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.

32 A CASENOTE REVIEW OF PARENTERAL INFUSIONS IN DYING PATIENTS; A RESPONSE TO RECENT MEDIA HYPE

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10.1136/bmjspcare-2019-ASP.55

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 MDT 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 care 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 infusion oxycodone were known to HPCT. Other drugs infused: midazolam (21), anti-secretory (18), levomepromazine (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.

33 INEQUALITIES IN HOSPICE CARE PROVISION: A SYSTEMATIC LITERATURE REVIEW AND NARRATIVE SYNTHESIS

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10.1136/bmjspcare-2019-ASP.56

Background Hospice care is often perceived as being associated with stereotypical patients: white, middle-class, young and with cancer.

Aim To review the literature concerning who is/is not referred for hospice care, with a focus on diagnosis, age, gender, marital status, ethnicity, geography and socio-economic status.

Design of study Systematic literature review and narrative synthesis.

Methods Searches of Medline, PsycINFO, CINAHL, Web of Science, Assia and Embase databases from January 1987 to December 2017 were conducted, with further citation, reference and hand searches. Studies of adult patients living in the UK/Australia/New Zealand and Canada and receiving a range of hospice care (inpatient, outpatient, day hospice, hospice at home, community specialist (Macmillan) nursing) were included. Case studies, opinion pieces and systematic reviews were excluded. Of 28 433 articles reviewed, 152 met the inclusion criteria. Extracted data were analysed using NVivo with a narrative synthesis of emergent themes.

Results Since 1987, there has been extensive research demonstrating inequalities in hospice care provision. There is some evidence that some inequalities are reducing, particularly for those with non-malignant diseases. Nonetheless, there are still important groups with less access to hospice care, including the oldest old, ethnic minorities and those living in areas of high socioeconomic deprivation. Gender and marital status have little effect on hospice care provision. The literature concerning hospice care provision for the LGBTQ community and those living with HIV/AIDs is very limited.

Conclusion Prognostic uncertainty and fragmentation of care remain barriers to receipt of hospice care for those with non-malignant disease. The oldest-old, the socio-economically deprived and those from ethnic minorities continue to receive less hospice care. There is a persisting challenge to the hospice movement to provide equitable access to all.

34 THE DEVELOPMENT OF A FRAMEWORK TO PERSONALISE HYDRATION MANAGEMENT IN CANCER CARE: THE USE OF NON-INVASIVE TECHNOLOGY TO EVALUATE FLUID STATUS AND DEHYDRATION-RELATED SYMPTOMS

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10.1136/bmjspcare-2019-ASP.57

Background The role of hydration in causing or alleviating suffering in advanced cancer is poorly understood. The evidence for the efficacy of clinically assisted hydration in advanced cancer is inconclusive. Bioelectrical impedance vector analysis (BIVA) is an accurate validated method of assessing hydration status. Previous work with BIVA demonstrates

significant relationships with hydration status, symptoms and survival in advanced cancer. However, further work is needed to study these associations in the dying.

Aim This feasibility study aimed to develop the necessary methodology to evaluate hydration and its relationship with clinical symptoms and quality-of-life in dying cancer patients.

Methodology An observational study of thirty patients with advanced cancer in a hospice and hospital-based specialist palliative care inpatient unit. An advanced consent methodology was used to conduct assessments in the dying phase. Assessments involved hydration (BIVA), symptoms, physical signs, quality of life, myoclonus and survival. Family-caregivers experiences of hydration were evaluated via questionnaire.

Results The feasibility aspect of the study was successful in recruiting patients and caregivers across the research sites. The overall recruitment rate for patients was 60% (30 out of 48 approached agreeing to participate) with six (20%) of those recruited receiving a further hydration assessment in the dying phase of their illness. Eighteen caregivers completed questionnaires.

Conclusion It is feasible to use BIVA to assess hydration in the dying. This study will support the next phase of the study which include recruitment from additional palliative care units. The outcomes from this work will help to identify hydration-associated variables to support development of a clinical hydration assessment tool. Ultimately, this will help to develop a framework to clinically assess and manage hydration states patients with cancer.

