Methods A multi-stakeholder team updated the form and processes with user feedback. Improvements included:

- rewriting and expanding symptom management guidance
- providing a starting 'recipe' of anticipatory medicines that can be adjusted to individualise care
- an electronic version of the CD1 form including options to integrate into SystmOne and EMIS
- the ability to tailor the CD1 form for local prescriber preference
- additional resources including formularies for SystmOne and EMIS
- making all resources openly available on www.eolc.co.uk

Evaluation The updated CD1 form and resources were published in May 2018. Its use is being promoted alongside encouraging associated behavioural change within Lincolnshire around anticipatory prescribing. Initial feedback around clarity and ease of use is positive suggesting the revised CD1 form has addressed previous barriers around its use.

Next steps Formal user feedback survey. Data is to be collected from out of hours providers pre- and post- implementation to evaluate if the new process results in a reduction in calls to these services for symptom management in dying patients.

P-121 A NEW ANTI-EMETIC: OLANZAPINE FOR THE PREVENTION AND TREATMENT OF CANCER-RELATED NAUSEA AND VOMITING

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We undertook a new Cochrane Systematic Review to assess the efficacy and safety of oral olanzapine when used as an anti-emetic in the prevention and treatment of nausea and vomiting related to cancer in adults. We searched published and unpublished trials up to the 8th September 2017. We included randomised controlled trials (RCTs) of olanzapine with or without adjunct therapies for the prevention and/or treatment of nausea or vomiting in patients with cancer aged 18 or over, in any setting, with ≥ 10 participants per treatment arm. Standard Cochrane methodology was used.

We included 14 RCTs (1917 participants) from high, middle and low income countries in which olanzapine was administered orally, in people with over 24 different cancers, none of which were funded by pharmaceutical companies. Participants received: highly emetogenic (HEC) or moderately emetogenic (MEC) chemotherapy (12 studies); chemoradiotherapy (one study); or no active treatment (one study). Eight studies await classification and 13 are ongoing. The majority of studies were at low or unclear risk of bias across most domains. A high risk of bias, related to issues of blinding, was present in 10 RCTs.

Oral olanzapine probably almost doubles the likelihood of freedom from nausea and vomiting during chemotherapy from 25% to 50% (RR 1.98, 95% CI 1.59 to 2.47; 561 participants; solid tumours; HEC or MEC therapy; moderate quality evidence) when added to standard therapy. Number Needed to Treat for additional benefit (NNTB) was 5 (95% CI 3.3–6.6). Serious concerns have been raised regarding the efficacy and safety of injectable olanzapine (intravenous, intramuscular

or subcutaneous). Olanzapine probably increases somnolence and fatigue compared to no treatment or placebo (RR 2.33, 95% CI 1.30 to 4.18; anticipated absolute risk 8.2% more). It is unclear if anti-emetic efficacy differs between 5 mg and 10 mg doses.

P-122 EMBRACING INFORMAL CARERS AS PART OF THE HEALTHCARE TEAM

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The aim of this project is to empower patients and families to take an active role in symptom control at end of life. A multiprofessional team has been working together to develop a policy which will enable informal carers to administer as required subcutaneous medication at end of life. This project has been informed and guided by patients and carers. The rationale for this project is to:

- Enhance symptom control by more rapid administration of as required injectable medication, potentially enabling patients to remain at home
- To support and empower family members who want to provide this type of support to the patient, ensuring underpinning training and education is in place
- To complement rather than replace existing services, district nursing support will continue to be required
- To have a positive impact upon bereavement, enabling families to feel that they have done all that they can do for their loved one.

We have faced multiple challenges in developing this policy not least professional concerns relating to prescribing medication which will be administered by an informal carer and the professional implications of supporting informal carers to administer the prescribed medication. Initially it was hoped that this project would include the acute sector but this has been too difficult to achieve. Careful multiprofessional working has been critical.

We now have support to proceed from Worcestershire Clinical Commissioning Group, St Richard's Hospice and a General Practitioner (GP) locality team. An outline paper, inclusion/exclusion criteria and process has been agreed. Supporting documentation and underpinning training is being developed. We aim to pilot the policy commencing August 2018. Our approach will be on a patient by patient basis. Patients will be highlighted to the GP by St Richard's Hospice Clinical Nurse Specialists. There will be ongoing review of this policy's use.

P-123 THE OPIOID CONVERSION WORKBOOK: A NOVEL EDUCATIONAL INTERVENTION TO ENHANCE PATIENT SAFETY

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Background Proficiency in safely converting between opioids is an important skill for doctors and nurses working in palliative care. Rigorous opioid conversion training is rare (Webster, Bremner, Oosenbrug *et al.*, 2017; Spitz, Moore, Papaleontiou

et al., 2011), representing potentially widespread unmet educational needs.

