

screening discussed, suggesting there is a key role for palliative care in this aspect of patient and family support. Further work will now be undertaken with the regional genetics team related to referral criteria and process.

### 132 IMPLEMENTATION AND EVALUATION OF A PALLIATIVE CARE INPATIENT UNIT'S DELIRIUM GUIDELINES: A SERVICE IMPROVEMENT PROJECT

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**Background** Delirium is characterised by acute onset of fluctuating confusion and altered conscious level. It is common in palliative patients and associated with worse outcomes. Recognition and management of delirium is poorly supported in palliative care inpatient units.

**Aim** To produce a sustainable improvement in prevention, recognition and management of delirium in St. Gemma's Hospice Inpatient Unit, Leeds.

**Methods** This mixed-method service improvement project uses a behaviour change and normalisation-process theory based approach formed of three evaluation and two implementation stages. The evaluation stages use a mixed-methods approach to gather data from several sources:

- Retrospective case note audit
- Staff survey
- Staff interviews

The first implementation stage modified the delirium guidelines including:

- Introduction of the 4AT rapid clinical test for delirium.
- Delirium severity assessment replaced by agitation assessment, using the Richmond Agitation–Sedation Scale for palliative care inpatients (RASS–PAL).

Members of staff were appointed as 'delirium champions' to address sustainability and ongoing training. The second implementation stage will design and implement a behaviour change intervention:

- Data from evaluation sources will be collated to identify behaviours to be targeted.
- The delirium guidelines and strategies for its implementation will be modified using behaviour change techniques.

**Results** In the first evaluation stage 77 patient admissions were audited. 58 delirium episodes were retrospectively identified, of which 19% were diagnosed during admission. 27% of admitted patients were screened for delirium. No patients were risk assessed for delirium and no delirium prevention measures were taken. 17% of delirium episodes had appropriate non-pharmacological management while 88% received pharmacological management as per guideline.

**Conclusion** This baseline audit shows that prevention, recognition and management of delirium is poorly conducted. The first implementation phase has completed, and the second evaluation stage is in progress. I anticipate results from this phase will be available to present at The Palliative Care Congress.

### 133 DIALYSIS AND END OF LIFE: AN ANALYSIS OF COMMUNICATION AND OUTCOMES ACROSS HOSPITAL AND COMMUNITY SETTINGS

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**Background** The aim of the Renal Supportive Care Register (RSCR) at Birmingham Heartlands Hospital is to identify patients who are requiring dialysis with a prognosis of less than 12 months. This project aims to explore whether patients were identified appropriately on the RSCR and if advance care planning took place.

**Methods** We reviewed the inpatient and outpatient consultations of patients who died whilst listed on the RSCR between 2016 and 2018. We recorded the dates when patients were added to the RSCR and when they died. We reviewed conversations around dialysis withdrawal and events at the end of life.

**Results** There were 80 deaths on the RSCR in the 3 year period. 88% of patients were listed on the RSCR within 12 months of death; 69% of these were listed on the day they died. 38% of patients were offered a conversation on withdrawal of dialysis; 70% of these then opted to withdraw. Cited reasons for continuing dialysis were families' refusal to accept palliation and denial. 87% had valid Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. 2 patients who did not have DNACPR forms received CPR (without return of spontaneous circulation) on the day of their death in hospital. Preferred place of death (PPD) was established in 20% of patients. 21% were referred to the hospital palliative care team, often to help achieve PPD. 15% on the RSCR were known to their local community palliative care teams.

**Conclusions** Our data suggests that the deterioration and deaths of these patients may have been unexpected or unrecognised. Our work particularly suggests that patients' families put up barriers during conversations around withdrawal of dialysis. PPD was rarely discussed in our patient cohort. The majority of our patients died in the hospital setting, often without being known to community palliative care.

### 134 USE OF NALOXEGOL FOR THE MANAGEMENT OF OPIOID INDUCED CONSTIPATION IN AN INPATIENT CARE UNIT OVER 12 MONTHS: A RETROSPECTIVE CASE NOTE ANALYSIS

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**Background** Opioid induced constipation (OIC) affects approximately 40% of people taking opioids and is a cause of significant morbidity. Naloxegol is a peripherally acting mu-opioid receptor antagonist used in people who have had an inadequate response to laxative treatment. Most evidence for its use is in patients with non-malignant chronic pain with opioid induced constipation and there is little data for its use in palliative care. The aim of this project is to evaluate the use of naloxegol in people receiving inpatient specialist palliative care.