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### CARING FOR DYING PATIENTS IN CRITICAL CARE SETTINGS: SURVEY OF PALLIATIVE CARE AND CRITICAL CARE PRACTICES AND PERSPECTIVES

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**Background** A significant proportion of hospital deaths occur in critical care settings, many have palliative care needs. Palliative care involvement is variable, and little is known about the differing perspectives and practices of palliative care (PC) and critical care (CC) professionals in caring for dying patients in this setting.

**Methods** This was an electronic survey developed as part of a regional guideline development process. It was distributed across North-West England via service leads for critical care and palliative care, with all professionals involved in the care of patients dying in critical care settings invited to participate February-March 2019.

**Results** 36 professionals from a PC background (30 providing face-to-face reviews and 6 telephone advice only) and 31 from a CC background completed the survey. Confidence in prescribing medication for common symptoms was high in both CC professionals and PC professionals providing face-to-face reviews. CC professionals reported a preference for the intravenous route for both as required (68% of respondents) and continuous infusions (58%) of symptom control medication, whilst PC professionals preferred the subcutaneous route (79% and 83% respectively). The most common reason CC professionals reported referring to palliative care was rapid discharge of dying patients (84% of respondents), whereas the most common area PC professionals reported assisting with was symptom control, both during face to face reviews (100%) and telephone advice (94%). Priorities for further education included symptom control medication (both groups), withdrawal of ventilation (PC professionals) and preparing families (CC professionals).

**Conclusions** Palliative care and critical care professionals report differing practices in symptom management for dying patients on critical care and differing perspectives of the role of palliative care in this setting. Understanding these practices and perspectives is valuable in developing guidelines for the management of dying patients in critical care units and identifying areas for increased education and support.

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### PRIORITIES FOR FUTURE CARE: ADVANCE CARE PLANNING FOR NURSING HOME RESIDENTS

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**Background** This work was spurred following a presentation from a paramedic at the All Wales Palliative Care Conference in Gregynog in 2018, which highlighted the challenges for paramedics' making clinical decisions for nursing home residents. For a patient nearing the end of their life, transfer from a nursing home to the emergency department can be inappropriate and have undesirable consequences.

#### Aims

- To ensure smooth transition of care from hospice patient to nursing home resident.

- To ensure patients' wishes nursing home residents are clearly communicated.
- To reduce unnecessary medical interventions and hospital admissions.

**Method** Based on feedback from paramedics, a patient-specific information document titled 'Priorities for future care: Nursing Home Residents' has been implemented at the hospice. This two-page document has been completed upon discharge over a six-month period.

**Results** From February to July 2019 we have successfully completed the care priorities document in 92% of our discharges (n=11). Of the 11 discharges, 2 patients were re-admitted acutely and died as an inpatient. Patient feedback has been universally positive whilst for Health Care Professionals, it has been used an opportunity to re-visit and review patient wishes prior to discharge. Quantitative data and feedback from the Welsh Ambulance Service is ongoing.

**Conclusion** The care priorities document aims to improve confidence and communication in future decision-making for patients entering nursing home residential care. It is hoped that the results from piloting this initiative will aid in the refinement of a single, standardised form for use across Wales.

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### A SURVEY OF ANTICIPATORY PRESCRIBING PRACTICES IN THE WEST MIDLANDS

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**Background** Anticipatory prescribing is considered good practice in helping to ensure patients near the end of their lives are cared for promptly and in their chosen place of care. Practice varies, need for more agreement on prescribing (accepting prescriptions must also be individualised), may be of benefit. Determining a baseline of current practice sought.

**Method** 12 different palliative care institutes (hospices, hospital and community teams) were approached to seek information on their guidelines for prescribing anticipatory medication. Interest in which drugs are used for what symptoms, with doses, frequency ranges and maximum doses were requested in writing. Information on use of guidance for syringe pumps and use of patient information leaflets also requested (July 2019). Institutes were selected which tend to follow regional guidelines from the Specialist Palliative care Audit & Guidelines Group (SPAGG) and those out side this group to compare practices.

**Results** Generally agreement on which medications to prescribe with those outside the SPAGG area offering more choice on opioids and antiemetics. Only some centres routinely suggest anticipatory medication for dyspnoea. Less agreement on frequency of prescribing; mainly prn or 1 hourly but a considerable number of centres suggesting administration less frequently. Variable agreement on recommendation on maximum dose in 24/hrs for most drugs. Small number of centres advise on anticipatory syringe pumps, only 2 have leaflets to describe anticipatory prescribing.

**Conclusions** Those centres outside SPAGG give a range of medications for prescribers to choose from, SPAGG guidelines are quite specific. PRN prescribing guidelines recommend that a dose, frequency and maximum dose/no of doses in 24hrs

are given; not all teams follow this practice. Agreement on how frequent doses should be given and suitable maximum daily ranges would be beneficial. Some teams give more advice relating to renal failure. Few teams routinely give a Patient Information leaflet- may benefit.

