The Dorothy House Hospice Care RUH Compassionate Companions service is a joint partnership between Dorothy House Hospice Care and the Royal United Hospitals Bath NHS Foundation Trust (RUH) Palliative Care and End of Life Team. This inspiring and progressive approach to caring for people was launched on 15 May 2019 with the support from the RUH Forever Friends Appeal and funding from the Sperling Trust for three years.

- To support the provision of compassionate and dignified care at the end of life for those dying in hospital, whilst aiming to improve carer outcomes reported through the bereavement feedback questionnaire;
- The service will supplement the quality nursing care that patients require in their final days or hours of life. Being able to spend time sitting with a dying patient, talking to them and their family and listening can be an enormous comfort at an emotionally challenging time for patient, family and ward staff;
- To provide a 7 day service that meets the needs of patients, carers and their families throughout the hospital. Volunteers work up to three-hour shifts from 9 am – 9 pm;
- Provide extra care and support for patients who are thought to be in the last 48 hours of life, are inpatients at RUH, and have limited or no family support or have family that would benefit from respite;
- The service is starting with three wards and will expand to cover the whole hospital.

P-230 COMPASSIONATE COMPANIONS: QUEENSCOURT VOLUNTEERS IN HOSPITAL

Helen Birch, Julie Davidson, Louise Charnock. *Queenscourt Hospice, Southport, UK*

10.1136/bmjspcare-2019-HUKNC.252

Background It was recognised there was a gap in companionship and empathic support for certain patients in hospital approaching end of life.

Aim Queenscourt in Hospital, an extension of Queenscourt Outside Volunteer Service, is launched to provide comfort and companionship for patients in hospital who are in the last hours to days of life, and whose families are absent or need support to take a short break.

Method Volunteers are recruited with previous health and social care experience and who are available at very short notice to respond to patient's changing condition. Volunteers are aligned with the hospice's vision and values. A bespoke training programme was put in place to prepare, educate and allay any potential anxieties and fears.

Results Patients eligible to benefit from service are identified by members of the Queenscourt Supportive and Specialist Palliative Care Services working in hospital. Volunteers may read quietly, provide gentle hand massage or may just simply be present. Volunteers may escalate a patient's needs and concerns to the ward staff if unsettled. Volunteers are fully debriefed following each shift and consequently report feeling empowered and valued for having made a difference. Challenges around hospital policies and procedures were overcome by liaising between HR departments, and open communication.

Conclusion Queenscourt delivers compassionate and emotional support to patients and their families across all settings. Our

new volunteers in hospital are an integral part of this. By enlisting the support of volunteers, patients in hospital who are reaching the end of their lives have an empathic presence and companion by their side. We aim to support more people dying in hospital and communicate with secondary care colleagues ensuring all professional boundaries are respected. Training and support of volunteers ensures retention and continuation of a worthwhile service.

P-231 USING VOLUNTEERS FOR BEDSIDE COMPANIONS TO SUPPORT THE CONCEPT OF 'BEING THERE' AT END OF LIFE

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Background 'Being with' dying people is an integral part of nursing (Tornøe, Danbolt, Kvigne, Sorlie, 2014), with hospices best placed to holistically achieve this (Gomes & Higginson, 2008). However, an increasing demand of patients with complex end of life care and support needs, without requisite increase in funding, means the future challenges facing hospices are considerable (Commission into the Future of Hospice Care, 2012). The value of volunteers supporting people at end of life has now been widely recognised as a response to these challenges (Commission into the Future of Hospice Care, 2012; Radbruch & Payne, 2009). As hospice nurses identify less availability to sit with dying patients and their families, support was sought from a successfully established volunteer-led bedside companion scheme.

Aim To deliver innovative experience-led training to hospice volunteers: giving them confidence to visit and support patients in the hospice inpatient unit, particularly at end of life. Service will be closely monitored and evaluated to inspire future expansion.

Methods

- May 2018: met with Volunteer Communications Tutor for initial consultation and model planning;
- June 2018: Scoping for volunteers;
- July 2018: Focus group with hospice multidisciplinary staff;
- Aug–Oct 2018: Final volunteer recruitment;
- Sept 2018: Staff awareness sessions;
- Nov 2018: volunteer training delivered by Volunteer Communications Tutor. Volunteers visit local established bedside companion scheme to 'shadow';
- Jan 2019: Service begins, comprising of mostly rostered scheduled sessions with a written summary recorded and reviewed by ward Sister. Six-weekly debriefing/supportive sessions between volunteers and staff are on-going.

Results

- 8 volunteers recruited. Pilot from January – end April 2019;
- 81 shifts;
- 257 visits;
- 41 patients;
- Taking 114 hours;
- Positive qualitative data collected from volunteers, inpatient staff and patients.

