

Approach To ensure the service was responsive and effective the Duty CNS, who provides a first response telephone service, and the Urgent Response Nurse would work closely together. The majority of Urgent Response referrals were from the Duty CNS following an identified need. The Hospice @ Home service allocates a Band 5/6 nurse each day to carry out Urgent Response visits. Each visit involves a holistic assessment and management of urgent concerns and problems.

Outcome Following a three month pilot an audit of the 30 patients referred was carried out. 95% of the visits were carried out within two hours of referral. The service:

- Supported patients in crisis to remain at home
- Assessed and managed symptoms
- Identified patients with palliative care emergencies and facilitated admission
- Supported patients and families in emotional distress
- Carried out urgent assessment/review.

Direct feedback from patients, relatives and colleagues was extremely positive highlighting that the service provided timely, effective and supportive care.

Conclusion Due to the audit results and positive impact of the service the pilot was extended and the service continues. In addition the service facilitated more effective working relationships and team integration between H@H and the CNS team.

P-157 CINDERELLA SERVICE – IMPROVING CARE AT HOME WITH THE GSF DOMICILIARY CARE PROGRAMME

Keri Thomas. *The National GSF Centre for End of Life Care, London, UK*

10.1136/bmjspcare-2018-hospiceabs.182

Aim Domiciliary care workers play an important but often unrecognised role in supporting people to remain at home as they near the end of life, especially those with dementia and frailty. Despite this, few receive specific training in end of life care. Focussed training enables home care workers to improve the quality of care for such people who choose to remain in their homes, and contribute to better coordinated cross boundary care.

Method The fully revised GSF Domiciliary Care training programme focuses on enabling generalist frontline staff in end of life competencies. The Train-the-Trainer cascade programme works with Domiciliary Care Agency Trainers; using action based, interactive learning and reflective practice in six modules, with support from the virtual learning Zone/DVD, and resources. Comparative before and after qualitative and quantitative evaluation is intrinsic and includes frontline care worker confidence self-assessments, supportive care analyses and organisational competency questionnaires.

Results Homecare workers in various areas of the country show improvements in:

- Confidence and competence of home care staff
- Communication, working relationships and collaboration with primary care
- More advance care planning discussions, with service users keen to be involved in these discussions
- Encouragement and empowerment of staff to advocate for their service users leading to improved communications with other professionals
- Increased awareness of the knowledge they already possessed and future training needs.

Conclusion This highlights the important role that domiciliary care workers play, and the importance of empowering care staff that interact with the service users on a daily basis. The GSF Domiciliary Care Training Programme boosts the confidence and competence of care workers, improves collaboration and coordination with others and helps to improve care for more people nearing the end of life at home – which is for most the best place to be.

P-158 INCREASING THE RESPONSIVENESS OF THE COMMUNITY CLINICAL NURSE SPECIALIST TEAM

Melanie Holmes, Andrew Fletcher, Simon Walker. *St Catherine's Hospice, Preston, UK*

10.1136/bmjspcare-2018-hospiceabs.183

Background Referrals to the community team are increasing and demand for community palliative care services has led to a longer community waiting list. Consequently, the hospice is struggling to respond quickly to referrals for community assessment. In 2016/2017, 200 patients died whilst waiting to be seen.

Aims To reduce the time from referral to initial palliative care assessment for patients who have un-managed symptoms at the point of referral. To reduce the number of patients who die before being seen by specialist palliative care. To reduce unnecessary emergency hospital admissions. To support earlier discharge from hospital. To facilitate appropriate hospice IPU admissions in a timelier manner. To reduce the need to contact the GP or district nurse (DN). To reduce on-going distress of the patient/family member/carer. To create a positive experience for the patient/family member/carer.

Methods The new way of working involved creating capacity in order that a Clinical Nurse Specialist was able to respond in a timely way to patients who have been deemed to need an urgent response due to un-managed symptoms or an expected short prognosis. The urgent response role was intended to have minimal caseload responsibilities, having the capacity to be responsive.

Results The project data extracted was in three phases: (1). 12 weeks pre-project; (2). 12 weeks with an additional 1.0 WTE working as an urgent response nurse; (3). 12 weeks without additional capacity having a substantive CNS working in an urgent response way. The results showed that the different way of working increased the number of assessments completed and the numbers of patients that died before being seen reduced considerably, whilst increasing the number of active patients on caseloads. The project produced positive data that working in a different way could improve responsiveness, but additional capacity improved outcomes even further.

P-159 USING EXISTING RESOURCES TO ENHANCE COMMUNITY PALLIATIVE CARE: 30 MINUTES TO MAKE A DIFFERENCE

¹Laura Edwards, ²Sarah Hussey, ¹Suzanne Lomax, ³Jill Pinington. ¹Bolton NHS Foundation Trust, Bolton, UK; ²Bolton Hospice, Bolton, UK; ³Bolton NHS Foundation Trust, Bolton, UK

10.1136/bmjspcare-2018-hospiceabs.184

Background Bolton NHS Foundation Trust serves a population of approximately 260,000. Specialist palliative care services are integrated between hospital, community and

Bolton Hospice. Seamless care for patients is dependent on collaboration between these specialist services and community services provided by primary care and district nursing services.

