THE FREQUENCY AT WHICH DOSES AND DRUGS STRIVING TO REMAIN RESPONSIVE: A RETROSPECTIVE

Abstracts

51 were assessed as being chemically compatible after 48 hours at ambient temperatures (20–26°C). Midazolam appears to be drug at greatest risk of clinically significant chemical degradation. Microbiological stability was only reported for one combination.

Conclusions There is currently limited evidence for the physical, chemical and microbiological stability of solutions for continuous subcutaneous infusion over a period of 48 hours. More stability data is required before the use of 48 hour CSCIs can be evaluated for use within clinical practice.

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P-27 THE FREQUENCY AT WHICH DOSES AND DRUGS ADMINISTERED BY CSCIS ARE CHANGED: A SERVICE EVALUATION OF CLINICAL PRACTICE IN THE UNITED KINGDOM

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Background Continuous subcutaneous infusions (CSCIs) are an effective method of multiple drug administration in end of life care when the oral route is compromised. At present, currently available chemical and microbiological stability data limits the infusion time of a CSCI to a maximum of 24 hours. The ability to deliver prescribed medication by a continuous subcutaneous infusion (CSCI) over 48 hours may have numerous benefits in both patient care and health service resource utilisation.

Aim To gather data regarding the most frequently prescribed CSCI drug combinations and the frequency at which CSCI prescriptions are altered.

Design Prescription details of CSCIs containing a minimum of two drugs were collected by hospital pharmacists or members of palliative care teams at 10 Acute NHS Trusts on a daily basis for a minimum of 2 days, to a maximum of 7 days.

Setting/participants Anonymised CSCI prescription data were collected from an average of 50 patients at 10 Acute NHS Trusts in the United Kingdom.

Results and Conclusion Data collection is due for completion January 2017 and results will be presented.

Acknowledgements This project was funded through a grant issued by NHS Liverpool CCG.

REFERENCES

P-28 STAFF EXPERIENCES OF DELIRIUM IN THE HOSPICE SETTING


Background Delirium affects up to 88% of patients with advanced cancer and is associated with significant morbidity and mortality. Despite this it remains under recognised in hospice settings and the management is not always in line with national guidelines. This research study explores the views of staff nurses and healthcare assistants in hospices in order to identify underlying reasons for this.

Method Semi-structured qualitative interviews were conducted with registered nurses (12) and healthcare assistants (6) in three North-East England hospices. Data was analysed using interpretative phenomenological analysis.

Results The main themes to emerge were knowledge and management. Data highlight that knowledge of delirium is variable leading to uncertainty about what constitutes delirium in hospice inpatients with subsequent difficulties in management.

Subthemes in management include the emotional response evoked by caring for patients with delirium, ensuring patient safety within the hospice environment and staff perceptions about the appropriate place of care. Disparities in staff opinion are apparent between drug and non-drug approaches and there is also concern about the possible effects of medication.

Conclusion Results from three different hospices across the North East region consistently highlight similar barriers to the assessment and management of delirium. The data provides valuable insights which help to guide future staff education and multidisciplinary team working in order to improve the care of patients with delirium.

P-29 STRIVING TO REMAIN RESPONSIVE: A RETROSPECTIVE ANALYSIS OF LONGER LENGTHS OF STAY ON AN INPATIENT PALLIATIVE CARE UNIT

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Background Current UK agendas for end of life care advocate ‘timely specialist palliative care’ and ‘effective’ hospices that are ‘responsive to people’s needs’. Hospices need to maintain capacity for admissions, whilst facing increasing demands from a rapidly growing, multimorbid, complex population. Hospices cannot afford to accommodate protracted lengths of stay. We aimed to identify patient and service factors associated with hospice in-patient longer lengths of stay (LLOS), 21 days to enhance our ability to provide quality, effective and equitable care.

Methods Mixed methods: Retrospective cohort review of all LLOS admissions in 2015, analysing sociodemographic and disease variables contrasted against a retrospective case-control analysis of admissions totalling 7–20 days. This was
complemented by a retrospective case-control, thematic analysis of electronic patient records, to examine the patient journey throughout the duration of the hospice stay. Results LLOS admissions accounted for 23% (76) of admissions to our hospice in 2015 (2342 bed days), median stay 28 days, 55% female, median age 69 years, 96% (73 admissions) referred for symptom control. Admission outcome: 38% (29) of patients discharged, of which 59% (17) had a new care arrangement following their stay.

No significant findings when analysing the following against LLOS admissions and admission outcome: Patient age, gender, primary diagnosis, number of comorbidities, presence of formal social care support, and permanent residence.

Thematic analysis identified 4 overarching themes implicated in LLOS: Uncertainty, In-house interventions, clinical and social complexity. This analysis emphasised, in particular, the interplay between communicating and managing uncertainty and social complexity.

Conclusion Our results would suggest that there are no sociodemographic or disease factors associated with LLOS. Thematic analysis provides an alternative and successful method of service evaluation. Thematic results emphasise the need for research into managing complexity and uncertainty in addition to highlighting the fact that our growing capacity to provide in-house interventions comes, ultimately, at a cost to bed availability.

P-31 A RETROSPECTIVE AUDIT OF SURVIVAL DURATION IN PATIENTS WITH POOR PERFORMANCE STATUS RECEIVING SYSTEMIC ANTI-CANCER THERAPY AT MID YORKSHIRE NHS TRUST

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Background Research undertaken in patients with a cancer diagnosis and poor performance status (PS) has shown a lack of survival benefit or improved quality of life from chemotherapy. A review by the National Confidential Enquiry into Patient Outcome and Death found that poor PS was linked to an increased rate of death within 30 days of systemic anti-cancer therapy (SACT). We analysed survival duration in patients with a poor PS prescribed SACT in our local NHS trust.

Methods Details for all patients who were prescribed SACT in our local hospice (chemocare) and electronic case records (PPM). Patients included had an Oncological ICD-10 classification and had a performance status of 2 or less at the start of cycle 1 of treatment. Duration of survival for these patients was calculated.

Results From the total 747 patients, 39 were identified to fit the criteria. 33 had a PS of 2, and 6 had PS of 3 at the first cycle of SACT. Common diagnoses were lung carcinoma (n=23) and breast carcinoma (n=8). 33 patients received chemotherapy with palliative intent. 3 of these patients died within 30 days of receiving SACT, and a total of 8 patients died within 60 days (23%). All 4 patients who received neoadjuvant, adjuvant or disease modifying chemotherapy were still alive at time of analysis, with a survival of at least 421 days.

Conclusions Nearly 1 in 4 patients with a PS of 2 or less who were prescribed palliative chemotherapy had died within 60 days of receiving SACT. Quality of life and best supportive care need to be the first consideration for patients with poor PS, but carefully chosen and counselled patients with chemosensitive disease can benefit from SACT (further research needed).

REFERENCES