

We plan to develop this service by training more volunteers and encouraging a 'buddy' system to review goals particularly around exercise/activity and weight loss.

P-130 BEREAVED CAREGIVERS' EXPERIENCES OF END-OF-LIFE CARE FOR PEOPLE WITH ADVANCED HEART FAILURE

Melanie Diggle, Sue Schutz, Dan Butcher. *Oxford Brookes University, Oxford, UK*

10.1136/spcare-2021-Hospice.147

Background Heart failure is a life-limiting condition with a debilitating symptom burden (McMurray, Adamopoulos, Anker, et al., 2013). The prognosis for those living with heart failure is unpredictable and poor (Jaarsma, van der Wal, Hjelmfors, et al., 2018). Research has indicated that end-of-life care can improve symptom management and decrease caregiver burden (Buck, Harkness, Wion, et al., 2014; McIlpatrick, Doherty, Murphy, et al., 2018). However, despite this, referrals to palliative care services for people with heart failure remains low (Gadoud, Kane, Macleod, et al., 2014). Therefore, exploration of bereaved caregivers' experiences of providing end-of-life care to a person with heart failure is required.

Aim The aim of this review was to present and synthesise the current evidence around bereaved caregivers' experiences of providing end of life care for people with heart failure.

Methods A systematic review of the literature was undertaken using a search of four electronic databases (CINAHL, PubMed, BND, PsycINFO). Due to a scarcity of literature relating to heart failure, the search was expanded to include other long-term conditions. Research published between January 2000 – March 2021 with a qualitative methodology, focusing on bereaved caregivers' experiences of providing end-of-life care for people with heart failure and other long-term conditions was included. Data was analysed and presented using a narrative synthesis approach.

Results Nineteen articles were critically appraised and included within this review. Four broad themes were identified: Limited and inadequate communication around the condition (including prognosis, preparations for death and the role of palliative care), the burden of caregiving, the positive experience of providing care at the end-of-life, limited provision of services and formal support.

Conclusion Bereaved caregivers experience significant challenges when caring for a loved one dying of heart failure or another long-term condition. This includes high levels of caregiver burden which is exacerbated by perceived inadequate communication, limited service provision and access to formal support. However, further research is required in this area to greater understand the specific end of life care experiences of bereaved caregivers of people with heart failure.

P-131 HOW CONFIDENT DO PALLIATIVE AND NON-PALLIATIVE PATIENTS FEEL ABOUT MANAGING THEIR LYMPHOEDEMA?

Olivia Core, Lucy Houghton, Annie Campbell. *Dorothy House Hospice (Bath), Winsley, UK*

10.1136/spcare-2021-Hospice.148

Background Lymphoedema is recognised as a chronic condition that requires lifelong management (National Lymphoedema Partnership, 2019). One of the NHS' core requirements

for supporting individuals with a long term condition is promoting self-management, through professional led training, support and information sharing (NHS England, 2017). Clinical intervention is adapted to the patient needs, although often involves skin care, exercise, lifestyle and risk reducing advice, alongside the provision of a compression garment (British Lymphology Society, 2016).

Aim To explore palliative and non-palliative patient confidence with oedema self-management, via a clinical evaluation survey before and after a clinical intervention.

Methods New palliative and non-palliative patients attending the Dorothy House Hospice lymphoedema service between November 2020 and May 2021, received a questionnaire via post, or via their lymphoedema practitioner, for completion prior to initial assessment (Time 1), and at six weeks (palliative) or three months (non-palliative) follow-up (Time 2). Participants rated their confidence in self-managing their lymphoedema, and if swelling increased, on a five point Likert scale (Not at all confident-Very confident). Exclusion: re-referral of patient who had received previous lymphoedema input.

Results 27 patients (n=15 palliative) were invited to participate in the survey. Two patients declined participation. 25 patients took part (palliative n=15 & non-palliative n=10). Complete data n=12 participants. Incomplete data n=13 (n=1 declined participation during study, n=3 misplaced forms, n=7 died, n=2 deteriorating health).

