variations in the wastage costs of individual drugs; Haloperidol and Cyclizine contributed 49% of the total wastage costs. Conclusion The prescription and wastage costs of anticipatory medications are higher than previously estimated but remain modest. Usage of prescriptions is lower than previously expected. There may be scope to reduce the quantity of drug vials that are routinely prescribed without adversely affecting care; prospective clinical trials are needed to explore this possibility.

**167 CLINICIANS’ PERSPECTIVES ON MORPHINE USE IN CHRONIC BREATHLESSNESS: FINDINGS FROM AN IMPLEMENTATION SURVEY**

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Background Morphine may help people with chronic breathlessness. This sub-study investigates clinicians’ perspectives on morphine use as part of the Morphine And BrEathLessness (MABEL) trial to assess the effectiveness and cost-effectiveness of morphine in chronic breathlessness.

Method Mixed-methods study using Normalisation Process Theory to organise data collection and analysis of clinicians’ perspectives on morphine use for chronic breathlessness. Clinicians completed two surveys: 1. Learning Needs Assessment (LNA) survey; 2. Modified Normalisation Measurement instrument (NoMAD) at two time-points (immediately and four months post-training) to identify implementation barriers and facilitators.

Results 59 clinicians were recruited from 12 sites, (28 doctors; 22 non-prescriber nurses; 6 prescriber nurses; 3 other healthcare professionals; 90% hospital-based; 74% female; years of experience 1 to >15 years). 1. LNA survey. More than two-thirds of clinicians strongly agreed, agreed, or somewhat agreed they had learning needs about using morphine for chronic breathlessness. 2. NoMAD 1. 93% saw the potential value of morphine for breathlessness and drive appropriate use of it. However, only one third agreed that sufficient staff training and resources were available to support use of morphine for breathlessness in practice. NoMAD 2 showed a small increase in the proportion agreeing that the intervention was familiar and felt ‘normal’ compared to NoMAD 1 (70% to 85%).

Conclusion Clinicians recognise learning needs about the safe prescription and management of morphine for chronic breathlessness in practice. The potential value of morphine is recognised, but lack of training and resources are barriers to implementation.

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**168 CASE REPORT – HUNGRY FOR THE OPTIMAL REGIME: A PATIENT-DESIGNED METHOD TO WITHDRAW ARTIFICIAL FEEDING AT THE END OF LIFE**

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Background There is currently no defined approach for altering feed volume to withdraw artificial feeding when a patient with neurological disease requests it, at the end of their life.

Aims We present a patient-designed regime used to withdraw artificial feeding in the community, without the patient experiencing distressing symptoms of hunger, enabling peaceful death at home.

Case Study Description: A 58 year old man with Motor Neurone Disease chose to stop artificial feeding when his communication and movement were severely limited. The patient decided they no longer had quality of life and wanted to withdraw feed to allow natural death. At this stage they were receiving 1000mls of feed via PEG tube within 24 hours. The patient’s main concern was to avoid developing hunger and related pains. They chose to reduce their feed in 250ml per week stages, over a 4-week period. Their reasoning was due to a previous positive experience of reduction of feed by 250mls for symptom management of secretions. The patient felt this would be the least symptomatic approach to withdrawal.

Results No hunger was experienced during staged withdrawal. At the point when feed and fluids were stopped completely, the patient experienced some mild, intermittent hunger but was not distressed by it. Nausea and secretions occurred and were addressed with standard palliative approaches.

Conclusion This approach was effective for this patient, who only experienced mild symptoms of hunger; however, we cannot be certain it would be effective in all situations. There is currently no recognised guidance for withdrawal of artificial feeding in these circumstances. Given the relative infrequency of these cases, research on a large scale would allow collation of data to devise and develop the optimal regime. We feel it is important this can be facilitated in a patient’s home as well as in healthcare settings.
experiences/perceptions. This research was guided by Critical Realism philosophical approach, which helps to understand the causal mechanism of breathlessness in relation to complexity and stratified realities in study sample. Braun and Clarke’s reflective thematic analysis was used to frame study data.

**Results** Mean age was 56 (18–83). The sample consisted of 8 (40%) men and 12 (60%) women. Participants experienced daily breathlessness with exercise/basic activities. Fatigues, sleep problems, and stress/anxiety were other commonly reported symptoms associated with heart failure. Interconnected three themes were identified: Breathlessness evaluation (interconnected sub-themes: factor-related breathlessness, description, and impact of breathlessness), Breathlessness management (breathing exercise/resting, coping with emotional distress (to reduce stress), and retrospective/prospective life changes) and Needs for improving breathlessness management (psychological/emotional and family support).

