

Conclusion There is clearly a need for greater awareness of the pharmacology in symptom control in end-stage liver disease. As a result of this study, peer-reviewed clinical standards and guidelines are being formulated for the management of specific symptoms related to end-stage liver disease to provide standardised care across the network.

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**PLANT: 'PALLIATIVE LIFE-STATE & NUTRITION TOOL'
© – REVIEW OF THE USE OF PLANT IN A HOSPICE**

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Background Palliative patients have a number of dietary concerns. The first step to good nutrition care is nutrition assessment. The PLANT tool, developed with the support of a multidisciplinary team, highlights problems that affect the intake, digestion and assimilation of food and overall quality of life. It has been offered to the community and in-patient unit teams of a hospice for use.

Methods a retrospective review of 30 randomly chosen PLANT tools filled in the last 6 months was done. Hospice staff were asked to give feedback about its' use.

Results 13% of patients had special dietary requirements and 13% food allergies and intolerances. 77% had lost weight while 23% had gained weight. 70% of patients were concerned about their weight. In 73% of cases current weight was recorded, while BMI was calculated in only 33%.

Symptoms in order of frequency were: fatigue 100%, dry mouth 87%, sadness or depression 87%, reduced appetite 83%, flatulence 83%, sleep problems 80%, constipation 77%, taste or smell changes 73%, nausea 73%, abdominal bloating 67%, abdominal pain 63%, belching 63%, sore mouth/throat 60%, hiccups 60%, vomiting 53%, loneliness or isolation 53%, diarrhoea 43%, nocturnal defaecation 43%, heartburn/acid reflux 33%.

Hospice healthcare professionals found the tool innovative and useful. However, some thought it was inappropriate to ask palliative care patients about weight and eating related symptoms and voiced their concern that it would cause unnecessary distress to patients. Furthermore, some of the staff thought that it was adding to their workload by having to fill in yet another tool.

Conclusions The PLANT tool can help to identify key symptoms that affect the nutritional state and overall life-state of patients. More work is needed to increase awareness amongst healthcare professionals of the impact of nutrition problems on patients' health, disease and sense of wellbeing.

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**AUDIT OF COMPLIANCE WITH NICE GUIDANCE ON
PRESCRIBING STRONG OPIOIDS**

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The 2012 NICE guidelines on prescribing strong opioids cover prescribing in advanced disease. The aims of our audit were to demonstrate compliance with these guidelines at The Mid Yorkshire Hospitals NHS Trust (MYHT).

A prospective audit was undertaken and data collected from 97 patients who had been started on strong opioids across MYHT. Patients included were those reviewed by the hospital and community Specialist Palliative Care Team (SPCT) and inpatients on both respiratory and oncology wards. Patients reviewed by the SPCT team were identified using the weekly patient MDT list and further information found using SystemOne. Hospital inpatients were identified using the controlled drug books and cross referencing with medical notes.

48% of patients were initiated on a strong opioid without having previously been on a weak opioid. Information giving was poor with only 0%–20% of the audited patients being informed about specific matters documented in the NICE guidelines, including advice regarding drowsiness and driving. Disappointingly, only 42% of patients commenced on a strong opioid were also prescribed a laxative. Prescribing in renal impairment was not fully in line with NICE guidance suggesting consultation with a specialist if moderate to severe impairment present – in 4/6 cases where inpatients (excluding those reviewed by the SPCT) had an eGFR of <30 no specialist input was sought.

Limitations of the audit include that a relatively small data set was collected from each clinical area. In addition, the audit relied on healthcare professionals formally documenting decision making and discussions with patients in the notes.

Recommendations include sharing the results with the audited specialities and specific education regarding the benefits of using a trust-wide opioid leaflet to assist with information giving. A quality improvement project focusing on improving co-prescribing laxatives was subsequently undertaken within the respiratory department.

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**HYPONATREMIA IN PALLIATIVE CARE; IS IT ALWAYS
SIADH?**

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Background Hyponatremia, the most common electrolyte disturbance in clinical practice affecting up to 15%–28% of admitted patients, is defined as a serum sodium concentration ($[Na^+]$) <135 mmol/L. Hyponatremia at admission is known to increase the duration and cost of stay of hospitalized patients. The prevalence of hyponatremia in palliative care is about 28% of at the time of referral. Hyponatremia can be asymptomatic or can cause symptoms like nausea and lethargy to convulsions and coma. It is important to evaluate the cause of hyponatremia to have a targeted management strategy.

Methods A retrospective case note analysis was carried out among patients admitted under a palliative care unit of a tertiary referral hospital in South India, over a period of 6 months. The sodium level on admission and during the inpatient stay, along with symptoms, drug history and cause of hyponatremia was evaluated.

Results Out of 11 patients who presented with hyponatremia, median age was 59;7 patients were male. All the patients had a cancer diagnosis, with 28% had cancer of GI tract,91% had stage IV disease. The median sodium level on admission was 125;82% had hypotonic hyponatraemia. 37% were asymptomatic on presentation,while 18% had generalised weakness.