

respectively. Diarrhoea was the only AE observed in $\geq 5\%$ of patients in either group (19.6% vs 7.3%). No clinically meaningful changes in opioid withdrawal scores and pain intensity were observed in both groups. In EXT, 107 patients completed a 12 week treatment with naldemedine 0.2 mg QD, and the safety profile was similar to that in DBT.

Conclusions Naldemedine improved the symptoms of OIC and was generally well tolerated.

O-10

AN OBSERVATIONAL STUDY OF THE PREVALENCE OF VIVID DREAMS, NIGHTMARES AND SLEEP/NIGHT TERRORS IN PATIENTS WITH ADVANCED CANCER AND THEIR ASSOCIATION WITH OPIOID ANALGESICS

Shuchita Patel, Andrew Davies. *Royal Surrey County Hospital, Guildford, UK*

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Aim The aim of this study was to investigate vivid dreams, nightmares and sleep/night terrors in patients with advanced cancer.

Methods The study was a multicentre, prospective observational study. Single interviews were conducted with 174 patients and data were collected on their demographics, cancer diagnosis, co-morbidities, current medication and patient's assessment of the ECOG performance status. In addition data were collected on the frequency of vivid dreams, nightmares and sleep/night terrors, as well as the patient's sleep quality and physical and psychological symptoms (Memorial Symptom Assessment Scale and Pittsburgh Sleep Quality Index).

Results Sixty (34%) patients reported vivid dreams, 31 (18%) patients reported nightmares and 14 (8%) patients reported sleep/night terrors. Vivid dreams were associated with presence of psychological symptoms, but not physical symptoms ($p=0.315$). Nightmares were associated with presence of both physical and psychological symptoms. None of these phenomena were associated with the use of opioid analgesics.

Conclusion Vivid dreams are relatively common in patients with advanced cancer, although nightmares and sleep/night terrors occur less frequently in this population (and no more frequent than in the general population). Vivid dreams appear to be primarily associated with psychological problems, and so patients reporting these should be screened for psychological problems. Similarly, patients with nightmares should be screened for psychological problems, and have their physical symptoms adequately controlled.

Poster Presentations

P-11

WHAT DO END STAGE RESPIRATORY DISEASE PATIENTS GET FROM HOSPICE SERVICES?

^{1,2}Dedan Cawley, ¹Pauline Dand, ¹Andrew Thorns. ¹*Pilgrims Hospices, Canterbury, UK;* ²*University Of Kent, UK*

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Background Non-malignant respiratory diseases (NMRD) are increasing in incidence and prevalence with figures rises with our globally ageing population. This coupled with multi-morbidity is likely to increase the needs of individuals from a supportive and palliative care approach. The challenge within fiscally constraint health economies, is to ensure equity of

care across all care settings so the individual gets care of an expected standard rather than duplication or omissions within the current services delivering the care.

Aim To explore how patients with non-malignant respiratory diseases traverse through the hospice organisation and how consistent is this approach across 3 hospice sites.

Method A retrospective case note of review of patients referred with NMRD to a hospice organisation within 1 year.

Results 169 case notes were identified with a convenient sample of 100 explored for further analysis. Length of contact varied for days to months (18) with median being 30–90 days. The majority of patients (97) had COPD, were Males (59) with median age 78 years. 63 patients had multi-morbidity (>2) with Heart Failure, IHD and Cancer being the most common. Only 60 cases had an identified carer with 50% having external professional help. Breathlessness (81) and anxiety (34) were the common presenting symptom with the vast majority of patients having a formal holistic clinical review (60), medication review (65) and attendance at a breathlessness management group (58). Opioids were commonly taken (57) along with benzodiazepines (58). Advance care planning (ACP) was attempted in the majority of cases with DNAR (63), PPOD (49) with only 15 cases explicitly reporting ceilings of care.

Conclusions Hospice care and the need for supportive and palliative care needs to dovetail with existing services and articulate clearly what and when it intends to provide input. Prognostic uncertainty, awareness and parallel planning for EOLC requires a whole systems approach.

P-12

USE OF ANXIOLYTIC AND ANTIPSYCHOTIC MEDICATIONS IN THE DYING PHASE AMONGST HOSPICE INPATIENTS

Amy Hawkins, Emily Sills. *Woking and Sam Beare Hospices, Weybridge, UK*

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Background Terminal agitation and delirium at the end of life are common.¹ Whilst anxiolytic and antipsychotic medications are widely used during the last week of life, clinical evidence regarding their use is limited.^{2,3} Our aim was to audit current practice at two inpatient units.

Methods A retrospective audit was carried out of all patients who died during a four-month period (June to October 2015) at two hospices ($n=75$). Data were collected on whether anxiolytic and/or antipsychotic medications were used in the last week of life, the drug(s) and dose(s) administered, and the indication. Use of Levomepromazine and Haloperidol for nausea and vomiting were excluded. Audit standards were set according to guidance in the PCF-5⁴ and a compliance target of 80% was set.