Conclusion Oakhaven's response to the challenges of a changing health and social care landscape by empowering volunteers with the skills to 'be with' hospice patients, as suggested by literature, has shown to be supportive to inpatient staff and

patients. Future training sessions will widen the scope of available bedside companion support.

P-232 BEFORE WE CHANGE, LET US UNDERSTAND: A PROSPECTIVE CHARACTERISATION OF HOSPICE INPATIENTS

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10.1136/bmjspcare-2019-HUKNC.254

Background Hospice service redesign aims to achieve the greatest impact for the greatest number of people within limited resources. The strategic direction within the NHS is towards care as close to home as possible, reducing avoidable admissions and improving patient experience of end of life care. However, there is little published evidence describing patient use of a specialist palliative care inpatient service, despite this significant resource.

Aim To enhance the understanding of why patients are admitted to two hospice inpatient units within one Health Board area, to describe the characteristics of patients admitted and to explore their needs and wishes in this process.

Method We are conducting a prospective mixed methods evaluation. Using case note review, we are collecting data on approximately 250 hospice inpatient admissions over a four month period. In addition, we are conducting up to 40 interviews with patients and carers to explore expectations and feelings around the admission; and seek feedback from the referrer and the receiving staff about appropriateness of admission and alternatives to admission.

Results We will present preliminary data on the reasons for referral to the hospice inpatient services, describe characteristics of patients referred including Adapted Karnofsky Performance Score, Phase of Illness and iPOS at time of referral; along with preliminary qualitative findings regarding patient and carer perspectives about hospice inpatient admission.

Our findings will inform our understanding of the use of hospice inpatient services and how resources can be most effectively allocated to meet patient and family needs and preferences within a locality. This will allow meaningful service redesign, ensuring the patient experience informs change.

P-233 DYING TO WORK TOGETHER – PARTNERSHIP AND POTENTIAL

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'The path to successful partnerships is littered with many attempts that have failed' (Mitchell & Karoff, 2015).

Over a period of more than a decade, the hospice had an in-reach specialist palliative care team working in the local hospital, during which time the hospital developed its own end of life care team. Both teams worked in isolation, challenged by different structures, values and approaches. It

became clear that expectations regarding leadership, goals, roles, processes and responsibilities of partnership working differed significantly. The concept of the two teams working collaboratively was strong, but many challenges soon emerged. Joining forces to make a difference was not going to be an easy prospect. We had not aligned our values and as a result, became disconnected in our day-to-day interactions to such an extent that it was on the threshold of being unsustainable.

In October 2018, the Trust appointed a Clinical Director for End of Life Care and this was the beginning of the integration of the two teams. Together with the Director of Nursing from the hospice, leadership of this team is based on trust in each other's ability to lead effectively and with integrity. One of the early pieces of work we commenced together was to acknowledge the two organisations values, missions and operating principles and collectively agree our operational values and behaviours moving forward.

For this partnership to be successful, it will require strong leadership, common understanding, a shared vision and purpose, mutual understanding and an acceptance of differences. It will require resilience in the face of inherent tensions and inevitable conflict. Partners frustrate each other; partners will let each other down – if we can accept these challenges and work with them, together we have a much better chance of making a difference.

P-234 SPIRITUAL CARE SUPPORT WITHOUT WALLS AT ROWCROFT HOSPICE

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10.1136/bmjspcare-2019-HUKNC.256

Background Spirituality is a hugely important part of the end of a person's life: what matters to them most, who they are; their story; their friends/family; those that care for them. When the hospice's existing Anglican Chaplain retired after 17 years, an opportunity arose for us to review our provision of spiritual care, moving away from a traditional chaplaincy model to support our ever-changing communities. Evidence, identified as part of the process, highlighted the gaps in the care we already provide.

Aim To create an updated model for spiritual care, led by a newly appointed Spiritual Care Specialist, achieving inclusive support for all that come in to contact with Rowcroft regardless of religion, beliefs, faith, or no-faith.

Method September 2018 – Jan 2019: we conducted a service evaluation, set up a Task and Finish Group which consisted of core representation across the organisation; different nurses from the ward attended each group, undertook a literature review, contacted other hospices, hospitals and Healthwatch Torbay, developed a Spiritual Care Model and gained Senior Management Board and Trustees buy-in.

Results A Spiritual Care Specialist was appointed. The existing on-site Chapel was de-registered and renamed The Sanctuary. Marriages, celebrations and other events for all (regardless of faiths, beliefs, religions) can take place in the space, also providing a 'quiet' space. There are seven further recommendations within the new model that will now be progressed to fully achieve the desired outcomes with the help of a Spiritual Care 'Custodian' Group.