1223 of those trained came from 8 other countries within the region. MPCU staff gained: 5 BSc, 2 Masters, 1 PhD qualifications. 103 abstracts presented at national and international conferences and 11 papers published. Impact assessments include: evaluation of integrated model including link nurses; outcome of PC interventions; educational impact; research capacity building; morphine use; experience of patients and staff; and evaluation of specific projects.

Conclusions Developing a strategic plan embedding a coherent and integrated approach to PC ensures evidence based practice has become routine and outcomes regularly assessed. Partnerships have allowed for wide project work and dissemination. An integrated model allows generalist PC to be empowered with specialist support. This review is helping shape the next strategic plan.

Pain | Posters 101–104

**101 TIMELY ADMINISTRATION OF ANALGESIA**
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10.1136/bmjspcare-2018-ASPabstracts.128

**Background** An expectation-reality gap exists between the length of time on-request analgesia is requested and the time it is administered. In addition to the physical and psychological benefits of prioritising patient comfort, prompt access to analgesia has been shown to reduce length of hospital stay and improve patient overall satisfaction with care.

**Objectives**
- To identify the median time taken from when a patient requests prescribed analgesia to when the analgesia is administered.
- To consider the feasibility of creating a local standard relating to the time taken from when a patient requests analgesia to when it is administered.

**Method** Patients on two oncology wards requiring PRN analgesia were invited to participate in a prospective audit. Data collection was via a patient held self-evaluation analgesia request diary. In addition to recording time taken to administer analgesia following request, participants also recorded pain scores and overall satisfaction with care. Written consent was obtained from all participating patients.

**Results** In total 15 patients were consented although not all patients recruited ultimately returned data. Data was evaluated relating to 16 episodes of administrated analgesia. Oramorph was the analgesia most frequently administered although Naproxen, subcutaneous morphine and Oxycodone MR were also used.

Time taken from the patient requesting analgesia to the time it was administered ranged from 4 min to 30 min; the median time was 9.75 min.

**Conclusion** Despite the lower than expected number of participants recruited into this audit, the audit process highlighted the variable complexities and barriers that exist if aiming to create a Hospital Standard Relating to the time taken to administer on request analgesia, these include: type of pharmacology, medicines management policies, environmental and organisational factors.

This audit concludes that developing a Pain Pledge may be more apposite than creating a Pain Standard.

**102 IS THE USE OF SUB-CUTANEOUS ALFENTANIL OUTSIDE THE CCU SETTING COMPLIANT WITH LOCAL GUIDELINES? A RETROSPECTIVE AUDIT IN A TERTIARY CANCER CENTRE**
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10.1136/bmjspcare-2018-ASPabstracts.129

**Background** The Royal Marsden NHS Foundation Trust is a tertiary referral cancer centre. The Symptom control and palliative care team have opioid prescribing guidelines. There are specific guidelines for Alfentanil given that it is an infrequently prescribed drug on the inpatient wards, to reduce the risk of error. We carried out a retrospective re-audit of our adherence to the trust alfentanil prescribing guidelines.

**Methods** We identified, using the ward controlled drug log books, all inpatients across the trust (except those on CCU) who had Alfentanil prescribed at any point during 2016. We extracted data on the grade of prescriber, whether the palliative care team were consulted, indication for use, documentation of calculation, the breakthrough dose prescribed and if the calculation had been checked with a senior team member.

**Results** 59 patients in 2016 had been prescribed alfentanil. In 100% of cases the palliative care team had been consulted. In 59% of cases the prescriber was SHO level. The most common indication was renal impairment. In 99% of cases the indication was appropriate. In only 45% of cases there was documentation of a calculation. 85% of those in whom alfentanil was used as a PRN had an appropriate PRN dose charted. In only 54% of cases there had been discussion with a senior team member.

**Conclusion** There are improvements we can make in the documentation of the calculation of the alfentanil dose and also in engagement with the need to discuss the dose calculation. We proposed that the ward pharmacists check the dose conversion and verify that there has been discussion with a senior palliative care team member, as part of their routine inpatient drug chart checking process. We also proposed that specific guidance is given on the trust standards for prescribing alfentanil as part of the junior doctor induction programme.

