Improvements in dyspnoea were graded according to improvement in BORG score. An adverse effect of a headache was noted in one patient occurring 48 hours after nebulised morphine had commenced.

Conclusion Nebulised morphine and fentanyl have been used to improve dyspnoea due to CF in a very limited number of patients, therefore no conclusion advocating the use of nebulised opioids can be made. Further research in the form of randomised controlled trials is needed to improve the evidence base of symptom control in patients with CF. This research must also focus on adverse gastrointestinal side effects such as constipation increasing the risk of DIOS.

158 RECOGNITION OF SEPSIS IN HOSPICE PATIENTS WITH FEVER

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10.1136/bmjspcare-2019-ASP.181

Background Historically, patients in hospices have not had routine physiological observations recorded, with the focus being on maintaining comfort at end of life. In recent years, more patients admitted to hospices still wish to receive active life-prolonging treatment, including for sepsis. NICE issued guidance on the recognition of possible sepsis in the community and hospital settings in summer 2016. Recognition includes assessment of patients' basic physiological observations.

This audit was performed to assess the extent to which basic physiological observations are completed to allow careful assessment of patients in the hospice for the presence of sepsis.

Assessment for sepsis risk includes

- Presence of risk factors
- altered conscious state,
- reduction in functional ability
- respiratory rate
- new need for oxygen to maintain saturations
- heart rate, blood pressure
- skin/lip/tongue colour
- temperature
- when the patient last passed urine
- Site of any likely infection.

Method retrospective review of patient records.

Results 15 episodes of pyrexia were identified in 11 patients in a four month period. Two of these were related to blood transfusion and not included in analysis. On assessment of the patients, blood pressure, heart rate, conscious state and functional level were the most frequently recorded sepsis risk factors. Skin colour, respiratory rate, presence of signs of skin or wound infection and urine output were hardly ever or never recorded as assessed.

Nursing staff requested medical assessment in all cases although this could be delayed until normal working hours. Intravenous antibiotics were started in two patients and oral antibiotics given in five. Ceiling of care was discussed in three cases.

Conclusion Decisions are made about the presence of sepsis and the use of antibiotics based on a limited patient assessment. Staff need to be reminded that fuller assessment of basic physiological observations may improve decision-making.

159 OPIOID AUDIT – IN PURSUIT OF APPROPRIATE SYMPTOM MANAGEMENT

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10.1136/bmjspcare-2019-ASP.182

Background In a recent spate of referrals regarding pain control we found constipation was the major issue. This prompted us to question the commonality of this, as assessing and managing pain are core medical skills which, if done inadequately, can result in incorrect/inappropriate patient management.

Opioids, an important part of pain management, are widely used, by all doctors. The common side effects are well recognised. There are several different opioids, all of which can cause temporary nausea/vomiting and persistent issues with constipation. Prescribing errors are not uncommon. Thus we conducted an in-patient, Trust-wide spot audit of drug charts for prevalence of opioid prescribing, and anticipation of common side effects.

Method All adult care (non-ITU) wards were visited, drug charts reviewed and spreadsheet data collection tool populated.

Results In total, 782 charts were assessed – 440 (56%) included an opioid.

Morphine was commonest, 55%, codeine 32%, oxycodone 4%, fentanyl 3%, buprenorphine, methadone and tramadol 2% each, dihydrocodeine 1%, one prescription each for pethidine and alfentanil.

Of the prescriptions, 229 were for 'regular' opioids and 418 'as needed' – 28 (4%) of these did not specify frequency of opioid use.

Bowel habit was recorded on 69% of the charts. At least one laxative was prescribed on 267 charts (61%), totalling 450 prescriptions – senna 176 prescriptions, lactulose 144, macrogol 77, docusate 31, glycerine suppositories 11, six phosphate enemas and one for naloxegol.

Conclusions Appropriately used, opioids are invaluable for managing pain, but cause well recognised common side effects of which constipation can cause the greatest pain, distress and misery for our patients. It's relatively straightforward to manage, but needs to be anticipated, monitored for and addressed effectively to minimise patients suffering because we aren't questioning and recognising symptoms for what they are and prescribing correctly. More education planned.

