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A CLINICAL AUDIT OF XEROSTOMIA ASSESSMENT AND TREATMENT PRACTICES AMONGST ADVANCED CANCER PATIENTS IN A PALLIATIVE CARE SETTING

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Background Xerostomia is the subjective sensation of dry mouth. It is the fourth most common symptom in advanced cancer patients and impacts negatively on physical and psychosocial wellbeing. Older age and polypharmacy are risk factors for dry mouth and are common in advanced disease. This study aims to evaluate prevalence of xerostomia, as well as compliance with assessment and treatment practices.

Methods A retrospective chart audit was conducted on 173 admissions from an in-patient palliative care unit. Data were collected pertaining to patient demographics, cancer diagnosis, medications, oral health assessment and xerostomia treatment. Audit standards were based on local policy as follows: Oral Health Assessment Tool (OHAT) completed on all patients; OHAT completed within one day of admission; oral care plan completed if problem diagnosed; xerostomia treatment prescribed where necessary. Descriptive statistics were used to report compliance with standards. Cohen's Kappa and Intraclass Correlation Coefficient were used for inter- and intra-rater reliability based on a 10% sample of the dataset.

Results Palliative in-patients were significantly more likely than the general population to experience dry mouth ($p < 0.001$). 86% of admissions had OHAT completed and 91% of these were on day of admission. Care plans were completed for 76% of patients with oral care needs. Appropriate medications were prescribed for 34% of patients with dry mouth. Inter- and intra-rater reliabilities were high or perfect for all primary outcomes.

Conclusions Results indicate that oral health is evaluated in the majority of patients, however treatment appears low. This may be partly due to poor instrument design, where non-prescription treatments or 'treatment unnecessary' cannot be documented. Existing tools could be amended to reflect patient care needs more accurately. A change project is currently underway within the care setting to improve practice as a result of the study.

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AUDIT OF OPIOID PRESCRIBING IN A HOSPICE IN-PATIENT UNIT

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Background Morphine is the recommended first line opioid by NICE for severe pain. However, many patients on the Hospice in the Weald ward were noted to be on alternative opioids such as Oxycodone and Fentanyl. The reason for choosing an alternative opioid was not always clear. It is accepted practice that oxycodone is a suitable alternative for those who develop adverse effects with morphine that are not controlled by usual measures and Fentanyl and Alfentanil are suitable with poor renal function.

Aims This audit aimed to identify if prescribing of opioids in IPU followed both NICE and local guidelines.

Methods This prospective audit ran over a 6 week period during November and December 2015. Once a patient had been identified as being prescribed an alternative opioid information was obtained by talking to the patient or relatives if appropriate and/or looking through paper notes, electronic entries, telephoning GP surgeries or community pharmacies.

Results 38 patients were admitted to IPU during the audit period of whom 47% were prescribed an alternative opioid. The most common reasons for switching a patient to an alternative opioid were due to renal function (33%) or patient being intolerant of morphine (39%). The most commonly reported side effect leading to a change in opioid was hallucinations and in 71% of all cases a decreased dose of medication was tried before switching opioids. 72% of switches to an alternative opioid were deemed appropriate according to NICE and local guidelines.

Conclusions Although alternative opioids are frequently prescribed on IPU, the majority of prescribing is appropriate according to NICE and local guidelines. Improvements could be made in documenting in the electronic notes the reason an alternative opioid was prescribed, side effects experienced and whether a reduced dose or supportive medication was tried first.

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CHALLENGING THE PRESSURE ON NHS RESOURCES: COULD 48-HOUR CONTINUOUS SUBCUTANEOUS INFUSIONS (CSCI) HELP? A SYSTEMATICALLY-STRUCTURED REVIEW OF THE CURRENT EVIDENCE BASE

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Background The majority of patients express a preference to die at home, yet the most commonly recorded place of death is hospital; in 2012, 36.7% of deaths in Liverpool occurred in the person's usual place of residence. With an ageing population, NHS resources will be placed under increasing pressure to meet the needs and care preferences of chronically ill patients. Accordingly, innovative approaches to existing therapies are one way to improve care and maximise service delivery. For example, the ability to deliver prescribed medication by CSCI over 48 hours may have numerous benefits in both patient care and health service resource utilisation: current practice limits infusion time to a maximum of 24 hours due to available chemical and microbiological stability data.

Aim To examine the evidence on stability of 48 hour multiple-drug syringes/CSCIs in current clinical practice.

Design A systematically-structured review following PRISMA guidelines.

Data sources Three electronic databases (CINAHL, EMBASE and MEDLINE) and grey literature were searched with no time limits. Studies published in English reporting empirical data on the chemical or microbiological stability of continuous subcutaneous infusions or solutions stored in polypropylene syringes were included.

Results Chemical compatibility and stability of 51 different combinations of 12 drugs were reported across the ten studies included in this review. Of the 51 combinations reported, all

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.^{1,2} 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.

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P-28 STAFF EXPERIENCES OF DELIRIUM IN THE HOSPICE SETTING

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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