

84 THE USE OF ANTIBIOTIC THERAPY IN THE HOSPICE SETTING

Sophie Hancock, Andrew Fletcher. *St. Catherine's Hospice, University of Lancaster*

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Background There is a paucity of research regarding the use of antibiotics in palliative care, particularly in the hospice setting. Many hospices rely on local hospital antibiotic guidelines which may not be appropriate. With a shift in the focus for palliative patients and concerns nationally regarding antibiotic resistance, it is crucial to review antibiotic usage in specialist palliative care.

Methods Patients commenced on antibiotics between 1st September 2017 and 30th November 2017 at the hospice were included in the study. Patients admitted already receiving antibiotics or prescribed antibiotics by another service (e.g. in a hospital outpatient clinic) were not included. The notes and prescription chart of eligible patients were reviewed for details of antibiotic therapy and the subsequent patient outcomes.

Results A total of 11 patients were eligible for inclusion. The most common suspected source of infection in these patients was chest or urine (10 of the 11 patients). 3 patients received antibiotics intravenously. 2 patients were commenced on antibiotics based on positive specimen cultures, however all 11 patients had investigations to screen for infection, and 7 of the 11 had specimens sent for culture analysis. Only one patient was unable to complete the antibiotic course. Of the 11 patients receiving antibiotics, 5 died during their hospice admission. 4 of the 5 patients who died had received antibiotics within seven days.

Conclusions The patient numbers are small, and this may reflect low prescription rate of antibiotics in the hospice setting. 36% of the patients included died within 7 days of receiving antibiotics and this may indicate inappropriate prescription and misdiagnosis of the patient entering the dying phase. This study has not examined instances where antibiotic therapy was considered but not prescribed. Further studies with this scope are required to gain a more comprehensive view of antibiotic prescribing tendencies in the hospice setting.

85 RELATIONSHIP BETWEEN EASTERN COOPERATIVE ONCOLOGY GROUP PERFORMANCE STATUS (ECOG-PS) AND ACTIGRAPHY-DERIVED ACTIVITY PARAMETERS IN A HETEROGENEOUS GROUP OF ADVANCED CANCER PATIENTS

Shuchita Dhiwren Patel, Andrew Davies, Derk-Jan Dijk. *Royal Surrey County Hospital, University of Surrey*

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Introduction Discrepancies between physician-assessed and patient-assessed performance status, have been associated with an increased risk of mortality. Quantification of activity through actigraphy may be a better, objective method for prognostication. The actigraphy-derived dichotomy index (I<O) has been reported to be of prognostic value in the metastatic colorectal cancer and advanced lung cancer populations. However, the association between the I<O and ECOG-PS has not been fully explored.

Objectives To assess the relationship between physician-assessed ECOG-PS scores and the I<O and other actigraphy-derived

activity parameters such as daytime activity and mean 24 hour activity.

Methods 50 adult outpatients with advanced cancer and an estimated prognosis of less than a year were recruited as part of a feasibility study. Patients and the palliative care physician independently assessed the patient's ECOG-PS both at baseline and after 7 days. Participants were instructed to wear an Actiwatch Spectrum Plus for seven consecutive 24 hour periods on their non-dominant arm, and to concurrently complete a sleep diary.

Results On Day 8, there was moderate agreement between the palliative care physician and individual patient's assessment of their ECOG-PS, with a Kendall's correlation of 0.70 ($p<0.001$). A moderate negative correlation was observed between physician-assessed ECOG-PS and the dichotomy index (I<O) ($r=-0.55$; $p=0.0003$). There was no correlation between physician-assessed ECOG-PS and mean daytime activity ($r=-0.29$; $p=0.073$) or mean 24 hour activity level ($r=-0.2$; $p=0.218$).

Conclusions Physician-assessed ECOG-PS and patient-assessed ECOG-PS scores are moderately correlated. A poor performance status is significantly associated with a measure of day-night difference in activity, but not with absolute activity measures.

86 THE BURDEN OF POLYPHARMACY IN THE HOSPICE INPATIENT SETTING

Shahlaa Walsh, Emily Sills, Amanda Free. *Woking and Sam Beare Hospices, Princess Alice Hospice*

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Background Polypharmacy is a concern due to increasing adverse drug events (ADEs), drug interactions, poor concordance and increased pill burden, especially in the palliative care population who are taking other medications for symptoms control or their disease. Potentially inappropriate medications (PIMs) include those for primary prevention of disease that palliative patients may not develop within their lifespan. There is potential to deprescribe many of these PIMs in palliative care, without the need to restart them, improving quality of life. Lindsay et al have developed a guideline for deprescribing unnecessary medications in the palliative care population, which may assist in discussions around deprescribing in palliative care.

Aim The aims of this service improvement project were to quantify hospice inpatients prescribed potentially inappropriate medications and at risk of polypharmacy; review current practice with a view to consider introducing a deprescribing tool to aid doctors in discussions with patients around rationalising unnecessary medications.

Method A retrospective audit of 40 patient notes from two hospice inpatient units. An audit proforma was developed based on Lindsay et al's deprescribing guideline, recording medications prescribed pre- and post-admission, length of stay, and PIMs prescribed. The agreed standards were for 80% of medications with limited benefit to be stopped and 80% of patients to be discharged on 7 medications or less.

Results 82.5% Patients were on at least 1 PIM pre-admission. On discharge, 77.5% patients continued on at least 1 PIM. Only 37.5% patients were discharged on 7 or fewer medications and 40% of patients were discharged on 10 or more