

**P-18 AN AUDIT OF THE USE OF ALL-WALES DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) ORDERS WITHIN A SPECIALIST PALLIATIVE CARE UNIT (SPCU) IN SOUTH WALES**

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**Background** In 2015, an 'All Wales' DNACPR policy was implemented with the intention of providing consistency and continuation of DNACPR decision making throughout all health care settings within Wales. The aim of the audit was to investigate the use of this policy within a SPCU in Swansea against audit standards outlined in the All Wales DNACPR guidance.

**Methods** A case note analysis of all patients who died in or were discharged from the SPCU during two 8 week periods between August 2015 and May 2016 was performed. The audit measures included accurate DNACPR form completion, time taken to senior review and wider communication of the DNACPR decision. The audit standard for each measure was 100%. Changes introduced following the first audit included formalisation of the ward clerk role in coordinating DNACPR forms on discharge and use of the handover list to prompt DNACPR form distribution.

**Results** Adequate completion of DNACPR forms improved from 44% to 89% between the two audit periods. Senior review of this decision improved from 81% to 96%, although mean time to review increased from 1.2 days to 3.8 days. Communication of the DNACPR decision to the GP increased from 77% to 91% and communication to the out-of-hours GP increased from 11% to 73%.

**Conclusions** This is, to the author's knowledge, the first complete audit cycle in relation to the new All Wales DNACPR policy. Whilst significant improvement was made during completion of the audit cycle further improvements are required to reach the audit standard. Future recommendations include modifying the ward discharge 'check-list' to include the DNACPR form. The audit highlights the challenges of ensuring thorough documentation and dissemination of DNACPR decisions. These results have been shared with the national DNACPR audit which will hopefully influence further evolution of the current policy.

**P-19 FAMILY AND CARER INVOLVEMENT IN DECISION MAKING IN PALLIATIVE CARE**

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**Background** Communication with patients and their families/carers is key to excellent palliative care and both the GMC and NICE state that families/carers should be routinely offered information about their relative within the confines of confidentiality. An audit was conducted at Hospice in the Weald to review the involvement that families/carers had in key decision making for patients on the ward. It reviewed whether all important clinical decisions made whilst the patient was on the ward had been discussed with families/carers

**Methods** A retrospective case note audit was carried out for all the patients on the ward during one month (September

2015). Information was drawn from the Electronic Care Record (ECR) and paper notes including DNACPR forms. 6 key clinical decisions were identified as instances when a discussion with families/carers would be appropriate. Discussions had to be clearly documented for it to be considered eligible that discussion had taken place.

**Results** 5/6 (83%) DNACPR decisions made in the Hospice ward were discussed with families/carers, 30/36 (88%) families/carers had discussions about ceilings of treatment, 31/32 (97%) families/carers were involved in discussions regarding medical interventions, 27/27 families/carers (100%) were told that their relative had deteriorated and 23/23 (100%) of families/carers had an opportunity to discuss their relatives' end of life needs.

**Conclusions** These results show that the vast majority of important clinical decisions are communicated with the families and carers of the patients involved however there is room for improvement especially around DNACPR and ceilings of treatment discussions. Often these discussions had been had previously with other healthcare professionals and so were not revisited. This highlights a need for robust shared clinical records and the increased use of EPaCCS to ensure full communication between services.

**P-20 A RETROSPECTIVE AUDIT OF BLOOD PRESSURE, ORTHOSTATIC HYPOTENSION AND FALLS IN ADVANCED CANCER**

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**Background** Orthostatic Hypotension (OH) is a drop of  $\geq 20$  mmHg systolic blood pressure (BP) and/or diastolic 10 mmHg within 3 minutes of orthostatic stress.<sup>1</sup> OH seems highly prevalent in advanced cancer. Comorbidities and anti-hypertensives increase OH risk and falls risk. Consequently cancer patients in palliative settings are high fall risks.<sup>2</sup>

**Objectives** BP and OH measurement practices and post-fall interventions were audited amongst in-patients with advanced cancer.

**Methods** A retrospective analysis of four consecutive months of cancer admissions to a specialist palliative care unit was conducted. Data was obtained from 168 non-randomly selected clinical records. Information recorded included: demographics, falls risk assessment, falls occurrence, BP and relevant medications. The audit was against standards for current institutional clinical policies.

**Findings** Of 168 admissions, 136 (81%) had the Falls Risk Screening Tool completed. 143 of them (85%) had BP recorded, while 25 (15%) did not. There were 7 falls during the first week post-admission. Post-fall, 5 had BP measured; 2 did not. Only 1 of the 7 who fell had OH measured.

**Conclusions** During the audit period none of clinical standards were fully completed. There were 7 falls in one week and only 1 had the required OH measurement conducted. Some admission tools were misinterpreted or were ambiguous. Review of institutional admission tools could increase compliance and clinical standard adherence, especially if tailored for a palliative care cohort. OH may be underdiagnosed.