

HRV reduced SDNN & RMSSD very low: 21.3, 11.5ms spont; 27.2, 19.2ms paced, normal >50, >42 respectively

Strain significantly different (19.1, 24.3, $p=0.02$) in groups with/without fatigue.

BFI correlated with HRV, TUG with Strain (0.875, $p=0.001$), & HRV.

All found study acceptable No participant withdrew. One participant each:

- unable to complete STS
- felt echo interfered with privacy
- found paced breathing 'bothersome'

Conclusions

1. Objective assessment of fatigue, cardiac muscle & ANS feasible, acceptable & warranted in palliative populations
2. Majority of participants fatigued subjectively & objectively
3. Significant diastolic dysfunction & loss of HRV present
4. Correlations between subjective & objective fatigue, myocardial strain & HRV
5. These bedside tests can be used in palliative populations to guide symptom management

146 THE IMPACT OF A NEW INTEGRATED SUPPORTIVE CARE SERVICE FOR PATIENTS WITH INTERSTITIAL LUNG DISEASE

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Background Interstitial Lung Disease (ILD) can have a prognosis of 2–5 yrs with symptom burden comparable to lung cancer. Advance Care Planning (ACP) is poor and dying is often unrecognised. Funding was obtained for a Palliative Care consultant and ILD nurse to provide a fortnightly clinic, alongside the ILD consultant. The aim of the service: to improve symptom control and ACP, alongside routine respiratory care.

Methods Outcomes were reviewed for the first 50 patients attending clinic within 6 months of the service commencing. Patients were selected by the ILD consultant. Symptoms were assessed using the Integrated Palliative Outcome Scale (IPOS). ACP conversations were documented electronically to the GP with a request to update the Scottish Key Information Summary (KIS). The IPOS scores and information on the KIS were compared from first to last consultation.

Results First and last IPOS scores were available for 33/50 (66%) patients. Symptom burden was high: breathlessness (90%), Fatigue (80%), Anxiety (78%), Depression (60%), Pain (30%). Cough (20%) and insomnia (15%) were mentioned (not routinely measured by IPOS). Most symptoms improved; pain ($p=0.035$) and anxiety (0.040) reduced significantly. Pre-service 11/50 (22%) patients had ACP documented on KIS with DNA CPR documented in 4/50 (8%). Post-service, 31/50 (62%) had ACP documented ($p=0.003$). ACP was uploaded to the KIS in 25/31 (81%). DNACPR discussions were documented for 19/50 (38%) ($p=0.008$) with 17/19 (89%) of these uploaded to the KIS.

Preferred place of death (PPD) was documented for 29/50 (58%) patients. 19/29 (66%) stated a PPD for home, 10/29 (33%) for hospital.

11/50 (22%) patients died within the 6 months. Of these, 7/11 (64%) had documented PPD for home. This was achieved in 6/7 (86%).

Conclusion The integrated ILD Supportive Care service improves symptom burden for patients, improves ACP and may reduce unwanted hospital admissions at end of life.

147 USING AN IMPLEMENTATION STRATEGY TO IMPROVE GUIDELINE-ADHERENT DELIRIUM CARE IN HOSPICES: EMERGING FINDINGS OF THE DAMPEN-DELIRIUM FEASIBILITY STUDY

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Background Delirium is a complex condition, distressing for patients, family members and staff, and associated with poor outcomes. Despite high prevalence in the palliative care setting, it remains under-diagnosed. Delirium guideline-adherent care may both prevent and alleviate delirium. The best way to improve delirium-guideline adherence, and whether better adherence is reflected in reduced delirium, is not known. Prompt dissemination of feasibility findings is critical to avoid research waste.

Methods To inform a definitive large study, working closely with Patient Public Involvement members, we conducted a co-design and feasibility study (ISRCTN55416525) to assess the feasibility of collecting data (delirium diagnosis; guideline-adherence) from clinical records. Clinical record data (evidence of: delirium using a validated chart-based instrument; guideline-adherent delirium care) was collected from 50 consecutive in-patient admissions at three hospices pre- and post-implementation of a co-designed implementation strategy (data collection completed 3 December 2022). Analysis: Pre-post comparison of percentages for continuous data (delirium outcomes); nominal data (raw count of guideline-adherent metrics).

Results Target clinical record data collection ($n=300$) was achieved within timeframe, despite data collection during COVID-19. Delirium prevalence was comparable pre-and post-implementation with two-thirds of patients having a delirium episode during admission. There was a reduction in the proportion of delirium-days during admission 62% to 49%. We observed modest post-implementation improvements in most guideline-adherent metrics: delirium diagnosis as documented by the clinical team 15% to 26%; evidence of reversibility 33% to 36%; delirium risk assessment 0% to 12.5%; screening on admission 21% to 35%.

Conclusion Data collection about delirium outcomes and guideline-adherence from hospice clinical records is feasible. Our findings show the disparity between need (high delirium-incidence) and documented action (low guideline-adherence). However, there is a signal of patient benefit even with small documented improvements which needs to be formally evaluated in a multi-site study of effectiveness of an implementation strategy for improving delirium guideline-adherence.