

The hospice employed an autogenic psychotherapist to treat a patient who was in a chronic state of stress. It was identified that stress management would have a profound effect on the patient's overall condition. Teaching sessions were provided to staff enabling them to use techniques that have shown positive symptom management results.

Conventional practice is to treat with medication – analgesia and anxiolytics. The aim was to introduce a variety of techniques giving both patients and their carers strategies to use to help relieve symptoms of anxiety and pain within palliative care.

Training sessions included experiential learning and reflective practice, taught staff to use simple breathing exercises, progressive muscular relaxation, guided imagery and visualisation techniques.

Staff discovered a powerful tool to help patients and their carers to take control of their own situation, using non pharmacological interventions to give control over physical responses to symptom management.

Using a toolkit of techniques, patients are supported to use the techniques on a face-to-face basis, using technology with CDs, and personalised recordings that they can use when and where required.

Enabling patients when they feel most out of control has shown improvements in psychological distress and physical symptom control. Staff have felt more empowered and able to introduce accessible psychological interventions alongside conventional pharmacological prescriptions.

**P-130 A TABOO SYMPTOM? ASSESSING MALODOUR FROM MALIGNANT FUNGATING WOUNDS**

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10.1136/bmjspcare-2017-hospice.155

**Background** Symptom control of malodour in patients with Malignant Fungating Wounds (MFW) can be challenging as there is little evidence or guidelines. Malodour can be a taboo in society. Human response to smell is complex. A literature review showed that malodour is a major concern to patients, families and staff. As a nurse working in a hospice, I wanted to look at how we could develop a standard for assessing malodour.

**Aim** My presentation shares my experience in setting a standard for auditing the assessment of the symptom of malodour for patients with MFWs in a UK hospice. I chose this area because malodour from MFWs is a challenge in practice.

**Methods** I carried out a literature search to see what evidence and guidelines there were to inform my audit standard. I analysed the information and reflected on my 11 years' experience as a hospice nurse.

**Results** Patients with the symptom of malodour from MFW are affected physically, emotionally and socially. The symptom also affects their family and friends and can be distressing for other patients and staff. I felt the practice of assessing malodour at the hospice could improve so would start a clinical audit with my standard that;

'All patients that are admitted to the hospice with a malignant fungating wound will have the symptom of malodour

holistically assessed to support the development of a patient-centred plan of care aimed at improving quality of life.'

**Conclusions** I was then able to audit the assessment of malodour as a basis for change in our practice aims at improving the management of this distressing symptom. The results have informed my leading a multidisciplinary group to devise a holistic assessment tool for assessing the symptoms of malignant fungating wounds.

**P-131 HOSPITAL COMPLIANCE WITH NICE GUIDANCE – INITIATING STRONG OPIOIDS FOR PAIN IN PALLIATIVE CARE**

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10.1136/bmjspcare-2017-hospice.156

**Background** When strong opioids are initiated for pain in patients receiving palliative care, practice varies. As a result, there is a risk that patients will receive either sub-therapeutic or potentially toxic doses of opioids. Choice of formulation is important from a patient concordance and cost perspective. In May 2012, the National Institute for Health and Clinical Excellence (NICE) published guidelines on initiating strong opioids for adults with advanced and progressive disease ('Opioids in palliative care: safe and effective prescribing of strong opioids for pain in palliative care of adults'). We reviewed the prescribing practice on hospital wards and assessed our compliance with the guidance and considered the barriers to compliance.

**Aim** To assess compliance with NICE guidance when initiating strong opioids for pain in adults with a life-limiting illness.

**Methods** We identified 20 patients with a life limiting illness and that were initiated on strong opioids for pain during their current hospital admission. We reviewed the medical notes and prescriptions measuring prescribing practice against 10 standards outlined by NICE. The patients were from 12 wards including medical and surgical wards. The data was collected over three months.

**Results** Out of the 10 standards, compliance was 100% in three standards, 50% or above in six standards, and less than 50% in one standard.

**Conclusions** The results highlighted areas for improvement. The main barrier appeared to be lack of awareness of the guidance. Due to the high turnover of medical staff, continued education is crucial. We have developed an e-learning module, highlighting the guidance, which will be part of the Trust's mandatory training. The Trust is implementing electronic prescribing and endeavours to include alerts when opioids are prescribed to encourage compliance. With improved compliance, prescribing practice will be safer and the management of pain in our patients will be more effective.

**P-132 APPROPRIATE AND INAPPROPRIATE USE OF NALOXONE IN PALLIATIVE CARE – TWO CASE REPORTS FROM A HOSPITAL**

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10.1136/bmjspcare-2017-hospice.157

**Background** Many patients with life-limiting illnesses will require analgesia. Patients with complex pain symptoms are commonly prescribed regular strong opioids. A number of factors, both intrinsic and extrinsic can lead to opioid toxicity whilst this can often be managed conservatively; naloxone is sometimes required. Clinical staff who are not familiar with managing patients with palliative care needs may not be aware of the potential adverse effects if naloxone is used inappropriately. Here, we describe two cases where naloxone was used. Both of these patients had metastatic malignancies and were in-patients at an acute trust.

