Background Successful hospital discharge and prevention of readmission often depend on carers’ ability to support patients. 
Aim To investigate how carers are supported during patient discharge from acute care towards end-of-life (EOL) and suitability of using the Carer Support Needs Assessment Tool (CSNAT) to improve carer support at discharge.

Methods Qualitative design: focus groups (FGs) with 40 practitioners supporting patient discharge from three English acute hospital trusts; interviews with 22 carers of patients discharged. 14 practitioners and five carers joined two final workshops. FGs/interviews/workshops explored current discharge processes and potential value of using CSNAT. Thematic framework analysis conducted.

Results Discharge processes were heavily focussed on patients’ needs: there was no systematic approach to supporting carers. Practitioners and carers viewed CSNAT as highly relevant and could be used to facilitate much needed EOL conversations which often were absent and to manage carers could be used to facilitate much needed EOL conversations which often were absent and to manage carers’ needs: there was no systematic approach to supporting carers.

Conclusions In addition to managerial support, establishing a team of practitioners to lead facilitation of the CSNAT intervention and regularly review implementation progress, is vital for implementation success.

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Background A 2014 court ruling in the UK established that the only justification for NOT discussing a “Do Not Attempt Cardio-pulmonary Resuscitation” (DNACPR) order with a competent patient is either patient choice or potential “harm” to the patient (not distress).

Aims This study aimed to establish current practice in communication when making DNACPR decisions, the impact of the ruling and the interpretation of “harm”.

Methods The records of 150 hospice inpatients admitted after the ruling were screened. An anonymous survey was sent to hospice doctors and hospice nurses trained to complete DNACPR orders.

Results DNACPR decisions were made without discussion with competent patients in 6/150 cases. Reasons documented included: patient choice, the decision was implied from previous discussions, the patient was too unwell. All six decisions were discussed with the family.

Survey response rate was 90% (28/31) with equal numbers of specialist nurses and doctors. 21/28 respondents made DNACPR decisions at least monthly, 6/28 had made these decisions without discussion with the family. All 6 decisions were discussed with the family. All six decisions were discussed with the family.

Examples of impact on practice included: increased awareness of need to keep up-to-date, forcing earlier DNACPR discussions, pressure to discuss decisions with all patients, increased likelihood of exploring patient choice, increased involvement of family.

Interpretations of “harm” included: more than distress, physical harm to self/others, psychiatric disorder, damage to doctor-patient relationship, distress close to the end-of-life.

Conclusions Only a minority of decisions were not discussed with competent patients. Not all relevant health care professionals are aware of the recent court ruling. Of those who were, over half felt it would impact upon their communication practice. There is a need for clarification of what constitutes harm rather than distress.

Background 2016 NICE guidelines on assessment and management of Motor Neurone Disease (MND) recommend that patients should have access to multidisciplinary, integrated care with access to local services and support groups.