

## Free papers 22–24 | Symptom control

## 22 DELIRIUM MANAGEMENT BY SPECIALISTS IN PALLIATIVE MEDICINE: AN ASSOCIATION FOR PALLIATIVE MEDICINE (APM) OF GREAT BRITAIN AND IRELAND SURVEY

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**Background** Delirium is common in patients receiving palliative care. Management includes assessment, reversal of underlying causes, non-pharmacological interventions and family support. Given recent evidence, antipsychotics should be avoided in mild-moderate delirium.

**Methods** A 20-question online anonymous survey was emailed to all Association for Palliative Medicine (APM) members. UK and Irish palliative medicine specialists in current clinical practice (n=859) were asked about delirium assessment, management and research priorities.

**Results** Response rate was 39% (335/859). Of these, 70% (234/335) were consultants, 15% (51/335) were specialist trainee registrars in palliative medicine and 15% (50/335) were associate specialists. Overall, 85% (285/335) had over 5 years of specialist palliative medicine experience. They worked in a variety, and often multiple settings, across hospital, hospice and community. Delirium guidelines were inconsistently used, with 42% (115/276) using local guidelines and 38% (104/276) using no guidelines. Most, 184/314 (59%) never use a tool to screen for delirium at inpatient admission. Most would use non-pharmacological interventions to manage delirium, either alone (106/275; 39%) or more commonly with an antipsychotic (160/275; 58%). The majority, 248/273 (91%) would prescribe an antipsychotic to a delirious patient with distressing hallucinations, with 190/273 (70%) using typical antipsychotics and 43/273 (16%) using atypical antipsychotics first line. Most inpatient (153/270; 57%) and community teams (97/161; 60%) do not formally support family carers. Informal verbal support was offered by 24% (64/270) in the inpatient setting and 22% (35/161) in community settings. Research priorities were prevention, prediction of reversibility and management (non-pharmacological and pharmacological).

**Conclusion** Most responding APM members do not formally screen for delirium at inpatient admission. Many use an antipsychotic along with non-pharmacological interventions to manage delirium, and nearly all prescribe an antipsychotic to treat distressing hallucinations. Further rigorously designed clinical trials are urgently needed in view of management variability, emerging evidence and perceived priorities for research.

## 23 THE ASSOCIATION OF BENZODIAZEPINES AND Z-DRUGS WITH MORTALITY IN PATIENTS WITH CANCER: A SYSTEMATIC REVIEW

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**Background** Benzodiazepines and Z-drugs are commonly used in patients with cancer for the management of symptoms such

as anxiety, agitation and dyspnoea. Clinical staff, patients and relatives have concerns about the impact of these drugs on survival. This potentially decreases prescribing leading to sub-optimal symptom control.

The aim of this systematic review was to find and assimilate the evidence assessing the association of benzodiazepines and Z-drugs with survival in patients with cancer, to assist in clinical decision-making regarding the use of these drugs in cancer patients.

**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. The review protocol was registered on the PROSPERO prior to commencing the searches. The electronic databases MEDLINE, EMBASE, PsychINFO, Cochrane Library, AMED were searched and hand-searches were performed. Screening, extraction and quality assessment were performed in duplicate.

**Results** A total of 2257 unique records were identified, 116 full-text articles assessed for eligibility, 18 met the inclusion criteria. These contained data on 4117 patients with cancer. All studies were low or very-low quality. Most studies were conducted in patients in the last days/weeks of life. No study found an association between benzodiazepines and survival in patients with cancer.

**Conclusions** There is no evidence demonstrating an association between benzodiazepines and survival in patients with cancer. These results should be interpreted with caution as all studies were low/very low quality, most did not report or account for other medications and did not have survival as a primary outcome. No study assessed the effect of long-term benzodiazepines on survival. Therefore, definitive conclusions regarding survival impact of benzodiazepine in patients with cancer can be made. Further investigation using high-quality long-term randomised control trials with survival as a primary endpoint are needed.

## 24 THE ASSOCIATION OF ORAL INTAKE WITH THIRST AND SURVIVAL IN ADVANCED CANCER: A SECONDARY ANALYSIS OF OBSERVATIONAL DATA

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**Background** Oral fluid intake commonly reduces in advanced cancer patients as they approach the end of their lives. The relationship of oral fluid intake with thirst and survival has not been fully evaluated. Better understanding of how oral fluid intake affects physical health and clinical outcomes may enable health professionals to identify which patients require hydration-based support.

**Aim** To explore the association of oral fluid intake with thirst and survival in advanced cancer patients.

**Method** A secondary analysis of an observational study database of 90 patients with advanced cancer from a previous study by Nwosu et al 2016. Regression analysis evaluated the relationship between oral fluid intake and thirst, and examined the predictive properties of recorded variables. Kaplan-Meier analysis evaluated the relationship between survival and oral fluid intake. A Cox regression was used to adjust for potential confounding factors: performance status, metastatic disease and age.

