Parallel Session 5.1 – Perspectives on patient care (Friday 5 November, 09:00 – 10:15)

O-17 OUR PATIENT IS NOT MUDDLED, THEY HAVE DELIRIUM: IMPROVING RECOGNITION AND CARE IN HOSPICE SETTINGS

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Delirium is a common condition in palliative care (11-40% prevalence), is often distressing for patients and families and can result in a high care burden for staff. Despite this, delirium is often under-recognised and poorly managed. National guidance and validated tools are available but more tailored approaches in palliative care may be needed; a national Delphi study is currently researching outcomes and introduction of hospice-specific guidelines can improve delirium management. Here, we describe a successful quality improvement project focussed on improved delirium care for hospice inpatients.

In 2019, we set up a multidisciplinary Delirium Working Group in response to local audit showing areas requiring improvement within delirium care. The team met monthly and comprised an advanced nurse practitioner, social worker, doctor and two occupational therapists.

The main aims were to improve inpatient delirium care, focussed on supportive and non-pharmacological measures: promoting medication use only for marked distress and risk to self/others; consistently assessing for reversible causes; communicating with patients and carers specifically about the condition; improving assessment and documentation of cognition and capacity; changing culture in order to engage the whole clinical team in recognising and collectively managing delirium.

We therefore developed a Delirium Toolkit, consisting of a ‘Step-by-Step’ checklist (accessible in electronic patient records); patient information leaflet, non-pharmacological checklist (occupational therapy-led), ‘This is Me’ document (HCA-led), 4AT tool, fuller hospice-specific guideline and NICE Quick Guide for Care Homes. This was embedded through an Awareness Week and enhanced Education Programme for each MDT group. A new induction/refresher e-learning module was developed (clinical/non-clinical versions). Delirium Champions were recruited and ‘Delirium’ is now a component of our ‘Transfer of Care Form’.

Supported by excellent buy-in from senior management and staff, this project has improved confidence across the hospice team in managing delirium. Audit results regarding toolkit use will be presented, alongside feedback and future plans involving our community teams.

O-18 USE OF THE 4AT TOOL FOR IDENTIFICATION OF DELIRIUM IN HOSPICE INPATIENTS

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10.1136/spcare-2021-Hospice.17

Background Delirium has a prevalence of around 1/3 admissions to hospice inpatient units (IPUs) (Hosie, Davidson, Agar, et al., 2012). Detection and management of delirium is a priority for NICE and use of the 4AT (https://www.the4at.com/) is recommended by the SIGN Scottish guidelines (National Institute for Health and Care Excellence. Delirium: prevention, diagnosis and management, Clinical guideline, 2010; Scottish Intercollegiate Guidelines Network. Risk reduction and management of delirium, National Clinical Guideline, 2019) Patients with delirium in acute settings have been shown to have worse outcomes and higher mortalities (Schubert, Schürch, Boettger, et al, 2018). The majority of palliative care clinicians do not use a delirium screening tool (Woodhouse, Siddiqi, Boland, et al., 2020).

Aims To implement use of a validated tool (4AT) for assessing delirium in an IPU and measure the recognition of delirium following this. To assess whether recognition of delirium changed patient outcomes.

Methods 1st cycle: Survey IPU clinical staff regarding delirium assessment. 4AT implemented for IPU admissions. Data collection on admissions including: 4AT score, age, diagnosis, comorbidities, reason for admission and outcomes.

2nd cycle: Guidance published regarding use of 4AT tool on IPU. Four teaching sessions for IPU staff. Data collection as per 1st cycle for further 1 month period. Project write up and conclusions presented to IPU staff.

Results 59% of palliative clinicians reported they do not use a delirium screening tool.

1st cycle results: 9 out of 22 appropriate patients had 4AT completed (41%). 9 out of 24 total admissions identified as having delirium (38%).

2nd cycle: 14 out of the 18 appropriate patients had 4AT completed (78%). 58% of admissions identified as having delirium. In patients with delirium 80% died and 0% went home. In patients without delirium 27% died and 27% went home. (The remaining percentage being admitted to full time care facilities.)

Conclusions The 4AT appears to have been successfully embedded on the IPU and improved identification of delirium. Utilisation of the tool was improved with further education sessions for clinical staff. This study was too small to draw definitive conclusions, but rates of delirium were very high in IPU setting and indicated delirium as a negative prognosticator in mortality and discharge destination.

O-19 EYE DONATION IN PALLIATIVE AND HOSPICE CARE SETTINGS: PATIENT VIEWS AND MISSED OPPORTUNITIES

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Background There is a global shortage of donated eye tissue for use in sight saving and sight restoring operations such as corneal transplantation (Madi-Segwagwe B C, Bracher M, Myall M, et al., 2021). Patients who die in palliative and hospice care settings could potentially donate eye tissue, however, the option of eye donation is not routinely raised in end-of-life planning discussions as health care providers (HCP) are very reluctant to discuss eye donation as they perceive it as something that will distress patients and family members.

