28 THE ETHNIC AND CULTURAL IMPACT ON DELIVERY OF PALLIATIVE CARE IN NEWHAM GENERAL HOSPITAL: A BRIEF REPORT

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Background Cultural beliefs and ethnicity can impact access to and delivery of palliative care. This includes the planning and communication of details surrounding end of life care such as advance care planning (ACP) and individualised end of life care plans, also known as compassionate care plans (CCP), in acutely deteriorating patients. Newham General Hospital (NGH) provides for a population with a significant ethnic minority. This study aims to investigate the quality of palliative care received by inpatients at NGH in their last days of life.

Methods This was a retrospective cohort study conducted in NGH. The study looked at patients admitted within 90 days of their deaths and the various aspects of palliative care received during their admission, including whether a palliative care referral was made, whether CCP was started and whether anticipatory medications were prescribed.

Results In this study, 56.3% of patients were from ethnic minorities. 99.6% of patients were reported to have palliative care needs during their admission. 98.5% of patients were referred to the palliative care team and 97.3% had anticipatory medications prescribed. However, only 53.2% of patients had a completed personalised CCP and only 6.13% had a completed urgent care plan (UCP), an electronic system sharing patients' ACP decisions with healthcare professionals across London.

Conclusions The vast majority of patients in this study were referred to the palliative care team, had discussions around ACP and anticipatory medications prescribed. However, this study highlighted important gaps in the form of poor uptake of personalised CCP and UCP documentation. Among patients in NGH, barriers to accessing palliative care could include language, religious or cultural beliefs surrounding death and lower health literacy. Further interventions to bridge this gap would minimise inappropriate admissions and treatment and improve quality of care for terminally ill patients.

Poster 29: Ethics

29 HOSPITAL ADMISSIONS TOWARDS THE END OF LIFE: AN ETHICAL EXPLORATION OF DECISION MAKING

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Decision making towards the end of life involves navigating and addressing the values, experiences, beliefs and fears of patients and their loved ones- more so than in other areas of medicine. This moral consideration of what we should do for an individual is largely uncontroversial but how it precisely translates into practice may be unclear. This presentation will focus on one aspect of ethical decision making at the end of life: whether or not a person should be admitted to hospital. It is important to consider the reality of situations where hospital admissions decisions are made, and this presentation will include case examples and empirical research to ensure our discussion is relevant. We speak from a commitment to the importance of empirical work within ethics.

We will consider two separate aspects of hospitalisation decisions:

1. Why do hospital admissions specifically deserve moral scrutiny? We will illustrate some of the potential hazards of end of life admissions and then focus on the concepts of uncertainty, risk and the extent to which we can know the preferences of others.

2. The role of the clinician as a moral agent: Here we will consider how clinicians may face competing moral commitments or judgements and how these could be navigated. Not all questions of what we should do involve conflict but may still require reflection. We will discuss how ethical frameworks may be suited to retrospectively frame a problem but that thinking of the clinician as a 'moral craftsman' may be more appropriate to proactively help them make difficult decisions.

This presentation covers work within a larger PhD project exploring the lived experience of hospital admissions decisions and what 'good' decision making in this context might look like.

Posters 30–31: Global palliative care

30 ACCESS TO OPIOIDS FOR PALLIATIVE CARE IN HUMANITARIAN SETTINGS: TWO CASE STUDIES OF MÉDECINS SANS FRONTIÈRES (MSF) EXPERIENCE IN INDIA AND BANGLADESH

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Background Alleviating suffering and preserving dignity are essential components of healthcare. Patients in need of palliative care often require opioid medication to relieve breathlessness and pain. However, lack of access to essential opioids, particularly morphine, remains a major challenge in low and middle-income countries (LMICs). This is notably critical in the humanitarian context. We conducted two case studies to identify the barriers to and facilitators of access to opioids, particularly morphine, for palliative care patients in humanitarian settings, while exploring humanitarian healthcare workers' perceptions and experiences with opioid use.

Methods Two case studies were carried out based on Médecins Sans Frontières (MSF) projects which integrated palliative care: advanced HIV care in Patna, Bihar, India, and paediatric and neonatal care in the refugee context, in Cox's Bazar, Bangladesh. Six semi-structured interviews were conducted with key MSF humanitarian healthcare workers. Interviews were conducted in English, video- and/or audio-recorded and transcribed verbatim. Transcripts were coded and analyzed using the grounded theory approach.

