needed to explore the interactions between patient, carer and clinician perceptions of non-medical devices and, ultimately whether this influences the benefits for patient self-management of chronic breathlessness.

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IMPROVING THE IDENTIFICATION AND MANAGEMENT OF CONSTIPATION ON THE PALLIATIVE CARE UNIT, WANSBECK GENERAL HOSPITAL

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Background In 2020 the palliative care team at the inpatient palliative care unit at Wansbeck General Hospital identified the notable burden of constipation on patients, and the barrier to symptom improvement it caused. Our team designed a quality improvement project to identify and tackle this issue.

Aims Our team aimed to assess the documentation, identification and management of constipation on the unit. This was undertaken via¹ instigating health care education, and (2) developing a patient information leaflet to empower patient's control of constipation.

Methods A 8 month QI project was undertaken on the unit, assessing the written and NerveCentre, and documentation of bowels, prior to and following the instigation of staff education and patient leaflets, promoting patient lead documentation of their constipation. This project followed several PDSA cycles and identified an initial absence of patient perception of autonomy over constipation, as well as prescriber's limited knowledge of the regional guidance. The data from the measures gathered continuously using an electronic pro forma, with alternations following each cycle with further staff and patient education, and alternations to the language of the leaflets. A flow chart was generated following the measures indicating response to intervention.

Conclusion The prevalence of overall constipation halved from 46 to 22%, with an increase on the NerveCentre documentation of 19%. In those for whom constipation was appropriately identified 100% used the regional guidance to manage this. It was noted however that following the initial spike of identification of constipation this deteriorated after the change was instigated, demonstrating the need for on-going education to both patients and staff.

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WHAT ENABLES AND CONSTRAINS SHARED DECISION-MAKING ABOUT OPIATES FOR PEOPLE LIVING WITH CHRONIC BREATHLESSNESS? A SYSTEMATIC NARRATIVE REVIEW AND FRAMEWORK ANALYSIS OF PUBLISHED DATA USING A PROGRAM THEORY OF SHARED DECISION-MAKING

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Background Despite the evidence supporting the use of opioids to manage chronic breathlessness, these are rarely prescribed, indicating the need for enhanced SDM in this field. The Waldron 2020 SDM program theory explores the relationship between various factors in patients' and healthcare

professionals' (HCPs) engagement in SDM. This systematic narrative literature review assesses enablers and constraints of SDM in the prescription of opioids for chronic breathlessness and evaluates whether the Waldron's SDM program theory can explain the operation of these factors.

Methods A literature search was conducted on Medline, Embase, PsychInfo, Cochrane Database of Systematic Reviews, CINAHL, Scopus, and Web of Science (1946 – June 2020). Studies were selected if they took place in Europe, Canada, or Oceania, and addressed an element present in decision making for the management of chronic breathlessness with opioids. Thematic analysis identified patient and HCP factors involved in the prescribing of opioids for chronic breathlessness. Their effect on SDM was assessed using Waldron's SDM programme theory.

Results Six themes were identified: concerns with side effects, knowledge of opioid use for breathlessness, acceptability, prior experiences, awareness of symptom severity, and system support. HCPs were reported to have more negative attitudes towards opioid use for breathlessness, particularly in the context of COPD, than patients. HCP's support by the MDT improved engagement in SDM. Open, clear communication addressing patients' questions and concerns, alongside HCP's revisiting of the discussion enabled SDM. A simple change in attitude from either the patient or HCP could be determining to increasing engagement with SDM.

Conclusions Research is scarce on SDM in opioid prescription for breathlessness. Limitations include the lack of quality appraisal of evidence. The Waldron SDM program theory appropriately supports SDM in this context. This review informs patient-centred care on management of chronic breathlessness with opioids through SDM, and highlights gaps in the literature.

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BALANCING PATIENT BENEFIT AND RISK OF RESISTANCE: AN AUDIT OF HOSPICE ANTIMICROBIAL PRESCRIBING

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Background Antimicrobial stewardship aims to improve the safety and quality of patient care and reduce the risk of antimicrobial resistance. Symptoms of infection are often part of the natural deterioration towards end of life. Clinical evidence for the benefit of antimicrobials at the end-of-life is scarce and results inconclusive. Within our hospice, our aim of prescribing effectively whilst observing the principles of advance care planning led to an audit of practice as part of our antimicrobial stewardship.

Methods A retrospective audit was completed of all patients admitted over 3 months, where antimicrobials had been prescribed, considering; whether antimicrobials were prescribed in accordance with local trust guidelines; presence of indication, review and stop dates on each prescription and whether advance discussions were documented in relation to the use of antimicrobials.

Results Of 56 admissions identified, 23 (41%) patients had 37 individual antimicrobials prescribed. The commonest sources of infection were chest (18), urinary tract (4), skin and soft tissue (4).