160 SURPRISING FINDINGS IN TRACKING PAIN PROGRESSION IN AN INPATIENT COHORT WHO WERE ADMITTED TO A SPECIALIST INPATIENT UNIT

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10.1136/bmjspcare-2019-ASP.183

We aimed to identify whether we are managing our patients pain symptoms effectively using the IPOS as a measuring tool. IPOS forms part of the validated OACC suite of outcomes measures. And also to validate our approach to pain management across all categories and severity of pain and address any deficiencies found. We studied patients over a 3 month period. Interestingly, in the patients with starting higher pain scores 3–4, we found that 53% of patients showed improvements in their pain scores, 38% did not show any

improvement and 7% showed worsening. However, in the patient group of starting lower pain scores 1–2 we found that only 12% showed an improvement, while 28% did not show any change and an astonishing 60% showed worsening in their pain scores. Going into this study we were not expecting to find the above result. Reassuring that we are impacting positively for those patients with higher pain scores. However patients with lower pain scores did not appear to have their pain as well controlled. We need to consider possible hypothesis why is this the case. Is it that their AKPS is deteriorating and this is reflected in their pain score? (Total pain theory). Have they fewer distractions at the hospice and is this making their pain worse? Are they witnessing other patients in pain and this is impacting on their impression of their own pain? Are those with higher pain scores getting more attention/time with trained staff and is this having a placebo effect on their pain? At this time we do not have conclusive hypothesis butwe will be undertaking a prospective study following new inpatients that have been identified with low pain scores initially, which has increased on 2nd IPOS. We will be creating a short questionnaire to identify and test our hypothesis.

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161 PALLIATIVE CARE FOR YOUNG PEOPLE WITH LIFE-LIMITING ILLNESS: WHAT SHOULD WE BE TEACHING SPECIALIST PALLIATIVE CARE TRAINEES?

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10.1136/bmjspcare-2019-ASP.184

Background Advances in medicine mean children with life-limiting illness are living into, and therefore dying in, adulthood when they would once have died in childhood. Studies suggest a lack of training for physicians is a major obstacle to achieving adequate care for these young people (YP). The adult palliative care specialist training curriculum requires attainment of broad-brushstroke objectives only. The curriculum needs to provide a workforce competent to deliver palliative care for YP with life-limiting illness.
Aims To identify what issues experienced doctors working with YP with life-limiting illness perceive are key to delivering good palliative care to this group of patients.
Methods 15 semi-structured, face-to-face interviews with experts were undertaken exploring the key issues faced by YP with life-limiting illness. Participants were also invited to comment on the current palliative care specialist training curriculum. Data were analysed using the principles of grounded theory analysis.
Results Six main themes were identified: context, challenges, clinical care, communication, decision-making and planning ahead.
Conclusions The learning-objectives pertaining to YP and transition in the current curriculum are unlikely to generate a workforce competent to provide palliative care to this group. An understanding of the unique contexts of these YP and their families as they transition from children's services is required to provide excellent holistic palliative care. Challenges and clinical skills were identified that should be considered within the curriculum for delivery of services and good clinical care to this relatively unfamiliar group of YP. Adolescents, YP with cognitive- and communication-problems and families with long-established patterns of interacting require a distinct set of communication skills. Prior experiences of decision-making should be taken into account. A common framework for prognosticating, identifying palliative care need and supporting advance care planning in this group of YP is yet to evolve.

162 ROLE OF SPECIALIST PALLIATIVE CARE IN CARE CONFERENCES IN A TERTIARY REFERRAL HOSPITAL IN INDIA: A RETROSPECTIVE CASE NOTE ANALYSIS

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10.1136/bmjspcare-2019-ASP.185

Background Care conferences are team meetings held for every patient receiving health care in hospital or other care facility. It involves the patient, carers and family and it facilitates sharing information and working together to meet the person's needs. Successful communication is an important component of the process which results in appropriate decisions being made in relation to available care resources. Integrating early palliative care with cancer treatment improves quality of life and survival. Effective communication among physicians, patients and their loved ones is crucial to end-of-life, hospice and palliative care discussions. The palliative care team in our hospital has been actively involved in the care conferences organised by various specialities. The aim of this study was to evaluate the role of the specialist palliative care team in care conferences held in a tertiary referral hospital
Method A retrospective case note analysis was completed on patients who had care conferences conducted while they were inpatients in the hospital over a period of 6 months.
Results The team were involved in advanced care planning of fourteen patients during this period. The median age was 44; the youngest patient was of 6 months of age. Our team was involved in discussion around goals of care and discharge planning. The median duration from admission to care conference was 17 days while the duration to discharge was 3.5 days. The outcome of meeting varied from agreeing for best supportive care, decisions about not attempting resuscitation, early shift out from intensive care unit and facilitating discharge home with involvement of home care team.
Conclusion Specialist Palliative care team has an important role in initiating and leading care conferences to enable better communication between specialities, provide quality care to patients and families and prevent futile medical treatment at end of life.