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DOCUMENTATION OF RESUSCITATION DECISIONS IN AN SPECIALIST PALLIATIVE CARE IN-PATIENT UNIT

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Background We are based in what was the South Central Health Authority which introduced a Unified DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation) policy and document (lilac form). This enabled the transfer of DNACPR decisions across different settings. This document is still recognised since the introduction of the clinical commissioning groups. When patients are admitted to an in-patient Palliative Care unit we make a decision about the patient's resuscitation and transfer (to an acute hospital in case of sudden acute deterioration) status. We document whether the patient/ carer has been informed and review the decision weekly. We also document whether a patient brought in a lilac form on admission. On discharge we offer the patients who were DNACPR during, but not prior to admission, the opportunity to 'own' the DNACPR decision by offering them to take the lilac form home. All the above is communicated to the clinicians in the discharge letter.

Aims of the audit We did 2 retrospective audits of 40 consecutive set of notes to assess the completion of the resuscitation documentation and whether this information is documented on the discharge letter sent to GP and other clinicians involved in the patient's care.

Results We will present the results of the first audit which showed a fairly good compliance both in filling in the resuscitation and transfer documentation in the notes and the documentation in the discharge letters. Specific recommendations were made about the documentation, timing of review of the decisions and on when to offer patients, who did not have a lilac form prior to admission but were DNACPR during admission, the option of taking a lilac form home on discharge. The results of the re-audit will be presented and whether the recommendations improved decision making and communication with patients, carers and professionals.

Background Health systems in Africa which were mainly designed to manage acute communicable diseases based on a biomedical model now need to be able to handle the emerging non-communicable disease epidemic. Cardiovascular diseases such as heart failure are increasingly prevalent. Research from high income countries reveals that patients with heart failure have multidimensional needs especially a high symptom burden even when on drugs with a mortality benefit. We predict outcomes are likely to be even worse in African settings where access to these drugs is limited and poverty is rampant. Currently palliative care is mainly for HIV and cancer patients and has little impact on heart failure patients. In order to plan care based on needs it is necessary to elicit patients' perspectives of their needs and experiences of living with incurable illness.

Aim To understand the multidimensional experiences, needs, and use of services of patients living and dying of heart failure.

Methods In depth qualitative interviews are being conducted using the grounded theory approach with patients with heart failure recruited in Mulago hospital in Uganda. The interviews are supplemented by administering the African APCA POS questionnaire. Purposive sampling is being used for recruitment. Thematic saturation is expected to be achieved at a total of about 16 patients.

Results Preliminary analysis has identified the following themes: Lack of awareness of symptoms of heart failure which lead to late presentation, association of symptoms to witchcraft, significant distress from physical symptoms, recurrent admissions, increasing dependency associated with loss of dignity, loss of valued self, psychological distress, different theological ideas relating illness and the Divine and financial problems.

Conclusion Heart failure patients in Uganda have multidimensional needs some of which are similar to high income countries but others are unique to the African setting. Such patients could greatly benefit from a palliative approach.