**Aim** To review and reflect on two cases where naloxone was used in patients with terminal malignancies who were receiving regular strong opioids and exhibiting signs of opioid toxicity. To compare the practice seen in the two cases against the available guidance on naloxone use in palliative care patients.

**Methods** Two palliative care patients were identified as receiving naloxone for opioid toxicity. Local and national guidance on the use of naloxone in palliative care was used to review the case management.

**Results** One case exhibits the appropriate use of naloxone, which led to a satisfactory outcome. In contrast the other case illustrates inappropriate use of naloxone, leading to severe rebound pain. This review demonstrates the importance of being able to identify when naloxone is necessary in palliative care patients without risking unnecessary reversal of analgesia.

**Conclusions** These cases illustrate the importance of appropriate use of naloxone in palliative care patients receiving regular strong opioids. Inappropriate use of naloxone can result in severe rebound pain and opioid withdrawal. Raising awareness of local and national guidelines alongside continued education to clinical staff is vital to ensure the appropriate and safe use of naloxone in palliative care patients.

#### P-133 HYPOMAGNEAEMIA – DOES IT EXACERBATE PAIN?

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10.1136/bmjspcare-2017-hospice.158

**Background** Hypomagnesaemia is a common electrolyte abnormality, in the chronic state its symptoms are insidious and often non-specific. It is often undiagnosed and thus untreated. There is evidence from animal studies to suggest that magnesium is involved in pain control including an animal model of hyperalgesia which is induced by hypomagnesaemia. However the role of magnesium as an analgesic in patients is unclear. We report two cases of patients with advanced cancer who were admitted to a hospice for pain control which improved when their hypomagnesaemia was treated.

**Cases** Case 1 was a 73 year old man with non small cell lung cancer with metastatic bone pain. Case 2 was a 64 year old man with large cell neuroendocrine cancer with rib wall invasion.

**Case Management** Both patients were found on admission to have asymptomatic hypomagnesaemia and were treated with IV magnesium. Case outcome treatment for hypomagnesaemia resulted in an improvement in pain control such that analgesia was significantly decreased.

**Conclusions** The incidence of hypomagnesaemia in palliative patients is unknown although it is thought to be common.

These cases suggest that treating hypomagnesaemia may improve patients' pain control.

#### P-134 PATIENT-CENTRED QUALITY IMPROVEMENT IN PALLIATIVE AND END OF LIFE CARE: LEARNING FROM ONLINE FEEDBACK

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10.1136/bmjspcare-2017-hospice.159

**Background** Patient and family feedback is fundamental to care as it provides information about the quality of care experiences and involves patients and the public. Feedback methods vary e.g., face to face conversations, questionnaires, touch screens etc. However, *near real-time, online feedback* about care and services is under developed in palliative and end of life care (PEOLC).

We report upon a 'work in progress' quality improvement project using an online platform which enables patients/families to feedback recent PEOLC experiences, leading to learning and change in the organisation. Experience with online feedback suggests that both patients and staff feel that clinical teams should be directly involved in responding online.

**Aim(s)** The aims over two years are to:

1. Test the value and effectiveness of near real-time online feedback in 10 UK-wide PEOLC hospital, hospice or community teams

2. Teach and support the teams how to use the online platform and use feedback for learning, service development, change and demonstrate patient-led outcomes.

**Methods(s)** May 2017 to Sept 2019; 10 PEOLC clinical teams (up to 20 people per team) are being educated and supported in using online feedback in their service. This includes creating email alerts, responding, reporting, and data visualisations. The programme offers a 'community of practice' (CoP) approach to supporting staff in learning to use feedback for quality improvement and wider cultural change.

**Results** A mixed method evaluation using qualitative (to understand the experience) and quantitative (to measure the activity) data, from patient, team and organisation perspectives, including: online platform data, experiences, outcome measurements, staff confidence, patient/family views, QI activity, CoP interaction and turning learning into care.

**Conclusion** Over two years the project will provide an ongoing understanding of the challenges, opportunities and outcomes in using near-real time feedback via an online platform in PEOLC. With recommendations for implementing in other PEOLC settings.

#### P-135 PATIENT CASE STUDIES – LEARNING FROM OUR SERVICE USERS

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10.1136/bmjspcare-2017-hospice.160

**Background and Aims** An organisation that places the patient voice at the centre of its delivery, is an organisation that will be totally fit for purpose. Capturing this voice is a constant challenge to hospices given the nature of palliative care. However, it is a challenge which we are continually striving to