Aims Following several drug incidents at our hospice, we aimed to design an educational intervention to facilitate sustained learning of opioid conversion skills. It was intended to be resource-efficient to administer and transferable to community, hospice and hospital settings. The initial target audience was registered nurses (RNs) and junior doctors at a single hospice.

Methods Fifteen clinically relevant questions were formulated to assess baseline ability in opioid dose conversion, calculation of appropriate breakthrough requirements and background dose amendment. A symmetrical final assessment was written using different dose integers. A workbook was written to constructively align with the assessments and evolved following small pilots, incorporating feedback. After a didactic introduction, each section included a calculation example and five self-marked practice questions (41 in total), with increasing complexity. Participants attempted the 32-page workbook after sitting the baseline assessment and before completing the final assessment. Interval reassessment was undertaken to evaluate learning durability.

Results 39 hospice staff have completed the programme to date (26 RNs, 13 doctors). The overall mean baseline test score was 3.3/15 (range 0/15 – 10/15, RN mean 2.8/15, doctor mean 4.2/15). After completion of the workbook, 38 of 39 participants scored 15/15 (mean 14.6/15). The mean score at interval reassessment of 14 RNs (mean six months after workbook completion) was 14.8/15 (range 14/15 – 15/15). Opioid-related patient safety incidents also decreased following workbook introduction.

Conclusions The workbook is an effective educational intervention that significantly improves opioid conversion ability and is sustained six months after completing the training. We plan to introduce the evolving workbook at a local hospital and seven other hospice sites over the next eight months.

P-124 **PALLIATIVE USE OF STEROIDS: COMPLIANT OR COMPLACENT?**

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Background Novel oncology therapies mean many palliative patients are living longer and therefore long term side effects of medical interventions require more consideration. Steroids are widely used in the palliative setting for both specific and nonspecific symptoms and ‘The adverse effects of oral corticosteroids are dose-related. They can often be predicted...’ (NICE, Clinical Knowledge Summaries: Corticosteroids – oral, last rev. Aug. 2015).

Aims To evaluate whether monitoring for side effects, whilst on steroids (Dexamethasone/Prednisolone), was in accordance with NICE guidance and if this was appropriate for the hospice patients.

Methods A retrospective audit of inpatient case notes – August to September 2017. Inclusion criteria:

- Patients already on steroids on admission
- Patients initiated on steroids during admission.

Evaluation of whether the following were checked on and during admission as per NICE guidance:

- Blood pressure
- Weight
- Capillary blood sugar (CBG) [surrogate for HbA1c]
- Potassium.

Results Over two months there were 55 admissions to the inpatient unit. 62% (n=34) fulfilled the inclusion criteria. 76.5 % of these had a pre-existing steroid prescription and were more likely to have these increased than stopped. Only 29.4% had CBG documented on admission and other parameters were not regularly reviewed. Overall, the hospice did not fully comply with NICE guidance.

Conclusions Of those included, 58% died during admission. This suggests regular parameter testing may be inappropriate in this cohort as long term side effects (SE) may be prognostically irrelevant. The SE profile may be more acceptable than unmanaged ongoing symptoms. Therefore repeated testing for certain parameters (e.g. weight/potassium) may not be appropriate. However, diabetes mellitus is more likely to be an early side effects of steroid use and therefore CBG testing would be of symptomatic importance. A re-audit is planned following implementations of these recommendations:

- Steroid alert box on drug charts
- Health care professional teaching on steroid SEs and monitoring.

P-125 **DELIVERING CHC TO ACHIEVE PATIENT WISHES TO DIE AT HOME: MEDICINE COMPETENCIES FOR HCAs**

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Background We recently commenced a Continuing Health Care Fast Track Pilot Project which aims to enable patients with a deteriorating and life-limiting illness to remain at home by preventing avoidable admissions to hospital and facilitating early discharge from in-patient care, either hospital or hospice. We offer up to four times a day care which may include prompting or administration of medication by the staff member who are predominately health care assistants (HCAs). Recent guidance has made it clear that if HCAs have been appropriately trained and their competence is regularly assessed it is legal for them to carry out this enhanced role.

Aim To ensure the staff are competent and supported in prompting and administering medication to patients in their own home.

Method In house training undertaken by the team included the supply, storage and disposal of medicines, safe administration, accurate record keeping using the MARs sheet, accountability, confidentiality and commonly identified issues linked with errors in administration. One to one observation of healthcare assistants prompting/administering medication. Competency assessed and signed off.

Results The service can accept patients with more complex needs that may include the prompting or administration of medication. This increases patient choice and enhances the patient experience. The overall aim of meeting the patient's preferred place of death in the patient's home is achieved. The team are trained and supported to carry out medicine tasks in a safe and effective manner for the benefit of the people they are caring for.