2. Delirium screen in 100% of patients with abnormal cognition
3. If screening is deemed inappropriate, it should be documented in 100% of patients

**Results** In total 55 inpatient admissions were reviewed, with delirium developing in 53% of this population. A formal cognitive assessment was undertaken in 17% of patients however 85% of patients subjectively required assessment for confusion. No patients underwent a formal delirium screen or documentation to this effect. Of those individuals with documented confusion, 87% subsequently developed delirium. In those with subjective confusion but not documented 71% developed delirium. A total of 35% of patients developed delirium in whom subjective confusion was negative.

**Conclusion/Lessons Learned** Despite the presence of impaired cognition in significant numbers, formal assessment of delirium is not routine practice. It is evident that formal assessment is likely to unveil an underlying cognitive impairment process and facilitate early intervention. We have subsequently delivered multidisciplinary education and implemented a management pathway to reduce the burden of delirium in our inpatient unit. We plan to reaudit effectiveness in the coming months.

## P-126 THE HAEMATOLOGICAL RESPONSE TO IRON INFUSION IN PALLIATIVE CARE PATIENTS WITH ANAEMIA

Amy Wood, Jane Whitehurst. *St Barnabas House Hospice*

10.1136/spcare-2022-SCPSC.147

Response to intravenous iron in a hospice population with anaemia

**Background** St Barnabas House provides intravenous iron (IVI) to patients with symptomatic iron deficiency anaemia (IDA). Interpreting iron studies is difficult; colleagues expressed concern they might miss IDA when combined with anaemia of chronic disease (ACD). Ferritin, typically low in IDA, is raised in malignancy. Low iron levels are unhelpful as occur in both IDA and ACD; total iron binding capacity (TIBC) and MCV can be used in diagnosis. We reviewed the notes of 16 patients who received IVI for presumed IDA over 12 months to assess type of anaemia and outcome.

**Method** We determined type of anaemia according to the following criteria - IDA: ferritin <30 mcg/l or TIBC >70; ACD: ferritin ≥30 + TIBC ≤ 70 + MCV ≥80; Mixed: ferritin ≥30 + TIBC ≤ 70 + MCV <80fl. Response was measured by an increase in Hb ≥ 5 g/dl/month and subjective symptom improvement.

**Results** Eight patients (50%) had IDA: Hb increase in 86% symptom benefit 43%. One patient had mixed IDA/ACD: Hb increase, no symptom benefit. Seven patients had ACD: Hb increase in 29% , symptom benefit 0%. 100% of patients experienced fatigue, 56% dyspnoea. 30% of patients died within 3 months of IVI.

**Conclusion** Defined criteria for cause of anaemia identifies patients most likely to benefit from IVI – those with haematological and biochemical markers of IDA. Patients with ACD had less benefit suggesting misplaced anxiety around missing mixed IDA and ACD. Collectively, less than 50% of patients had symptomatic benefit highlighting the multifactorial causes of fatigue, and dyspnoea and delay in response to IVI. This provides reassurance that defined diagnostic criteria enables access to IVI to those most likely to benefit whilst reducing non-beneficial interventions. Prognostic estimation should inform decision making as response to IVI can take several weeks.

## P-127 OUR RESPONSE TO GOSPORT INQURY: A PROSPECTIVE REVIEW OF OPIOID AND SEDATIVE PRESCRIBING

Shahlaa Walsh, Dola Awoyemi, Angela Halley. *The Royal Marsden NHS Foundation Trust*

10.1136/spcare-2022-SCPSC.148

**Background** The Gosport Independent Panel found lives had been shortened over an 11-year period at Gosport Memorial Hospital due to high or inappropriately prescribed opioids. Recommendations for safe prescribing of opioids via continuous subcutaneous infusions (CSCI) were implemented as a result. Symptom control and palliative care team (SCPCT) conducted an audit evaluating all CSCI with opioids or sedatives prescribed for inpatients and on discharge within a Specialist Cancer centre to ensure they met the standards set by the Gosport Panel.

Standards:

- Clinical indication recorded
- CSCI dose ranges prescribed (outpatients only)
- Appropriate doses and drug combinations prescribed

Trust standards:

- Anticipatory ranges for discharge discussed with SPCT
- No inpatient ranges
- Prescribing opioids within trust guidelines

**Method** Prospective audit of inpatients with CSCI containing opioids or sedatives over an 8-week period, identified from SCPCT or pharmacy dispensing records.

**Results** 28 inpatients received strong opioids for pain (morphine n=17, oxycodone n=8, alfentanil n=3) and 4/28 (14%) patients were prescribed sedatives for terminal agitation. The doses prescribed were appropriate for the clinical situation except in one case where a higher opioid dose was prescribed without discussing with SCPCT. Most patients (22/28, 78%) had a dose titration in line with their changing clinical condition. Doses were increased by 30–50% (n=22), <30% (n=2), and > 50% (n=2). 4 patients were discharged with pan-London MAAR charts for anticipatory CSCI and subcutaneous PRNs. 1/4 had a dose range prescribed by SCPCT. All charts had appropriate clinical indications for prescribed opioids and sedatives, however PRNs were prescribed with a shorter interval than recommended within guidelines.

**Conclusions** All inpatients were prescribed appropriate doses of CSCI opioids and sedatives for their clinical indication in line with Gosport recommendations. 30–50% dose titration was common but within the highlighted standards. Improvement in discharge prescription for PRN medication was highlighted & fed back to prescribers.