decision receiving specialist palliative care in hospital, hospice or community settings.

Results 73 HCP’s participated in the survey and 87% had discussions about CPR. In HCPs having conversations about CPR 75% rated their confidence in doing so as 8/10 or higher.

187 case notes were reviewed. While DNACPR forms indicated whether the decision had been discussed with the patient in 87% only 72% had a record of this in the written notes. 68% of case notes had a record of discussions or reasons for non-discussion with those important to the patient. 34% of patients moved care setting after the DNACPR decision, of these 64% transferred with a unified DNACPR form.

Conclusion This audit shows ongoing challenges in communicating with patients and those important to them about CPR. Improvement is required in disseminating DNACPR decisions when patients transfer care settings.

53 TRANSFER OF CARE FROM HOSPITAL TO HOME IN THE LAST DAYS OF LIFE: IS IT SAFE AND EFFECTIVE?

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Background Hospital teams must plan a safe and effective transfer of care for patients returning home in the last days of life. To support this Leeds Teaching Hospitals NHS Trust (LTHT) launched a revised Rapid Discharge Plan (RDP) in January 2014.

Aim To assess the quality of transfer of care (ToC) for patients returning home from LTHT who died within a week of discharge (June 2014 – May 2015).

Methods A convenience sample of 45 patients was selected from a database of 228. Clinical notes were reviewed for recognition of dying (prognosis days) pre-discharge, RDP use, and evidence of eight key interventions necessary for a successful ToC.

Results Median survival from discharge was 4 (1–7) days. Thirty-one (69%) had a progressive life-limiting illness and 12 (27%) had multi-morbidity/frailty.

Twenty-five patients (56%) were recognised to be dying. Key interventions took place for the majority, including: advance care planning (ACP) (96%), Fast Track discharge (92%), anticipatory prescribing (88%) and do not attempt cardiopulmonary resuscitation form (DNACPR) (84%).

The RDP was used in 11 (44%) of those recognised to be dying. The RDP patients had a median of six (5–8) key interventions compared to four (1–5) for those without an RDP.

Eight (18%) were perceived to be in the last weeks to months of life and twelve (27%) were not recognised to be approaching the EoL at all. Ten (83%) of those not recognised to be near the EoL had multi-morbidity/frailty, whereas 29 (87%) of patients in the other two groups had a life-limiting illness. The majority (73%) of those not recognised had two or more markers of deteriorating health.

Conclusion Appropriate planning occurred for the majority of patients recognised to be dying. This was enhanced by use of the RDP. Recognition is a barrier to planning; particularly in those with multi-morbidity and frailty.