Self confidence in managing their lymphoedema

Non-palliative patients [n= 6] reported:

Not at all confident/Not confident – at T1=58% & at T2=50%,

Neutral [no change in confidence] at T1 & T2=17%,

Somewhat confident/Very confident at T1=25% & at T2=33%.

Palliative patients [n= 6] reported:

Not at all confident/Not confident – at T1=33% & at T2=8%,

Neutral [no change in confidence] at T1 & T2=25%,

Somewhat confident/Very confident at T1=42% & T2=67%.

Conclusion This small service evaluation suggests non-palliative patients are globally less confident about self-managing their lymphoedema than palliative patients pre- and post- our clinical intervention. Patients were generally more confident about their oedema management in stable and worsening conditions following clinical intervention. Further qualitative exploration with patients around their confidence in lymphoedema management, our clinical intervention and service delivery would be valuable.

P-132 ADMINISTRATION OF SUBCUTANEOUS FLUIDS IN THE COMMUNITY SETTING; A QUALITY IMPROVEMENT PROJECT

¹Joy Ross, ²Stefan Rakowicz, ¹Eva Trowers, ²Amrit Aujla, ³Amanda Rees, ¹Emma Hall. ¹St Christopher's Hospice, London, UK; ²Bromleag Care Practice, Bromley, UK; ³Bromley Clinical Commissioning Group, Bromley, UK

10.1136/spcare-2021-Hospice.149

Aim To identify patients suitable for subcutaneous fluid administration (SCF) in the home/care home setting and standardise clinical approach to assessment, decision making and evaluation of response.

Methods A standardised decision support tool was developed which supported bedside assessments. Patient/carer information leaflets were given and documentation of discussions/outcomes recorded in relevant clinical records (EMIS or SystmOne). We evaluated clinical response over three days: symptoms, side-

effects/complications, observations or bloods and collated case vignettes.

Results Between April 2020-Feb 2021, 28 patients were assessed, median age 87.5(43-97) years, 20(71%) female. Place of care: 13(46%) own home, the remaining 15 (54%) resided in care homes/extra care housing. Diagnoses: 19 dementia; 6 cancer, 2 heart failure, 1 Motor Neurone Disease. Frailty scores (Rockwood): median 7(6-9).

17(61%) received SCF. Equipment was sourced equally from hospice and local pharmacy. Four had clear benefit, symptom relief, admission avoidance, alive >1mth post-intervention. Six cases demonstrated psychological benefit for patient/family with no harm/side-effects (all died 4-17 days post-intervention). Two had possible benefit but diuretics were withheld/reduced concurrently (1 alive >1mth post intervention, 1 died 3wks).

Five had no clear benefit, but no harm. 6/11 cases where SCF were not given, died within a week (2-8 days). Five with dementia in care home/extra-care housing were managed with mouthcare/encouraging oral fluids (3 alive >1month post-assessment).

Fluids were stopped due to side effects in three patients: none experienced ongoing harm. Volumes of fluid given varied. Feedback from clinicians and families suggested the tool facilitated discussion/understanding of rationale for giving/withholding.

Conclusion SCF was of clinical benefit for some patients, with minimal harm. The tool increased clinicians' confidence to assess benefits/harms of SCF and address family concerns in a structured way. Further robust data collection is needed to monitor use/outcomes of SCF in a community setting and to better identify patients who may benefit.

P-133

SUBCUTANEOUS FUROSEMIDE USE IN THE COMMUNITY SETTING: CLINICAL BENEFIT AND HOSPITAL AVOIDANCE

Isobel Jackson, Bruna Burmeister, Fiona Hodson. *St Christopher's Hospice, London, UK*

10.1136/spcare-2021-Hospice.150

Background There is little evidence on the use of subcutaneous furosemide infusions in heart failure patients, especially in the community setting (Beattie & Johnson, 2012). Integrated working is key to smooth the transition from management in the hospital to community settings, particularly for patients who are increasingly fatigued with short prognoses but who may still benefit from parenteral therapy.

