- That having a hospice–based paracentesis service helped patients to remain in their preferred place of care;
- That our hospice–based paracentesis service significantly decreased the costs to our local acute NHS services.

Method Retrospective review of patient data collected from all ultrasound scans undertaken by the hospice medical team between 2015–2018.

Results Access to ultrasound at the point of care enabled over 95% of patients to be safely managed within the hospice setting.

Only 3% of patients required transfer to hospital over a four-year period therefore avoiding either hospital admission or interventional radiology need for paracentesis.

The service was extended to include outpatients and the community. This coincided with an increase in cases with non-malignant liver disease referred to the hospice.

Conclusion The study demonstrated that we are able to avoid hospital admission for the majority of our patients resulting in significant cost savings for our local NHS trust as well as keeping patients in their preferred place of care for symptom management. What are the next steps?

P-172 DRAINING FEELING! RE-AUDIT OF HOSPICE PLEURAL ASPIRATION

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10.1136/bmjspcare-2019-HUKNC.194

Background Hospice pleural aspiration has been undertaken for the last 27 years, following training by a local chest physician. When the requirement for ultrasound (US) guided aspiration was introduced, an ultrasound machine was purchased and staff training undertaken. The British Thoracic Society issued guidance for pleural drainage in 2003 and standards were adapted for use in respect of pleural aspiration in hospice. An audit undertaken in 2015 showed 36 procedures undertaken over a period of three years. 14 of 19 standards were 100% met; two met in 97% and two in 94%. Following this there were changes to the documentation template, patient information leaflet and consent form to ensure the capture of missing items.

Method Retrospective review of all pleural aspirations undertaken since the last audit, drawn from electronic clinical record. Documentation of the procedure was audited against 19 standards identified.

Results 16 procedures for eight patients identified. 18 of 19 standards were 100% met compared to 14 at last audit. In two procedures, aspiration of fluid at the end of instilling local anaesthetic was not confirmed by documentation. One procedure failed to obtain more than 10 ml of fluid despite initial aspiration of fluid via syringe and needle prior to procedure. There were no complications of pneumothorax, pain during procedure, haemorrhage or visceral injury during any of the procedures.

Conclusions Almost all the standards are now comfortably met. Further documentation changes and reminders to clinicians undertaking procedure should ensure thorough documentation. Out of hours procedures should continue to take place when essential for symptom management, but undertaken by most experienced clinician.

Service Development, Models and Collaborative Working

P-173 THE CARE HOME REVOLUTION – A PERSON CENTRED APPROACH TO EDUCATING CARE HOME STAFF TO DELIVER EOLC

Rachel Shovelton. *Bolton Hospice, Bolton, UK*

10.1136/bmjspcare-2019-HUKNC.195

End of life care education in care homes needs to be as person-centred for their staff as the people in their care. Too often care home staff feel undervalued, media attention is frequently negative, and staff receive the brunt of this. Public perception that staff can't do anything else, that they don't really care about people that live in the care home. As a former nursing home manager, now an End of Life Care Educator for care homes, I can provide real examples of support that is tried and tested with care home staff to challenge public perception.

All end of life care education sessions are accessible to all care home staff. Learning needs addressed included literacy, confidence, the fact that some were failed by the education system in our schools. Photos and real stories helps inclusivity, rather than providing handouts. Often staff can recall exact details. Using person-centred approaches during introductions instantly brands sessions as something different to what staff are used to.

An HCA asked if I was the '*new death teacher thingy*'. I said I also taught people about living. She stated '*people like her didn't do sessions*', '*I'm rubbish at school, at work and no one invites me to these things*'. I took this challenge. The visit following my teaching session, I was greeted by the HCA, excited to tell me what she had started to implement, by gut instinct helping staff to identify residents' end of life care needs. She was visibly very proud and so was her manager.

There is lots of negativity in and around care homes. By encouraging support and belief in each other, I am proud to support all care home staff to feel empowered. Care homes are our backbone in the care of our older adults. Where would we be without them? Join the care home revolution.

P-174 SIX STEPS TOO... A UNIQUE, REAL LEARNING AND SUPPORT PROGRAMME OF END OF LIFE CARE FOR CARE HOMES

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10.1136/bmjspcare-2019-HUKNC.196

By using a unique insight as a former nursing home manager and now an End of Life Care educator, I am able to approach the learning needs for all staff with a wide range of techniques. Based in the hospice, I can reflect the good practice of the hospice and demonstrate good practice across all care homes. The programme has been developed using known models such as the Six Steps, but, this is more than that. This is Six Steps Too... The programme has six modules. Each learning session is provided four times across each locality ensuring staff can access them easily (often transport

BMJ Support Palliat Care: first published as 10.1136/bmjspcare-2019-HUKNC.195 on 17 November 2019. Downloaded from http://spcare.bmj.com/ on February 21, 2024 by guest. Protected by copyright.