

assessment and daily. Assessment of colic is often missed and prompt commencement of anti-colic therapy would benefit patient care. Standardisation of anti-emetic choice in MBO would be beneficial, leading to reduced inappropriate prescribing.

P-135 AMENDED MOUTH CARE MATTERS PROJECT

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Background A common problem in palliative care is that of a dry and sore oral environment often resulting in infections, bad breath (halitosis), and changes in taste, therefore high quality mouth care is a very important aspect of palliative care in all care settings. When these problems are not managed effectively, they can negatively affect a patient's self-esteem, ability to communicate and socialise plus the ability to enjoy food and drinks (resulting in inadequate nutrition/hydration). It is vital therefore that mouth problems should be assessed regularly and treated as soon as possible (Marie Curie. Mouthcare, see: mariecurie.org.uk/professionals/palliative-care-knowledge-zone/symptom-control/mouth-care/).

Aims The Mouth Care Matters programme (Health Education England, see: <https://mouthcarmatters.hee.nhs.uk/>) was designed to help deliver better clinical outcomes by evidencing the importance of good mouth care and how this positively impacts on general health and quality of life.

Methods We piloted the original '(Mouthcare Matters) Assessment and Recording Form' in the inpatient unit with the aim of providing a thorough method of assessing and addressing oral challenges experienced by our palliative/end-of-life patients (Venkatasalu, Murang, Ramasamy, et al., 2020). We then audited outcomes by publishing a scored staff feedback form to colleagues to measure effectiveness of the intervention and explore whether amendments to the tool could be implemented to make it more bespoke to our care setting (National Institute for Health and Care Excellence: Palliative care: oral. See: cks.nice.org.uk/topics/palliative-care-oral).

Results When feedback was submitted, qualitative evidence identified the need to amend the standard to truly fit the hospice model of care.

Conclusions We amended the template in the following ways:

- The addition of 'saliva' as an identifiable problem (Paine & Snider, 2020).
- Changed 'weekly' assessment to 'daily' to reflect the pace of change some of our patients experience.
- The original tool identified low, medium and high risks but there was no advice to prompt intervention so we added an 'action checklist' section to help direct care.

We launched this amended version in April 2021 and are due to audit results in September 2021.

P-136 FOUR STAGE LOW FIBRE DIETARY GUIDANCE FOR PATIENTS SUFFERING SUBACUTE MALIGNANT BOWEL OBSTRUCTION

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Background Patients with subacute malignant bowel obstruction (MBO) not amenable to surgical or interventional procedures are often highly symptomatic of pain, bloating, nausea and vomiting. Diet often exacerbates symptoms so intake is limited. UK medical treatment of MBO includes medicines and interventions to improve bowel transit and to manage symptoms (Ahmad, Jeffries, Longford, et al., 2015; Scottish Palliative Care Guidelines, 2020) but often little specific advice is given on low fibre diet compared to approaches worldwide (Lee, Jivraj, Wang, et al., 2019; British Columbia Cancer Agency, 2019).

Aim To develop a low fibre staged diet plan for patients with subacute or resolving MBO. To offer patients choice and taste variety within the limitations of a clear fluid or low residue diet in order to improve symptom control, chance of resolution and quality of life.

Methods A review of literature was undertaken to better understand diet in MBO. A UK hospital's oncology dietician team use a phased model on which, with permissions, our diet is based. A collaborative approach was taken including input from the local trust dieticians and hospice multi-disciplinary team including catering and hospitality.

Results A four staged diet plan was created for our inpatient unit. Stage one, clear fluids; Stage two, liquid low fibre; Stage three, soft low fibre; Stage four, normal texture low fibre. MBO patients often start with bowel rest and move up or down the stages as tolerated. Stage four may also be used prophylactically for those at risk of developing MBO symptoms.

Conclusion Most patients have welcomed specific guidance on diet. The menu provides variety despite the restrictions and many patients report significant relief of their symptoms. Patients may choose to eat off plan, as part of our 'Eat for Comfort' policy. A community MBO diet advice booklet has subsequently been created for those living with or at risk of MBO, enabling patients to stay at home longer and be more in control of their symptoms.

P-137 VIRTUAL REALITY IN PALLIATIVE CARE

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Introduction COVID-19 pushed us as an organisation to step-up our ability to change and adapt. Our workforce has embraced the opportunities generated by digital transformations during the pandemic. Virtual Reality (VR) is revolutionising healthcare. We wanted to explore the use of VR as part of a non-pharmacological approach to symptom management and start to measure patient outcomes in a meaningful way while improving the patient's overall experience.

Actions Our initial proposal was that the use of the VR headset could positively impact on patient wellbeing. Our living well centre team commenced a pilot in conjunction with our inpatient unit. As new technology becomes more accessible use of these as part of the patient's overall plan of care is a realistic possibility even for small organisations.

