Patients with admission 6MWD=100 m had mean improvement 62.2 m (±73.1), MBI improved from 69.1 (±13.9) to 82.1 (±12.7) (p=0.001). Patients with MBI 75 on admission had mean improvement of 16.2 (±11.7) (p=0.05). 30 day readmissions for non-infective exacerbations was 15.6% (vs 29.2% from historical data). Median duration to exacerbation, death, or censure was 116.5 (IQR 53–206) days. Mean number of issues identified by COAT was 5.6 (±2.5), 80.3% were improved or resolved before discharge.

**Conclusion** ICARE is a novel inpatient dyspnea support service that improves functional capacity and exercise tolerance, identifies and treats co-morbid medical conditions, and potentially reduces 30 day re-admission to tertiary institutions.

**45 THINKING AHEAD ABOUT MEDICAL TREATMENTS IN ADVANCED ILLNESS: THE COMPLEXITIES OF SUPPORTING DIVERSE COMMUNITIES IN LEICESTERSHIRE**

Zoobia Islam, Lucy Taylor, Helen Eborall, Christina Faull. LOROS, The Leicestershire and Rutland Hospice; University of Leicester

10.1136/bmjspcare-2018-ASPabstracts.72

**Background** Advance care planning (ACP) supports people who are seriously ill to be cared for in the way, and in the place that they prefer. Yet, evidence suggests there are lower levels of ACP in people from Black, Asian and Minority Ethnic (BAME) communities. Little is known about how the model of resuscitation decision-making fits with the social, cultural and religious values and beliefs of BAME groups. Health care professionals (HCPs) also report a lack of confidence in having culturally appropriate discussions with BAME patients and their families. Equipping professionals to be more confident about such ACP discussions may lead to achieving patient preferences.

**Aims** This study explores professional views and experiences of ACP with patients from BAME backgrounds. With a focus on making decisions about resuscitation, it aims to identify barriers and enablers and person-centred outcomes to such discussions and provide evidence for training professionals.

**Methods** Thematic analysis of qualitative semi-structured interviews with HCPs across primary, secondary and tertiary care in Leicester, including GPs, hospital doctors and nurses.

**Results** There was an emphasis on building rapport, the timing of discussions and navigating communication barriers. Barriers to decision-making included: patients’ and their families understanding of both prognosis and resuscitation; and differing values amongst generations of migrants. Professionals struggled with how to find a balance between acting in a non-discriminatory way whilst respecting cultural differences. Patients and family members, who wished to prolong life at all costs, commonly framed religiously or the sanctity of life, was described as a key challenge to discussions. Most HCPs highlight the need for further training and/or support.

**Conclusion** There are significant barriers for HCPs when discussing resuscitation decisions with people from BAME communities. This increases the complexity of navigating ACP and achieving patients’ preferences. HCPs would benefit from further training and support.
a complex intervention for people with advanced dementia, but is not well specified, can be implemented differently, with limited evidence of effect, nor understanding of its optimal delivery.

Aims a) To develop a programme theory(ies) of how the Namaste care intervention achieves particular outcomes, and in what circumstances.

b) To refine and develop an evidence based Namaste Care intervention specification and training package acceptable to nursing care home staff and families.

Methods A two phase approach incorporating both a realist evidence review and consensus methods. Consensus workshops first explored readability, understandability and utility of stimulus materials with Namaste Care naïve care home staff. Next emerging findings from the review were presented to stakeholders (care home staff, volunteers and family carers) with experience of Namaste Care, and nominal group techniques used to identify how intervention materials and resources required to support implementation could be refined. Drawing on nominal group technique analytical methods, analysis considered both the frequency of statement rankings alongside a thematic analysis of reasoning for preferences.

Findings Presentation to Namaste Care naïve staff resulted in changes to language and clarification of terms such as ‘personal care’. Two consensus workshops (n=15 care home staff participants, n=1 family carer participant, n=1 volunteer participant) further refined materials. An additional section of the intervention guide developed between workshop one and two focused on organisational preparation for Namaste Care implementation. Issues such as intervention timing, frequency, focus and staffing requirements were identified as requiring further specification.

Conclusion A careful, staged, process of intervention specification and refinement revealed important issues that required attention. Addressing these before trial commencement could increase the likelihood of intervention fidelity.

49 A REVIEW OF DOCUMENTATION OF DNACPR DECISIONS WITHIN A HOSPICE IPU SETTING OVER TIME

Christina Radcliffe, Ruth Roberts, Birmingham St Mary’s Hospice

Background DNACPR decisions are an important but small part of decision making and advance care planning at end of life. Historically, patients and families have not always been involved in these decisions, as they relate to a medical intervention which is often unlikely to benefit patients. Clinical practice of DNACPR decision making may have changed in light of court judgements in the cases of Tracey and Winspear, and updated guidelines from governing bodies and the resuscitation council. A review of historical audits of documentation of DNACPR decision making within the hospice inpatient unit took place to review changes over time.

Methods Annual audit was undertaken over a five year period using standards taken from local and national guidelines. This was then compared and contrasted to review the impact over time.

Results The percentage of patients in the hospice inpatient setting with a decision about resuscitation recorded has remained steady. There has been a gradual increase in the proportion of patients who have a clear rationale recorded for DNACPR. In a significant number of patients, the rationale for the DNACPR decision being made was patient choice.

There has been an increase in the proportion of patients involved in decision making about resuscitation from 35% in 2013 to 100% of those with capacity in 2016 and 2017. There has also been an increase in the proportion of relatives involved in decision making, particularly where the patient lacks capacity.

Conclusions Changes to the legal framework and guidance around DNACPR have increased the number of patients and families involved in DNACPR decision making. It is unclear from this data what patients and their families thought about their involvement, and whether this was perceived to be beneficial. Further research in this area is encouraged.