

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

Results 73 HCPs 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.

54 ARE MODERN DAY PALLIATIVE CARE NURSES RITUAL SPECIALISTS?

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Background Recent research in palliative care has focused on understanding how the dying (and immediately post-mortem) process affects nurses. The literature notes the increasingly complex environments in which nurses find themselves, such as in the care of heart-beating and non-heart-beating cadaver donors, whose legal status as variously ‘alive’ or ‘dead’ is often less clear-cut in practice. Nurses often report feelings of emotional ‘burnout’ due to a lack of suitable support structures.

Methods A review of literature from 1980 to the present, predominantly from specialist nursing journals was consulted to provide an overview on the role and emotional responses of contemporary palliative care nurses. The findings were contextualised using research frameworks derived from common themes in archaeological and anthropological literature, such as personhood and liminality.

Results Themes such as the liminality of the dead are recurrent in both modern palliative nursing and in the archaeological and ethnographic record. Moreover, the need for ritual specialists to mediate in transitions between the worlds of the living of the dead is ubiquitous in the latter, as is the elevated status of these individuals within the community.

Conclusions By understanding the important and conflicted nature of their roles as mediators between worlds, and by placing their daily practices within a broader theoretical framework and deep-time perspective, nurses can better understand the inherently complex and sensitive nature of their work, and gain a degree of empowerment over their roles and associated emotional responses.

55 THE UTILITY OF A TRUSTWIDE CONSULTATION TO PROMOTE AND INFORM THE IMPLEMENTATION OF AN END OF LIFE CARE STRATEGY

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Background The Trust’s Strategy for End of Life Care (EOLC) outlines a vision that ensures care at end of life is as comfortable, dignified and individualised as possible. The importance of staff engagement to achieve success and effective implementation of the Strategy was recognised and the following outlines how this was approached.

Method A stakeholder analysis was undertaken to identify target staff groups and invitations were sent through a variety of communication methods. Consultation events were held with staff at all levels (clinical and non-clinical) during March and April 2017, led by Service Improvement, across a variety of Trust sites. These took the form of short interactive sessions lasting 30 min: a short presentation explaining the project background, followed by the opportunity to comment on 3 specific areas – what works well/could be improved for patients; for staff; and what would help improve staff confidence in delivering EOLC.

Results 140 staff attended from a wide range of professions; 891 comments were received, collated, analysed and grouped

to identify areas of commonality. Emerging themes included communication and information sharing, education and training, care planning, DNACPR, support and supervision for staff, and environment of care. From these themes, five key workstreams were developed (review of Trust guidance for care in last days of life, development of a staff EOLC intranet site, development of an EOLC planning toolkit, review compatibility of information platforms, education and training) and are currently being addressed by the EOLC working group.

Conclusion The comments collated from the consultation events provided a valuable source of rich qualitative data on the views of staff and have informed areas for development. The interest and engagement for this process confirmed the enthusiasm of staff, who valued the opportunity to shape future developments; many have since become involved in aspects of this work.

56 ARE THERE INAPPROPRIATE PALLIATIVE PATIENT DEATHS IN EMERGENCY DEPARTMENTS (ED)? A RETROSPECTIVE STUDY LOOKING AT THE DEATHS IN A DISTRICT GENERAL HOSPITAL ED

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Introduction Palliative patients sometimes present to emergency departments when dying and current policy aims to reduce such unnecessary admissions. This study provides a description of palliative care related deaths in an ED and an assessment of how many of these were preventable.

Methodology 32 consecutive deaths were reviewed in a district general ED department in Shropshire during 2016/2017. Death certification details, palliative status and DNACPR status were identified. We retrospectively judged whether their admission was potentially avoidable.

Results

Epidemiology

- Median age 83 years (range 40–95)
- 15 female patients (47%).

Mode of death

- 12 patients died from respiratory pathology (37%), 6 from cardiac (18%), 6 from gastrointestinal (18%), 3 from infection (9%), 3 from stroke (9%), 1 from cancer (3%) and 2 were uncategorised.
- Frailty and palliative status
- Frailty and old age was documented on 10 death certificates (29%), dementia on 3 (9%).
- 4 patients (12%) had oncological disease.
- 2 patients (6%) were known to be palliative, 16 patients (50%) were not. There is uncertainty regarding the palliative status of the remaining patients and clarification using the gold standard framework is ongoing.
- 25 patients were DNACPR (81%).

We believe 3 admissions were preventable (9%), 17 were unavoidable (53%) and the remaining 12 are unclear (38%).

Conclusion This study suggests that some palliative patients do present to ED and die, and that some of these admissions were avoidable. With ever increasing ED pressures we suggest

it's imperative to understand the reasons, assess the scale, and find solutions to inappropriate palliative ED admissions.

57 UNIFIED DO NOT ATTEMPT RESUSCITATION (UDNACPR) ORDERS – AN AUDIT OF COMMUNICATION BETWEEN DIFFERENT HEALTHCARE SETTINGS

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Background The use of unified Do Not Attempt Resuscitation ('uDNACPR') orders aims to facilitate effective communication of DNA-CPR decisions between primary and secondary care. The document remains valid in primary and secondary care facilities and ensures continuity of care. The Salford uDNACPR policy reinforces the importance of communication of such decisions with all healthcare professionals involved in the patients care.

Aims/objectives To review the quality of communication of uDNACPR decisions with General Practitioners (GPs), out of hours services and the North West Ambulance Service (NWS) on discharge from hospital.

Method A retrospective audit included 26 patients who had a uDNACPR order introduced whilst an inpatient at Salford Royal Hospital. Data was collected from the electronic patient record, uDNACPR paper forms, GP practices, out of Hours services and the NWS Electronic Referral Information Sharing System: 'ERISS'.

Results In 33% of cases, GPs had no record of uDNACPR decisions. The NWS had no record of uDNACPR orders in 81% of cases, and Out of Hours services had records of only 1/26 orders.

Conclusion Current communication of uDNA-CPR decisions to community providers is inconsistent and there is clearly room for improvement. This may result in patients receiving futile and undesired interventions. One key factor identified for poor communication of uDNACPR orders was poor knowledge amongst healthcare professionals on communication channels for such decisions. Work is currently being done to facilitate and support communication to different providers on discharge from secondary care. This includes education sessions on electronic systems such as EPaCCS, discussions with the individuals responsible for 'electronic note templates' within the hospital electronic patient record and involvement in work aiming to introduce a 'Medical intraoperatively gateway' (MIG) allowing GP/hospital/other systems to communicate and share information.

58 ANTICIPATORY PRESCRIBING PRACTICE AT A DISTRICT GENERAL HOSPITAL: A SERVICE EVALUATION

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Background NICE guidelines (NG31, 2015) advise that suitable anticipatory medicines (AMs) are prescribed as early as possible for people likely to need symptom control in the last days of life. To date, there has been limited evaluation of this practice. This study aimed to characterise anticipatory prescribing (AP) at a district general hospital in relation to three main