6 ABSTRACT WITHDRAWN

Free Papers 7 – 9 | Service Development I

7 SERIOUS ILLNESS CONVERSATIONS CYMRU PROJECT: OUTCOMES FROM TEACHING FOR WALES AMBULANCE SERVICE NHS TRUST STAFF

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The Serious Illness Conversations Cymru project was initiated in response to the Welsh Government's Palliative and End of Life Care Delivery Plan (2017) which places developing skills such as serious illness conversational skills as an essential part of upskilling generalists in palliative care.

This article describes the delivery, outcomes and potential impact of the Serious Illness Conversations Cymru project delivered to Welsh Ambulance Service Trust (WAST) staff. Over an 18 month period in excess of 360 front-line Welsh ambulance staff attended 4 hours of face-to-face teaching, to include serious illness conversation/communication skills; symptom control at the end of life and 'shared decision making'. Mixed methodology outcomes, in terms of quantitative and qualitative data were collated and analysed to gain both insight as to how WAST staff view themselves within the context of end of life care and the impact of the teaching on their confidence and the wider service.

Qualitative outcomes indicate WAST staff view themselves in several important and necessary roles, acting as 'facilitators' to patient centred, seamless care. The difficult questions and situations pertaining to end of life care were largely around patient death and dying, and the expectations of those involved. Quantitative outcomes of six communication domains indicate there was a statistically significant improvement in self-assessed confidence. The overall impact to the wider ambulance service indicates a trend toward increased conveyancing of patients to alternative settings rather than to A and E, increased administration of injectable medicines for end of life care by ambulance service staff and better use of resources such as increased attendance of a rapid response vehicle only as an alternative to an ambulance.

8 THINKING AHEAD CLINIC

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Managing patients with end-stage cirrhosis unsuitable for liver-transplantation is challenging because of unpredictable disease trajectory, complex psychosocial needs, and lack of experience in primary care. Consequently most patients with end-stage cirrhosis die in hospital. We have recently implemented the 'Thinking Ahead' clinic (TAC), and report the design and outcomes from the clinical, patient and carer perspectives.

The cornerstones (results) of TAP are as follows

1. An advanced care planning MDT: focuses on case-identification, defining prognosis and performance status. Over 18 months, 39 out of 47 patients were identified as being suitable for 'TAC'.
2. The nurse-led 'Thinking Ahead' Clinic: focuses on support and understanding regarding identification of end-stage cirrhosis, explores fears, anxieties and future plans, including resuscitation and treatment escalation decisions and preferred place of care.
3. The advanced care planning register: (4/39) generates an automated email alert to the Hepatology team triggered by an emergency department (ED) attendance enabling rapid specialist review.
4. Planned Domiciliary visits: undertaken in 27 patients that had no further hospital episodes subsequently.
5. Emergency domiciliary visits: Five joint palliative care 'rescue' domiciliary visits were performed, enabling recognition of last hours/days of life, avoiding hospital admission.
6. Management of refractory ascites: 13 patients with paracentesis dependent ascites received permanent Rocket drains, avoiding further hospital admission and facilitated participation in the ReDUCE Trial.
7. 100% identified home as their preferred place of death this was met in 93% of patient cohort.
8. Bereavement follow-up: telephone contact to carers post-bereavement, enabled an opportunity to resolve issues and offer some closure.

Conclusion 'Thinking Ahead' provides a model of patient focused holistic care by offering a staged and open approach to identifying end-of-life patients, ensuring robust multi-professional decision making, and a setting for advanced care-planning decisions. Most patients preferred place of care was home; 93% died at home through TAC.

9 ENHANCING COMMUNITY HEALTH OUTCOMES (PROJECT ECHO): DEVELOPING A COMMUNITY OF PRACTICE FOR PARAMEDICS IN END OF LIFE CARE (EOLC)

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Background Paramedics report unique challenges when delivering EOLC, including accessing education and having low confidence. Yorkshire Ambulance Service (YAS) covers a large geographical area and education is typically centralised. Project ECHO uses a tele-mentoring network to share best practice, enable case-based learning to manage complexity, develop communities of practice and build capacity in logistically and geographically challenged services. Prior implementations demonstrated improved knowledge, confidence and self-efficacy in participants. We piloted the ECHO model to develop EOLC amongst YAS clinicians.

Method This project began in October 2018 and is planned to run until March 2019; it recruited to capacity (30 participants) within a day. Participants joined a virtual knowledge event to shape the curriculum. Five ECHO sessions, occurring monthly, were facilitated by a Consultant Palliative

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