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.

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 specialties 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.
Interest in Cannabis as a medicinal product is growing globally; recent scheduling review of Cannabis by the Chief Medical Officer puts forward a strong case for the therapeutic benefit of cannabis-based medicinal products. We have noticed an increased incidence of questions, from patients and carers relating to Cannabis use. More patients appear to confide in us about their use of Cannabis. The incidence of Cannabis use in a palliative care population is little known.

We undertook a sequential survey of fifty patients referred into and triaged as requiring domiciliary review by the Severn Hospice Nurse Outreach team. Each patient was asked at the end of the usual initial assessment whether they would take part in the anonymised survey.

Results 50 consecutive patients referred to the Shropshire community palliative care team (outreach specialist nurses) 36 patients completed the survey.

Of 36 questionnaires completed 8 patients declined completion. 10 patients (almost a third of those completing the survey) had considered using Cannabis, 18 had not.

The study population (n=36) were mainly aged over 70 (n=21). Gender split was fairly equal. Of those who had considered cannabis (n=10), the main reason was for pain relief (n=6). Other reasons included general wellbeing and treatment/cure. Half of those who had considered cannabis were on chemotherapy. Ages in the ‘cannabis curious’ group tended to be younger – with 40% aged less than 70. Half of these had researched Cannabis using only Media sources.

Conclusions In a survey of 50 palliative care patients in a rural county of England asked ‘Have you considered the use of Cannabis’ most had not. Of 10 patients who said they had considered it, the most commonly cited reason was Pain relief.