

(<1–36), and 10 years working in palliative medicine (<1 year – 31 years, one working as bank).

Most reported confidence in recognising and managing TA as well as the specific use of midazolam, haloperidol and levomepromazine. Respondents were less familiar with phenobarbital (table).

Lowest levels of confidence in managing TA were reported in respondents with the least experience of this.

Free text replies indicated that making patients settled was the most rewarding aspect of managing TA; impact on family was another common theme.

Respondents however described a number of challenges including difficulty in recognising TA, and regarding medication decisions.

Conclusions With support of a local guideline, high levels of confidence were reported in use of first and second line medications for TA. However respondents still reported challenges in its management.

Future considerations We recommend regular education and training alongside ongoing reflection amongst medical and nursing teams after events of TA, to ensure best practice, team well-being and confidence with guidelines.

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EXPLORATION INTO USE OF CONTINUOUS SUBCUTANEOUS LEVETIRACETAM WITHIN PALLIATIVE CARE

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With advances in medicine and people living longer with chronic medical conditions new subsets of patients emerge. One such subset is a group of patients for which seizure control is paramount yet they are not actively dying and their oral and intravenous route of administration has become unavailable/inappropriate. Traditional treatment for seizure management has been subcutaneous (S/C) midazolam, however this often does not balance Quality of Life (QOL) favourably for this interim period, primarily due to associated drowsiness. There have been numerous case reports using continuous subcutaneous infusion (CSCI) levetiracetam as an alternative for this group of patients, as a consequence of the perceived more favourable side effect profile.

We have collated the research published to date which outlines the appropriate scenarios and limitations of levetiracetam S/C route (either intermittent or CSCI). We have outlined the side effects, dose regimens and practical issues regularly encountered.

We have sought expert neurological advice and explored the limitations of other anti-epileptics via the S/C route and noted hopeful upcoming newer therapies such as Brivaracetam and Lacosamide.

We have made recommendations regarding starting doses, disease aetiology considerations and practical titration and conversion issues.

Within this area of rapidly progressing research, collating what has been studied so far and gaining support out-with specialist palliative care organises our thoughts and creates an overview on which we can base future research and develop guidelines to encourage consistent safe practice.

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PATIENT AND CAREGIVER EXPERIENCES OF DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) CONVERSATIONS: AN INTEGRATIVE REVIEW OF THE LITERATURE

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Background Following recent changes in UK case law, DNACPR decisions must be discussed with patients unless that conversation will cause harm. CPR should not be given if it is an inappropriate treatment. DNACPR conversations are therefore happening more frequently; yet evidence to support staff in knowing how to undertake these conversations is scarce from the patient/caregiver perspective. This integrative literature review aims to identify patient and family experiences of DNACPR conversations.

Methods A search of multiple databases was performed for adult patients and caregivers, from all settings worldwide (2004–2014). Abstracts were reviewed for relevance and quality. First person, retrospective accounts of patient/carer experience of DNACPR conversations were gold standard. Relevant full texts were appraised and recurring themes analysed and tabulated.

Results The initial search identified 559 abstracts. Of these, 46 full texts were deemed relevant including 9 UK and 37 international papers. Only 22 papers were original research with patients or carers who had experienced these conversations. Themes revealed the importance of DNACPR discussions being conducted by someone trusted and the importance of family/carer involvement, as well as perceived concerns about burdening family members. Timing preferences for discussions was variable revealing difficulties in finding the ‘right time’ to discuss. Discussions held at home or the GP surgery are preferable to discussions during acute admissions to hospital.

Conclusions This review highlights potential discrepancies between patient and carer preferences for DNACPR conversations, and the reality of how these conversations are currently taking place. Public health approaches to tackle the societal taboo around death and dying may encourage people to think about and expect such conversations during their illness trajectories. Discussion of DNACPR decisions with the patient is now a legal requirement, but patient centred care remains paramount. More evidence is essential to bridge these expectations.

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THE USE OF AN ONCOLOGICAL PALLIATIVE DEPRESCRIBING GUIDELINE TO AID RATIONALISING MEDICATIONS IN PATIENTS IN THE LAST SIX MONTHS OF LIFE

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Background It is widely recognised that large numbers of patients remain on unnecessary medications after transition from a curative to palliative pathway. This is often the result of a lack of vigilance and confidence amongst healthcare professionals when rationalising medications^[1]. This can negatively impact on quality of life, through ‘pill burdens’ and