### 89 INPATIENTS WITH PALLIATIVE CARE NEEDS ANTICIPATORY PRESCRIBING REVIEW – UNIVERSITY HOSPITAL HAIRMYRES, NHS LANARKSHIRE

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**Background** The Scottish Palliative Care Guidelines published in 2014 outline best-practice to support clinicians with end of life care. These guidelines include recommendations on anticipatory prescribing for patients nearing the end of life to allow these people to have timely access to injectable symptom control medication.

**Aim** To improve anticipatory prescribing in Hairmyres Hospital in line with Scottish national guidelines through evaluation of current practice and an educational programme for prescribers.

**Method** Inpatient medication prescription charts were reviewed and data analysed retrospectively. Inpatients referred to the hospital palliative care team for whom anticipatory prescribing was appropriate, over a four week period (n=20) were included. Data about patient demographics, anticipatory prescribing and subcutaneous infusions was collected. A teaching session on anticipatory prescribing was arranged for medical staff along with on-going case-by-case feedback and education from the palliative care team. Data was then collected in a further quality improvement cycle (n=12).

**Results** 60% (n=12/20) of patients were prescribed all recommended anticipatory medications. Of these, 77% of prescriptions were in accordance with the national guidelines (n=53/68). 71% of continuous subcutaneous infusions were prescribed correctly (n=5/7). Following the education programme, 67% (n=8/12) were prescribed all recommended anticipatory medications and of these, 86% of medications were prescribed in accordance with the guidelines (n=32/37). 100% of continuous subcutaneous infusions were prescribed correctly (n=6/6).

**Conclusion** This education programme improved the rate and accuracy of prescribing of anticipatory medication for patients nearing the end of life. More work is required to ensure awareness amongst prescribers of how and when to prescribe these medications with the aim of full compliance with the Scottish National Palliative Care Guidelines.

### 90 RETROSPECTIVE AUDIT OF THE PRESCRIPTION OF OPIOIDS AT THE END OF LIFE IN A HOSPICE AND HOSPITAL SETTING IN THE WAKE OF THE GOSPORT INQUIRY

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**Background** The Gosport Inquiry (GI) found that unsafe opioid use led to around 450 excess deaths over 14 years. We compared their findings to local, current use in a hospice and hospital setting.

**Methods** Notes were reviewed retrospectively for inpatient deaths in January 2019 at Ealing Hospital and Meadow House Hospice. We collected the same data as was analysed in the GI, using notes and drug charts. We focused on indications, doses and routes of administration of opioids.

**Results** At the hospice, 92% (24/26) of patients received regular opioids. 100% (26/26) had appropriate indications documented. The mean initial dose was 30 mg oral morphine equivalent per day; the mean final dose was 35 mg. 62% of patients (16/26) were switched to continuous subcutaneous opioid administration prior to death. At the hospital, 42% (26/62) of patients received opioids. 23% (14/62) received regular opioids, and of these 93% (13/14) had appropriate indications documented. The mean initial dose was 20 mg oral morphine equivalent per day; the mean final dose was 24 mg. Of total deaths, 5% (3/62) received opioids via continuous subcutaneous infusion, 18% (11/62) were reviewed by palliative care. The narrative in the notes suggested a lack of confidence in prescribing opioids and diagnosing dying.

**Conclusions** It is reassuring that opioid use at both sites appears safe. In contrast to the GI, opioid doses used were low and indications well documented. The proportion of patients receiving opioids was lower at the hospital than the hospice, with an apparent preference for low dose, immediate release rather than background opioids. The size of the difference could represent truly different patient populations, or could be under-utilisation of opioids as a result of lack of confidence or education. This signposts possibilities for future investigation as to why this might be, and potential improvements to clinical practice.

### 91 ARE WE READY?

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**Introduction** Annually at Ashford and St Peter's Hospital (ASPH) we hold an event to promote dying matters week. This aims to remove the stigma of talking about death and dying within our community. In 2019, dying matters week theme was 'Are we ready?'

**Methods** The Specialist Palliative care team (SPCT) designed a survey to gauge if the ASPH community 'were ready?'. We asked questions including: have you cared for someone who was dying?, did you feel ready?, have you thought about future wishes? i.e. medical treatment, how would you like to be cared for?, where you would like to be cared for?, most importantly have you discussed these wishes with those important to you? The survey was distributed to all areas of the hospital.

**Results** 80 surveys were returned: 56 (70%) Staff, 1 (1%) patient, 4 (5%) Carer/family member, 3 (4%) Visitor, 16 (20%) not completed. 86% were aged 20–60 which is representative of the ASPH community. Of the respondents 57% felt ready to care for someone who was dying. However only 45% had thought about how they would like to be medically treated at the end of life (EOL) and 38% knew where they would like to be cared for at the EOL. Only 50% of respondents had discussed this with those important to them.