

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

1st October 2019. Patients were subsequently asked about driving, where appropriate, and the junior medical team provided education on the national drug driving guidance.

Results All 18 patients:

- Had prescriptions of medications listed in the drug driving guidance
- There was no knowledge or documentation of whether a patient was a vehicle driver

5 patients admitted for end of life care were therefore excluded from further analysis. When the 13 patients were asked:

- 10 patients were not vehicle drivers
- 3 patients were vehicle drivers

The drug driving guidance was discussed within the department's service improvement meeting. An addendum on the clerking proforma was made to include whether the patient was a vehicle driver or not. If a patient was a vehicle driver it was highlighted on the joint MDT handover list, and if prescribed medication listed in the drug driving guidance, they were counselled on this. This was also communicated on the discharge summary for ongoing continuity of care.

Conclusion This project enabled joint collaborative work between doctors and the pharmacy team. It also highlighted the importance of not making assumptions about palliative care patients not driving a vehicle. Discussing the drug driving guidance with the medical team ensured that a patient was aware of the government guidance and ensuring public safety. A re-audit is planned in 2020 to ensure that this change in practice remains embedded.

110 RECRUITING MND PATIENT RESEARCH PARTICIPANTS: I THOUGHT WE WOULD HAVE MORE

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Introduction LOROS Hospice provides a service to all people with MND in Leicester, Leicestershire and Rutland from the point of their diagnosis and research is an integrated aspect of the services. We wished to offer patients the opportunity to participate in the COMMEND study, a randomised controlled study of commitment and acceptance therapy. Despite a first stage feasibility study no guidance was available to inform the likely number of eligible participants.

The aim of this work was to identify the potential number of patients that could be approached about the study and understand the differences between the total population and this sample and its implication for study feasibility assessments.

Methods The notes of all patients with MND who were registered at the Hospice were identified and mapped to the inclusion and exclusion criteria of the COMMEND study.

Results 70 patients were identified of whom only 19 (27%) were eligible for the COMMEND study. The largest number (33%) were excluded because of receiving nutritional and/or ventilator support. A further 20% were excluded because of cognitive issues and 6% did not speak English as a first language.

Conclusions That less than a third of patients were eligible for this relatively straightforward interventional study was a

surprise to us. It is a well known aphorism that potential participants disappear as soon as a study opens. This work provides a screening analysis which informs realistic feasibility assessment and more nuanced understanding of the MND patient population. As LOROS provides care to all patients in the geographical area these findings should be generalizable.

111 ONE HOSPITAL CLINIC – ACHIEVING DEATH AT HOME AND HOSPICE FOR PATIENTS WITH PULMONARY FIBROSIS

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Background Pulmonary fibrosis is a chronic respiratory condition with a poor prognosis and significant symptom burden, yet has traditionally been managed purely by respiratory physicians. It was the experience in the Greater Manchester town of Wigan that many patients with pulmonary fibrosis were not recognised to be in the last year of life and often presented to and ultimately died in hospital during their final illness. There were missed opportunities for improving symptom control, advance care planning (ACP) and achievement of preferred place of death (PPD).

Methods A new service was established where a Palliative Medicine Consultant and clinical nurse specialist reviewed patients in a dedicated clinic running alongside the respiratory clinic. The monthly face to face clinic was complemented with a fortnightly telephone follow up clinic in-between. Symptom issues were addressed guided by Integrated Palliative care Outcome Scale (IPOS) completion, hand-held fans given out to help manage breathlessness, referrals considered to the local AHP-run palliative care out-patient centre and ACP and PPD discussed and recorded.

Results Since December 2017, to date 36 patients with Pulmonary Fibrosis have been referred to the clinic. Three patients died prior to review. Of the 33 who have been assessed, 9 remain under active follow-up, 6 have been discharged to community palliative care services, 1 back to GP and 17 have died. Advance care planning was initiated in 26 patients (79%) and completed in 18 (55%). Of the 17 patients that died, all but two died out of hospital (88%), 11 in their own home/nursing home and 4 in hospice, significantly greater than national averages for non-malignant conditions.

Conclusion The development of a hospital-based dedicated palliative medicine clinic for patients with Pulmonary Fibrosis has resulted in a majority of out-of-hospital deaths for this group of patients.

112 SURVEYING THE USERS OF AN OPEN-ACCESS SUPPORT SERVICE FOR PEOPLE AFFECTED BY AN ILLNESS THAT HAS NO CURE

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Background In the UK, palliative care is a growing specialty; however, national inequalities in access to services persist. Those who are male, older, more deprived, belong to ethnic minority groups and have non-malignant disease are relatively