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.

## Abstracts

### 57

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

Imogen Sullivan, Tim Jackson. Salford Royal Hospital

**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 uDNA-CPR 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 uDNA-CPR decisions with General Practitioners (GPs), out of hours services and the North West Ambulance Service (N WAS) on discharge from hospital.

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

**Results** In 33% of cases, GPs had no record of uDNA-CPR decisions. The NWAS had no record of uDNA-CPR 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 uDNA-CPR 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**

Ayla Newton, Denise Dunseir, Brigid Purobell, Maria King, Penny McNamara, Richella Ryan. Bedford Hospital, Sue Ryder Hospice – Moggerhanger

**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