

Parallel session 4.1 – Patient care perspectives

(Wednesday 23 November, 13:30 – 14:45)

O-13

IMPROVING THE DETECTION, ASSESSMENT, MANAGEMENT AND PREVENTION OF DELIRIUM IN HOSPICES: THE DAMPEN-DELIRIUM FEASIBILITY STUDY

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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 (NICE. Delirium: prevention, diagnosis and management - Clinical Guideline 103, 2010). Strategies are needed to address the gap between knowledge and action (Featherstone, Hosie, Siddiqi, et al., 2021. *Palliat Med.* 35: 988).

Aim To assess the feasibility of timely and reliable clinical record data collection in hospices with different socio-economic profiles and record-keeping methods.

Methods Phase one of the ongoing feasibility study collects clinical record data (demographic; evidence of delirium; [Inouye, Leo-Summers, Zhang, et al., 2005. *J Am Geriatr Soc.* 53: 312] guideline-adherent delirium care) from 50 consecutive in-patient admissions at four hospices. Data collection will be repeated following implementation of the co-designed Creating Learning Environments for Compassionate Care-Palliative (CLECC-Pal) intervention to support delirium guideline-adherence. The variation around baseline number of patient days with delirium will be calculated to inform the sample size needed for a future multi-site effectiveness study.

Results To date, 100 clinical records have been reviewed from two hospices. In-patient characteristics differ considerably in age (mean 89 vs. 70 years), deprivation quintile (80% vs. 38% in least-deprived) and diagnosis (90% vs. 72% cancer). Overall, two-thirds of patients had a delirium episode during admission, for whom >75% of their in-patient days were delirium days. A delirium diagnosis was documented by the clinical team in <10% of cases. Guideline-adherent delirium risk assessment and screening was not documented in clinical records.

Conclusion Our ongoing study is demonstrating: i) the feasibility of systematically and reliably collecting clinical record data about delirium occurrence and management; ii) the gap between need for delirium care and action (low guideline-adherence). Our emerging findings demonstrate the imperative for, and feasibility of, conducting a multi-site effectiveness study of the CLECC-Pal strategy for improving guideline-adherence in delirium care.

For more on this study, see also Poster P-104: *Improving the Detection, Assessment, Management and Prevention of*

Delirium in Hospices: The DAMPEN-Delirium co-design process, by Mark Pearson et al.

O-14

IMPROVING RESPIRATORY SYMPTOM MANAGEMENT FOR PEOPLE WITH NEUROMUSCULAR CONDITIONS: IMPLEMENTING A NEW SPECIALIST NEURORESPIRATORY PHYSIOTHERAPIST ROLE BASED WITHIN AN EXISTING PALLIATIVE CARE SERVICE

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Background Respiratory muscle weakness is a common feature of neurological conditions (Hough A, 2014). It is essential patients at risk of respiratory difficulties have timely access to specialist support to manage symptoms (NICE. Motor Neuron Disease: assessment and management. [NG42], 2016) and improve quality of life (Oliver, Borasio, Caraceni, et al, 2016. *Eur J Neurol.* 23:30). Therefore, it is concerning that over half of people with neuromuscular conditions have insufficient access to community respiratory services demonstrating a 'postcode lottery' (Muscular Dystrophy UK, 2015) similarly indicated in the Swindon area (Moffatt, 2018).

Aim

- Implement and evaluate a specialist role within a hospice palliative care service.
- Manage a caseload, lead and co-ordinate care.
- Address local inequalities in accessing community respiratory provision for people with neuromuscular disease.
- Improve patients' and carers' experience, upskill health care professionals in respiratory symptom management.

Methods A new hospice, community and hospital based neurology and respiratory service was established.

Quality improvement methodology was used to provide an eight month review. This included:

- Cough augmentation clinical audit review against NICE guidance.
- Patient/carer interviews, questionnaires, case studies.
- Feedback and surveys from healthcare professionals.
- Plan Do Study Act (PDSA) cycles.

Results 20 patients, 22 carers and 96 health care professionals have accessed the service. Excellent patient, carer and professional feedback demonstrated the quality of coordinated and timely response of the service. 100% of interviewees (14) reported feeling more confident with positive impact on quality of life and respiratory symptom burden. This was a highly valuable, crucial role sitting perfectly in palliative care.

Qualitative feedback is available with patient stories - these include avoiding hospital admission and management of non-invasive ventilation. At this early stage it is apparent that more capacity is required to provide an equitable service for all patients.

People with neuromuscular conditions experience respiratory difficulties. Access to specialist respiratory community services is inconsistent. A dedicated service for this cohort can have a positive impact in supporting people to manage their symptoms.