

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**

Matthew Dore, Sharon Twigger, Kate Holyhead, Clare Marlow. *NHS, Compton Hospice, WM CARES (West Midlands Collaborative Actioning Research in End-of-life and Supportive Care)*

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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**

<sup>1,2,3</sup>Edward Rainbow, <sup>2</sup>Christina Faull. <sup>1</sup>Countesthorpe Health Centre, Leicester, UK; <sup>2</sup>LOROS Hospice, Leicester, UK; <sup>3</sup>Health Education East Midlands (HEEM), Leicester, UK

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**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**

<sup>1,2,3</sup>Edward Rainbow. <sup>1</sup>Countesthorpe Health Centre, Leicester, UK; <sup>2</sup>LOROS Hospice, Leicester, UK; <sup>3</sup>Health Education East Midlands (HEEM), Leicester, UK

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

Leicester, Leicestershire and Rutland, the real life experiences of healthcare professionals and surviving relatives, have not been previously documented locally, and are only in limited detail in academic literature. This project was conducted as part of an MSc in Palliative Care.

**Aim** To interview key stakeholders, including healthcare professionals and surviving relatives, regarding their experiences of prescribing, administering, dispensing and observing AM at the EOL.

**Method** Semi-structured interviews were conducted as individuals or in small groups, with both healthcare professionals and relatives. These were: Community Palliative Care Nurses (5), Hospice at Home Nurses (4), District Nurses (1), General Practitioners (3), Community Pharmacists (1), and Relatives (2). Qualitative thematic analysis of interviews was conducted identifying clusters of themes, themes and sub-themes.

**Results** There were two main clusters of themes; Decision points in AM; and Goals of treatment. There were nine themes which all influenced the main clusters which included; patient experience; family experience, emotions; finances; improvements; multidisciplinary working; decision making service delivery; and standardised systems. Each theme had promoting and inhibiting factors, which would affect the Decision Points and Goals of Treatment. Overall, standardised systems were felt to have improved the Goals of Treatment. Variations in service delivery, decision making, MDT working and financial concerns all potentially adversely affect the Goals of Treatment. All interviewees indicated one key element, the importance of managing symptoms at the EOL: 'The patient died peacefully at home'.

**Conclusions** Decisions about AM, and meeting the Goals of Treatment, are part of a complex healthcare system.

Effective EOL symptom management in the community is important for patients, relatives and carers, and healthcare professionals, and AM play an important role to achieve this.

Further research is indicated to interview greater numbers of key stakeholders to expand on this work.

**P-122** **CONSISTENT COUNTYWIDE GUIDANCE AROUND ANTICIPATORY MEDICATIONS USED DURING THE DYING PHASE**

<sup>1</sup>Jane Gibbins, <sup>1</sup>Kirsty Scott, <sup>2</sup>Michael Thomas, <sup>3</sup>Angela Carey, <sup>3</sup>Saul Ridley, <sup>4</sup>Rachel Newman, <sup>4</sup>Elizabeth Thomas, <sup>4</sup>Angela Hart, <sup>1</sup>Carolyn Campbell, <sup>1</sup>Melanie Huddart, <sup>1</sup>Deborah Stevens, <sup>3,4</sup>Joanne Smith. <sup>1</sup>Cornwall Hospice Care, St Austell, UK; <sup>2</sup>St Luke's Hospice, Plymouth, UK; <sup>3</sup>Peninsula Community Health, St Austell, UK; <sup>4</sup>Royal Cornwall Hospital Trust, Truro, UK

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**Background** Nationally, there is awareness of the need to improve symptom control for patients at end of life (National VOICES survey).

**Aim** Dissemination of unified Anticipatory Prescribing Guidance (APG) (incorporating opioid conversion chart, and Hospice 24 hour/7-days-a-week-advice-line-number) to all healthcare settings across Cornwall, backed by a programme of education.

**Methods** APG developed and rolled out with teaching by specialist palliative care (SPC) teams throughout the county and incorporating attendees' experience to inform the evolution of

the project, using Quality Improvement (QI) methodology. Participants were asked to complete a paper questionnaire at the time of teaching to assess changes in knowledge, and an electronic questionnaire 12 weeks after the teaching to capture the impact of such teaching on care of the dying. Quantitative data was analysed using the non-parametric-Wilcoxon-Matched-Pairs. Qualitative data was analysed using thematic analysis until saturation was achieved.

**Settings** All healthcare sectors; acute and community hospitals, hospices, nursing homes, GPs, district nursing services, secure dementia units and ambulance service.

**Results** 990 healthcare professionals (HCPs) were taught. There was a statistically significant shift in median knowledge scores (p value<0.001). HCP perceived there was an improvement of symptom control for the dying in clinical practice. Five main themes emerged from the qualitative data; common guidance, improved knowledge and assessment of symptom-control and opioid conversions, advice 24/7-feeling safe, recognising dying and considering what is important to patients, and confidence building.

**Conclusion** It has been possible to roll out unified APG to a wide range of HCPs to improve their knowledge and confidence. In clinical practice, HCPs perceive it enables improved care to patients in the dying phase by improving symptom control. HCPs described their practice as safer and more efficient. Healthcare professionals formally and informally described the positive impact of having specialist palliative care/hospice-advice-24/7 to back up the guidance on the ground.

**P-123** **THE RIGHT FORMULA FOR COST EFFECTIVE PRESCRIBING IN PALLIATIVE CARE**

Kate Campbell, Katrin Little, Paula Powell. *Willowbrook Hospice Merseyside UK*

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In 2016 Willowbrook Hospice had to make the change to an alternative supplier of drugs and drug costs increased substantially. This additional cost is picked up by the CCGs commissioning services from the hospice.

This resulted in a review of prescribing in the inpatient unit and outpatient clinics. Medical and nursing staff were quite often unaware of the cost of medications and prescribing was driven by what was familiar or in stock. We found that there were significant potential cost savings that could be made through better management of stock, brand and cost effective prescribing.

This poster describes the development of a hospice formulary and the initial impact of this on prescribing patterns and costs.

The first chapter of the formulary covered laxative prescribing – this has resulted in a 70% reduction in cost each month amounting to approximately £7000 per year. This has been achieved without any adverse impact on patients.

Further chapters on opioids and gastrointestinal medications are about to be added and we intend to continue this development alongside better education for staff on cost effective prescribing.