Aim This presentation shares findings regarding the views of patients and carers, including: their feelings and thoughts about the option of eye donation being raised with them, who they think should raise this issue, when this option should be discussed and who should be included in the discussion. Findings are drawn from the NIHR funded national study: *Eye Donation from Palliative and Hospice care contexts: investigating Potential, Practice, Preference and Perceptions* taking place in three palliative care and three hospice care settings across England *(EDiPPPP)* and the global literature.

Conclusion In view of data from the Royal National Institute of Blind People (RNIB, 2016) reporting that over two million people in the UK are living with sight loss and their prediction that this figure will double to nearly four million by 2050 it is imperative that anyone who could be, and would want to donate the gift of sight, is offered the opportunity to do so, especially as they approach their end of life.

O-20 LIVING WELL WITH AN ADVANCED LUNG CONDITION

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10.1136/spcare-2021-Hospice.19

Background Whilst our established support for people living with breathlessness was long-standing, it was not multidisciplinary or fully evidence-based. We wanted to address this for the benefit of patients and the wider health system. The Cambridge Breathlessness Intervention Service (CBIS) model is an evidence-based approach to support people living with advanced lung conditions to manage their breathlessness (Higginson, Bausewein, Reilly, et al., 2014). Consultation with service users suggested that patients wanted support to: manage breathlessness, improve mental wellbeing, mobility and symptom management as well as help with planning ahead and reducing isolation.

Aims To implement and evaluate a breathlessness intervention using a multidisciplinary skill mix and trained community volunteers.

Methods Using the CBIS model as a framework, we reshaped, redeployed and trained our team to deliver this intervention at home. We supplemented this with a layer of social support provided by experienced compassionate neighbour volunteers. We evaluated the impact of the intervention through: before and after breathlessness self-rating scales, interviews with patients and case studies documenting the use of different parts of the service (e.g. physiotherapist, nurse, occupational therapist, rehabilitation assistant, complementary therapy).

Results This project has been delivered during the COVID-19 pandemic, so there were practical issues around seeing patients face-to-face, and we were unable to support as many as expected. To date, 28 patients have been referred to the service. Of these, 18 received input. We will report on changes in self-rating scores and feedback from interviews with patients and families. To date, only a few participants opted to have a compassionate neighbour.

Conclusions Initial findings suggest that although delivery of this project was hampered by the pandemic, patients valued the service and benefitted from practical input from the MDT. Limitations on being able to provide face-to-face support may have influenced uptake of compassionate neighbours and reduced the number of patients seen.

Parallel Session 6.1 – Supporting children and young people: addressing choices and challenges (Friday 5 November, 13:00 – 14:00)

O-21 'EXHAUSTED, EMOTIONAL, AT BREAKING POINT': THE MENTAL WELLBEING OF YOUNG ADULTS WITH SHORTENED LIVES

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Background Young adults with life-limiting or life-threatening conditions (LLTCs) are ordinarily extremely challenged in terms of health and wellbeing and especially vulnerable to social isolation and exclusion (Johnson & Hodgson, 2018; Knighting K, Bray L, Downing J, et al., 2018). Society's response to COVID-19 poses an additional threat to this group who are at risk of being further left behind, creating long-lasting consequences for their mental wellbeing.

Aims To examine the unintended consequences of (COVID-19) epidemic-control decisions on young adults with LLTCs to (a) understand the needs of this group (b) develop guidance and support and, (c) determine how consequences could be mitigated.

Methods This inclusive research project, underpinned by an interpretive qualitative framework (Denzin, 2003) draws on the principles of co-design (Nind, 2014). Research participants were recruited using purposive and theoretical sampling using a variety of methods including advertising for participants, existing networks and snowballing. During July-September 2020, in-depth interviews were conducted via video-conference with 28 young adults aged 18-40. Data were analysed iteratively using constructivist Grounded Theory Method (cGTM) (Charmaz, 2006) and using the qualitative software analysis package QSR NVivo.

Results Participants experienced a decline in mental wellbeing with those with pre-existing mental health issues showing the most significant decline; in these cases, participants spoke about suicidal ideation, depression and anxiety and an increased need for medication and therapy. Many participants described a 'rollercoaster' of emotions and said that they had felt 'petrified' 'overwhelmed, 'worried' and 'forgotten'. Key themes included (a) the constant management of risk to avoid (physical) harm from COVID-19 while protecting mental health (b) the desire to 'keep busy' as a means of 'thinking less' in order stay mentally well (c) a re-evaluation of what matters in life.

Conclusion Main learning points: (1) acknowledgement that although people with LLTCs are typically isolated and excluded that the pandemic has magnified and exacerbated