

within their working day. Musicians from the orchestra have become aware of the hospice services, and have come in to play within the hospice itself. More formal evaluation of the impact of the experience on our participants is being developed.

**Conclusion** Orchestra Outreach is a way of offering patients, their families and carers a 'normalising' experience they can share. The orchestra are keen to continue their partnership with the hospice. A full evaluation of the project is recommended.

*'Music produces a kind of pleasure which human nature cannot do without', Confucius.*

**P-128 EVERY BREATH YOU TAKE: TRACHEOSTOMY VENTILATION IN PAEDIATRIC PALLIATIVE CARE**

Ellie Rushton, Chris Viney. *Wessex Children's Hospice Trust, Winchester, UK*

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**Background** Children's palliative care is changing. Medical and technological advances enable an increasing number of children with life limiting conditions to survive on long term ventilation (LTV) via tracheostomy. University Hospital Southampton identified that children spend months in hospital awaiting home adaptations and establishment of a care package. This can have a significant impact on family life.

**Abstract P-128 Table 1** Number of LTV patients started each year at University Hospital Southampton

2007	4	2013	21
2008	3	2014	35
2009	12	2015	43
2010	11	2016	45
2011	22	2017	48
2012	23		

#### Aims

- To set up a unit for tracheostomy ventilated children within a children's hospice in partnership with the hospital, providing accommodation and nursing support for three children and families preparing for discharge home;
- Facilitate care of the child outside the hospital environment.

#### Methods

October 2016 to March 2017:

- Literature review;
- Partnership working with respiratory team;
- Agreed practice framework.

March 2017 to October 2017:

- Collaboration with specialist paediatric respiratory, and hospice palliative care teams;
- Workforce planning;
- Development of clinical pathways, governance, policies;
- Practice Education team develop LTV Study day, Competency Framework, ongoing review of clinical practice;
- Preparation of children and families for transfer from High Dependency Unit to hospice.

#### Results

November 2017:

- Admission of first tracheostomy ventilated child and family from HDU to unit;
- Resident for six months, successful weaning off day time ventilation.

July 2018:

- Admission of second child from HDU to unit;
- Resident four months, discharged on weaning programme;
- No complications or significant infections acquired by either child;
- Saved hospital bed days: 308;
- Staff competency increased from 47% to 93.5%;
- Maintained good relationship with families.

**Conclusion** With robust education and governance, tracheostomy ventilated children can be safely cared for in a hospice environment. Parents reported the environment had a positive impact on family dynamics and improved children's physical and emotional well being.

**P-129 RECOGNISING DELIRIUM IN A PALLIATIVE CARE INPATIENT UNIT-ARE WE DOING ENOUGH?**

Sam Matthews, Rebecca Kean, Emer Mckenna, Salman Rafique Chatha. *Douglas Macmillan Hospice, Stoke on Trent, Staffordshire*

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**Background** As a hospice we had introduced several initiatives to improve care of inpatients including sepsis awareness and the butterfly scheme which support patients who are confused without a formal diagnosis of dementia. Amongst palliative inpatients, a recent systematic review found that occurrence rates varied by up to 30% on admission, during admission, and the weeks and hours before death.

**Aim** We wanted to understand within our inpatient setting how frequently confusion is an issue on admission, how we are detecting delirium and are we looking for reversibility. Between one-third and one-half of delirium cases are potentially reversible.

**Results** We conducted a baseline retrospective audit of admission records over March 2019. 39 notes meet criteria where patient had not died within 24 hours of admission. 25% (10) remained unconfused within 24 hours before death. 7% (3) were confused on admission but were reversed with medication changes and interventions such as antibiotics or oxygen suggesting delirium a feature of agitation and successfully went home. None of these patients has underlying brain pathology. 41% (16) who were confused died despite a small improvement in confusion. Delirium and accurately describing acute confusion was sporadic. Only one patient who remained confused from admission was discharged.

**Outcome** We implemented a lunch and learn mandatory programme for all clinical staff and introduced the 4AT tool and delirium checklist as first steps to earlier recognition and identification of reversible factors. We have also created a family and patient leaflet explaining what delirium is and how it can be managed.