

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.

48 WHY DO PALLIATIVE PATIENTS CALL OUT OF HOURS GPs?

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Background Primary care plays a significant role in the delivery of end of life care with most patients spending the majority of their last year of life in the community. 44% of deaths occur in care or private homes and 79% of people wish to die at home. Quality primary care ensures identified needs are met and expressed care preferences are carried out. Improving out of hours (OOH) care is a priority in Palliative Medicine. This study identifies why patients with palliative care needs access OOH GPs to aid understanding of need and service planning.

Methods A retrospective analysis of call records of all patients and carers who contacted OOH primary care providers from three clinical commissioning group areas in Southern England in a 6 month period. OOH call records were searched for cases labelled 'Palliative' – the only tag available. Data were anonymised and demographic information was collected.

Reason for call and call outcome were recorded. Data quality checks were performed. Descriptive statistics were performed using SPSS.

Results 801 calls for patients with palliative care needs were identified. Mean patient age was 79 years. 57% had cancer. 27.5% patients had anticipatory medications in place. Anticipatory medication requests comprised 16% of calls, pain accounted for a further 16% and 7% involved a death. The remainder of calls were about symptom control or intercurrent illness.

50% of calls resulted in prescriptions including anticipatory medicines and syringe drivers. 8.1% resulted in hospital admission.

Conclusion OOH primary care services are often used for end of life (EOL) prescribing. Advanced care planning could reduce OOH calls, improving end of life experience for patients and families. This would enable OOH GPs greater time to respond to the significant number of calls representing need for reassurance and support from a clinician.

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

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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.