Conclusion Coupled to the significant increase in referral numbers to our service there has been a noticeable increase in the number of patients referred with haematological diagnoses. Many require multiple recurrent transfusions over many months which allows a natural progression from active treatment into palliative services, within an environment which is well equipped to support them as their illness deteriorates. Our patient feedback shows we are running an excellent service for our patients, in a setting they enjoy.

P-123 USING ONE PAGE PROFILES TO IMPROVE PERSON CENTRED CARE ON THE INPATIENT UNIT (IPU)

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The Inpatient unit are constantly looking at the way in which we work and how we can improve and change practice. One of the current projects we are undertaking is based on person-centred care and One Page profiles.

A one page profile captures all the important information on a single sheet of paper under simple headings. We have produced our own one page profile and named it ‘What is Important to You’ the headings we are using are:

What must not happen?
What must happen?
What is important to me?
How will decisions be made, who will be involved in this?
How is important to me?
How to support me and those I love
What must happen?
What must not happen?

One page profiles are a way of learning and supporting people to achieve things that are important to them. Even if someone is
in the hospice for a short period of time it is vital that we know what matters to them and what is important to them not just their clinical condition. We are encouraging staff to discuss one page profiles with patients on admission so that staff can get to know their wishes right from the start. Patients can change their one page profiles at any time. We are receiving very positive feedback from patients that have completed them. Comments include:

‘I feel much more relaxed now that you know what my likes and dislikes are’

‘Suddenly after completing the one page profile I feel I have the strength to talk to my daughter about my wishes’

‘I am happy that my wife will be involved with decisions about my care this means a lot to me’

‘I feel safe and secure that my wish not to be resuscitated has been listened to and everyone will know my wishes’

We have a working group who are undertaking evaluations and will audit this work.

P-124  PREFERRED PLACE OF CARE – ROOT CAUSE ANALYSIS

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Introduction Surveys and research indicate that home is the preferred place of care at the end of life for many people (71%), whilst the most commonly recorded place of death remains hospital (53%).

Aim To identify barriers and enablers to the delivery of good end-of-life care for patients.

Methods The project was completed over a six-week period at a hospice in Northwest England. Each week at our multidisciplinary team meeting we discussed deaths of patients known to our community palliative care team and recorded our findings.

Results 48 patients known to the team died during the six-week period. Preferred place of death was achieved in 91% (30/33) of cases when this was home, and 85% (11/13) of cases when this was the hospice. None of our patients expressed hospital as their PPD. Preferred place of death was unknown in 4.2% (2/48) of patients. 8.3% (4/48) of patients died in hospital. In 50% (2/4) patients, a hospital admission was indicated due to acute unexpected deterioration. 77% (21/27) of patients dying in the community had face to face or telephone contact within three days of death. Identified barriers to good end-of-life care were: difficulties accessing oxygen at home for symptom management, one episode of difficulty accessing specialist care advice and challenges communicating directly with district nursing teams. Enablers were: appropriate use of DNACPR forms with no involvement of emergency services at the end-of-life as well as good team-working between specialist and generalist services.

Conclusions The majority of patients known to the team die in their preferred place of care, with a good quality of death as judged by the team. Lessons have been learned from after death analysis and action plans devised. This scoping exercise could be repeated on a periodic basis.

P-125  HOMEWARD BOUND: RAPID DISCHARGE OF PEOPLE TO THEIR PREFERRED PLACE OF CARE

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Following a period of sustained pressure on our local healthcare system, the gauntlet was thrown down from commissioners to the hospice to expedite discharges by providing care at home.

Our hospice, at the heart of the community, renowned for breaking barriers and a positive approach, rose to the challenge of this six-month pilot project.

We rapidly reorganised our community team to release their community support workers to form a team and recruited to expand the workforce.

This newly formed team received a week’s robust training in preparation for our crusade to get people home from an inpatient setting.

We met the needs of 56% of all fast track care requests. We have met the needs of 56% of all fast track care requests. 100% of these patients died in their preferred place of care.

Conclusion It is the intention of the Hospice to continue to expand this service.

P-126  AN AUDIT TO DETERMINE IF PEOPLE WITH A LEARNING DISABILITY (LD) AND KNOWN TO THE HOSPICE HAVE ACHIEVED THEIR PREFERRED PLACE OF DEATH (PPD) AND IF THE INITIAL DISCUSSION HAD TAKEN PLACE, WITH AN OUTCOME ESTABLISHED AND DOCUMENTED

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Aims and objectives To establish documented evidence of the preferred place of death (PPD) of people with a learning disability (LD) and establish if PPD was achieved and documented. Additionally; to establish where initial conversation took place with regards to PPD. To establish if an “easy read” Preferred