

This pilot suggests further study into the prevalence and management of glucocorticoids in patients with cancer, across all settings, would be beneficial to establish the need for formal guidelines.

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IDENTIFYING INAPPROPRIATE PRESCRIBING IN OLDER PEOPLE WITH DEMENTIA: A SYSTEMATIC REVIEW

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Background Older people with dementia are at risk of adverse drug-related events associated with the prescribing of potentially inappropriate medications.

Aim To describe how tools designed to identify potentially inappropriate prescribing have been used in studies of older people with dementia and to determine the prevalence of potentially inappropriate prescribing in this cohort.

Methods Systematic review with narrative synthesis designed and conducted according to the recommendations set out in Preferred Reporting Items for Systematic Reviews and Meta-Analyses-Protocol (PRISMA-P) and PRISMA statements. Electronic databases, including MEDLINE, EMBASE, PsychINFO, Cochrane Library, Social Science Citation Index, OpenGrey and Grey Literature Report were searched, along with hand-searches, for studies using tools/criteria to identify potentially inappropriate prescribing in older people with dementia. Screening, extraction and quality assessment (Hawker score) were performed in duplicate.

Results A total of 3,626 unique records were identified; 26 studies met the inclusion criteria (which included 26,534 participants, of which 21,285 (80%) had dementia or cognitive impairment). The mean participant age in these studies ranged from 72.5 to 86.8. The Hawker score ranged from 22/36 to 36/36, indicating all studies were fair to good quality. The Beer's criteria was the most commonly used tool (15/26 studies). There were variations in how the tools were applied, with 13 out of 15 studies using the Beer's criteria not using the full tool. Eight studies used more than one tool to identify potentially inappropriate prescribing. The prevalence of potentially inappropriate prescribing ranged from 14% to 74% in older people with dementia. The most commonly prescribed potentially inappropriate medications were benzodiazepines and anticholinergics.

Conclusions Variations in tool application may partly explain variations in potentially inappropriate prescribing rates across studies. Recommendations include a more standardised tool usage, ensuring the tools comprehensively identify all potentially inappropriate medications and that the tools are kept up to date.

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AN OBSERVATIONAL STUDY OF OPIOID-INDUCED CONSTIPATION (OIC)

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Background Opioid-induced constipation (OIC) is common, although there is a lack of consensus on diagnostic criteria, and as a result a lack of consistency around the prevalence

(with resultant impact on patient care). This study primarily aims to compare different methods of assessing OIC in a heterogeneous group of patients with cancer.

Methods Data was collected on 100 consecutive patients with cancer that were receiving regular opioid analgesics. Constipation was assessed using a simple question ('are you constipated'), the EAPC criteria, the so-called 'Camilleri' criteria (for OIC), the Rome IV criteria (for OIC), and assessment by a specialist palliative care professional. The degree of OIC was assessed using the bowel function index (BFI).

Results The median age was 62 (range 37–86); 46% were female, 54% were male. Cancer diagnoses were as follows: 34% gastrointestinal, 13% gynaecological, 12% head and neck, 11% urological, 11% breast, 10% lung, 5% haematological, 2% skin, 2% malignancy of unknown origin.

The prevalence of constipation using the different diagnostic criteria was:

- Simple question – 35% (with 17% 'unsure')
- EAPC criteria – 29% (with 6% 'unsure')
- Camilleri criteria (for OIC) – 63% (with 6% 'unsure')
- Rome IV criteria (for OIC) – 71%
- Assessment by specialist palliative care professional – 68% had constipation; of which 44% had OIC.

Of the patients identified as having OIC from the Rome IV criteria, 30% thought they were constipated, and the mean BFI was 65. In contrast, the mean BFI for patients that did not meet the Rome IV criteria was 32.

Conclusions The prevalence of OIC depends on the diagnostic criteria employed. It appears that many patients with OIC do not realise that they are in fact constipated (based on objective criteria).

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SEIZURE MANAGEMENT IN PATIENTS UNABLE TO TAKE ORAL MEDICATIONS: A MULTI-CENTRE AUDIT

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Background Seizures are common in the palliative care population. For patients who are unable to take oral medication, seizure management can become problematic but there is little consensus on best practice, particularly for patients with longer prognoses.

Aim To examine prescribing of non-oral and 'as required' anti-convulsant medication across multiple palliative settings (community/hospice/acute hospital).

Method A regional multi-centre audit of prescribing practice was conducted from October to December 2017. Inclusion criteria: adult patients requiring anticonvulsant medication but unable to take oral preparations. Practice was assessed against regional Palliative Care guidelines. Data was collected retrospectively via a SmartSurvey proforma.

