

Background Sex and intimacy are expressed by many patients to be essential at the very end of their lives. Different definitions of intimacy are presented in the literature, with studies reporting intimacy to be more than just sexual intercourse. Despite this, intimacy is not commonly assessed nor discussed with palliative and end-of-life healthcare professionals. It is therefore important to explore patients' perceptions and needs of intimacy towards the end of their lives, in order to inform service improvements.

Aim To explore existing literature to identify the sex and intimacy needs of patients at the end-of-life as expressed by patients and carers themselves, and to use the information gained to inform service improvement.

Method A systematic review of literatures was conducted between September and December 2021 using MEDLINE, CINAHL, PsycInfo and AMED databases. As literature on this topic is relatively recent, no time limit was put in the search terms. Perspectives from healthcare professionals, recovered patients, and quantitative studies were excluded as well as protocols and dissertations. Suitable articles were imported into Covidence for further screening and extraction.

Results 18 articles were included in the final review with an initial amount of 364. Studies included both young and older adults. Seven key themes emerged:

1. Age stereotypes impacting conversation with professionals.
2. Reprioritising survival over intimacy needs.
3. Influence of family/friends/carers.
4. Clinical settings inhibiting expression of intimacy.
5. Physical constraints inhibiting performance of sexual activities.
6. Person rather than patient.
7. The importance of conversations between healthcare professionals and couples (Let's talk about sex).

Conclusion Key themes generated from this study suggested any service changes should be practical and psychological, such as re-designing wards and acknowledging patients as a whole. Clinical settings should consider these in order to fulfil patients' sex and intimacy needs. Semi-structured interview data would help to further understand how interventions could be designed to support patients' intimacy needs.

P-100 PALLIATIVE CARE WORKERS' EXPERIENCES WITH AND BELIEFS SURROUNDING DEATHBED PHENOMENA

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Background Deathbed phenomena (DBP) are unusual perceptions reported by dying persons and those around them in the days and weeks leading up to death. These include phenomena such as deathbed visitors, visions and terminal lucidity. However, there has been little UK-based research surrounding this topic. This study aimed to describe palliative care workers' experiences with and beliefs surrounding deathbed phenomena and identify any implications for clinical practice.

Method An online questionnaire consisting of multiple choice and free text questions. The questionnaire link was shared with staff at 5 UK-based hospices.

Results 104 staff members responded: 13.6% doctors, 39.8% nurses, 43.7% healthcare assistants and 2.9% other; 42.3%

Scotland, 27.9% England and 29.8% Northern Ireland. 97.1% of respondents reported at least one DBP, mean of 7.7. There was no significant difference between those who identified with a religion and those who did not. DBP most frequently reported by staff were patients seemingly timing their own death (86.3%, 88/102) and deathbed visitors (74.8%, 77/103). 76.5% (78/102) of respondents agreed that deathbed phenomena are of a spiritual nature with no significant difference in response between those who identified with a religion and those who did not. 70.9% (73/103) of respondents agreed that deathbed phenomena tend to be positive experiences for the patient and 70.9% (73/103) of respondents agreed that DBP tend to comfort the family. 68.3% (70/103) of respondents agreed that formal training would be useful.

Discussion Many palliative care staff report experiences of DBP. These are generally perceived as comforting to the patient and their families. Discussions to encourage openness surrounding these experiences with palliative workers may help staff in responding to patients and families who report DBP.

P-101 EXPLORING PATIENTS' AND FAMILIES' EXPERIENCES OF SERVICE ADAPTATIONS IN THE CONTEXT OF COVID-19

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Background Necessary service changes arising from the COVID-19 pandemic provided an opportunity to review patients' preferences for the delivery of hospice care and support. Many face-to-face services were replaced with telephone and virtual methods which had not been routinely used previously.

Aim To identify and understand the impact of service changes on patients', clients' and families' experiences of Dorothy House Hospice (DH), Salisbury Hospice (Salisbury), and Prospect Hospice (Prospect) in the context of COVID-19, and explore respondents' communication preferences.

Method A postal questionnaire was disseminated to all patients and clients who had used the hospices' services in the prior 3 months (DH summer 2020, Salisbury and Prospect Autumn 2021). Using closed questions and free-text comments, the survey requested feedback on communications received and difficulties experienced. Preferences for future communication types were elicited. Data were analysed using frequency counts and thematic analysis of free-text comments.

Results 294 responses were received (patients n=166(56%); families and carers n=98(33%); bereaved n=29(10%); unknown n=1(1%)). Respondents were predominantly aged 65+ (71%).

The majority of respondents (86%) reported receiving the right amount of information, and were happy with the type of contact received (85%). The preferred format for future contact was face-to-face (74%), the least preferred was video calls (19%). Qualitative data indicated respondents were positive about the continuity and availability of support from their hospices despite the challenges of the pandemic. Those who engaged with virtual services, reported minor technical difficulties. Bereavement groups/buddy systems for patients and families to socialise with people who had similar experience to them, were particularly welcomed.

