

**P-40** PREPARING JUNIOR DOCTORS FOR DISCUSSING DNACPR WITH PATIENTS – A ‘BIT OF TRIAL AND ERROR’?

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**Background** Making Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and treatment escalation decisions facilitate a dignified death for patients in acute hospital settings, but not all doctors find it easy to have the necessary discussions with patients.<sup>1</sup> The GMC’s “Tomorrow’s Doctors” requires that medical schools adequately prepare trainees to “contribute to the care of patients and their families at the end of life”.<sup>2</sup> We conducted a survey of the experience of junior doctors in UHBristol NHS Trust.

**Method** An online questionnaire was sent to all junior doctors. Respondents were asked to rate their confidence when discussing DNACPR decisions with patients and their families, what training they had received and whether or not they felt their undergraduate training had adequately prepared them for these conversations. A comments space was provided.

**Results** We received 84 responses. 68% of juniors felt confident when discussing DNACPR decisions with patients and families. However 15% did not.

Only 5% felt they had been well prepared by undergraduate teaching. 40% felt they could have been better prepared and 22% felt very unprepared. 50% reported learning by observing senior colleagues in the clinical environment.

There were mixed comments regarding which grade was the most appropriately placed doctor to have these discussions with patients; some believed only a consultant should, but others stated junior doctors were usually first to recognise the need for escalation decisions.

Several commented that they had learnt by observing seniors conducting these consultations but noted they were not always done well. Some thought practicing in the clinical environment (trial and error) was the best way to improve their communication skills.

**Conclusion** Acute hospitals cannot assume their junior doctors feel prepared to discuss DNACPR decisions with patients. Formal teaching opportunities should be provided to supplement the observation of seniors, the current mainstay of their learning.

#### REFERENCES

1. The British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. Decisions relating to cardiopulmonary resuscitation. 3<sup>rd</sup> edition (1<sup>st</sup> revision) 2016.
2. General Medical Council. Tomorrow’s Doctors. Outcomes and standards for undergraduate medical education. September 2009

**P-41** EXPANSION AND DEVELOPMENT OF A HOSPICE PARACENTESIS SERVICE TO INCLUDE NON-MALIGNANT ASCITES

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**Introduction** Along with most UK hospices, Hospice in the Weald have an established paracentesis service for managing malignant ascites. These represent 10% of ascites cases in the UK with the majority of the rest attributable to cirrhosis.

Cirrhosis is the fifth commonest cause of death in the UK, but is less familiar to hospice services than malignancy. We present a successful QIP expanding the service to patients with non-malignant ascites

**Aims** A Quality Improvement Project to introduce intravenous albumin during paracentesis facilitating drainage of non-malignant ascites in a hospice setting.

**Methods** Through consultation with hospice and local trust pharmacies we were able to source 20% Human Albumin Solution initially on private prescription and then direct from the manufacturer. Guidelines were developed combining the International Ascites Club guidelines, local trust protocols and medical staff experience which were reviewed at the weekly hospice journal club.

**Results** Over 10 months we have successfully used albumin during paracentesis on 6 occasions. There have been no complications during the procedures and have been more haemodynamically stable than those with malignant ascites and similar drainage volumes.

**Conclusion** Through the introduction of albumin cover we have been able to expand our patient group, avoid hospital admissions, as well to provide opportunities for advanced care planning. It has been particularly helpful for patients with ascites with malignancy and a background of liver disease as previously there was a risk draining in the hospice without albumin. It is expected that as local referrers become more aware that the service will become more popular.

**P-42** INJECTABLE MEDICATION AT THE END OF LIFE: A COMMON TASK FOR GENERALIST COMMUNITY CLINICIANS

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**Background** Injectable medications are commonly prescribed for patients at home approaching the end of their lives, either in response to, or in anticipation of, symptoms.

**Aims** With regard to injectable drugs for patients approaching the end of their lives in the community, to investigate:

- a. What drugs are prescribed?
- b. What drugs are administered?
- c. Who administers the drugs?

**Design and setting** Service evaluation of the Bedfordshire PEPS (Partnership for Excellence in Palliative Support) Co-ordination Centre, a 24 hour support service for palliative care patients.

Medication data were extracted from patient records on SystemOne, the local community computerised healthcare record, concerning patients registered with PEPS who had died within a one year period.

**Results** Of 1087 patients registered with PEPS who died within a 1 year period, 392 (36%) were prescribed injectable medications, most commonly midazolam (88%), diamorphine (85%), cyclizine (72%) and glycopyrronium (67%).