Results The median age was 79 years (range 32 to 94) and 80% of patients had a primary diagnosis of cancer. In total, 91.7% ($n=33$) of patients at Hospice 1 and 82.1% ($n=32$) at Hospice 2 received anxiolytic and/or antipsychotic medications during the last week of life. The most common indication at Hospice 2 was terminal agitation ($n=16$, 50%), compared with mixed terminal agitation and delirium ($n=11$, 33.3%) at Hospice 1. Midazolam was the most widely used drug (used in 77.8% of patients at Hospice 1, $n=28$, and 74.4% of patients at Hospice 2, $n=29$). Haloperidol was more widely used at Hospice 1 whereas Levomepromazine

was used more at Hospice 2. None of the patients received Phenobarbitone. Compliance with the audit standards was 65%–75%.

Conclusions Anxiolytic and antipsychotic medications were widely used in the last week of life, with variations in practice in terms of the drugs and doses used. Classification of the indication for use was inconsistent. Following the audit we developed a framework for use of these drugs at the end of life.

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P-13

USE OF BONE PROTECTION IN PATIENTS WITH PRIMARY INTRACRANIAL TUMOURS ON LONG TERM CORTICOSTEROIDS

^{1,2}Jennifer Brennock, ²Norma O' Leary, ²Cliona Hayden-. ¹St. Vincent's University Hospital, Dublin 4, Ireland; ²Our Lady's Hospice and Care Services, Harold's Cross, Dublin 6W

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Background Long term use of corticosteroids can be associated with significant morbidity, including development of glucocorticoid-induced osteoporosis and resultant fractures, leading to increased pain and disability. There are currently no specific standards or guidelines pertaining to the use of bone protection in patients on long term corticosteroids in palliative care. However, given that a significant proportion of palliative care patients are on corticosteroids for prolonged periods, this is an area that should be explored further.

Aims

- To ascertain current use of bone protection in a palliative cohort of patients with a diagnosis of primary intracranial tumour on long term corticosteroid treatment
- To identify patients in this cohort who would likely have benefited from receiving bone protection

Standards Standards used were the American College of Rheumatology 2010 Recommendations for the Prevention and Treatment of Glucocorticoid-Induced Osteoporosis. These guidelines recommended for this cohort that patients on long term glucocorticoid treatment (dose ≥ 7.5 mg prednisolone daily for \geq three months) should be on bone protection therapy (bisphosphonate).

Methodology Retrospective audit using chart review of patients with primary intracranial tumours on initial referral to Palliative Care Team.

Results Initially 39 eligible patients identified. On manual review of these charts, 32 were eligible, $n=32$. 37.5% were on steroids on admission, and had been on steroids for > three months on initial assessment and had greater than three months to live. 12.5% had > six months to live and were on steroids on first assessment, and 6.25% had been on >3 month course of steroids.

Conclusions 62% patients who were initially assessed by palliative care team should have been considered for bone

protection therapy prior to referral. 45% of patients were not suitable for consideration for bone protection treatment. This leaves 55% which could have potentially been considered for bone protection therapy by the palliative team following initial assessment.

P-14

A RETROSPECTIVE AUDIT OF THE PRESCRIPTION AND USE OF END OF LIFE ANTICIPATORY MEDICATIONS IN A COMMUNITY SETTING

Annabelle Mondon-Ballantyne, Laura Cottingham. *St. Raphael's Hospice, Sutton, UK*

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Aims To ensure that PRN injectable medications for end of life care are prescribed safely, in a timely and appropriate manner and that the drugs are received and given in the community as required. Our intention was to ensure patient comfort and safety at the end of life; whilst providing assessment and reassurance for community teams and GPs that end of life medications are being prescribed appropriately.

Methods A retrospective snapshot audit examining 37 community deaths known to St Raphael's Hospice, between December 2015 and January 2016. Notes were accessed, results collated and analysed from online records held within the hospice.

Results Out of the 37 deaths recorded, 33 had injectable PRN medications requested. 35% of patients received medications within 24 hours of the request and 88% received them in less than two weeks. 78% of patients died within a month of PRN medications being prescribed. All patients had the correct opioids prescribed, with 43% receiving alternatives due to poor renal function. Once prescribed and received, 71% of patients used their medications within 24 hours of receiving them.

Conclusions The audit identified that the majority of patients are having their anticipatory medication prescribed appropriately prior to their death and were receiving them in a timely manner (within two weeks). However: considering that in most cases, medications were used within 24 hours, there is potential room for improvement. The process by which patients receive their PRN medication requires further investigation to identify and overcome possible problems. The audit also highlighted a number of cases of incomplete or inconsistent record keeping. This emphasised the importance of clear documentation, especially in the community, where multiple teams are involved in patients' care.

P-15

AN AUDIT OF THE STANDARD OF COMPLETION OF THE ACHIEVING PRIORITIES OF CARE (APOC) PAPERWORK – PILOT AUDIT IN THE WESSEX REGIONAL RENAL DEPARTMENT, QUEEN ALEXANDRA HOSPITAL, PORTSMOUTH

Rebecca Allan. *Portsmouth Hospitals NHS Trust, Fareham, UK*

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Background In 2014, The Leadership Alliance for the Care of Dying People developed the five priorities of care for people in the last hours or days of their life. To facilitate the implementation of these priorities in Queen Alexandra Hospital, Portsmouth, a regionally created document came into use in