is an issue). Every learner completes a knowledge, skills and confidence audit and the results are outstanding, an average increase of 60% in knowledge, skills and confidence for all learning objectives on every session. Each module is supported by two visits, one for implementation (‘show me’) one for evidence of the implementation of learning in practice (‘prove it’).

By using real experiences, the sessions are relevant, true and goals are realistic, often using the mantra ‘I can do it so can you’, staff soon learn that behind every ‘Fred’ and ‘Doris’ (safe names used on each session for confidentiality) is a real person; their legacy is their story, a gift for your learning.

Staff in all care homes I am supporting with the programme have evidence of residents’ stories, the impact on all those important to them is enormous.

To conclude, end of life care education for care home staff need not be dull, text book or irrelevant. We need our care home staff to feel motivated and empowered, that is exactly the aim of Six Steps Too...

P-176 AN INITIATIVE TO IMPROVE PALLIATIVE CARE PROVISION IN RURAL CARE HOMES
Liz Kennedy, Peace Hospice Care, Watford, UK
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Background Palliative care in care homes is mostly primary care, with limited access to specialist support, especially in rural settings. To plan for, and recognise anticipated events, thus preventing potentially avoidable hospitalisation and allowing residents to die ‘well’, requires new approaches to upskill staff. An emerging model, not yet trialled in rural settings, is the introduction of outreach specialist palliative care needs rounds (Chapman, Johnston, Lovell, Forbat et al., 2018; Johnston, Lovell, Liu, Chapman et al., 2019).

Aim To explore, through the experiences of staff and GPs, the provision of end-of-life care within rural care homes prior to, and after the introduction of needs rounds (or case-based educational monthly triage meetings with a palliative medicine specialist [physician] and care home staff).

Design This presentation reports the qualitative inductive data from a larger ethics approved quasi-experimental mixed method study. This ethnographic component utilised 14 open-ended interviews, conducted between 1 March and 18 November 2018, and observational notes. Eleven needs rounds were conducted, commencing 6 April 2018; 25 residents under the care of nine GPs were discussed; 18 care home staff participated in one or more needs rounds. Interviews were audio-recorded, transcribed, and analysed thematically.

Participants: Eight care home staff, working in two facilities, and 3 GPs located in a rural town (population 6,700) in south-eastern NSW, Australia.

Results Participants identified system and site-specific barriers to quality end-of-life care. Needs rounds strengthened: (1) awareness of end of life, reflective practice, and critical thinking by care workers; (2) end-of-life decision making and planning; (3) end-of-life pain management.

Conclusion This study provides a rural perspective on the needs rounds model of care in care homes. While the model of care strengthened the knowledge and confidence of care home staff in providing end-of-life care, its sustainability requires collaboration, co-ordination and increased engagement with GPs. Suggestions for future collaboration through multidisciplinary educational case conferences will be presented.