Adherence to local trust guidance was evident with regards choice of antimicrobial in 59%. The indication was recorded on the drug chart in 100%, with a review date in 35% and a stop date in 86%.

Advance discussions relating to antimicrobial treatment were documented in 48%. Seventeen patients died during the admission; the average time between stopping antimicrobials and death was 8 days.

Conclusions This audit highlights the importance of accessing updated guidelines which ensure appropriate prescribing whilst considering local resistance patterns. Alongside a drive to raise awareness, an advance care planning template was implemented for all patients, to record discussions and guide decision making when indications of infection arise. The continuing challenge lies in identifying patients who will benefit from the right antimicrobial and those for whom there will be minimal benefit, but could contribute to increasing antimicrobial resistance.

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MEASURING SERUM-ASCITES ALBUMIN GRADIENT TO OPTIMIZE MANAGEMENT OF ASCITES IN A HOSPICE SETTING

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10.1136/spcare-2021-PCC.148

Background Paracentesis for management of ascites is frequently performed in hospices. Serum-ascites albumin gradient (SAAG) should be measured to guide management. Patients with ascites caused by portal hypertension have a SAAG 11 g/L. Usual management is to:

- give human albumin solution (HAS) for renal-protective effects
- prescribe spironolactone to reduce re-accumulation of ascites

This practice is established in the management of portal hypertension due to cirrhosis. However, the incidence of portal hypertension in patients requiring paracentesis for malignant ascites is unknown.

Methods In 2019 guidelines were written to ensure SAAG was checked for patients admitted to the hospice for paracentesis. These guidelines were audited in 2020. The audit covered an 11-month period, looking at whether SAAG was available pre-procedure, and whether HAS and spironolactone were given.

Results 25 drains were inserted in 12 different patients. 100% of these patients had SAAG calculated.

67% (n=8) received HAS. 50% of this group (n=4) had a diagnosis of cirrhosis, and 50% (n=4) had metastatic malignancy. 3 of the patients given HAS were already on spironolactone, 3 were started on it post procedure (these were patients with malignant ascites), and 1 had their dose increased.

4 patients with malignant ascites received HAS and 3 were started on spironolactone.

Conclusions Measuring SAAG demonstrated cases of malignant ascites associated with portal hypertension. This led to a change in management with increased use of HAS and spironolactone in patients with malignant ascites. All patients undergoing abdominal paracentesis should have SAAG recorded and used to determine appropriate use of HAS and spironolactone.

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MYOTONIC DYSTROPHY: THE INTERFACE WITH PALLIATIVE MEDICINE, A SERIES OF CASES

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Background Myotonic Dystrophy (DM) is a multi-system disease that affects muscle function. DM is the most common muscular dystrophy occurring in adulthood and the prevalence is around 10 cases per 100,000. There are two distinct forms Type 1 and Type 2. DM predominantly causes weakness of the voluntary muscles but involuntary muscles can also be affected. As the disease progresses respiratory, cardiac and gastrointestinal symptoms can arise. Despite treatment options for management of complications, DM remains a progressive life limiting condition. Severn Hospice is now affiliated with Robert Jones Agnes Hunt Hospital in Oswestry to provide a symptom control clinic for DM patients; something that is not routinely done nationally. Palliative Care should be involved early in the diagnosis to allow more effective symptom control and discussions around Advance Care Planning.

Methods & Results We collated the data for the 5 patients with a DM diagnosis that were referred to Severn Hospice and/or joint symptom control clinics. All 5 patients were assessed for symptoms that included but were not limited to: breathlessness, pain, dysphagia and low mood. 3/5 patients are still alive and have ongoing support. We coordinated referrals to other specialities including PEG/Respiratory teams for ongoing assessment. 1 patient was admitted to the inpatient unit which allowed for symptoms to be optimised and Advance Care Planning to occur.

Conclusions The role of Palliative Care in the management of DM patients is paramount and early involvement in the disease trajectory is optimal for improving symptom control and providing opportunities for advance care planning relating to specific complications, e.g. cardiac arrhythmias/feeding tube insertion/respiratory support. Clinical guidelines for the role of Palliative Care in DM are limited, despite the fact it is a life limiting illness. This has prompted a focus group who are looking to put together some National Guidance moving forwards.

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DO ANTIBIOTICS IMPROVE THE IPOS REPORTED BURDEN OF SYMPTOMS OF PAIN, BREATHLESSNESS AND CONFUSION?

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Introduction The Integrated Palliative Care Outcome Scale (IPOS) offers potential to measure outcomes of palliative care interventions.¹ Antibiotics are commonly given for symptomatic relief in hospices but the evidence base is weak, supported typically from the perceived improvement in symptoms as judged by healthcare professionals.²⁻⁵ IPOS adds the patient's voice to this debate.

Methods A retrospective notes review of 31 inpatients at 2 hospices in Northamptonshire from 20/17/19 to 20/11/19