

**Conclusions** There are occasions when hospital admission is appropriate. However, there was clear evidence showing support from the night team could prevent or postpone hospital admissions.

#### 42 THE VALUE OF A NIGHT SERVICE FOR HOSPICE AT HOME; REASONS FOR MAKING CONTACT AT NIGHT

SG Spiro, A Ward, J Sixsmith, A Graham. *Rennie Grove Hospice Care, The University of Northampton, The University of Dundee*

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**Background** People approaching the end of their lives have physical and psychological needs that should be met in a timely way, at any point during the night or day, and met in a way which addresses their needs and preferences. Crises at any time requires prompt, safe and effective urgent care (NICE 2011).

**Methods** Rennie Grove (RG) provides 24/7 care, with a night service available from 9.15 pm to 7.15 am. RG conducted an independent study to identify the value of the service, including reasons people make contact at night and how many calls could be settled without a visit. Over the study period (145 nights) each call was charted with demographic details, reason for call and outcome.

**Results** 550 calls were received, resulting in 335 visits. On 7 nights there were no visits, the highest number in a night was 9, with an average 3.79 visits per night. Only those consenting to participate were analysed, reducing eligibility to 351 calls and 208 visits. Of these, reasons for a night visit included symptom control (64%), carer support (19%), death (13%), death verified by night team (9%), message (7.5%), planned visit (7%) and 'other' (4%). Major symptoms included pain (42%), anxiety (32%), nausea (17%) and a small number with chest problems, bowel issues, pyrexia, syringe pumps. In 143 cases a visit was not necessary due to telephone reassurance (55%), another service being more suitable (12%), the team were too busy (8%), and 12% were handed to the next shift.

**Conclusions** The night team plays a vital role in 24/7 care, with 40% of calls being managed without a visit. Visits were, in the main, for symptoms or problems concerning support. Death, for a Hospice at Home service also becomes a significant issue requiring a prompt and caring response.

#### 43 PERSONALISED CARE PLANNING TOOL FOR DYING PATIENTS; PEOPLES PERCEPTIONS AND IMPACT ON CARE

Kate Tredgett, Karen Brown. *Great Western Hospitals NHS Foundation Trust Swindon*

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**Introduction** In response to 'One chance to get it right' we developed a local tool to support the care of dying people in an acute hospital. It comprised a document with guidance and tear out elements for clinical staff and a patient/family information book. We report on the data acquired on the tool's impact on care and the perceptions of relatives and clinicians.

**Methods and results** -Impact on care; This was evaluated through feedback from bereaved families using a validated questionnaire. Questionnaire responses were compared for the

deaths supported and not supported by the tool. Overall score for quality of care from 123 completed questionnaires was 16% higher when care was supported by the tool (72% v 88%).

-Clinician Feedback; More than 75% of Trust staff have completed mandatory video based e.learning training in care of the dying and in using the tool. Feedback was collected from 60 medical and nursing staff of mixed grades following a learning event. 63% rated the tool 'very helpful' with the remainder rating it 'quite helpful'. Comments included that the tool provides 'written evidence of discussions' and 'staff are aware of the patient's wishes,' and highlighted practical issues including that 'it is necessarily extensive and takes a long time to complete'.

-Family Feedback; In addition to the completing the validated questionnaire, families were invited provide feedback on the tool itself. 96% of respondents rated it very or quite helpful with comments including 'discussed in detail' and 'I'm glad it was there'.

**Discussion** The findings suggest that the tool is helpful. Because deaths not supported by the tool may differ systematically from those supported by the tool, there may be bias which could dilute the tool's impact as evaluated by the questionnaire. Clinician and family feedback support its ongoing use and continued development.

#### 44 PRELIMINARY OUTCOME ANALYSIS OF INTEGRATED CARE FOR ADVANCED RESPIRATORY DISORDER (ICARE) – A MULTIDISCIPLINARY PALLIATIVE REHABILITATION PROGRAM FOR ADVANCED LUNG DISEASE IN A COMMUNITY HOSPITAL

Nicholas Lee, Neo Han Yee. *Lee Kong Chian School of Medicine Nanyang Technological University Singapore, Tan Tock Seng Hospital Singapore, Ren Ci Hospital Singapore*

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**Background** Dyspnea is a prevalent and debilitating symptom, especially in patients with advanced pulmonary diseases. Dyspnea support services have been shown to improve functional outcomes and quality of life. This report presents a retrospective audit of a novel inpatient dyspnea support service for advanced respiratory diseases in Singapore.

**Methods** ICARE employs multidisciplinary dyspnea management, pulmonary rehabilitation, structured comorbidity screening using CO-morbidity Assessment Template (COAT), and dyspnea self-management interventions for patients discharged from Respiratory Medicine. The primary outcomes assessed were 6 min Walk Distance (6MWD) and Modified Barthel Index (MBI). Secondary outcomes include clinical issues identified by COAT that were treated, as well as 30 day readmissions.

**Results** ICARE had 39 unique admissions with 4 recurrent patients. The patients were mostly elderly Chinese males who were exceptionally frail with considerable co-morbidity. Their mean age was 73.2 ( $\pm 9.5$ ) years, 87.1% had COPD of which 81.8% was GOLD stage 3/4. Admission 6MWD was 130.4 m ( $\pm 90.6$ ). 3.3 ( $\pm 1.3$ ) of 5 basic ADLs were affected by dyspnea. They had mean 5.1 respiratory hospitalisations 1 year prior to ICARE admission with median hospital LOS 30.0 (IQR 20.0–60.0) days, 12.8% had 10 hospitalisations.

The median program duration was 24.0 (IQR 12–35) days. 6MWD improved by median 30 m (IQR 20–60) ( $p=0.05$ ).

