

tolerated and has potential use as a non-invasive tool to evaluate hydration status in the dying.

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CAREGIVER VIEWS AND EXPECTATIONS ABOUT THE USE OF ARTIFICIAL HYDRATION IN THE MANAGEMENT OF DYING PEOPLE WITH ADVANCED CANCER: A QUESTIONNAIRE STUDY

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Background Evidence for the use of artificial hydration (AH) in people dying with cancer is inconclusive, which creates challenges for healthcare professionals. These situations can be distressing for family caregivers, who may have unmet information needs. Better understanding of caregiver perspectives about AH in the dying, can potentially help healthcare professionals to identify information needs to improve support for caregivers.

Aim To examine caregivers' beliefs, experiences and information needs about AH use in people dying with advanced cancer.

Methods Questionnaire study of caregivers for people with advanced cancer, who were participants in a research study which was evaluating hydration status, and its association with symptoms, in advanced cancer. Caregivers were recruited from three UK study sites, consisting of two hospices and one hospital palliative care in-patient unit.

Results Fifty-two caregivers participated.

Most participants were female (N=38, 73.1%) and aged between 50-59 (N=12, 23.1%) and 60-69 (N=13, 25%). Most participants (N=33, 63.5%) said they were not aware of the term 'artificial hydration'. Most (N=35, 67.3%) believed that AH represented good care for the patient, with the majority stating that AH improved thirst (N=33, 63.5%) and dry mouth (N=30, 57.7%). Most participants did not believe AH affected prognosis, with 11 (21.2%) stating that AH prolonged life and 8 (15.4%) indicated that prognosis would be shorter without AH. Most expected AH to be available for patients in hospitals (N=42, 80.8%), hospice (N=43, 82.7%), nursing home (N=37, 71.2%) and home (N=31, 59.6%) settings. Most participants believed patients had the right to demand (N=39, 75%) or refuse (N=48, 92.3%) AH in the dying phase.

Conclusion Our study provides information about caregivers' views and expectations of the use of AH in dying cancer patients. Further work should explore how healthcare professionals can better identify and address unmet information needs of caregivers, concerning the use of AH in the dying.

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COLLABORATIVELY UNDERSTANDING PATIENT PREFERENCES AND PROVIDING PATIENT-CENTRED NUTRITION

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Patients with a terminal illness may experience reduced oral intake, loss of appetite or dysphagia making eating and drinking more difficult. The impact from these symptoms, along with disease progression, deterioration and fatigue, not only affect the patient physically but also psychologically. Key to meeting nutritional needs is a holistic assessment with the involvement of the multidisciplinary team and the patient, to ensure a realistic plan of care to provide nutritional intake are discussed and documented.

We took a collaborative approach with clinical and catering teams working closely to identify areas for improvement. Feedback from our patients suggested it was timely to review our approach to our menu of traditional fayre. Compton Care reviewed our nutritional approach and scoped our patients to identify preferences. We learned that patients wanted choice, so the ability to offer a wide range of choices at any time of the day - when the patient wants it - was important to us. Our catering team worked hard using modern food preparation techniques, increasing efficiency and reducing waste to allow us to achieve this goal.

Our team initiated a number of new approaches to support this holistic approach to nutrition. The completion of a patient-led assessment for every patient is the start of the patient's nutritional journey. We developed an all-day menu allowing patients to have a wide range of choices, grouped into savoury, sweet or soothing. This menu was further developed to ensure options can be adapted to different textures (in line with IDDSI).

The all-day menu consists of smaller amounts of food, beautifully presented. Portion sizes can be overwhelming so this approach makes the food look more appealing and delicious. The vast majority of choices can also be adapted to meet specific dietary needs or preferences. The team still have a dish of the day in addition to the all-day choice and the ability to fulfil specific wishes for our patients. If a patient wants a crab sandwich for example, the team will facilitate that!

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IMPROVING EDUCATION ON LOW RESIDUE DIETS IN PALLIATIVE CARE

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Background and aims Partial or complete bowel obstruction is a common complication of advanced cancers within the abdominal cavity (Tuca, Guell, Martinez-Losada, et al., 2012. *Cancer Manag Res.* 159). Following a low residue diet may be part of the treatment of bowel obstruction and may reduce nausea, vomiting and abdominal pain (Vanhouwaert, Matthys, Verdonck et al., 2015. *Adv Nutr.* 6: 820).

Methods A quality improvement project was conducted to provide a new leaflet explaining low residue diets for hospice patients. Surveys were conducted assessing understanding of low residue diets before and after the introduction of a dietician-approved leaflet.

Results Surveys were completed by five patients and twelve staff members (doctors, nurses and healthcare assistants) before and after the introduction of the dietician-approved leaflet. Following leaflet introduction, self-rated confidence in identifying low residue foods increased, on average, by 84% in staff