Results Several barriers impeding access to and use of essential opioids in palliative care were reported by the participants. These included: limited availability, accessibility obstacles, socio-cultural challenges such as low awareness and misconceptions, lack of healthcare providers' training on opioid use,

and burdensome regulatory processes. Most participants reported that clinical guidelines, familiarization with the use of opioids and interdisciplinary team working were important facilitators to opioid prescribing. Participants expressed the urgency for further educational and advocacy initiatives to improve access to essential opioids for patients requiring palliative care.

Conclusions Humanitarian healthcare workers face multiple challenges leading to inadequate access to opioid medication, which undermines effective palliative care delivery. Adequate training on the use of opioids and strong advocacy led by humanitarian organizations and the medical community are critical to improve access to these essential medicines for relief of pain and suffering.

31 A QUALITY IMPROVEMENT PROJECT TO ASSESS THE PROPORTION OF WASTE WHEN GIVING SUBCUTANEOUS MORPHINE DERIVATIVES

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Background To determine quantity of medication discarded when giving a subcutaneous controlled drug (CD). There are multiple reviews and pledges to reduce overprescribing of medications[1] and recognising the increasing prescribing of opioids in the UK.[2 3] There are limited reviews of the amount that is wasted from opening a vial and having to discard leftovers.

Method This data spans January 2023, collected from CD record books at Winchester Hospice, a 10 bed unit. It focused on subcutaneous morphine derivates including morphine (10 mg/ml, 20 mg/ml, 30 mg/ml), oxycodone (10 mg/ml, 20 mg/2 ml, 50 mg/ml), and alfentanil (2 mg/ml). The data recorded a patient pseudonym, the date and time of drug administration, whether medication was given as required (PRN) or as a continuous subcutaneous infusion (CSCI), the quantity given and discarded.

Results

- For PRN doses, more medication was wasted than given (60% of morphine 10 mg/ml, 70% oxycodone 10 mg/ml).
- There were multiple examples of repeat PRN's being given at the same dose over 24 hours.
- It was only once recorded that a PRN was administered and a CSCI set up at the same time using the same vial.
- Some medications are more expensive than others (i.e. morphine 20 mg/ml, £17 a vial)
- 23% of the value of morphine derivates used in the hospice was wasted (total value of morphine derivatives given totalled £315.89; total wasted totalled £95.92)

Action: This lead to:

- Discussions with pharmacy – 20 mg/ml morphine vials discontinued due to significant cost differences and reviews if smaller vial sizes would be available (none identified)
- Discussions with the palliative team – to ensure there is a range for PRN doses and to escalate these if required, to consider whether the patient requires a PRN when setting up a CSCI and to use the same vial if so, and for prescribers to consider cost and quantities being used when prescribing.

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Poster 32: Pain

32 PAIN CASE REPORT – REPEATED INTRATHECAL PHENOL NEUROLYSIS FOR CANCER PAIN

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Introduction Intrathecal phenol neurolysis is a treatment of last resort for specific refractory cancer pains. However, there is a paucity of evidence in the academic literature and no documented evidence of repeat injections on the same patient. We aim to present our experience and learning from repeat interventions (3) on the same patient in order to further the evidence base for medical professionals managing chronic pain in a palliative care setting.

Case The patient, a 51 year old male, had inoperable rectal cancer and a defunctioning colostomy. Before treatment he was a hospice inpatient receiving a daily equivalent of 1280 mg oral morphine and subcutaneous midazolam, only comfortable lying flat in the lateral position.

Methods Informed consent included risk of permanent incontinence and lower limb nerve damage. Injections one and three were carried out sitting using Entonox. Injection two was carried out in the left lateral position due to pain. 6% phenol and 0.5% contrast formed the injectate. We positioned the patient in the sitting position post procedure to allow for appropriate Injectate spread. We recorded pre and post intervention analgesic requirements, subjective benefit, complications, and time to return of symptoms.

Results Injections 1 and 3 had instant prolonged analgesic effects; daily morphine doses fell by 870 mg and 240 mg respectively. Injection 1 lead to a temporary left foot drop and permanent urinary catheterisation. Injection 2 had little effect.

Conclusions Intrathecal phenol neurolysis can be highly effective in treating refractory cancer pain. Observed side effects were both temporary and permanent. Pain may return, but safely repetition of the intervention is possible. Patient position is important, our lateral injection was ineffective. This case study is the first described report of repeated interventions on the same patient. It adds to the body of documented evidence supporting its use in a palliative setting.

Poster 33: Psychosocial

33 WHAT COMES NEXT? A REVIEW OF SPIRITUAL CARE PRACTICES WITHIN A HOSPITAL PALLIATIVE CARE TEAM

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Background Guidance suggests that spiritual care is vital to a holistic approach to end of life care and we wanted to assess