

## 84 THE USE OF ANTIBIOTIC THERAPY IN THE HOSPICE SETTING

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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

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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

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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

medications. Gastric protection drugs (72.5%), antihypertensives (37.5%) and calcium supplements (30%) were the most common PIMs amongst inpatients.

**Conclusion** Although small-scale, these results indicate that there may be potential for deprescribing PIMs in the hospice inpatient unit.

**87 DISCHARGE DISCUSSIONS IN HOSPICE: PATIENT AND FAMILIES' EXPERIENCES**

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**Background** St Nicholas Hospice Care covers a population of 2 85 000 across West Suffolk/South Norfolk, with a 10-bed ward and community services. This project was prompted by feedback that discharge planning was a source of distress for some patients/families, particularly if the patient died during admission. We aimed to investigate the scale of the problem and identify areas for improvement.

**Method** Admissions April-July 2017 inclusive were identified. Demographics and details of admission and discharge were retrieved for each patient, collated and analysed.

**Results** 77 admissions were identified from 73 patients (4 readmissions). 40 (52%) patients died in hospice, 35 (45%) were discharged (3% were transferred to hospital). For those dying in hospice, only 15 (37.5%) had discharge discussed at any point, though for 11 (73%) of those, discussions continued, within a week of death. Discharge discussions were much more likely to be hospice-led for those who died here (13/15; 87%), whereas patients who were discharged initiated the planning discussions 60% of the time (21/35). Rearranging, in hospice-led discharge discussions, 48% (13/27) went on to die during admission, whereas in patient-led discussions, just 9% (2/23) died, a statistically significant difference ( $p=0.002$ ).

Of those discharged, 29 (83%) had a positive reaction to discussions; 6 (17%) had a neutral (accepting) reaction. For those who died in hospice having discharge discussions, reactions were 8 (53%) positive, 5 (33%) neutral and 2 (13%) negative. Families' reactions were very similar. Of those discharged, 20 (57%) lived for over four weeks after discharge. 10 (29%) died within 2 weeks of discharge: only one had a non-positive reaction to discharge planning.

**Conclusions** The majority of patients do not appear to have inappropriate discharge discussions very close to a death in the hospice. Hospice-led discharge discussions more often are followed by patients dying prior to discharge – a known source of distress – than patient-led discussions are. This study therefore suggests that hospice-led discharge discussions would be a time for caution.

**88 'THE MOST DIFFICULT CONVERSATIONS THAT WE HAVE'. THE DIFFICULTIES OF DISCHARGING HOSPICE PATIENTS TO CARE HOMES AT THE END OF LIFE: A QUALITATIVE FOCUS GROUP STUDY**

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**Background** Discharge from in-patient palliative care units to long term care can be challenging. In the UK, hospice palliative care unit in-patients move to a care home if they no longer require specialist palliative care and cannot be discharged home. There is evidence from the UK and Australia to suggest that patients and families find the prospect of such a move distressing.

**Aim** To investigate the experiences of hospice in-patient multi-disciplinary teams concerning discharging patients from hospice to a care home for end of life care.

**Design** A qualitative study, using thematic analysis to formulate themes from focus group discussions with hospice staff.

**Setting/participants** Five focus groups were conducted with staff at five UK hospices. Participants included multidisciplinary team members involved in discharge decisions. All groups had representation from a senior nurse and doctor at the hospice, with group size between three and eight participants. All but one group included physiotherapists, occupational therapists and family support workers.

**Results** Two main themes emerged: practical concerns and dilemmas around decision making. The latter are reported in this paper. Dilemmas included;

- Ethical concerns (dilemmas around the decision, lack of patient autonomy and allocation of resources);
- Communication challenges and;
- Discrepancies between the ideals and realities of hospice palliative care.

**Conclusions** Hospice palliative care unit staff find discharging patients to care homes necessary, but often unsatisfactory for themselves and distressing for patients and relatives. Further research is needed to understand patients' experiences concerning moving to care homes for end of life care, in order that interventions can be implemented to mitigate this distress.

**89 END OF LIFE CARE AND COGNITIVE IMPAIRMENT: A QUALITY IMPROVEMENT STUDY**

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**Background** A hospice retrospective in-patient case notes review explored care provision at the end of life, mapped against the four key principles in the Scottish Government guidance. Most patients had documentation of informative, sensitive and timely discussions about dying, and exploration of their fears, concerns, goals, wishes, and social, spiritual and psychological needs. However, this was less likely if patients had cognitive impairment.

**Aim** To understand from staff caring for patients with cognitive impairment in a hospice in-patient unit, what prevents them from exploring and documenting their wider holistic needs.

**Methodology** A qualitative study was undertaken, interviewing in-patient hospice medical and nursing staff, using the 5 Whys tool. Results were analysed using a framework analysis approach.

**Results** Fifteen staff members were interviewed – five doctors, five registered general nurses and five healthcare assistants. Themes that emerged included: confidence and skills when communicating with cognitively impaired patients and their informal carers; the importance of familiarity and developing