35 PRINCIPLES OF CARE FOR THE DYING PATIENT- AUDIT OF USE IN A TERTIARY REFERRAL CANCER CENTRE

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10.1136/bmjspcare-2019-ASP.58

Background The Leadership Alliance for the Care of Dying People set out an approach with focus on achieving the five priorities of care. Our trust developed an electronic version of the London Cancer Alliance document, The Principles of Care for Dying Patients. This audit set out to determine the number of expected deaths who had a document in place and if completed, adherence to the NICE Quality Standards for care of adults in the last days of life (NG31).

Methods Prior to the National Care at the end of life Audit, the hospital palliative care team undertook an audit of care of patients in the last days of life for deaths from 1st April 2017 to 31st March 2018. There were 230 deaths across the trust. Deaths in critical care and paediatric deaths were excluded. 177 case record reviews were undertaken by the palliative care team.

Results 65% of patients who were recognised as dying had a principles of care document initiated.

NICE Quality Standard 1: 100% of patients had daily review to assess for changes in dying phase, i.e. nearing death, stabilising or recovering.

NICE Quality Standard 2: 53% of patients had capacity to be able to discuss, and review an individualised care plan (ICP). 97% of cases showed documented evidence of a family discussion to ensure communication of recognition of dying and development of ICP.

NICE Quality Standard 3: – 94% of patients had appropriate anticipatory medications prescribed.

NICE Quality Standard 4–68% of patients had documented evidence of discussion of hydration status.

Conclusion The Principles of Care Document when used adheres to the Nice Quality Standard. The regular education of the multi-disciplinary team in caring for dying patients continues to focus on use of the document to direct excellent care of the dying.

36 DESCRIBING DEPREScribing – WHEN ARE WE STOPPING MEDICATIONS IN PALLIATIVE CARE?

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10.1136/bmjspcare-2019-ASP.59

Introduction Deprescribing is the process of withdrawal of medication with the goal of improving patient care. Research currently is within the context of polypharmacy and geriatrics, however despite its ubiquity within palliative care it has not been studied significantly. Anecdotally, deprescribing is performed adhoc and using ‘common sense’ but there appears no clear data on rational and benefit.

Aim To gather data on current deprescribing practice within palliative care, with the aim to inform our own specialty and others.

Methodology Prospectively palliative in-patient hospice and community patients had medications which were deprescribed recorded and the rational. This gained a timeline of medication stops respective to date of discharge and/or death.

Results Data collected from 13/3/18 to 30/06/18 with 647 medication stops of 197 differing medications. 56%(361) medication stops were due to approaching end-of-life. 15%(93) due to swallowing difficulties, 17%(109) due to ‘rationalising’ medications.

The median number of days of palliative care deprescribing any medication before death is 4, with 1st quartile (25%) being 1 day and quartile 3 (75%) being 9 days before death. Groups identified and measured, included statins (median 5 days), beta-blockers (median 2 days), ACEi (median 5 days), anti-platelets (median 9 days), and Warfarin/NOACS (median 5 days).

Conclusion/discussion By describing deprescribing we outline the short timespan between medication stopping and death for arguably minimal patient benefit at this point of life. The rational for stopping correlates with this postulation, outlining we are stopping the vast majority of medications due to the dying phase rather than preemptively. Arguably, gathering data alone might inform practice but does not in itself bring about change. We suggest therefore that this study should therefore be seen as a positive step into identifying the need for change in current practice, leading to future studies to outline how change is achieved and measured.

37 THE USE OF PERSONALISED END OF LIFE CARE PATHWAY AT THE ROYAL SURREY COUNTY HOSPITAL

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10.1136/bmjspcare-2019-ASP.60

Introduction National guidance has recommended locally developed personalised care plans to ensure needs are met as patients are approaching end of life. The Royal Surrey County