Conclusion The majority of responses were overwhelmingly positive; with patients, families, carers and bereaved people reporting confidence and feeling reassured about the availability and accessibility of alternative supports. Our data suggest mixed modalities of service delivery are acceptable to service users when they understand the rationale for change and have the necessary technical support for online communication.

P-102 ABSTRACT WITHDRAWN

P-103 ILLICIT DRUG USE – HOW TO MANAGE IN A HOSPICE SETTING

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Background 'Bill' was in his early 40s. Admitted from home to the hospice for symptom assessment and end of life care. A former IV drug user on a methadone programme with support from the Drugs and Alcohol Team. His partner was also known to be on a methadone programme. Bill had advanced metastatic cancer. After the discovery of un-prescribed pills, Bill confirmed that he had been taking a number of 'street' tablets a day. Drug paraphernalia was discovered in the hospice grounds. Bill admitted to taking heroin when out for a smoke. Now imminently approaching end of life.

Aims

- To develop a policy and guidance for illicit drug use in the hospice.
- To assess on admission if non-prescribed drugs are being used.
- To reassure staff that practice was good and look at improving knowledge, confidence and staff awareness.
- To collaborate with external agencies.

Methods

- Staff debrief, peer supervision and training opportunities (Galvani, 2012).
- Meetings for advice with Controlled Drugs Local Intelligence Network.
- MDT meeting re: admission paperwork and development of a policy.
- Link with Drugs and Alcohol team to build contacts for future work (Alcohol Change UK, 2019; Reith & Payne, 2019).
- Collaboration with: GP, Recovery Steps, Oncology, Police, Safeguarding, family (Alcohol Change UK, 2019; Reith & Payne, 2019).

Results The hospice now has an illicit drug use policy and guidance. Developed a relationship with the Controlled Drugs Local Intelligence Network and Drugs and Alcohol Team and shared our experience with other organisations for learning. Staff debrief led to training opportunities and more confident staff. Addition of generic questions on admission to ascertain if any non-prescribed medication being used (alcohol, homeopathic agents, illicit drugs).

Conclusion We continue to offer holistic care with a more robust admission assessment and a better awareness of addiction and drug use. We respect the rights of service users

whilst protecting them from, as far as possible danger/harm (Galvani, 2012).

P-104 IMPROVING THE DETECTION, ASSESSMENT, MANAGEMENT AND PREVENTION OF DELIRIUM IN HOSPICES: THE DAMPEN-DELIRIUM CO-DESIGN PROCESS

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Background Delirium causes severe distress for patients, families, and staff. One-third of people admitted to adult palliative care units have delirium and two-thirds develop delirium during their stay (Watt, Momoli, Ansari, et al., 2019. *Palliat Med.* 33: 865), yet implementation of clinical guidelines is poor and assessment tools are used infrequently (Boland, Kabir, Bush, et al., 2022. *BMJ Support Palliat Care.* 12: 73). Strategies are needed to address this gap between knowledge and action (Featherstone, Hosie, Siddiqi, et al., 2021. *Palliat Med.* 35: 988).

Aim To adapt the Creating Learning Environments for Compassionate Care (CLECC) strategy from acute settings for use in hospice delirium care.

Methods We conducted three 2-hour Experience-Based Co-Design online workshops (Locock, Robert, Boaz, et al., 2014. *Health Serv Deliv Res.* 2) co-Chaired by a Patient & Public Involvement member. Participants had lived experience of delirium (personally or as a carer) or were hospice clinicians, domestic staff, or management. Workshops used examples of key delirium events to trigger discussion between patients/carers (Workshop 1), staff (Workshop 2), and patients/carers and staff (Workshop 3). Workshops 1 and 2 focused on adaptations to CLECC components (team study day, action learning sets, peer practice observations, mid-shift 'cluster discussions' and twice-weekly reflective discussions), whilst Workshop 3 focused on refining CLECC based on initial testing. The final specification of CLECC ('CLECC-Pal') for hospices at Workshop 4 will be informed by Process Evaluation findings.

Results The workshops conducted to date prompted changes to CLECC delivery and content to address equity and implementation concerns and to reflect the different circumstances of hospices. Changes included: flexible access to study materials, recognition of staff working relationships, including all staff in reflective discussions, having core and adaptable CLECC components, and identification of hospice leads for each CLECC component.

Conclusions Online Experience-Based Co-Design is a practical and feasible way of involving patients, carers, staff and management in adapting an existing intervention for hospice use. Our ongoing work is assessing signal of benefit of CLECC-Pal on number of patient delirium days.

For more on this study, see also oral presentation (O-13): Improving the Detection, Assessment, Management and Prevention of Delirium in Hospices: The DAMPen-Delirium feasibility study, by Gillian Jackson et al. (Parallel session 4.1 – Patient care perspectives).