Patients with admission 6MWD=100 m had mean improvement 62.2 m ( $\pm 73.1$ ). MBI improved from 69.1 ( $\pm 13.9$ ) to 82.1 ( $\pm 12.7$ ) ( $p=0.001$ ). Patients with MBI 75 on admission had mean improvement of 16.2 ( $\pm 11.7$ ) ( $p=0.05$ ). 30 day readmissions for non-infective exacerbations was 15.6% (vs 29.2% from historical data). Median duration to exacerbation, death, or censure was 116.5 (IQR 53–206) days. Mean number of issues identified by COAT was 5.6 ( $\pm 2.5$ ), 80.3% were improved or resolved before discharge.

**Conclusion** ICARE is a novel inpatient dyspnea support service that improves functional capacity and exercise tolerance, identifies and treats co-morbid medical conditions, and potentially reduces 30 day re-admission to tertiary institutions.

45 **THINKING AHEAD ABOUT MEDICAL TREATMENTS IN ADVANCED ILLNESS: THE COMPLEXITIES OF SUPPORTING DIVERSE COMMUNITIES IN LEICESTERSHIRE**

Zoebia Islam, Lucy Taylor, Helen Eborall, Christina Faull. *LOROS, The Leicestershire and Rutland Hospice; University of Leicester*

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**Background** Advance care planning (ACP) supports people who are seriously ill to be cared for in the way, and in the place that they prefer. Yet, evidence suggests there are lower levels of ACP in people from Black, Asian and Minority Ethnic (BAME) communities. Little is known about how the model of resuscitation decision-making fits with the social, cultural and religious values and beliefs of BAME groups. Health care professionals (HCPs) also report a lack of confidence in having culturally appropriate discussions with BAME patients and their families. Equipping professionals to be more confident about such ACP discussions may lead to achieving patient preferences.

**Aims** This study explores professional views and experiences of ACP with patients from BAME backgrounds. With a focus on making decisions about resuscitation, it aims to identify barriers and enablers and person-centred outcomes to such discussions and provide evidence for training professionals.

**Methods** Thematic analysis of qualitative semi-structured interviews with HCPs across primary, secondary and tertiary care in Leicester, including GPs, hospital doctors and nurses.

**Results** There was an emphasis on building rapport, the timing of discussions and navigating communication barriers. Barriers to decision-making included: patients' and their families understanding of both prognosis and resuscitation; and differing values amongst generations of migrants. Professionals struggled with how to find a balance between acting in a non-discriminatory way whilst respecting cultural differences. Patients and family members, who wished to prolong life at all costs, commonly framed religiously as the sanctity of life, was described as a key challenge to discussions. Most HCPs highlight the need for further training and/or support.

**Conclusion** There are significant barriers for HCPs when discussing resuscitation decisions with people from BAME communities. This increases the complexity of navigating ACP and achieving patients' preferences. HCPs would benefit from further training and support.

46 **USING A QUALITY IMPROVEMENT APPROACH TO IMPROVE TREATMENT ESCALATION PLANS AND REDUCE CARDIAC ARRESTS AT A LARGE ACUTE NHS TRUST**

Adam Hurlow, Craig Pattison, Alison Cracknell, Anna Winfield, Sherena Nair. *Leeds Teaching Hospitals NHS Trust*

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**Background** Cardiopulmonary resuscitation (CPR) is effective for a minority of patients, with survival to discharge of less than 20%. A recent UK review of in-hospital CPR attempts identified failure to recognise patients at risk of cardiac arrest, discuss treatment escalation plans (TEPs) including CPR, and make do not attempt CPR decisions.

**Methods** In 2014, Leeds Teaching Hospitals NHS Trust (LTHT) established a quality improvement (QI) collaborative to improve the care of patients at risk of clinical deterioration and reduce avoidable deterioration or inappropriate CPR. It consisted of 14 pilot wards across specialty areas, supported by a multi-disciplinary faculty including Palliative Care.

Three key drivers for change were identified, including a work-stream focussed on timely TEPs for patients nearing the end of life. Over 12 months, pilot wards developed and tested improvement ideas. In June 2015, a bundle of five key interventions, including a TEP sticker and decision prompts, safety huddles and post-CPR debrief, was tested successfully across the 14 wards. A staggered trust-wide roll out of the bundle started in March 2016.

**Results** Statistical process control charts have shown a sustained and significant 25% reduction in cardiac arrest calls across LTHT, and a 32% reduction at the Saint James's University Hospital Site. This equates to 87 fewer cardiac arrests annually across the Trust than in 2015.

On pilot wards the proportion of patients with a treatment escalation plan and a CPR decision increased by 125% and 72%, respectively. The Trust incidence of cardiac arrests per 1000 admissions at SJUH is now 25% lower than the national average.

**Conclusion** A QI collaborative approach, empowering ward level innovation, with expert faculty support, can improve recognition of patients at risk of cardiac arrest, change behaviours and increase the number of patients with TEPs including CPR decisions; leading to a statistically significant reduction in cardiac arrests.

47 **DEVELOPING A STUDY INTERVENTION: A REALIST REVIEW AND CONSENSUS WORKSHOPS TO DEVELOP THE NAMASTE CARE INTERVENTION FOR PEOPLE WITH ADVANCED DEMENTIA PRIOR TO A FEASIBILITY STUDY USING A CLUSTER RANDOMISED CONTROLLED TRIAL IN NURSING CARE HOMES**

Catherine Walsh, Julie Kinley, Claire Goodman, Frances Bunn, Jennifer Lynch, Rachel Sharpe, Nancy Preston, Shakil Patel, Katherine Froggatt. *Lancaster University, University of Hertfordshire, St. Christopher's Hospice*

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**Background** Clear intervention specification is important, but often absent or incomplete in study reports. Namaste Care is