriate patients were identified using a ‘Stages of