patients' wishes. This session is now part of ongoing end of life training locally.

P-116 TO FEED OR NOT TO FEED

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10.1136/bmjspcare-2017-hospice.141

Background It is well known that swallowing problems are a common symptom in palliative care patients (Bogaardt et al., 2015). The emotional, physiological and psychological impact of swallowing problems cannot be underestimated on the patient, their families and carers.

Aims To reduce the impact of swallowing difficulties by ensuring patients can eat and drink safely, efficiently and nutritiously.

To develop and roll out a training programme for healthcare professionals involved in the preparation, formation and delivery of modified diets/fluids.

Method A collaborative working party including Speech and Language Therapy (SLT), Dietetics, Catering and Housekeeping was set up to review and improve the modified diets and fluids that are offered to our patients with swallowing difficulties. The review included patient and staff feedback and focused on consistency, appearance, taste and texture. As a multi-disciplinary team, each discipline provided a different knowledge base: SLT focusing on swallowing safety, Dietician focusing on nutritional content, Catering with the preparation and cooking of the food and Housekeeping with food presentation.

Results A new puree menu has been developed with standardised texture and consistency with the use of puree moulds to improve appearance. A daily smoothie round is now offered to our inpatients and day hospice. A formal evaluation is in progress. Initial feedback from patients and staff has been positive. 'It looked like chicken and even tasted like chicken. This is the first puree meal I have actually enjoyed!'

A training programme on modified diets was developed and is being delivered on a rolling basis.

Conclusions We believe by evaluating and improving our modified diets and fluids that are offered to patients with swallowing difficulties, these patients can continue to eat and drink safely and nutritiously through the development of an innovative new modified diet menu thus reducing the distress that can be caused by the impact of these difficulties.

P-117 PLANT: 'PALLIATIVE LIFE-STATE & NUTRITION TOOL'© – A PROTOTYPE TOOL

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Background Previous work by the author and, in collaboration with the Food and Nutrition Group at Hospice UK and the Department of Nutrition at the University of Surrey, highlighted the need for a specialist nutrition tool in palliative care. Nutrition can be influenced by disease and treatment-related factors as well as emotional, social and cultural factors. In addition, food allergies/intolerances and preferences should be taken into account when offering food or dietary advice.

Last but not least, weight and nutritional changes can be a useful adjunct to the prognostic algorithm.

Aim The PLANT tool has been designed to explore a number of symptoms that can affect the nutritional status of palliative patients.

Methods The prototype PLANT was designed and developed in the last two years with the feedback of patients, doctors, nurses and dietitians. It has two parts: a patient questionnaire and a clinical assessment. It has been used in different settings.

Results PLANT is a practical tool that can be used in the hospice, community and outpatient settings. It can:

- identify potentially reversible causes (such as pain, nausea, constipation etc) which can influence the patient's food intake and nutritional status
- highlight specific food and nutritional needs that can be translated into care plans
- facilitate communication between multidisciplinary team members
- assist healthcare professionals in estimating survival of patient.

Conclusions Nutritional and wellbeing status should be assessed, except if patients are within the last days of life ('dying' phase of illness). The PLANT tool, by taking into account aspects of life-state and food and nutrition, supports healthcare professionals in their history-taking and decision-making, to provide better care. There are a number of challenges for its use, such as changing practice, introducing yet another tool but, most importantly providing education and training on nutritional and lifestyle care.

P-118 JOINT WORKING WITH ANAESTHETICS: AN INTERVENTIONAL PAIN MANAGEMENT SERVICE FOR COMPLEX CANCER PAIN

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10.1136/bmjspcare-2017-hospice.143

Background A small number of cancer patients' pain syndromes remain inadequately controlled despite applying the principles of the World Health Organization Analgesic Ladder. These patients often have neuropathic pain and experience severe symptoms. They may also experience medication side effects which limit dose escalation. NICE guidelines recommend that specialist palliative care teams should have access to pain management specialists with nerve blocking and neuro-modulation expertise. A recent paper concluded that patient care and outcomes will be enhanced by establishing more formal relationships between pain services and palliative medicine. There is evidence of under-referral for advanced pain management procedures and a lack of integrated services nationally. Interventional pain management has been a long-standing gap in the commissioning of cancer services in our locality.

Aims To improve the care of patients with complex cancer pain by establishing a collaborative hospice-based service with a chronic pain management anaesthetist.

Methods A service-level agreement was established between the hospice and the local hospital trust to commission input from a chronic pain anaesthetist in January 2017. Fortnightly sessions were established to review hospice inpatients and to

attend hospice multidisciplinary community team meetings. Patients with complex cancer pain syndromes are discussed and proactive joint reviews and procedures arranged where appropriate. Joint consultation with the chronic pain consultant and palliative care team is emphasised to ensure that all options are explored pre-procedure and follow-up is safe post-procedure. It is anticipated that case reviews presented back to the clinical teams will encourage referrals and contribute to ongoing education. In addition, over the first year of the service, the systems to support hospice-based spinal infusion services for intractable cancer pain will be established.

Evaluation A service evaluation will assess numbers of patients identified for discussion, assessment and intervention; clinical team confidence and knowledge; and case note review of perceived patient benefits.

