Radiologist. Over the course of 16 days, 21 litres was drained with reduction in abdominal distension and leg oedema; her mobility and quality of life improved. To support management at home, Ms X's mother learned to perform the drainage independently. Bloods were monitored weekly and she was readmitted for IV albumin when blood albumin fell to 22 g/l.

The volume of ascites drained gradually reduced to nothing and the drain was removed due to concerns about infection after sepsis developed. The ascites did not recur and Ms X had no further admissions for decompensation of CCF. She died at home 10 weeks after the drain removal.

Conclusion Permanent ascitic drain insertion can reduce diuretic use and frequency of decompensations in patients with large volume cardiac ascites.

135 THE USE OF OPIOIDS IN SYRINGE DRIVERS: AN AUDIT ACROSS 2 SPECIALIST PALLIATIVE CARE SERVICES IN THE EAST MIDLANDS REGION

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Background There has been a recent increase in concern regarding the use of opioid medications in syringe drivers following the publicised report of the Gosport Inquiry, 2018. In our own clinical practice we have seen an increased anxiety and caution regarding syringe drivers, particularly in the community.

Aim To identify the average starting dose of opioids in syringe drivers for patients known to the Specialist Palliative Care Teams (SPC) across three settings; hospice, hospital and community. John Eastwood Hospice, Mansfield was the initial site in 2018 and a similar audit was conducted at Royal Derby Hospital in 2019.

Standards Our standards were taken from a number of sources, including the Palliative Care Formulary. For patients already on opioids, total daily dose should be appropriately converted to the opioid being used in the driver; for an opioid naïve patient, 10–20 mg morphine is suggested. Clinical judgement based on the patient's individual needs is vital.

Method Patients commenced on a syringe driver with an opioid across a 2-month period were identified; retrospectively in Mansfield, prospectively in Derby. Retrospective case note review was carried out using electronic and/or paper records.

Results The average (mean) starting dose of opioid in a syringe driver (morphine subcutaneous equivalent) prescribed or advised by SPC was 27 mg (range 2.5 mg–160 mg) in Mansfield, 21 mg (range 3.75 mg–80 mg) in Derby. All patients had a documented indication for both the use of an opioid and use of a syringe driver. Doses used were comparable to opioid use in the preceding 24 hours.

Conclusions The results from these audits are reassuring; demonstrating that when opioids in syringe drivers are used, the indication is considered, doses used are small compared to standards, and in the majority it is beneficial. The results between sites were similar, suggesting that practice is consistent across different areas of the region.

136 A REVIEW OF THE USE OF MUCOLYTIC AGENTS IN MOTOR NEURONE DISEASE (MND). IS THERE BENEFIT TO USING MULTIPLE AGENTS OVER MONO-THERAPY?

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Background/Aims In MND, progressive bulbar and diaphragmatic weakness cause weak cough and difficulty expectorating. This can cause difficulty in managing the amount of saliva produced, which can lead to sore skin, wet clothes, embarrassment and precipitation of choking episodes. Thicker sputum can compound this issue. Mucolytics can be useful here, however guidelines for their use tend to be based around anecdotal experience rather than using higher level evidence. This particularly applies to the use of multiple mucolytics. We aimed to learn more about the benefits and harms of multiple mucolytic therapy versus single mucolytic therapy in MND. We hoped to develop a guideline outlining when each, or multiple, agents are appropriate in MND.

Methods We reviewed the notes of all patients with MND under the care of a Shropshire Palliative Care Team over a one year period and identified those on multiple mucolytic therapy. We noted outcomes of symptom improvement and side effects reported following initiation of multiple mucolytic therapy.

Results Of 64 patients identified, 32 patients required mucolytic therapy, with 31/32 being started on Carbocisteine initially. Of these, 12/32(37.5%) went on to receive multiple mucolytics. Symptom improvement was reported in 2/12 (16.67%) with multiple mucolytic therapy - in both cases the benefit followed the addition of Erdosteine. Worsening of symptoms was reported in 1/12(8.33%) patients. In 9/12(75%) patients, there was either no symptom improvement or no data describing outcomes.

Conclusions In most patients receiving multiple mucolytic there was either no symptom improvement or no recorded evidence of outcome. Where multiple mucolytic therapy is used, Erdosteine may be the most effective second line agent, however larger numbers are needed to determine this. Prospective research to collect outcome data to assess the effect of mucolytic therapy in a wider cohort of patients with MND would be useful in ascertaining more definitive conclusions.

