

P-40 PREPARING JUNIOR DOCTORS FOR DISCUSSING DNACPR WITH PATIENTS – A ‘BIT OF TRIAL AND ERROR’?

¹Katherine Heil, ²Colette Reid. ¹Great Western Hospitals NHS Foundation Trust, Swindon, UK; ²University Hospitals Bristol NHS Foundation Trust, Bristol, UK

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Background Making Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and treatment escalation decisions facilitate a dignified death for patients in acute hospital settings, but not all doctors find it easy to have the necessary discussions with patients.¹ The GMC’s “Tomorrow’s Doctors” requires that medical schools adequately prepare trainees to “contribute to the care of patients and their families at the end of life”.² We conducted a survey of the experience of junior doctors in UHBristol NHS Trust.

Method An online questionnaire was sent to all junior doctors. Respondents were asked to rate their confidence when discussing DNACPR decisions with patients and their families, what training they had received and whether or not they felt their undergraduate training had adequately prepared them for these conversations. A comments space was provided.

Results We received 84 responses. 68% of juniors felt confident when discussing DNACPR decisions with patients and families. However 15% did not.

Only 5% felt they had been well prepared by undergraduate teaching. 40% felt they could have been better prepared and 22% felt very unprepared. 50% reported learning by observing senior colleagues in the clinical environment.

There were mixed comments regarding which grade was the most appropriately placed doctor to have these discussions with patients; some believed only a consultant should, but others stated junior doctors were usually first to recognise the need for escalation decisions.

Several commented that they had learnt by observing seniors conducting these consultations but noted they were not always done well. Some thought practicing in the clinical environment (trial and error) was the best way to improve their communication skills.

Conclusion Acute hospitals cannot assume their junior doctors feel prepared to discuss DNACPR decisions with patients. Formal teaching opportunities should be provided to supplement the observation of seniors, the current mainstay of their learning.

REFERENCES

1. The British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. Decisions relating to cardiopulmonary resuscitation. 3rd edition (1st revision) 2016.
2. General Medical Council. Tomorrow’s Doctors. Outcomes and standards for undergraduate medical education. September 2009

P-41 EXPANSION AND DEVELOPMENT OF A HOSPICE PARACENTESIS SERVICE TO INCLUDE NON-MALIGNANT ASCITES

James Coxon. *Hospice in the Weald, Pembury, UK*

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Introduction Along with most UK hospices, Hospice in the Weald have an established paracentesis service for managing malignant ascites. These represent 10% of ascites cases in the UK with the majority of the rest attributable to cirrhosis.

Cirrhosis is the fifth commonest cause of death in the UK, but is less familiar to hospice services than malignancy. We present a successful QIP expanding the service to patients with non-malignant ascites

Aims A Quality Improvement Project to introduce intravenous albumin during paracentesis facilitating drainage of non-malignant ascites in a hospice setting.

Methods Through consultation with hospice and local trust pharmacies we were able to source 20% Human Albumin Solution initially on private prescription and then direct from the manufacturer. Guidelines were developed combining the International Ascites Club guidelines, local trust protocols and medical staff experience which were reviewed at the weekly hospice journal club.

Results Over 10 months we have successfully used albumin during paracentesis on 6 occasions. There have been no complications during the procedures and have been more haemodynamically stable than those with malignant ascites and similar drainage volumes.

Conclusion Through the introduction of albumin cover we have been able to expand our patient group, avoid hospital admissions, as well to provide opportunities for advanced care planning. It has been particularly helpful for patients with ascites with malignancy and a background of liver disease as previously there was a risk draining in the hospice without albumin. It is expected that as local referrers become more aware that the service will become more popular.

P-42 INJECTABLE MEDICATION AT THE END OF LIFE: A COMMON TASK FOR GENERALIST COMMUNITY CLINICIANS

¹Rosamund Marvin, ²Sarah Grove, ¹Anna Spathis, ³Stephen Barclay. ¹Cambridge University Hospitals NHS Foundation Trust, Cambridge, UK; ²Arthur Rank Hospice, Cambridge, UK; ³The University of Cambridge, UK

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Background Injectable medications are commonly prescribed for patients at home approaching the end of their lives, either in response to, or in anticipation of, symptoms.

Aims With regard to injectable drugs for patients approaching the end of their lives in the community, to investigate:

- a. What drugs are prescribed?
- b. What drugs are administered?
- c. Who administers the drugs?

Design and setting Service evaluation of the Bedfordshire PEPS (Partnership for Excellence in Palliative Support) Co-ordination Centre, a 24 hour support service for palliative care patients.

Medication data were extracted from patient records on SystmOne, the local community computerised healthcare record, concerning patients registered with PEPS who had died within a one year period.

Results Of 1087 patients registered with PEPS who died within a 1 year period, 392 (36%) were prescribed injectable medications, most commonly midazolam (88%), diamorphine (85%), cyclizine (72%) and glycopyrronium (67%).

328 (84%) out of the 392 spent part or all of their last week of life at home. Of these, 232 (71%) had injectable drugs administered during that time: diamorphine (72%), midazolam (66%), glycopyrronium (41%) and cyclizine (31%). Most (81%) were given more than one drug and half (52%)