

Aim To examine the effectiveness of pregabalin and gabapentin for management of CIBP.

Methods A systematic review of clinical trials investigating pregabalin or gabapentin as the intervention for CIBP, with change or reduction in pain scores as outcome. Embase, Medline, Cinahl and Cochrane databases were searched from inception to March 2016. Grey literature, reference lists, conference abstracts, and hand searching of key journals were undertaken.

Results Five of 35 screened studies met inclusion criteria. Pregabalin was investigated in three RCTs, and gabapentin in one RCT and one case series, including a total of 458 patients. All studies used numerical rating scales to assess worst or average pain over 5 days-4 weeks following pregabalin or gabapentin introduction. Two pregabalin versus placebo RCTs were methodologically strong and of these the largest and highest quality RCT showed no differences in average worst pain scores. The other RCT terminated early due to slow recruitment hence was underpowered, but indicated a small trend favouring pregabalin. A further pregabalin RCT showed significant reduction in pain scores but had methodological limitations. There was no difference in pain scores in the gabapentin versus placebo RCT, whereas the gabapentin case series reported six patients whose pain scores improved. Both gabapentin studies had design weaknesses. The drugs were well tolerated. Data heterogeneity meant meta-analysis was not possible.

Conclusion The strongest evidence to date suggests lack of effectiveness of pregabalin for CIBP. Future well conducted trials should incorporate subgroup analysis of differing primary tumour types and metastases location when evaluating these neuropathic agents in CIBP.

P-127 ADOPTING AN INTEGRATIVE APPROACH WHEN TEACHING "ADVANCED COMMUNICATION"

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Background Studies have shown that graduating medical students consistently feel poorly prepared to communicate in difficult clinical situations and at the end of life.¹ These discussions should not be seen in isolation from other communication. We are concerned that specifically teaching advanced communication in conjunction with end of life care might result in students developing 'palliative communication skills', to be used only in specific situations rather than a holistic communication style. We aimed to show the utility of the same skills across a spectrum of communication themes in a range of settings, such as deciding whether to initiate a statin to anticipatory care planning.

Methods The project involved a new communication programme, integrating previously separate strands to deliver four half-day sessions for fifth year medical students. The students were given an "Advanced Communication Skills handbook" covering the key areas of:

- Sensitive discussions (breaking bad news)
- Decision discussions (risk and escalation)
- Challenging discussions (strong emotions and errors)

The programme used role-play and was delivered by several different disciplines to symbolically emphasise integration.

Results The students scored their ability (out of 10) to discuss the key areas listed above prior to the first session and after the final session. The results showed an increase in perceived skill level for each key area and written feedback about the sessions was very positive.

Breaking bad news: 5.3 to 7.8

Shared decision-making: 6.1 to 7.8

DNACPR discussions: 4 –to 7.4

Conclusion The feedback for these sessions, in conjunction with the increase in perceived skill level across the key areas suggests that this is an effective way of integrating communication strands and decision making in under-graduate teaching.

REFERENCE

1. Sullivan AME *et al.* End-of-life care in the curriculum: a national study of medical education deans. *Academic Medicine* 2004;**79**(8):760–8.

P-128 USE OF A WRITTEN CARE PLAN TO ACHIEVE THE "FIVE PRIORITIES FOR CARE" AT THE END OF LIFE AT NORTHWICK PARK HOSPITAL

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Background The "Five Priorities for Care" (5 PFC) at the end of life were established after the Liverpool Care Pathway (LCP) was phased out. In order to meet these priorities, London North West Healthcare created the "Last Days of Life Care Agreement" (LDLCA); a template for end of life discussions.

A 2016 audit of the use of the LDLCA within Northwick Park Hospital showed that it was not being adequately filled out. There was poor documentation surrounding end of life symptom assessment, ongoing discussions with family members and acknowledgement of spiritual needs.

As a result, the LDLCA was re-written and structured around the 5 PFC. A "symptom chart" from another trust¹ was introduced to record the severity of end of life symptoms. The new LDLCA was trialled on four wards and its impact on end of life care was re-audited.

Methods All patients on the new LDLCA were reviewed over an 11 week period from 9th August 2016 (n=18). Notes were assessed for evidence of the 5 PFC being achieved and frequency of end of life symptom assessment.

Results All 5 PFC were achieved in 100% of patients. An end of life discussion was had with 100% of relatives prior to commencing the LDLCA. Ongoing discussions with families were documented in 61% cases (previously 16%). Assessment of spiritual needs was done in 67% (previously 27%). There was evidence of symptom assessment in 100% of patients however these were only recorded on a four-hourly basis in 56%.

Conclusions A written care agreement can create a care plan focussed on the 5 PFC. Creating this from a discussion produces individualised care and reduces the risk of "tick-box" care seen with the LCP. A specialised "symptom chart" can aid assessment of end-of-life symptoms and help achieve the care plan.

REFERENCE

1. Mason LD. Brighton & Sussex University Hospitals NHS Trust.