

- 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

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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 causes 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

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**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-ordinator 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-ordinator 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!

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**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