**103 PRESCRIPTION OF BUCCAL FENTANYL IN DOROTHY HOUSE HOSPICE IPU**
Rebecca Bhatia, Patricia Needham. Dorothy House Hospice

10.1136/bmjspcare-2018-ASPabstracts.130

**Background** The IPU team experienced difficulties regulating the use of buccal fentanyl in a small number of patients.

**Methods** A review of notes and medication charts in all patients prescribed buccal fentanyl on IPU June 2015–6 was done to ascertain whether it was being prescribed appropriately and whether there were any risk factors for ‘concerning use’.

**Results**
- 18 patients were identified. All had a clear rationale for receiving buccal fentanyl.
- 11/18 patients found it clearly effective; of the remaining 7, 5 ‘sometimes’ found it effective.
- 5/18 patients showed what we defined as ‘concerning use’ – i.e. they were using it more than qds, using it to toxicity, were extremely unwilling to reduce usage or try other options,
used it covertly or admitted to using it for reasons other than pain.
- 4/18 had risk factors for addiction. 3 of these 4 patients showed ‘concerning use’.
- 9/18 patients were discharged on buccal fentanyl; there was scope for improvement in the quality of discharge instructions as to how the patient should use buccal fentanyl.

Conclusions 5/18 patients (28%) were felt to have ‘concerning use’ of buccal fentanyl, 3 of these had clear risk factors for addiction this that were identified on admission. Since the time of data collection, the manufacturers have produced a guide for healthcare professionals that includes standardised screening tests for assessing the risk for potential opioid abuse in patients with breakthrough pain. Routine use of these should be considered, with clear explanation of risks shared with all patients, but particularly those with pre-existing risk factors. Patients discharged on buccal fentanyl should be discussed with the GP and have a clear plan on the discharge letter as to the dose, frequency, and type of pain that this is to be used for, along with the rationale.

SODIUM VALPROATE SUBCUTANEOUS INFUSION; A VALUABLE ADJUNCT IN THE MANAGEMENT OF NEUROPATHIC PAIN IN PALLIATIVE PATIENTS

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Introduction Sodium valproate continuous subcutaneous infusion (CSCI) may be underutilised in the multi-modal management of neuropathic pain especially for patients requiring parenteral pain management due to phase of illness or symptom severity. We present a case series of adult patients treated with a sodium valproate CSCI.

Method Prospective data collection; six consecutive clinical cases managed by the Hospital Specialist Palliative Care Team (HSPCT) during final quarter of 2017.

Sodium valproate was commenced at a dose of 200–600 mg/24 hour, in conjunction with a separate opioid or midazolam CSCI. Doses were up-titrated individually to between 400 mg/24 hour and 1500 mg/24 hour (maximal increments of 300 mg/24 hour).

Results 4/6 patients had metastatic cancer, one cervical myelopathy and one osteoradionecrosis of the base of his skull; all had clinical reasons to require parenteral treatment. 5 experienced clinically significant improved pain control within 48 hours; allodynia resolved in the two patients who experienced this, one of whom had residual severe nociceptive pain due to rapidly progressive disease. There was no initial benefit attained in the patient whose starting dose was 200 mg/24 hour, but a dose of 400 mg/24 hour was beneficial. There were no complications attributable to this treatment. Only 2/6 patients required an increase in opioid dose.

Conclusion Unlike most neuropathic pain agents, sodium valproate is available in a parenteral preparation. Other benefits include that it is non-sedating and relatively safe in patients with renal impairment although dose modification is recommended. Six patients with a neuropathic component to their pain treated with sodium valproate CSCI as part of a multimodal analgesic strategy achieved rapid, efficacious control of their neuropathic pain. Titration was achieved over the course of days, the treatment was well-tolerated. We have found a starting dose of 400 mg/24 hour to offer clinically relevant improvement in pain control. This case series supports our impression that it is an opioid sparing intervention.