**Conclusion** Breathlessness evaluation and management of participants vary by factor and its effects. Psychological support is needed for improving breathlessness management (psychological/emotional and family support).

**Implications for practice/research** Individual breathlessness (symptom) assessment is key to heart failure management to increase motivation for self-care continuity and reduce adverse outcomes.

**170 CLINICAL CHARACTERISTICS AND RISK FACTORS FOR DISTRESS AMONGST HOSPICE INPATIENTS NEEDING PHENOBARBITAL FOR DEEP SEDATION AT THE END OF LIFE: A SINGLE-SITE SERVICE EVALUATION**

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**Background** Terminal agitation is a common symptom in the last days of life which is usually manageable using standard measures. In rare circumstances, it’s necessary to use Phenobarbital. This service evaluation aimed to describe the characteristics of patients requiring Phenobarbital for management of terminal agitation in an inpatient palliative care unit between November 2019 and May 2022, with a specific focus on identifying potential risk factors for its use.

**Methods** Cases were identified by searching the unit’s controlled drug books for the selected period. Clinical notes were reviewed and relevant data entered onto a proforma. Risk factors for terminal distress were summarised numerically and thematically using accepted holistic assessment domains (physical, psychological, social/family and spiritual/existential) as a framework. For comparison, the clinical notes of a control sample (consecutive deaths where phenobarbital was not used from a random month in 2021) were also reviewed.

**Results** Phenobarbital was used in 21/813 deaths (2.6%), of which 20 sets of notes were reviewed. Mean (SD) age was 53.8 (15.1) in the Phenobarbital group compared to 73.9 (17.0) in the control group. 17/20 Phenobarbital cases (85%) had risk factors across 3 or more holistic domains compared to 4/30 controls (13%). Physical symptoms included refractory pain and breathlessness. Psychological factors included fear of dying or pain, severe anxiety and significant mental health co-morbidities. Spiritual/existential factors included lack of acceptance of prognosis or engagement in advance care planning and being ‘too young to die’. Social factors included complex family dynamics, high levels of anxiety, unrealistic expectations in family members and having younger children.

**Conclusions** The frequency of Phenobarbital use was consistent with previous reports. Patients requiring it had multiple risk factors for distress in comparison with the control group. Prospective studies are needed to further examine this relationship.

**171 SYMPTOMATIC IMPROVEMENT FOLLOWING INTRAVENOUS IRON IN MULTIMORBID PATIENTS WITH HEART FAILURE: OUTCOMES FROM AN INPATIENT HOSPICE**

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**Background** Clinical trials have demonstrated the symptomatic benefit of intravenous (IV) iron in iron-deficient patients with Heart Failure reduced Ejection Fraction (HFrEF) independent of haemoglobin. However, paucity in data exists regarding the optimal strategy and symptomatic benefit of IV iron in heart failure (HF) outside of trial settings in heterogeneous cohorts. We report our experience of IV iron in multimorbidity patients with end-stage HF.

**Methods** All patients receiving IV iron at our hospice between March 2020-June 2022 for HF were retrospectively identified. All HF subtypes were included. Data encompassing demographic, echocardiographic and haematological findings, medication history, symptomatology (NYHA Class and IPOS), and treatment events were analysed in SPSS v28.

**Results** 13 patients (female:male 1:1.6, mean age 84.0±8.3 years) underwent IV iron infusion for NYHA Class II–IV HF. 5/13 (38.5%) had HFrEF. All patients had at least two additional major comorbidities. The mean baseline haemoglobin was 110g/L (±18.5g/L) with a median baseline ferritin of 21.0ng/mL (range 7–431ng/mL). A significant rise in ferritin post-infusion was sustained to a median of 4.5 months (median post-infusion ferritin 104ng/mL (range 51–431ng/mL), p=0.012). Median pre-infusion IPOS scores were 3.0 for breathlessness and 3.0 for fatigue. Of the 8/13 patients who had received their infusion over six months ago, 4/8 (50%) had documented evidence of symptomatic benefit of whom 3/8 (37.5%) received a second infusion. There were no adverse events recorded.

**Conclusion** Although small, our experience highlights the symptomatic benefit and sustained use of IV iron in a multimorbidity palliative HF cohort, and the deliverability of this specific service in a real-world hospice setting.

**172 ’CAN SOMEBODY DO SOMETHING? …THERE MUST BE SOMEONE WHO CAN HELP? ’ RESULTS OF A SURVEY OF A REGIONAL MULTIDISCIPLINARY WORKING PARTY OF THE FUNDAMENTAL ASPECTS OF ASSESSMENT OF SALORRHOEA IN PATIENTS WITH PROGRESSIVE NEUROLOGICAL DISORDERS TO SUPPORT PERSONALISED CARE**

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