participant per arm died, both unrelated to intervention. Qualitative data suggests feasibility and acceptability.

A randomised double-blind phase III trial of mirtazapine is feasible and acceptable in patients with COPD/ILD, with low toxicity, and is warranted.

34 NURSING STAFF ATTITUDES TO CLINICALLY ASSISTED HYDRATION AT THE END OF LIFE IN A HOSPICE SETTING

Stephen Cox, Charlotte Brigden, Ruth Harris-Skillman, Thomas Watkins. *Pilgrim Hospices in East Kent, UK*

10.1136/spcare-2019-mariecuriepalliativecare.34

Background Clinically assisted hydration (CAH) at end of life is a contentious issue (Cabañero-Martinez et al, 2016) There is disagreement as to its benefits and this can lead to a lack of concordance between medical and nursing opinions, with nurses feeling unable to challenge doctors (Churchman, 2010; Van Der Riet, 2008; Mayashita, 2007). Prior to introducing a feasibility study on CAH (Davies, 2018) on one hospice site, an unpublished survey of nursing staff revealed widespread dissatisfaction with the standard practice of not routinely offering CAH. Following completion of the study a staff survey was undertaken to see if attitudes had changed.

Aims To determine if nurses feel coerced into accepting the current hospice policy on CAH. To examine how nurses interacted with families when asked about CAH. To explore staff engagement with research on CAH.

Method A semi-structured questionnaire sent to all nursing staff including HCA's, with closed and open-ended questions. The responses were analysed using descriptive statistics and thematic analysis.

Results The responses indicated that;

The majority accept standard care without feeling coerced (68%).

Nurses felt they could challenge accepted practice (62%).

An overwhelming majority felt the hospice should be engaged in research on CAH (80%).

Nursing staff expressed the following;

Nurses wanted to be more involved in decision making around CAH.

Many felt that a standard practice should be replaced with individual patient decisions. Staff were frequently asked about CAH and felt able to discuss the risks and benefits with families.

Conclusions Overall, nurses accepted hospice standard practice on CAH and did not feel coerced. A few opposed further research, most welcomed it to establish an evidence base.

35 PAIN IN ADVANCED DISEASE: INITIAL FINDINGS FROM A QUALITATIVE INTERVIEW STUDY WITH BRITISH SOUTH ASIANS IN LEEDS AND BRADFORD, UK

^{1,2}Gemma Clarke, ¹Shenaz Ahmed, ³Wali Nazar, ²Clare Rayment, ¹Michael Bennett. ¹University of Leeds, UK; ²Marie Curie Hospice Bradford, UK; ³Bradford Community Specialist Palliative Care Team, UK

10.1136/spcare-2019-mariecuriepalliativecare.35

Background Population projections indicate that by 2051, the Black, Asian and Minority Ethnic (BAME) populations of England and Wales will rise to 3.8 million people aged 65

years and over, and 2.8 million aged 70 and over (Lievesley, 2010). This has important implications for palliative care services. Current evidence on ethnicity and palliative care is limited, and is often solely focused on access to services (Calanzani et al., 2013). Evidence is particularly limited for British South Asian populations (Shabnam, et al, 2019). South Asians have a high burden of life-limiting and chronic diseases compared to other groups (Nair and Prabhakaran, 2012). This study focuses on pain management, the impact of culture, and the quality of services for British South Asians with advanced disease.

Aim To explore the attitudes and perceptions of British South Asians with advanced disease concerning pain, pain management, and expression of pain; and to examine the differences in service provision.

Methods Qualitative interviews (N=25) with individuals who have serious life-limiting disease, are experiencing pain as a symptom, or having their pain controlled, and are from a South Asian background currently living in Leeds or Bradford UK. Fieldwork was undertaken in 2019. Interviews were audio recorded, transcribed verbatim and analysed using NVivo and Thematic Analysis (Braun and Clarke, 2006).

