FRAILTY SCORING FOR INPATIENTS OVER 65 YEARS ON AN ONCOLOGY WARD
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Background Population ageing is leading to more cancer diagnoses in individuals aged over 65, including those with concomitant frailty. Individuals with frailty have been shown to have palliative care needs, whilst frailty is also associated with need for adapted chemotherapy regimens or supportive care in patients with cancer. Older adults with cancer diagnoses are recommended to receive holistic assessment, such as comprehensive geriatric assessment, to evaluate unaddressed problems including frailty and palliative care needs. The aim of this audit was to assess whether frailty scoring was being completed for inpatients on an oncology ward, and to research the extent of frailty and discharge outcomes for this cohort.

Method Retrospective data collection for all inpatients ≥ 65 years on an oncology unit in North-West England over 4 months. Data collection included frailty score completion, degree of frailty, length of stay and changes in care/home circumstances on discharge.

Results 54% of patients admitted were ≥ 65 years of age. 69% of these patients had a frailty score completed on admission. 84% of patients ≥65 had at least mild frailty (clinical frailty score [CFS] of ≥4). Mean length of stay was 13 days for those with a CFS ≥4 compared to 7 days for those with a CFS <4. In total 42% of patients with a CFS ≥ 4 were discharged with additional care or change of discharge destination. No patients ≥65 years with a CFS <4 had a change in discharge circumstances.

Conclusions Frailty is prevalent in this inpatient oncology cohort and is associated with longer inpatient stays and changes in care/discharge destination circumstances. This indicates that holistic assessment of these patients, including review of palliative care needs, is both feasible (due to longer stays) and likely to be required (due to evidence of higher burden of care needs).

THE RESPONSES STUDY – A QUALITATIVE EXPLORATION INTO PSYCHOLOGICAL RESPONSES TO, AND POTENTIAL INFLUENCES OF, ADVANCE CARE PLANNING DISCUSSIONS FOR PEOPLE LIVING WITH ADVANCED ILLNESS
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Background Advance Care Planning (ACP) discussions can be beneficial to people living with advanced illness. While research has focussed on ACP barriers, outcomes and completion, little is known about how ACP discussions influence thoughts, feelings and behaviours.

Aim To explore psychological responses to ACP discussions, and their potential influences on the thoughts, feelings and behaviours of people living with advanced illness.

Design Semi-structured, qualitative interviews with purposively sampled adults receiving hospice care. Data were analysed using framework analysis. Reflexive journaling and discussion of coding framework and emerging themes supported rigour.

Results 20 adults aged 30–93 with cancer (15) and non-cancer (5) diagnoses were interviewed. Participants described a range of responses to ACP discussions, including relief and satisfaction in expressing wishes, confidence in decision making, and appreciation of the support, acceptance, expertise and honesty of clinicians and relatives. A smaller number of negative emotions such as worry, anger, and doubt about achieving wishes were expressed. Existential responses included acceptance of their illness, hopes and fears for the future, and difficulty of facing mortality. Responses were tied to factors such as attitudes towards having a terminal illness, previous thoughts about ACP, personality, and previous experiences of death and dying.

ACP empowered participants, confirming previous end of life wishes, allowing them to address existential concerns, promoting openness with relatives, and encouraging them to make the most of time left.

Conclusion Participants described positive, negative and existential responses to ACP discussions. When considering both how to approach and support people after ACP discussions, clinicians must sensitively navigate their potential impact, being aware that they encourage people to consider their future, and their own mortality.

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THE ROLE AND IMPACT OF PALLIATIVE CARE CLINICAL NURSE SPECIALISTS IN THE DELIVERY OF ENHANCED SUPPORTIVE CARE FOR PATIENTS WITH HEPATOPANCREATOBILIARY CANCER
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Background This abstract is taken from an article that was under review by International Journal of Palliative Nursing which was accepted for publication in late November 2022. At present, the article is in press. Integration of care between palliative care and oncology offers improvement in patient outcome and is increasingly recommended. There is evidence of improved patient and healthcare outcomes including quality of life, tolerability of systemic anticancer treatment in the last year of life and reduced healthcare cost. Alongside discussions of early palliative care integration, supportive care and its integration into oncology care has also come into focus. Supportive care is the prevention and management of the adverse effects of cancer and its treatment, including management of physical and psychological symptoms associated with cancer, its treatment and associated post-treatment care. Enhanced Supportive Care (ESC), led and delivered by palliative care clinical nurse specialists is a potential model to achieve this but is currently uneviedenced.

Aim To investigate the impact of a nurse-led integrated ESC model within the hepatopancreatobiliary (HPB) cancer care setting.
**Abstracts**

**Method** One-hundred and one patients with HPB cancer were supported by integrated ESC delivered within a co-located clinic structure. Data relating to symptoms and quality of life were collected prospectively. Survival data and chemotherapy usage was retrospectively analysed following minimum follow-up, utilising a matched control technique.