**Results** Low fluid intake was significantly associated with increasing thirst severity (Beta=-0.223, p=0.037). Increasing morphine dose also corresponded with increasing thirst (Beta=0.250, p=0.025). Oral care regimes were present in n=39 (43.3%) and their use was associated with higher thirst scores (Beta=-0.200, p=0.051). Daily fluid intake was 0–499 ml in 27 (30%); 500–799 mls in 42 (46.7%); and >800 mls in 21 (23.3%) participants. Lower oral daily fluid intake was associated with shorter median survival (800 mls=172 days. p=0.004). Oral fluid was an independent predictor of survival following adjustment with cox regression.

**Conclusion** In this advanced cancer sample, oral fluid intake was a statistically significant predictor of survival. Patients with fluid intake of <800 mls/day had higher thirst and shorter survival compared to those drinking larger volumes. Future studies can aim to improve mouth care and fluid intake in patients drinking <800 mls/day, to examine if this improves clinical outcomes.

## Free papers 25–27 | Palliative care in the community II

### 25 EVALUATION OF A MULTI SITE SPECIALIST PALLIATIVE CARE AT HOME INTERVENTION

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**Background** The Midhurst Macmillan Specialist Palliative Care at Home Service was founded in 2006 to improve community-based palliative care provision. Principal components include; early referral; home-based clinical interventions; close partnership working; and flexible teamwork. Following a successful introduction, the model was implemented in six further sites across England. This article reports a mixed methods evaluation of the implementation across these ‘Innovation Centres’.

**Aim** To assess the process and impact on staff, patients and carers of providing Macmillan Specialist Care at Home services across the six sites.

**Methods** A longitudinal, mixed methods research design. Data collection over 15 months (2014–2016) included: Quantitative outcome measures:- Palliative Performance Scale [PPS]; Palliative Prognostic Index [PPI] (n=2,711); Integrated Palliative Outcome Scales [IPOS] (n=1,157); Carers Support Needs Assessment Tool [CSNAT] (n=241); Views of Informal Carers – Evaluation of Services [VOICES-SF] (n=102); a custom-designed Service Data Tool [SDT] (n=88). Qualitative data methods:- focus groups with project team and staff (n=32 groups, [n=190 participants]), and, volunteers (n=6 groups, [n=32 participants]). Quantitative data analysis – SPSS vs 21; Qualitative data – thematic analysis.

**Results** Comparison across the different sites revealed contrasting modes of implementation. PPS, PPI and IPOS data exposed disparity in early referral criteria, complicated by conflicting interpretations of palliative care. The qualitative analysis, CSNAT and VOICES-SF data confirmed the value of the Macmillan model of care but uptake of the specialist home-

based clinical intervention component was limited. Significant findings included better co-ordination of palliative care through project management and a single referral point and multi-disciplinary teamwork including leadership from consultants in palliative medicine, the role of health care assistants in rapid referral, and volunteer support.

**Discussion** Specialist palliative care teams enhance the quality of palliative and end of life care in the community setting and should form an integral part of future policy in this area.

### 26 DESIGNING SAFER SERVICES FOR PATIENTS NEEDING PALLIATIVE CARE IN GP OUT OF HOURS SERVICES: A NATIONAL ANALYSIS OF PATIENT SAFETY DATA TO IDENTIFY PRIORITIES FOR SYSTEMS IMPROVEMENT

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**Background** Patients receiving OOH palliative care are at increased risk of unsafe care (Mazzocato & Stiefe, 1 1997; Dietz *et al.* 2010). The identification of improved ways of delivering palliative care outside working hours is a priority area for policy makers. (Best *et al.* 2015) To allow service redesign to provide safer care for patients, a means of identifying priority areas for systems improvement is needed.

#### Aims

- Explore the nature and causes of unsafe care delivered to patients receiving palliative care from primary care services outside normal working hours.
- Review literature to identify existing interventions addressing causes of unsafe care.
- Engage a stakeholder group in a large healthcare organisation in Wales to identify priority areas within the out-of-hours GP service.

**Methods** We characterised patient safety incident (PSI) reports submitted to the National Reporting and Learning System, using codes to describe what happened, underlying causes, harm outcome, and severity of harm. Exploratory descriptive and thematic analyses identified factors underpinning unsafe care. Results of this analysis informed a scoping review of the literature (Tricco *et al.* 2016), and findings were presented as a driver diagram (a one-page summary of where and how to improve the system).

**Results** 1072 reports of suboptimal care, described: medication-related issues (n=613); access to timely care (n=123); and non-medical management of pressure ulcers or urinary catheters. (n=102). Almost two thirds of reports (n=695) described harm with outcomes including increased pain, distress and dying in a place not of their choosing. A scoping review identified interventions to improve confidence of staff around end of life medications, improve advanced care planning and improve documentation across providers. The driver diagram facilitated discussions amongst stakeholders (lay and professional) to contextualise findings and identify priorities for service improvement.

**Conclusions** Analysis of PSI reports and associated literature review can be used to inform service improvement initiatives.