137 IMPROVING SAFETY OF OPIOID PRESCRIBING AND ADMINISTRATION ON A HOSPICE INPATIENT UNIT (IPU)

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Introduction Opioids are commonly used drugs in palliative care, in both healthcare and community settings. The risk for harm from these drugs means that they are subject to additional regulations and good prescribing practice should be followed. NICE guidance on safe prescribing practice recommends that decimal points should be avoided. There should be consideration that palliative care patients often have a significant tablet burden and there is increased risk for error

when multiple tablets are needed to supply the prescribed dose. We completed a quality improvement project to improve opiate prescribing and administration safety on the IPU.

Method We created two aide memoire charts to encourage safer prescriptions of opioids. These provided guidance on whole number doses of immediate release (I/R) opioids with corresponding easily measured volumes and doses of modified release (M/R) opioids which could be provided by the smallest number of tablets. We reviewed prescribing practices on the IPU before and after the introduction of each chart and education to the medical team.

Results Prior to the I/R opioid chart introduction 30% of I/R opioid dose prescriptions had an avoidable decimal point and 40% of corresponding volumes were not easily measured. This improved to 6% and 20% respectively after the interventions. Prior to the M/R chart introduction 55% of M/R opioid prescriptions required 2 or more tablets to supply the required dose. After the interventions there was a moderate improvement with 45% requiring 2 or more tablets.

Conclusion There was improvement in I/R and M/R opioid prescribing practice following the introduction of the aide memoire charts and education to the medical team. More education to medical staff around the use of the charts is required to see a continued improvement in prescribing practices on the IPU.

138

THE USE AND PRESCRIBING OF OPIOIDS, BENZODIAZEPINES AND ANTIPSYCHOTICS IN SYRINGE PUMPS

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Background The Gosport independent panel reviewed 2024 deaths that occurred at The Gosport War Memorial Hospital between 1986 to 2001. According to the report, patient's families had raised concerns regarding the use of opioids and syringe drivers. Families felt that their loved ones had been given opioids and started on syringe drivers without a clear indication. These findings caused concern amongst patients and families around the use of opioids and syringe pumps. Opioids, antipsychotics and benzodiazepines play a fundamental role in symptom alleviation in palliative care and patients at the end of life. We have conducted a review of prescribing practice of opioids, antipsychotics and benzodiazepines via syringe pumps in patients under a specialist palliative care team in different care settings.

Method We looked into the indication of using opioids, benzodiazepines and antipsychotics in a syringe pump. We collected data on initial starting doses, prescription of dose ranges and dose escalations. This was a retrospective survey of patient medical records carried out at multiple centres in the North West of England including hospital, hospice and community settings. The participating organisations completed an online questionnaire.

Results We had a total of 267 responses. In the majority of cases, indications for syringe pumps were discussed and

documented. Different prescribing practices were observed with regards to starting doses of medications, dose ranges and dose escalations. 5 mg of morphine (or dose equivalent) was the most common starting dose giving via a syringe pump in patients who were opioids naïve. 5 mg of midazolam was the most frequent dose prescribed initially in a syringe pump. Levomepromazine was the most frequent prescribed antipsychotic.

Conclusions This project has generated a vast amount of data. Further scooping exercise is needed to review practice in cases where specialist palliative care teams are not involved.

Posters 139 – 140 | Transition

139

CLINICAL LEARNING FROM A TRANSITION SERVICE

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Introduction This study is part of a wider evaluation of a pilot to improve the experience of young adults with life-limiting conditions as they transition to adult services. The project was funded by Together for Short Lives. We developed a multidisciplinary outpatient clinic supporting young people aged 16–25 with life-limiting conditions, based in an adult hospice. Adult palliative care multidisciplinary teams (MDT) have many of the transferable skills and resources required to meet the needs of young adults with life-limiting conditions. By exploring the clinical needs encountered by the team in this project, we hope to improve palliative clinicians' confidence in their ability to meet those needs, and to highlight areas where practice may need to be adapted or developed.

Methods The Transition Team recorded in-depth team reflections around activity and learning over a period of 12 months between March 2019 and March 2020. The reflections concerning all clinical interactions with 7 patients were collated and analysed for themes. The themes were then developed alongside literature and expert opinion to form recommendations for other adult palliative care teams who wish to support young adults.

Results Overall, three major themes were identified from the team reflections: Clinical learning, Carer support, and Relationships with other clinicians.

The subthemes within clinical learning were:

- Role in identifying unmet needs and signposting to other services
- Identifying dying in patients with long term disability
- Safe management of complex symptoms when multiple teams are involved
- Anticipatory care planning.

Recommendations were developed highlighting areas where additional training and research are needed as well as areas to prioritise in service development.

Conclusions Reflecting on clinical interactions with young adults with life-limiting conditions enabled the project team to identify priorities for learning and further development of services for this patient group.