

for dying patients in need of care which was inaccessible in the community.

70 RENAL REPLACEMENT THERAPY IN PATIENTS APPROACHING THE END OF LIFE: A CASE SERIES OF 3 PATIENTS WHO MADE DIFFERENT CHOICES

Zoe Kantor, Aaron Braddy, Andrew Findlay. *Department of Renal Medicine, East and North Herts NHS Trust, The Lister Hospital, Stevenage, UK*

10.1136/bmjspcare-2018-ASpabstracts.97

Objective To explore decisions regarding the use renal replacement therapy (RRT) as patients approach end of life.

Background End stage renal failure (ESRF) has many potential treatment options, including RRT, renal transplantation and conservative management. Complexities exist (including the impact on quality of life and length of life) regarding the instigation or withdrawal of RRT in patients who are nearing end of life. RRT is unique as no other organ function can be as readily and effectively replaced; this alone can make it difficult for people to choose not to have treatment.

Method We reviewed three cases of patients with ESRF approaching the end of life:

Patient 1 – On renal replacement therapy, wishing to withdraw from RRT

Patient 2 – A patient with a short life expectancy due to comorbidities but who wanted to commence RRT for acute-on-chronic renal failure who developed immediate cardiac complications requiring end of life care

Patient 3 – A patient who was being conservatively managed who then developed acute-on-chronic renal failure due to an acute illness who declined RRT

The role of the multi-disciplinary team in the decision-making process, in conjunction with discussions with patients and their relatives, was also considered.

Results The three patients made different choices for the management of their renal failure as they approached end of life. They made informed decisions about their care with the support their family and the renal multi-disciplinary team.

Lessons learnt The impact of RRT on quality and length of life should be considered in patients nearing the end of their lives. Renal MDT involvement in the decision-making process is imperative to ensure the patient makes an informed decision. The three patients considered made different choices as they approached end of life reminding us of the importance of patient's wishes in their end of life planning.

71 THE ROLE OF NURSES IN CARE OF THE DEAD PERSON

Christina Faull, Lindsey Buster, Laura Green, Karina Croucher. *LOROS Hospice, Leicester, University of Bradford*

10.1136/bmjspcare-2018-ASpabstracts.98

Background The care of a person who has died is of importance to the person themselves and to their loved ones. Nurses have a unique role in providing this care. This work explored the literature concerning the formal practices of the care of a dead person, the teaching of such practices and the cultural and informal curriculum by which such practices are passed on in nursing.

Methods A pragmatic review of UK and US published literature since the establishment of nursing as a trained profession in 1860. Journal databases, textbooks of nursing as well as historical archives were searched for materials.

Results The care of the dead person is ritualistic and prescribed. There are strong cultural influences on practices and little evidence base upon which these practices are based. Geo-political, religious and local cultures all have strong influences in both the practices and the tone of the care. The informal or tacit curriculum, such as the placement of tokens of respect such as flowers or the opening of windows to 'let the spirit out' is absent from teaching materials but alluded to in memoirs and personal accounts.

The care of the dead person is secretive and professionally guarded. By some it is seen as a privileged activity and by others as an activity akin to punishment or of low value in the work of that shift, even one to avoid.

Conclusions The care of the dead person is an area of secrets and diversity of cultural values and approaches. There is a paucity of literature and evidence base.

72 TALKING RESUSCITATION – CAN WE GET IT RIGHT AT THE HOSPICE?

Alexandra Rusby, Aruna Hodgson. *Wigan and Leigh Hospice*

10.1136/bmjspcare-2018-ASpabstracts.99

Background There have been a number of high profile cases about resuscitation decisions in recent years.^{1,2} This has prompted regular updates in the national guidance on decisions relating to cardiopulmonary resuscitation (CPR).^{3–5} At the hospice a specific template is used to document CPR decisions on SystmOne, electronic patient record system. Current practice on the inpatient unit was audited against the hospice resuscitation policy following local and national guidance.^{3,6} Fourteen standards were set specifically reviewing documentation on admission, at multidisciplinary team meetings and discharge. A 100% target was set for each standard due to the important implications of the do not attempt cardiopulmonary resuscitation (DNACPR) decision. The aim was to establish whether CPR decisions were documented and communicated appropriately to highlight any areas for improvement.

Method Retrospective review of 39 patient notes on SystmOne for patients admitted to the hospice from October to November 2016.

Results Of the fourteen standards set, only one standard met the 100% target. This was informing the GP of the unified DNACPR (uDNACPR) status at discharge.

Standards that achieved over 90% included: making a resuscitation decision on admission and discussing this with the patient, as well as reviewing resuscitation status at multidisciplinary team meetings.

Standards that achieved less than 80% included: discussing resuscitation decision with relatives when the patient lacks capacity and documenting decisions for uDNACPR at discharge.

Conclusion Using SystmOne templates has been helpful for documenting CPR status on admission, at multidisciplinary meeting review and on discharge letters to the GP. Recommended amendments to the CPR template include a prompt for a uDNACPR decision at discharge and an updated discharge checklist.