Discussion Key themes: experiences of pain and pain management related to cultural background; help-seeking behaviour and barriers; strong pain management at the end of life; and differences between those utilising specialist palliative care services and those receiving care elsewhere.

36 PREFERRED AND ACTUAL PLACE OF DEATH IN PATIENTS WITH HAEMATOLOGICAL MALIGNANCIES

¹Rebecca Sheridan, ¹Eve Roman, ¹Alexandra Smith, ²Russell Patmore, ³Martin Howard, ¹Debra Howell. ¹Epidemiology and Cancer Statistics Group, Department of Health Sciences, University of York, UK; ²Queen's Centre for Oncology and Haematology, Castle Hill Hospital, UK; ³Department of Haematology, York Hospital, UK

10.1136/spcare-2019-mariecuriepalliativecare.36

Patients with haematological malignancies are more likely to die in hospital than those with other cancers (Cohen et al. 2015), but little is known about their preferred place of death and the discussions surrounding this. This study aimed to investigate this using data from the Haematological Malignancy Research Network (www.HMRN.org); a population-based cohort that, since 2004, has collected detailed information on all newly diagnosed patients across 14 hospitals (catchment populations ~4 million). Additional data for the present study were collected from the medical records of 892 HMRN patients (>18 years) who died 2011–2012.

Fifty-eight percent of patients died in hospital (home, 20%; care home, 11.9%; hospice, 10.2%). Half had a preferred place discussion recorded, with the majority of these having more than one discussion. At the discussion nearest death, the most common preferred place was home (44.9%) followed by hospice (20%), hospital (19.5%), and care home (15.6%). However, preferences varied over time; for patients whose final recorded preference was hospital, 14.3% had the same preference at their first discussion. When home was the final choice, 80.4% also chose home at their first discussion. Patient involvement was less common during final discussions. Almost all of those who wanted to die in hospital did so, yet only half of those who wanted to die at home achieved this.

Although hospital death may sometimes be unavoidable, these findings suggest that greater support may be needed to facilitate discussions and, where possible, enable patients to die in their preferred location.

37 USE OF ANTIBIOTICS IN DETERIORATING PALLIATIVE PATIENTS – A RETROSPECTIVE ANALYSIS

¹Andrew Page, ²Clare Rayment. ¹St Gemma's Academic Unit of Palliative Care, University of Leeds; ²Marie Curie Hospice, Bradford

10.1136/spcare-2019-mariecuriepalliativecare.37

Background In palliative care, 24–48hr antibiotic trials are prescribed in patients who have clinically changed and may be entering the last days of life(LDOL), but where infection is considered a possible reversible factor. Does this treatment benefit or burden patients?

Aim To determine the incidence of this in hospice practice, assess survival rates and identify common predictive factors of poor response.

Method Using SystmOne, a retrospective analysis of admissions to Marie Curie Hospice, Bradford Inpatient Unit between August–October 2018 was conducted. Data was collected for all inpatients starting antibiotics including diagnosis, OACC, details of antibiotic therapy, and admission outcome (discharge/death). Patients documented to be potentially entering LDOL when therapy was initiated were identified.

Results 78 patients were admitted, of which 40% (31/78) received antibiotics. Of those receiving antibiotics, 77% (24/31) had cancer and 25% (8/31) received multiple antibiotic courses. In 35% (11/31) cases, concerns the patient may be entering LDOL were documented when antibiotic therapy was initiated. Of these, 91% (10/11) died during the admission. Of those who died, all had cancer; the majority with metastatic disease(8/10), Karnofsky scores =40% (7/10), a 'Deteriorating'(5/10) or 'Unstable'(3/10) Phase of Illness and mean duration from antibiotic initiation to death was 5.4 days (range:1–12). In patients who received multiple antibiotic courses, 75%(6/8) died during admission.

