P-128 IMPLEMENTATION AND EVALUATION OF A PALLIATIVE CARE INPATIENT UNIT'S DELIRIUM GUIDELINES: A SERVICE IMPROVEMENT PROJECT

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Introduction 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 units. I aimed to produce sustainable improvement in delirium care in an in-patient hospice unit.

Methods This service improvement project used a behaviour change Theoretical Domain Framework and Normalisation Process Theory based approach comprising one intervention stage and two evaluation stages, and co-design of a refined intervention. I used a mixed-methods evaluation to gather data from: case-note review, staff surveys and interviews.

The first intervention modified existing delirium guidelines, replacing the screening test with the 4AT and simplifying the symptom severity assessment. I integrated the guidelines into the electronic patient record system and appointed 'delirium champions' for sustainability. The second intervention was co-designed using a theory-led approach targeting barriers and facilitators to guideline implementation and focussing on sustainability. Feasibility was evaluated using the APEASE criteria (Acceptability, Practicability, Effectiveness, Affordability, Side-effects, Equity).

Results The first intervention delivered an improvement in delirium episodes diagnosed (19% to 39%), receiving systematic assessment of reversible causes (33% to 52%) and managed appropriately with non-pharmacological interventions (17% to 59%). Where risk assessment was conducted, 89% of patients were at high-risk. The co-design developed an intervention focussing on a hospice-wide 'delirium-friendly' environment, and the importance of 4AT screening as the pathway to guideline-adherent delirium care. Many elements are applicable to other palliative care inpatient settings.

Conclusion A theory-driven approach to complex intervention design and implementation is feasible in a hospice setting. Given the high-risk for delirium in hospice in-patients, focussing on applying delirium risk reduction strategies to all seems appropriate. Delirium screening appears to be a 'gateway' component of delirium care, facilitating delirium recognition and guideline-adherent delirium management.

P-129 END OF LIFE DRUG PRESCRIBING IN PALLIATIVE CARE: WESSEX REGIONAL BENCHMARKING PROJECT

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Background The CQC recommends palliative care units benchmark their controlled drug prescribing against similar units. We gathered prescribing data across Wessex to enable units to meet this aim, as well as comparing prescribing of other common end of life drugs.

Methods We collected data on the first ten deaths to occur in January 2021 from specialist palliative care units (SPCUs) and hospital palliative care teams (HPCTs) across Wiltshire, Dorset and Hampshire. Data was collected from two time points (24 hours and 5 days before death) concerning the prescribing of opioids, benzodiazepines, adjuvant analgesics and other anxiolytics.

Results 21 units participated: 8 HPCTs and 12 SPCUs. Data for 210 patients 24 hours before death and 144 patients 5 days before death. 73% of patients on regular opioid 24 hours before death (39% under HPCT, 88% SPCU, 82% community), oral morphine equivalent dose range 10–800 mg, mean dose 88 mg (69 mg HPCT, 99 mg SPCU). 59% on regular benzodiazepine 24 hours before death (35% under HPCT, 76% SPCU, 55% community), midazolam equivalent dose range 5–70 mg, mean dose 17.8 mg (15.2 mg HPCT, 18.3 mg SPCU). 34% of patients received Levomepromazine in the 24 hours before death (20% under HPCT, 43% SPCU) and 6% Haloperidol. 19% of patients received adjuvant analgesics 24 hours before death, compared to 27% five days before.

Conclusion This project enabled the participating units to meet the CQC recommendation. It highlighted wide variation amongst prescribing at the end of life; possible explanations for this include differences between specialist and generalist settings in terms of staff experience and patient cohort. We acknowledge the limitations of our small sample size and the possible influence of COVID-19. It may be helpful in future to repeat with larger numbers in order to draw more generalisable conclusions about end of life prescribing.

P-130 CLINICAL AND ECONOMIC EVALUATION OF SOMATOSTATIN DEPOT TO SUPPORT SYMPTOM MANAGEMENT IN PALLIATIVE CARE

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Background Somatostatin analogues such as Octreotide are used in Palliative care to support symptom management as an anti-secretory agent in the context of malignant bowel obstruction. This is usually given via a continuous subcutaneous infusion over 24 hours. There are also depot preparations available, however locally these haven't been used in this context.

Methods We reviewed the clinical effectiveness and financial cost of using somatostatin analogue depots in two patients known to the Coventry Community Palliative Care team.

Results Two patients received somatostatin analogue depots over a three month period, with prior titration of an Octreotide syringe driver for three months. Both patients had requested other ways to manage their symptoms other than a syringe driver. The indications were for malignant bowel obstruction and management of immunotherapy related diarrhoea. A 20 mg octreotide depot provided clinically significant benefit in management of immunotherapy related diarrhoea and improvement of symptom control beyond that of the syringe driver. Which provided increased freedom and quality of life. A 60 mg Lanreotide depot was administered which