Results Twenty-six patients across six centres were included. When unable to take oral medications, 25 patients (96%) commenced a continuous subcutaneous infusion (CSCI). Fourteen patients were prescribed levetiracetam (250 mg-3 g/24 hours), seven were prescribed midazolam (15–30 mg/24 hours), two were prescribed sodium valproate (600 mg/24 hours) and two were prescribed combination levetiracetam (3 g) and midazolam (30–40 mg). One patient had no regular

anticonvulsant as they were imminently dying. Where prognosis was estimated, 80% of patients commencing a midazolam CSCI were felt likely to survive less than a week. Seizures were controlled in 69% of patients with initial doses prescribed. 'As required' anticonvulsant medication was prescribed for 23 patients (88%); all were prescribed subcutaneous midazolam (2.5 mg-10 mg). Phenobarbital (8 patients), buccal midazolam (one patient) and rectal diazepam (one patient) were also prescribed. The majority of patients (92%) died and almost half (46%) died within a week of parenteral anticonvulsant prescription.

Conclusion Levetiracetam via CSCI was the most commonly used parenteral anticonvulsant. Midazolam via CSCI tended to be used for patients with a poorer prognosis (under one week). Regional guidelines need to be reviewed to reflect clinical practice. Given the widespread use of levetiracetam, further research is warranted to guide use in the palliative care setting.

176 SYRINGE DRIVER (CSCI) SITE REACTIONS IN SPECIALIST PALLIATIVE CARE IPU

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Background Syringe drivers are routinely used in palliative medicine for the subcutaneous infusion of drugs. Local site reactions can lead to patient discomfort and the potential for sub-optimal symptom control. A site reaction is defined as 'an adverse incident occurring at the point of drug delivery'. Anecdotally, we observed frequent site reactions in our clinical practice without formal record of prevalence within our inpatient unit. We decided to perform an audit to determine whether our practice is in keeping with local/national guidance and whether outcomes were within acceptable limits.

Methods Aims/objectives -

- Site reactions are within 'acceptable limits'
- Site reactions are recognised
- Recommendations/guidelines regarding site management are followed
- Appropriate drugs/diluents used.

Standards

- Prevalence of site reactions <20%,
- Sites inspected 4 hourly (100%),
- Sites rotated every 7 days (100%)
- Reactions recorded (100%)
- Diluents appropriate (100%).
- Line changed with prescription change (100%)

Results 46 prescriptions and sites reviewed (completed 13/12/2017). Site reactions observed in 8.6%. 100% of sites recorded as inspected every 4 hours but zero reactions identified/recorded. Rotation frequency documented -72% -average 10 days, and not documented -28%. Diluent appropriate -100%. Line changed with a change in prescription -39%.

Conclusion We have demonstrated compliance with standards 1, 2 & 5. However, problems were identified with standards 2, 3, 4 & 6. 100% of reactions identified were documented as inspected 4 hourly highlighting poor recognition of reactions. Average length of site rotation exceeded 7 days. And only 38% of lines were changed with prescription change. Our recommendations include reviewing processes of site

inspection. To provide education on site reaction recognition and the importance of line change in conjunction with prescription change. And to standardise clear documentation of site rotation and local policy adherence. Following implementation of these interventions we recommend annual re-audit to ensure standards met.

177 CHANGING THE GOAL POSTS: EXPLORING THE EXPERIENCES OF COMMUNITY PALLIATIVE CARE NURSES IN THE MANAGEMENT OF DELIRIUM

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Background Delirium is a syndrome of decreased cognitive function, consciousness and attention. It has an acute onset and fluctuating course. The prevalence of delirium amongst palliative care in-patients is about 30%. There is no similar data for out-patients. A focus group was conducted at a Scottish hospice to explore the experiences of clinical nurse specialists (CNSs) in managing delirium in the community. This formed part of a wider quality improvement project on hospice patients with delirium.

Method Two facilitators explored the experiences of CNSs in the management of delirium. Discussions were recorded and transcribed to allow analysis of themes.

Results The focus group involved eight CNSs and generated 21 pages of text. Data was reviewed by two members of the project team. Themes emerged including importance of skilled assessment, impact on families, challenges in the management of delirium at home and the impact of delirium on choices available at the end of life.

The CNSs reflected on the impact of delirium on patients' families, who experienced guilt, fear and a sense of early bereavement. They also recognised particular challenges associated with managing patients with delirium in the community. They felt pressure to avoid admission to hospital but also felt there was a lack of the support services required to offer a non-pharmacological approach to management at home. Drugs were resorted to earlier than would be necessary in a different care setting to manage symptoms and risk. The CNSs also spoke of 'walking away' but being left with feelings of responsibility for the situation. Delirium was also felt to negatively impact on choices at the end of life e.g. place of death.

Conclusion Management of delirium in the community represents unique challenges compared with an in-patient setting. There is a need for educational resources targeting professionals working in the community.

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178 FACTORS ASSOCIATED WITH AN EFFECTIVE TRANSITION FROM CHILDREN'S TO ADULT SERVICES BY YOUNG ADULTS WITH LIFE-LIMITING CONDITIONS IN IRELAND

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