21 DYING MATTERS SO WHY DON'T WE TALK ABOUT IT: A SURVEY OF STAFF AND VOLUNTEERS IN HOME, HOSPICE AND HOSPITAL SETTINGS IN SOMERSET UK

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Background Discomfort talking about death and dying inhibits advance care planning (ACP) conversations. This survey aimed to raise awareness of end of life care (eolc) across home (community), hospices and NHS hospitals in Somerset and to explore staff and volunteers' views about talking about dying. Respondents were encouraged to think beyond the patient-clinician relationship and consider how they interact with their families and communities when considering eolc.

Methods Staff and volunteers working in 2 district general hospitals, community services and 2 hospices were invited to complete an online survey during Dying Matters week (May 2019). Volunteers also encouraged completion of the survey on an iPad. The survey questions explored: most common worries for people at eol; attitudes towards talking about death and dying with other people (colleagues/patients/own family/friends); how much was known about ACP; perceived education needs. Free text data was extracted into word clouds and 10 point linear scale responses analysed using excel.

Results 58% of 1045 respondents were staff with clinical responsibilities. The 3 most frequently-used words around worries at eol were: family, pain, leaving. 20% were not comfortable talking with another person about dying, with similar distribution of responses from clinical and non clinical respondents. They were all more comfortable talking with colleagues. 44% of respondents said they knew little or nothing about ACP with non clinical respondents having less knowledge. More than half wanted training to develop skills to talk about dying, including 61% nurses and doctors.

Conclusions Care of the dying is not the exclusive domain of clinical staff. More dying people need to have opportunity to talk about what is important to them and their future. Empowering people through education and training (clinical/non-clinical/staff/volunteers) in their 'outside-work' lives to have conversations about 'the future' is fundamental to achieving sustainable quality improvements in eolc.

22 OPIOID PRESCRIPTIONS AND PATIENT UNDERSTANDING OF OPIOIDS WITHIN AN ACUTE HOSPITAL SETTING

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Introduction There are guidelines on the prescription of opioids relating to choice in renal impairment and the ratio of modified release to immediate release. When prescribing opioids, it is essential patients understand what they are, how to take them, and they are counselled on side effects and limitations. Staff must also understand prescribing and counselling regarding opioids.

Method 2 part study:

1. Service Evaluation - Questionnaires filled in by both staff and patients, regarding their prescribing, knowledge and perception of opioids.
2. Audit - Comparing whether patients are prescribed the correct opioid in relation to their renal function, and whether the ratio of modified release opioid to immediate release is correct.

Results At the time of writing, we had 36 patient and 10 staff responses to the questionnaires, as well as 45 recordings of patients' MR:PRN ratio. We had reviewed approximately 700 prescriptions of opioids to compare with renal function.

Service Evaluation: 80% of staff said they never provided opioid information leaflets to patients, and many staff mentioned fear associated with opioid dependence and terminal illness when prescribing. 22.2% of patients could not name the opioid they were receiving, and only 16.7% said they had received the opioid information leaflet.

Audit: 30% of patients with an eGFR <30 had been prescribed morphine (in contrast to guidelines). 67% patients had an incorrect MR:PRN ratio.

Conclusion and further work Staff showed good competency levels of opioid understanding and prescriptions but many patients had not been given adequate information regarding opioids. The audit shows reasonable prescribing of opioids in renal impairment however need for education about MR:PRN ratios. We aim to further educate staff about opioids and their prescription and also trial a full roll out of our patient leaflet 'strong opioids for cancer pain' re-auditing its use over the next year.

23 FROM AN INTENSIVE CARE UNIT (ICU) TO A HOSPICE; A CASE STUDY HIGHLIGHTING THE NEED FOR TAILORED STAFF EDUCATION IN RESPONSE TO THE INCREASINGLY COMPLEX CASE-MIX IN SPECIALIST PALLIATIVE CARE

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Background Palliative Medicine has expanded rapidly as a specialty to encompass non-cancer patients, with multiple co-morbidities, in a wider range of settings. Adaptation of existing services with ongoing staff training is essential to meet the evolving demographics and demand.

Case report An 81-year-old diabetic patient with peripheral vascular disease developed necrosis of the foot. Revascularisation attempts were complicated leading to ICU admission for intravenous antibiotics and haemodynamic support. They were diagnosed with necrotising fasciitis but were not fit for further surgery. Referral was made from ICU to hospice, their preferred place of death. After inotrope withdrawal, the patient was transferred with a bupivacaine spinal line in-situ for pain control. Diabetic control was challenging in the context of variable oral intake and sepsis. Morphine and midazolam syringe drivers were titrated; the patient died peacefully eight days after admission.

Evolving case mix: Admissions to the hospice inpatient unit from 2015–2019 were reviewed retrospectively. Although we were unable to identify those patients transferred directly from ICU to hospice, the proportion of patients admitted to