Discussion Antibiotic use in this context appears relatively common and generally has a poor outcome, suggesting treatment could be an unnecessary burden for this patient group. Metastatic cancer, Karnofsky scores =40%, an 'Unstable' or 'Deteriorating' Phase of Illness and multiple antibiotics during admission may help predict a poor response.

38 GROWING NEED, GROWING COMPLEXITY: PROJECTIONS OF PALLIATIVE CARE NEED AND MULTI-MORTALITY IN SCOTLAND

¹Anne Finucane, ²Anna Bone, ²Simon Etkind, ³David Carr, ⁴Richard Meade, ³Rosalía Muñoz-Arroyo, ⁵Sebastian Moine, ⁵Scott Murray, ⁵Aghimien Iyayi-Igbinovia, ²Catherine Evans, ²Irene Higginson, ⁵Kirsty Boyd. ¹Marie Curie Hospice Edinburgh, UK; ²Kings College London, UK; ³Information Services Division, UK; ⁴Marie Curie, UK; ⁵University of Edinburgh, UK

10.1136/spcare-2019-mariecuriepalliativecare.38

Background Due to population ageing, serious health related burden is rising. In England and Wales, the number of people requiring palliative care is projected to grow by 42% by

2040 (Etkind et al. 2017). We sought to estimate future palliative care need in Scotland, extending previous work by examining the contribution of multi-mortality (deaths from multiple conditions), to identify priorities for future service delivery.

Methods Simple linear modelling of deaths requiring palliative care from 2017–2040, using national death registry data (National Records of Scotland) and official mortality forecasts (Office of National Statistics). Palliative care need was estimated using previously defined chronic progressive illnesses, identified from i) leading cause of death; ii) contributory causes of death.

Results Using different methods, we projected that by 2040, the number and proportion of people requiring palliative care will increase, equating to between 75% (minimal estimate) and 94% (maximal estimate) of all deaths. Deaths due to >2 disease groups (cancer, organ failure, dementia, other) are projected to account for 42% of all deaths by 2040, up from 27% in 2017.

Deaths due to dementia and cancer will increase. Most deaths will occur for those aged >85. If current trends continue, care complexity will rise.

Conclusions Estimates of palliative care need using leading and contributing causes of death demonstrate the complexity and extent of care needs. The forthcoming rise of palliative care need in Scotland requires strategic action to prepare, including greater palliative care training provision for generalist health professionals where people reside and receive care.

39 WHAT CHARACTERISES A GOOD DISSEMINATION/ENGAGEMENT STRATEGY WHEN COMMUNICATING RESEARCH FINDINGS TO PATIENTS, STUDY PARTICIPANTS AND MEMBERS OF THE PUBLIC: A SURVEY OF UK-BASED RESEARCHERS' PERSPECTIVES

¹Mirella Longo, ¹Maria Giovanna Palmieri, ²Clive Gregory, ³Mala Mann, ³Julie Hepburn, ¹Annamarie Nelson. ¹Marie Curie Palliative Care Research Centre, Cardiff University UK; ²Division of Population Medicine, Cardiff University, UK; ³Cardiff School of Medicine, UK

10.1136/spcare-2019-mariecuriepalliativecare.39

Background Ethical research practice requires that researchers have a clear plan about how research findings should be reported back to patients, study participants and members of the public. Communicating results solely through research journal publications is no longer sufficient. The GIRASOL study covers three stages: a review of the literature, three surveys of the public, participants and researchers, and a consensus meeting. Here we report on researchers' views around the elements of a good dissemination/engagement strategy, on their perceptions of good dissemination/engagement strategies and on what would encourage them to get more involved in dissemination and other engagement activities.

Method Content and thematic analyses were used to analyse the three open-ended questions included in the on-line survey directed to UK-based researchers.

Results 89 out of the 106 respondents addressed the open-ended questions. 80% of these respondents have at least six years of research record and around 30% are/were members of funding committees. Researchers agree that when communicating results to patients/study participants, adhering to