328 (84%) out of the 392 spent part or all of their last week of life at home. Of these, 232 (71%) had injectable drugs administered during that time: diamorphine (72%), midazolam (66%), glycopyrronium (41%) and cyclizine (31%). Most (81%) were given more than one drug and half (52%)

were given drugs both by continuous subcutaneous infusion and as stat doses. The drugs were most often given by generalist community nurses or nursing home staff (91%). There was little difference between drug prescription and administration in malignant or non-malignant disease.

**Conclusions** When prescribe, injectable medication is frequently used in the last week of life, especially diamorphine, midazolam, cyclizine and glycopyrronium. Administration is usually by staff who are not specialist in palliative care, highlighting the need for support and education for community healthcare professionals.

**P-43** **EVALUATION OF OPIATE PRESCRIBING AND ADJUSTMENT IN RENAL IMPAIRMENT IN AN ACUTE MEDICAL ADMISSIONS UNIT**

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**Background** Incorrect opioid prescribing can have significant consequences for patient safety and quality of care (1), adjustment of opioid is often needed in renal impairment (2,3). The audit aimed to assess if an acute medical assessment unit (AMU) was meeting current guidance regarding opioid prescribing in acute medical admissions

**Methodology** A retrospective case note audit was conducted of all patients admitted to AMU who were prescribed an opioid from 1 st to 7 th March 2016. Notes were reviewed to establish: the opioid and dose prescribed; any change to an established opioid or dose on admission; initiation dose of opioid if opioid naïve; any documentation of a rationale behind prescribing in impaired renal function. Laboratory results were reviewed to look for AKI and calculate eGFR.

The audit standards used were the local trust guidelines (4) and the North of England Cancer Network Palliative Care Guidelines (5).

**Results** 14 patients were prescribed an opioid and only 5 met the audit standards. 4 out of 6 opioid naïve patients commenced on morphine IR solution were prescribed a dose higher than recommended. 1 of 5 patients on a long-acting opioid had a correct PRN dose prescribed. A half of patients with a reduced eGFR were prescribed morphine. There was no documentation regarding rationale behind opioid prescribing.

**Conclusion** The results demonstrated that opioid prescribing on AMU did not adhere to local or regional guidance.

**Recommendations**

1. Conduct a live audit of patients admitted to AMU over two weeks to expand data
2. Develop specific guidance for opioid adjustment in AKI and for initiating opioids in patients with a reduced eGFR on AMU.
3. Share audit findings and conduct teaching for acute medicine trainees regarding opioid prescribing in acute medical admissions.
4. Repeat audit after interventions taken place.

**P-44** **THE EFFECTS OF EHEALTH INTERVENTIONS IN PALLIATIVE CARE: A META-REVIEW**

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**Background** eHealth involves the use of information and communication technologies (ICTs) for the delivery of healthcare and health information, including direct consumer technologies. eHealth strategies may help alleviate the burden on health systems in a cost-effective way and expand palliative care services.

**Aim** To systematically identify and synthesise evidence from published systematic reviews on the effects of eHealth interventions in palliative care for patients, caregivers and health professionals.

**Methods** Systematic reviews focused on eHealth and palliative care were eligible for inclusion in this meta-review. Nine databases including MEDLINE, EMBASE, PsychINFO, and the Grey Literature Report were searched for reviews in any language between 2006 and 2016. The Assessment of Multiple Systematic Reviews (AMSTAR) tool was used to critically appraise all included reviews. Data was then extracted and results were presented in a narrative synthesis.

**Results** Thirteen reviews were included. Methodological quality was low to moderate with AMSTAR scores ranging from 2 to 5 out of 11. eHealth interventions were primarily used for facilitating communication, symptom reporting and monitoring, education, information provision, clinical consultations, and decision-making in palliative care settings. There were positive effects of eHealth interventions on cost-effectiveness, decision-making, communication, education, and support for patients, caregivers and health care professionals. Inconsistent findings were reported regarding effects on quality of life (QOL), depression, and anxiety.

**Conclusion** The majority of reviews on eHealth interventions in palliative care report positive effects of interventions on patients, caregivers and professionals. While there were inconsistent findings in regards to depression, anxiety, and QOL, no negative outcomes were reported. This provides promising evidence for the value of eHealth interventions in palliative care. Further research, cost-analyses, and clinical studies are needed to strengthen the evidence base for eHealth interventions and to inform policy in this area.

**P-45** **AUDIT OF ADULTS WITH INCAPACITY DOCUMENTATION IN AN ACUTE PALLIATIVE CARE UNIT**

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**Background** In-patients receiving palliative care may lack capacity to make decisions regarding their medical treatment for many reasons e.g. delirium, dementia. If it is felt that a person cannot consent to treatment an Adults with Incapacity (AWI) Act (Scotland) Section 47 certificate can be completed, allowing healthcare staff to provide treatment while enshrining a number of safeguards for the patient. In 2016 NHS