**Results** ESC patients illustrated improvements in certain key symptoms including pain, nausea, vomiting and mood over time. Patients also had less aggressive treatment towards the end of life amounting to 31% less chemotherapy than controls with comparable survival.

**Conclusion** An integrated nurse-led ESC model can be effective in improving outcomes for patients with HPB cancer. This model resulted in improved quality of life and a reduction in the amount of chemotherapy administered in the last year of life with comparable survival.

**DEPRESCRIBING: A QUALITY IMPROVEMENT PROJECT IN COMMUNITY PALLIATIVE CARE**

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10.1136/spcare-2023-PCC.174

**Background** Deprescribing is a positive, patient-centred, safe, effective, and cost-efficient process. It takes time, skill, confidence, and teamwork. It is an established part of good holistic care therefore suitable for quality improvement.

**Study Aim and Methods** This Quality Improvement Project was conducted at the interface of community palliative care and General practice in Southwest England. The aim was ‘For 100% of patients on the palliative care registers in South Somerset West Primary Care Network to have the opportunity of a deprescribing conversation with a skilled healthcare professional between diagnosis and death’. Four GP surgeries under one management participated (patient population 37,107). Background data collection evidenced the problem and highlighted that the register numbers did not reflect the national expected prevalence (Gold Standard Framework estimate prevalence at 1%). This had to be addressed to make the project equitable. Process mapping and discussion of primary and secondary drivers informed initial interventions including re-establishing regular multidisciplinary team meetings, creating a coded template to improve their structure and aid documentation and data collection and education. Eleven Plan Do Study Act cycles ensued over eight months.

**Results** The percentage of patients on the palliative care registers having the opportunity of a deprescribing conversation increased from 0% to 33%. This process measure proved more responsive to change than the outcome measure. The register size increased from 0.2% to 0.39% of the practice population. The most successful interventions were education (p>95% causative) and ensuring key professionals were available, highlighting the need for cultural change and the impact of human factors. Simple IT interventions were also effective.

**Conclusion** The aim was unrealistic in the timeframe because deprescribing could not be isolated from improvement in holistic care (benefit acknowledged, future research needed). Limitations included lack of staff cover. Continued work at these sites plus local expansion is planned.

**AN INTEGRAL PART OF TREATMENT: WHAT ONCOLOGISTS THINK ABOUT EARLY INTEGRATION OF PALLIATIVE CARE INTO ONCOLOGY CLINICS**


10.1136/spcare-2023-PCC.175

**Background** The Integrated Symptom Control and Palliative Care ‘Triggers’ service was developed to support oncology outpatients to live as well as possible throughout their cancer journey.

The aim of this survey was to evaluate the views of oncology clinicians about the ‘Triggers’ service in a tertiary referral oncology centre 6 years after the service was initially established.

**Methods** A brief anonymous staff feedback questionnaire was developed with PPI input comprised of four questions with structured answers and one free text question. The survey was carried out in 2018 and repeated in 2022. All oncology staff working in clinics where the ‘Triggers’ service was invited to participate. Descriptive analysis was carried out on the structured questions and thematic analysis on the free text question. This service evaluation was approved by the local Committee for Clinical Research.

**Result** Feedback forms were received from 42 staff members in 2018 and 52 in 2022. 49/52 (94%) rated the value of the service for patients and families as very positive. (69% in 2018). 50/52 (96%) thought the service had a very positive impact on patients. (69% in 2018). 96% (50/52) felt it had a positive effect on the running of the clinic. (76% in 2018). Three strong themes were identified from the 2022 free text responses. The ‘Triggers’ service provides urgent and prompt access to the palliative care team for management of patients with complex needs. The oncology teams felt that the ‘Triggers’ service was helpful to the clinics and staff working in them. Finally, they recognised that the ‘Triggers’ service is integrated and routinised into the oncology clinics.

**Conclusions** As the ‘Triggers’ early palliative care service has become embedded and integrated into the oncology outpatient clinics over time, oncology clinicians have become increasingly aware of the associated benefits for patients and staff.

**Poster Nos 156–158: Survivorship and Rehabilitation**

**FALLS PREVENTION: THE IMPORTANCE OF LOWER LIMB NEUROLOGICAL EXAMINATION ON HOSPICE ADMISSION AND INPATIENT FALLS**

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**Background** Multiple factors contribute to inpatient falls. Spinal metastases occur in 3–5% of all cancer patients, with incidence up to 19% in breast, prostate and lung cancer patients. Median survival following diagnosis of metastatic spinal cord compression (MSCC) is reported to be 2–3 months. Back pain occurs in 95% of these patients with second most common