Objective To improve services for palliative patients and those at end of life by implementing weekday community liaison meetings attended by the Hospice Liaison Nurse, Community Palliative Nurse Specialist, District Nurse neighbourhood representatives, AHPs, Social Worker and Community Consultant. Meetings are face-to-face and held at Bolton Hospice with a set agenda and prompt start and finish. Meetings typically last 30 min.

Outcomes 160 patients were discussed in detail in the first six months of the project. Of these 113 died: 54 at home, 46 in the hospice, nine in hospital and two in residential or nursing homes. Meetings resulted in improved communication, decreased repetition of work, peer support, appreciation of alternative professional perspectives and care from the right professional at the right time. A number of patient stories illustrate the value of the meetings.

Discussion Daily community palliative care meetings can enhance communication and care for patients and may contribute to efforts to fulfil the wishes of patients and carers at end of life. This in turn may help to reduce unnecessary hospital admissions. The use of technology to facilitate remote attendance will improve efficiency and staffing costs. Improved IT and clerical support will allow communication of outcomes to other healthcare professionals such as out of hours services. Seven day liaison meetings may be implemented alongside further review of seven day specialist palliative care services.

P-160 COMMUNITY PALLIATIVE CARE SPECIALIST NURSE 7-DAY SERVICE: DOES IT MAKE A DIFFERENCE?

Claire Blakey, Jane Jones. *Ashgate Hospicecare, Chesterfield, UK*

10.1136/bmjspcare-2018-hospiceabs.185

Background The Community Palliative Care Specialist Nurse (PCSN) team identified challenges faced out of hours (OOH), for patients, carers and health care professionals (HCP) with reported experiences of poor symptom management, carer distress and absence of specialist palliative care (SPC) support and advice.

These observations supported the Parliamentary and Health Service Ombudsman report (2015), that patients and carers 'suffered' due to difficulties accessing SPC OOH, concluding that; 'for the benefit of their comfort, dignity and wellbeing, all in need should have access to SPC services whenever they need it'. In response, the PCSN team implemented a service extension to seven days a week.

Aim To evaluate the PCSN service extension, explore outcomes and interventions, and evaluate patients', carers', HCPs' and PCSN team experiences.

Method The evaluation included analysis from a workshop review, staff focus groups, patient, carer and HCP feedback, data collection and analysis of activity and outcome data.

Results The following themes emerged from the evaluation analysis;

Improved symptom management – timely, proactive interventions and face-to-face assessments, with a focus on utilising specialist skills for patients in the unstable phase of illness

(Witt, de Wolf-Linder, Dawkins *et al.*, 2013). Interventions contributed to reduced medication errors.

Place of care – patients remained at home, acute admissions avoided and appropriate hospice or hospital admissions facilitated.

Collaborative team work – improved external and internal working relationships.

Improved experience – feedback indicated feelings of reassurance, support and reduced anxiety.

Conclusion The evaluation has demonstrated improved patient, carer and HCP outcomes and experiences through access to a seven-day PCSN service. Additionally, evaluation supports national directives on access to seven-day SPC services as essential and offers experience into the challenges of delivering this within the community. Research is planned to further explore the effectiveness of PCSN interventions in improving patient outcomes.

P-161 DOES HAVING A TRIAGE NURSE CHANGE OUR PRACTICE?

Sharon Brown, Eiran Thomas. *Severn Hospice, Telford, UK*

10.1136/bmjspcare-2018-hospiceabs.186

Background Palliative care provision is becoming increasingly complex, and more of this care needs to be delivered within the community. Demands on our community Outreach Team are increasing; therefore new models of care are needed (Spencer, 2015).

Aim To assess the impact a triage nurse role would have on the quality of service delivered by the hospice outreach team.

Method (i) A time and motion study to capture the team's activities in a typical working week (ii) The secondment of an experienced nurse from the in-patient unit to work with the outreach team as a triage nurse (iii) The time and motion study was repeated two months following the introduction of the triage nurse role (iv) Evaluation of the new service was gained via questionnaires from hospice colleagues and members of the multidisciplinary team in the community.

Results Reduction of time spent on the telephone facilitated:

- Regular case reviews to prioritise care
- Opportunity to provide additional education
- Opportunity to explore research
- Recognised boost to staff welfare – able to have lunch/attend supervision.

Conclusion Triage is the process of prioritising patient care based on the severity and complexity of their situation and has been found to enable services to respond promptly to patient demand. Feedback from the questionnaires was universally positive.

Examples 'Really nice to hear a voice, not an answer phone' (Patient); 'Response is immediate, confident and knowledgeable and very helpful' (Social Worker).

This study has demonstrated that the addition of a triage nurse working with the hospice Outreach team has changed practice and enabled the beginnings of a uniformed, structured approach – enhancing channels of communication; developing professional relationships whilst being flexible enough to meet the ever-changing needs of the local population.