P-119 A RETROSPECTIVE STUDY EXPLORING SUBCUTANEOUS LEVETIRACETAM USE AND PRACTICE WITHIN THE WEST MIDLANDS

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Background Levetiracetam is increasingly used subcutaneously to control seizure activity in selected palliative patients, whereby seizure control is paramount without the same perceived sedative effect of subcutaneous benzodiazepines. Despite this becoming a well recognised approach the literature and quality evidence to support this remains sparse.

Aim To perform a retrospective audit exploring subcutaneous Levetiracetam use and practice, over the past year across the West-Midlands, comparing it to guidance in PCF5.

Method An electronic survey sent to all palliative care units and hospital teams across the West Midlands generated information from 31 cases where subcutaneous Levetiracetam had been used. Information gathered included seizure aetiology and type, antiepileptic history, delivery of Levetiracetam, side effects and effectiveness.

Results Seizure aetiology was heterogeneous; 50% caused by space-occupying lesions. 42% of patients had seizures in the week prior to commencement and 58% of seizures were described as tonic-clonic. Nearly all (93%) had anti-epileptics prescribed prior to commencement. The majority of Levetiracetam was delivered via a continuous subcutaneous infusion (92%), the remaining given by bolus subcutaneous regimen. The mean dose on commencement was 1268 mg (range 250 mg–3000 mg) and 12% of infusions were titrated over time due to seizure activity. Levetiracetam was successfully mixed with morphine, midazolam, metoclopramide and dexamethasone with no issues reported. In 69% cases concurrent midazolam administration was used, although the rationale varied and was not solely seizure related. 81% reported no side effects attributable to Levetiracetam, 16% reported a local site skin reaction. No further seizures were documented in 70% whilst on subcutaneous Levetiracetam and 62% of subcutaneous Levetiracetam regimens continued till death.

Conclusion This study outlines current varied practice in the West-Midlands demonstrating the targeted patient group and practical issues in using subcutaneous Levetiracetam. Collating this information adds to the evidence base and will allow for composition of informed local guidelines.

P-120 DESCRIBING ANTICIPATORY MEDICINE USE IN THE COMMUNITY AT THE END OF LIFE

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10.1136/bmjspcare-2017-hospice.145

Background Anticipatory Medicines (AM) are injectable medicines prescribed and administered to patients to alleviate symptoms at the End of Life (EOL). Whilst prescribing of these medicines is encouraged by the healthcare system in Leicester, Leicestershire and Rutland, the actual patterns of prescribing and administration of AM have not been documented locally.

Aim To describe the prescribing and usage of AM in the community, matching this to EOL symptoms experienced by patients.

Method A retrospective audit of 150 sets of patient notes was conducted at the start of 2017, comprising 50 deaths from one General Practice list, 50 deaths from Community Palliative Care Nursing teams, and 50 hospice discharges. Data included the main diagnosis at death; and details of prescription and usage per ampule of each AM.

Results General Practice data analysed thus far indicates:

- Death by primary diagnosis: Cancer 16/50 (32%), Chronic Disease 5/50 (10%), Frailty/Dementia 22/50 (44%), Sudden Death 5/50 (10%)
- AM issued by diagnosis: Cancer 10/16 (62%), Chronic Disease 0/5 (0%), Frailty/Dementia 11/22 (50%), Sudden Death 1/5 (20%)
- Median number of days AM issued and started [X] before death: Cancer 14[4], Chronic Disease (N/A), Frailty/Dementia 6[4], Sudden Death 11[6].
- Number of patients documented having EOL symptoms (13): Cancer 4, Chronic Disease (N/A), Frailty/Dementia 8, Sudden Death 1
- EOL symptoms experienced: Pain: 12 (Cancer 3, Frailty/Dementia 8, Sudden Death 1), Breathlessness: 3 (Frailty/Dementia 3), Agitation 2 (Cancer 1, Frailty/Dementia 1), Nausea 1 (Cancer 1), Vomiting 2 (Frailty/Dementia 2).
- Syringe Driver use: Cancer (2), Frailty/Dementia (5), Sudden Death(1)
- Total AM ampule usage [Number patients]: 0 [10 Cancer (3), Frailty/Dementia(7)], 0–9 [8, Cancer (2), Frailty/Dementia(6)], 10–19 [2, Cancer (1), Sudden Death (1)], 20–49, [2, Frailty/Dementia (2)], ≥50 [1, Cancer (1)]

Conclusions Patients with frailty/dementia have EOL symptoms similar to cancer, but with greater numbers in the community. AM prescription occurs a few days before their use. The data regarding Chronic Disease deaths in the community is limited in this audit. Further work is needed to analyse all datasets.

P-121 A THEMATIC ANALYSIS OF ANTICIPATORY MEDICINE USE IN THE COMMUNITY AT END OF LIFE

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10.1136/bmjspcare-2017-hospice.146

Background Anticipatory Medicines (AM) are injectable medicines prescribed and administered for patients to alleviate symptoms at the End of Life (EOL). Whilst prescribing of these medicines is encouraged by the healthcare system in