Aim To retrospectively evaluate clinical effectiveness of subcutaneous furosemide used in the community setting at end-of-life.

Method We reviewed case notes of patients treated with continuous subcutaneous furosemide by the community palliative care team (2019–2021). A standardised proforma was used to assess patient demographics, indications, clinical outcomes and barriers/facilitators to the process.

Results 16 patients received a total 22 interventions. Median age 77(50-94), 11(69%) male, primary HF (Heart failure) diagnosis 6 HFREF, 5 HFpEF, 2 RHF, 2 Valvular, 1 unknown aetiology.

Phase of Illness, 13 unstable and 9 deteriorating with AKPS 30–60%. Oral diuretics included loop diuretics (furosemide 15/22 and bumetanide 6/22), aldosterone receptor antagonists (spironolactone 4/22), mineralocorticoid receptor antagonists (eplerenone 11/22) and thiazides (indapamide 1/22). Majority

of interventions had stage 3 renal function (16/22 episodes). Patients were discussed with cardiology or palliative care consultant. Median dose given was 160mg (range 80-240mg) for 11(1-33) days.

Outcomes 15/22 showed symptomatic improvement, 6/22 had side-effects including worsening renal function, hypotension, hypokalaemia and site reaction needing antibiotics. 21/22 interventions avoided a hospital admission; 12/16 patients achieved preferred place of death (1 was admitted to hospital; 3 alive). Barriers to community administration included: challenges obtaining medications, burden of a continuous subcutaneous infusion [CSCI].

Conclusion There is a clear benefit for individual patients, allowing those in last year of life to spend as much time as possible at home. We plan to develop a decision support tool to aid wider community decision making, facilitating timely use of subcutaneous furosemide, therefore maintaining effective symptom control in community settings.

P-134

SYMPTOMS MATTER; AN AUDIT OF SYMPTOMATIC MANAGEMENT OF MALIGNANT BOWEL OBSTRUCTION

Oliver Emmerson. *Pennine Acute NHS Trust, Manchester, UK*

10.1136/spcare-2021-Hospice.151

Background The diagnosis, assessment and management of malignant bowel obstruction (MBO) varies across organisations. Different levels of emphasis are placed on resolution of the obstruction or symptomatic management. Yet there is currently a lack of comprehensive guidance or clinical pathways to ensure an equivalent high-standard level of care is offered to all patients.

Aims

- To determine current practice in the management of MBO.
- To inform future guidance and direct the emphasis placed on specific management strategies.
- To improve future patient care and experience through more effective symptomatic management.

Methods Patients with an inpatient diagnosis of MBO were identified from the specialist palliative care (SPC) multi-disciplinary [MDT] lists from March 2019-January 2020. Data collected included: demographics, admission length/outcome, diagnosis, symptomatic reviews and treatment methods. Data was tabulated and analysed in Microsoft Excel.

Results Fifteen inpatients were identified. Seven patients (47%) died in hospital on average 22 days after admission. Nine (60%) had known colorectal malignancies. Fifteen (100%) had nausea and vomiting or colic on admission. Of the nine (60%) who had colic on admission five (34%) still had colic on day 4.

Only five (45%) had a daily review of symptoms. By day four, 10(67%) had PRN anti-emetics prescribed and 5(34%) had regular anti-emetics prescribed. The most commonly used agents were cyclizine (PO/IM/IV) and ondansetron (PO/IM/IV). Ten (77%) had naso-gastric [NG] tubes inserted and none underwent surgical procedures. All were reviewed by the inpatient SPC team at least once during their admission.

Conclusions Surgical management of MBO is uncommon and so emphasis should be placed on symptomatic relief and conservative therapy options. This would enable greater patient autonomy to decide preferred place of death. Assessment of symptoms of MBO should be clearly documented on