

103 **CASE REPORT: USE OF A PATIENT CONTROLLED DEVICE FOR DELIVERY OF BOLUS DOSES OF INTRATHECAL ANALGESIA IN CANCER RELATED PAIN UNRESPONSIVE TO CONVENTIONAL PAIN MANAGEMENT**

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Intrathecal analgesia is being used more frequently for patients with cancer pain unresponsive to regular treatments. In this case patient controlled intrathecal analgesia was used in a setting where the patient's pain was severe and unrelenting despite maximum tolerated doses of numerous analgesics, radiotherapy and nerve blocks. With the addition of the MyPTM device the patient's symptoms were markedly improved and as a result some baseline analgesia could be reduced. Though the intervention was relatively successful it did result in bothersome side effects and also brought with it new and challenging difficulties in relation to opioid management for us, the treating team to overcome.

104 **THE PAIN OF WAITING FOR PAIN RELIEF: USING E-PRESCRIBING DATA TO STUDY SUBCUTANEOUS SYRINGE DRIVER DELAYS IN A LARGE TEACHING HOSPITAL IN ENGLAND**

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Background Continuous subcutaneous infusions (CSCIs) are often used in the palliative care setting where patients require regular medication but the oral route is not available. Symptoms may include debilitating pain, nausea or seizures so medication should be started promptly after clinical review. While there is no clear definitive time frame for these, we would aim for infusions to begin within 2 hours, with anything above 4 hours an unacceptable delay.

This study took place at the Queen Elizabeth Hospital, Birmingham UK and its purpose was to determine whether CSCIs are being commenced promptly after being prescribed.

Methods Using the electronic data system, we looked at all of the patients to have a McKinley infusion commenced, and who were referred to the palliative care team during the period 1 April – 31 July 2018.

Results 104 patients fitted the inclusion criteria. 45% of infusions were commenced within 2 hours and a total of 74% were commenced within 4 hours. The mean time to start (TTS) was 225 minutes (range 14–1581 minutes). There were 9 infusions that took over 600 minutes (10 hours) to be commenced. These affect mean calculations considerably.

Discussion One common reason cited by ward staff was the prescriber not informing nurses that they had prescribed a CSCI. We noted that a prescriber can prescribe remotely from another ward in the hospital, giving barriers to good verbal handover to nurses. Other reasons cited include prescriptions being erroneous and having to be re-prescribed, or having to wait for McKinley pumps to be delivered by equipment stores. This study highlights an important patient experience issue for individuals towards the end of life, and additionally for prescribers. The very best medical knowledge and nursing skill can be undone by an avoidable delay in the commencement of a basic infusion.

105 **INAPPROPRIATE USE OF NALOXONE IN A HOSPITAL SETTING COMPROMISING PATIENT SAFETY: A QUALITY IMPROVEMENT PROJECT**

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Background Life threatening opioid toxicity is a rare but recognised complication of opioid use. In 2014, NHS England released a patient safety alert on inappropriate prescribing of naloxone in patients with chronic opioid use, citing 2 fatal cases. A retrospective audit (2017) of naloxone use in an acute London hospital demonstrated that 90% (18/20) of administrations did not meet recommended standards. This prompted a quality improvement project to improve practice.

Methods A trust guideline was developed using the Palliative Care Formulary and UK Medicines Information naloxone evidence review. This was disseminated through education sessions and email updates. An alert was created on the trust electronic prescribing system. Following this, repeat data was collected retrospectively over 3 months for all adult hospital inpatients (excluding ITU and ED) administered naloxone. Electronic clinical notes were reviewed for: reason for naloxone use, respiratory rate, oxygen saturation, level of consciousness and dose given.

Results Repeat audit (2019) demonstrated 3 administrations of naloxone, of which 2 did not meet the guideline standard - an 89% reduction in inappropriate administrations of naloxone compared to baseline. The dose which was appropriately administered was also of the recommended dose.

Conclusion/Discussion There has been a marked decrease in inappropriate administrations of naloxone in patients with chronic opioid use since the intervention. However, continued work is needed as reduced conscious level often triggered naloxone use despite absence of respiratory depression or hypoxia.

Recommendations Continued dissemination of the guideline, particularly with rotation of staff.

Ensure that the prescribing alert is maintained on future prescribing systems.

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106 **ROLES AND EXPERIENCES OF NURSES WHEN MEETING THE PSYCHOLOGICAL NEEDS OF PATIENTS RECEIVING PALLIATIVE CARE**

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Background Patients receiving palliative care experience psychological distress towards the end stage of their life and though some cope effectively, some do not. The psychological needs of these patients are sometimes overlooked by healthcare provider because physical symptoms such as pain, vomiting and respiratory distress are prioritised. Nurses are well positioned to recognise psychological distress and help patients manage it leading to a better experience at the end of life.

