Results Two patients with PDOC were admitted to the hospice over a 12 month period for withdrawal of CANH. A 28-year-old man who had been in a vegetative state for 15 months secondary to a cerebral abscess and a 73-year-old woman who had been in a vegetative state for 6 years following a hypoxic brain injury. They both died at the hospice 9 days after discontinuing CANH. Key themes identified were educational needs of hospice staff especially an understanding of how reflex reactions may be misunderstood as purposeful actions in PDOC, the value of providing an opportunity for staff to debrief following episodes of care and the importance of the hospice team being involved in the development of a detailed end of life plan prior to hospice admission.

Conclusion There are numerous medical, ethical and legal challenges encountered in making the decision to withdraw CANH and then in providing end of life care for these patients. Learning from our work may help other professionals caring for similar patients as we predict an increase in referrals to hospices to be involved in managing the care of similar patients.

A CASENOTE REVIEW OF PARENTERAL INFUSIONS IN DYING PATIENTS; A RESPONSE TO RECENT MEDIA HYPE
Eilidh Burns, Carol Davis. NHS University Hospital Southampton Foundation Trust

Background In the aftermath of the Gosport Independent Panel Report (June 2018), the National Audit of Care at End of Life presented an opportunity to examine the use of continuous parenteral infusions for symptom relief in dying patients.

Methods Casenote review of acute hospital in-patients who died in April 2018 recording patient location, diagnosis and hospital palliative care team (HPCT) involvement. For patients who died on an infusion MTU involvement, rationale for starting infusion, duration and drugs used were recorded.

Results 86 casenotes reviewed. 34/86 (40%) patients died on an infusion.

21/60 (33%) dying of non-malignant conditions and 13/26 (50%) dying of cancer were on an infusion. 29/49 (59%) being reviewed by the HPCT and 5/37 (15%) not known to HPCT were prescribed an infusion. 9/14 (64%) patients on an oncology ward and 8/28 (29%) on a ward of the elderly (COTE) ward were on infusions.

30/34 (88%) started infusions including an opioid (12 morphine, range 5–30 mg, median 10 mg; 18 oxycodone, range 5–20 mg, median 5 mg). 33/34 (97%) died with an opioid (12 morphine, range 5–30, median 10 mg; 21 oxycodone, range 5–50 mg, median 5 mg). 19/21 (90%) receiving infusional oxycodone were known to HPCT. Other drugs infused: midazolam (21), anti-secretory (18), levomepramazine (10), haloperidol (5), metoclopramide (2).

Mean infusion duration 2.2 days (range 0–13).

Conclusions Patients with non-malignant conditions and those on COTE wards were less likely to die on an infusion. Not all patients with cancer, nor all those known to HPCT, died on an infusion, however, patients on an infusion were more likely to be known to HPCT.

Average doses of opioids on starting were low and did not substantially increase, which could be related to the short duration of infusions. Poor documentation precluded detailed qualitative analysis.