

## REFERENCES

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## PALLIATIVE MEDICINE PHYSICIANS ARE EXCEEDINGLY OPTIMISTIC INDIVIDUALS!

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10.1136/bmjspcare-2017-00133.21

**Background** Oncologists (and other healthcare professionals) often perceive palliative medicine physicians as being overly pessimistic, whilst palliative medicine physicians often perceive oncologists as being overly optimistic. However, there appears to be no scientific evidence to support these perceptions. Hence, we set out to examine the relationship between choice of medical specialty and levels of optimism/pessimism.

**Method** In April 2016 all oncologists and palliative medicine physicians employed at four cancer centres within the United Kingdom were contacted to complete an online survey. Participants were asked to complete the Life Orientation Test - Revised (LOT-R), which is a validated measure for assessing optimism and pessimism, and also asked to describe a picture of a partially filled wine glass (ie, would you describe the glass as “half full” or “half empty”).

**Results** 112 participants of different grades (consultant, specialty trainees or “other” doctors) completed the on-line survey in full. There was no difference in LOT-R scores between oncologists and palliative medicine physicians, but there was a statistically significant difference in LOT-R pessimism scores between consultants and specialty trainees ( $p=0.03$ ). There was also no difference in the glass half full/half empty question between oncologists and palliative medicine physicians, or in this case between consultants and specialty trainees.

**Conclusions** The results of this study refute the perception that palliative medicine physicians are overly pessimistic (and that oncologists are overly optimistic). Interestingly, specialty trainees were generally less optimistic than consultants, which may reflect the current challenges facing junior doctors in the United Kingdom or that experience and/or training can indeed influence an individual’s outlook on the world.

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## DECISION MAKING AROUND END OF LIFE CARE IN THE EMERGENCY DEPARTMENT

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10.1136/bmjspcare-2017-00133.22

**Background** Every day, Emergency Department (ED) doctors are confronted by the challenges associated with patients who are dying or who are nearing the end of life. Recognising that a patient is dying and identifying the need for a more palliative approach is crucial if the patient is to receive appropriate end of life care. Such decision making in the ED will also minimise harm to this patient group by avoiding treatments which would be futile, burdensome or contrary to the patient’s wishes.

**Method** A communication tool was devised for use in the ED (named Hospital Anticipatory Care Plan - HACP). It allowed for the attending ED doctor to document what they felt were appropriate treatment options and also level of escalation in terms of any ITU/HDU referral. If considered that end of life care was most appropriate then this could also be indicated. Training in use of the tool was provided for medical and nursing staff of all grades.

**Results** One year after introduction of HACP, the tool is now commonly used in conjunction with DNACPR. An audit of cases admitted through the ED with HACP completed showed that in 73% of cases the patient died within 48 hours of admission - without being subjected to futile interventions or inappropriate escalation of care.

**Conclusions** Senior ED staff have fairly reliable clinical acumen in identifying patients who are on an end of life trajectory. Recognising that a patient is nearing the end of life makes it less likely that a patient will have a “bad death” ie, one that involves futile over treatment of their underlying condition while under treating their palliative needs.

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## AN AUDIT OF INPATIENT HOSPICE METHADONE CONVERSION IN THE WEST MIDLANDS

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10.1136/bmjspcare-2017-00133.23

**Background** This audit was completed to review adherence to the current 2012 Pan Birmingham guidelines for the use of methadone in adults with pain in palliative care.

**Methods** Anonymised data collection tools were sent electronically to six hospices in the West Midlands. Data was collected retrospectively from controlled drugs record books over a 2 year period from 01/07/2013–30/06/2015. The audit was limited to patients who were inpatient at the hospice and excluded those who were admitted already taking methadone on admission or taking it for an alternative reason eg, as part of a drug replacement programme.

Standards for the audit were derived from the current 2012 Pan Birmingham Guidance.

**Results** Results were received from five hospices. In total 28 patients were audited retrospectively over a 2 year period from July 2013 to June 2015. Ten patients were excluded. A protocol or guideline was in use in only 2 hospices (40%). Of the 18 patients included in the audit methadone was commenced in 14 patients (78%) due to poorly controlled pain despite other opiates. In one patient it was commenced due to tolerance to the analgesic effects of other opiates. In three patients methadone was commenced due to unacceptable side effects of other opiate medications. An ECG was performed prior to commencing methadone in only three patients. A variety of starting doses of methadone were used, most commonly 30 mg. Furthermore, breakthrough dosages of methadone prescribed were wide ranging from 2–30 mg.

**Conclusions** This audit shows that the current local guidelines are not always being adhered to. A wide variation in prescribing exists for both regular and PRN dosages of methadone. Additional areas for improvement have been identified including nursing training and QTc monitoring with pretreatment ECG.