Utilising freely available innovative apps the team supported patients in immersive experiences including guided relaxation meditation and visits to locations such as white sandy beaches, forests and mountain ranges. Initial outcomes were positive utilising a simple wellbeing score and numerical pain scoring. This has led us, in conjunction with a digital fabrication laboratory based at a local college, to look at

opportunities for using emerging technologies in interventions and training. Our next project is a VR tour of our inpatient unit and grounds filmed using a 360 degree camera for patients to watch at home to try and alleviate some of the worries and anxieties they may have about staying with us or accessing our services.

Conclusion The use of VR in healthcare has endless possibilities. Working with our local education partners is an opportunity to explore this for our patients. Positive outcomes have provided the impetus to try new approaches that will have real impact on patient wellbeing and symptom management.

P-138 EXPANDING THE REACH OF VIRTUAL REALITY FOR PALLIATIVE PATIENTS

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Background The use of virtual reality (VR) for symptom management in palliative care has grown over the last five years; most of the studies have been of its use in hospice (Popert & Riat, 2017) and hospital inpatient (Nwosu, Mills, Roughneen, 2021; Niki, Okamoto, Maeda, et al., 2019) and day therapy units (DTU). The advent of the COVID-19 pandemic resulted in the temporary closure of our DTU, so we therefore also offered patients the opportunity to use the headsets in their own homes.

Aim This study explores the impact of using VR on reported pain, anxiety and mood in palliative patients and the feasibility of using it in the home.

Method Patients are instructed how to use VR headsets on the inpatient unit or in their own home. Participants complete questionnaires on its influence on pain and anxiety scores and their experience of use. Volunteers were trained to teach patients how to use the headsets.

Results 30 sets of data have been collected from the inpatient unit and 10 from patients' homes, results for both groups are similar. All patients reported ease of use, a positive experience, and no adverse effects. 98% of those who reported pain before using VR reported a reduction and 93% of those who reported anxiety before using VR reported a reduction. For the majority of participants in this study using VR induced emotion with positive valence – happiness, excitement. The ability of VR to induce emotions with positive valence is deemed to influence its analgesic effect (Triberti, Repetto, Riva, 2014).

Conclusion The majority of palliative patients are managed in the community setting, and enabling the use of VR in their own homes means more patients can experience the benefits. There are multiple small studies on the impact of VR on symptoms in palliative patients but randomised controlled trials are needed (Austin, Lovell, Siddall, 2019). It is an intervention that puts a smile on patients' faces.

P-139 EMERGENCY SYMPTOM CONTROL NEAR THE END-OF-LIFE: A CLINICAL AUDIT EXAMINING AMBULANCE CLINICIAN CARE

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Background The London Ambulance Service NHS Trust (LAS) performs a vital role in the assessment and management of symptoms in end-of-life care (EoLC) patients during times of crisis. A previous clinical audit identified symptom control as an area requiring improvement. Following funding of a Macmillan EoLC team and release of national guidance, a re-audit was conducted to assess symptom control by ambulance clinicians.

Aim Review ambulance clinicians' assessment and management of symptoms for patients nearing their end-of-life.

Method A retrospective clinical audit was conducted using data from 01/11/2019- 30/11/2019. From a total of 363 cases, 58 were excluded due to the patient having no identified EoLC needs. A resulting sample of 305 patient report forms were clinically reviewed.

Results Several elements of practice were encouraging but results highlighted a number of areas for improvement:

- Pain assessment: 84% of patients had an appropriate pain assessment documented.
- Pain management: 65% of patients presenting with pain/discomfort had analgesia administered by the attending ambulance clinicians.
- Pharmacological symptom control: 61% of patients received an appropriate pharmacological intervention when necessary. This included providing LAS issued medication for nausea/vomiting or anticipatory medications.
- Non-pharmacological symptom control: non-pharmacological interventions (e.g. re-positioning for breathlessness) were documented for 18% of eligible patients.

Conclusion End-of-life care is a novel area of pre-hospital care and whilst service improvement progresses (Murphy-Jones, Laverty, Stonehouse, 2021) it will take time to embed guidance and education into practice. Inherent actions in pre-hospital practice, such as non-pharmacological interventions may be undertaken but not documented and thus not captured by the audit process. It is clear however that EoLC symptom control requires improvement. The Macmillan EoLC team have shared findings with staff to highlight areas for improvement, created new guidance and enhanced education, covering both pharmacological and non-pharmacological symptom control. A continuous EoLC clinical audit within the Trust has been introduced to monitor and improve compliance.

P-140 SINGLE NURSE ADMINISTRATION OF DRUGS IN A HOSPICE IPU

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Background St Gemma's Hospice recognises the national shortage of registered nurse (RN) recruitment with increasing dependency of patients (The Kings Fund. The NHS workforce: our position, 2021). As part of our ongoing development and cost effective use of resources, the nursing team are keen to use the existing RN resource as efficiently as possible. By moving to a workplace where it is usual practice for a single nurse to check and administer drugs (SNAD) would enable greater safety, more timely symptom management and more effective use of the workforce (Cross, Bennett, Ockerby C, 2017; Armitage, 2008).

Aim Inpatient unit (IPU) moves to single nurse administration of most drugs by June 2021.