Method Semi-structured interviews were conducted with registered nurses working in hospital (n=6) and hospice (n=29) settings. The roles and experiences of nurses when meeting the psychological needs of patients receiving palliative care were explored. Interviews were audio recorded, transcribed verbatim and analysed thematically.

Result Four themes were generated after analysis of the data collected. These are: assessing, observing, intuition and experience; trust and managing uncertainties; little things that have great impacts; maintaining professionalism when grieving.

Conclusion Nurses are well placed to detect, assess and manage psychological problems experienced by patients receiving palliative care, with frequent contact being a key factor. Nurses are faced with emotional stress when caring for patients at the end of life and coping mechanisms and strategies are needed to enable them to continue to function well as a compassionate carer.

107 AUDIT OF THE PHARMACOLOGICAL MANAGEMENT OF DEPRESSION IN PALLIATIVE CARE

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Background Depression management in palliative care is challenging. The North West Palliative Care Audit Group (NWAG) coordinated a review revealing poor adherence to guidelines. Participating organisations were therefore asked to develop action plans.

Aim To audit the pharmacological management of depression against evidence-based standards (references 1–5).

Methods A multi-centre retrospective case note review of patients who were commenced antidepressants for depression was undertaken. 90% compliance was deemed acceptable. Four areas were audited: assessment and diagnosis, communication, follow up and information sharing.

Results Seven hospices and three hospital teams returned 58 forms. Mirtazapine was used in 67%, citalopram in 19% and sertraline in 11%. Only two sub-standards out of a total of 42 achieved compliance. These were regarding concomitant use of a benzodiazepine or a review of medication where a patient becomes agitated on initiation of antidepressant and also regarding sharing the diagnosis when a patient changed healthcare setting. Particular areas requiring improvement were documentation of: the duration of episode (50%), the severity (21%), functional impact (57%), previous episodes (30%); medications used (17%); contributory causes (76%); alternative diagnoses (34%); suicidal ideation (22%) and poor communication to patients. Only 72% were documented to have an explanation of the concept of depression, 59% regarding non-pharmacological treatments, 50% regarding side effects and 29% the lag in effect. No patients were offered written information. There was poor documentation of follow up and hand over to health care professionals.

Conclusion Practice was poor in all areas except two. Findings support the need for education of staff regarding diagnosis, communication, follow up and information sharing. In particular: documentation of suicidal ideation (22%); severity (21%); past history (30%) and provision of written information to patients (0%) was poor. Recommendations were made to run

educational sessions and a depression prompt was devised for local adaptation. A re-audit is planned. (References: 1–5 supplied on poster).

108 LONELINESS IS COMMON AMONG HONG KONG CHINESE CANCER PATIENTS RECEIVING PALLIATIVE CARE

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Background The negative health impact of loneliness is increasingly recognized, however, its prevalence among cancer patients receiving palliative care is yet unknown.

Methods This is a cross-sectional study performed in the palliative care unit of Caritas Medical Centre, Hong Kong. Patients were invited to response the single-item questions, 'Are you feeling lonely? (Yes or no.)' Loneliness severity was assessed using the local version of De Jong Gierveld Loneliness Scale (short form). Symptom burden was assessed by the local version of the Edmonton Symptom Assessment Scale (ESAS) with the 10th item assigned as 'most lonely'. Patient's demographic and health-related data were extracted thru interview and health record.

Results Fifty-six patients participated in the study, the mean age of participants was 72.7 years old. The median Palliative Performance Scale was 70. Eight patients had a concomitant psychiatric illness. Seventeen patients (30.4%) answered 'yes' on the single-item question of loneliness. Eleven and ten patients were scored as severe loneliness in the emotional and social loneliness subscale of De Jong Gierveld Loneliness scale respectively. For those who admitted themselves lonely in the single-item questions, they scored higher in ESAS-Depression (5 vs 0), Anxiety (5 vs 0), Impaired Well-Being (5 vs 3) and Loneliness subscale (7 vs 0) as well as HADS-Depression (13 vs 8), -Anxiety (9 vs 4) and Total Score (22 vs 12). (Mann-Whitney U test, <0.05). Half of the patients rated 0 out of 10 in the ESAS loneliness subscale, while 21 patients rated 5 or above. It was correlated with HADS-Depression, -Anxiety and -Total score (Spearman correlation, $p < 0.001$).

Conclusions Loneliness is common among Hong Kong cancer patients receiving palliative care. The severity of loneliness may correlate with the severity of depression and anxiety.

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109 UNDER THE INFLUENCE? THE HIDDEN DRUG DRIVING CONCERNS

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Background The implications of the drug driving guidance on our specialist palliative care unit is unknown. We make assumptions that patients don't drive a vehicle. It's not a routine question on admission or something that is addressed whilst inpatient medication changes are being made and also not something discussed when a patient is discharged.

Methods A snapshot assessment of the 18 patients admitted to the inpatient specialist palliative care unit was performed on