

established to capture the impact on sleep, pain and wellbeing, as reported by patients and carers. The impact on the clinical team was also monitored.

**Methods** The service operated three nights per week from 7pm-10pm, October to December 2022. The service was evaluated using questionnaires to recipients and staff. Further feedback was gained from focused discussion. For patients and carers a score (0–5) was noted pre and post session. Self-reported outcome of impact on wellbeing, sleep and pain using a Likert scale was recorded. For staff, impact on workload, communication and impact on patients, carers and the team were explored.

#### Results

- A total of 68 sessions were carried out with 63 patients and 5 carers.
- 45 out of 48 forms were returned with a rating before and after.
- 93% of people reported an improved rating.
- 7% reported no change.
- 70% found an improvement in sleep quality, 50% showed a reduction in pain and 80% showed an improvement in mood or anxiety.
- Average rating before being seen by a therapist was 2.31 and after 4.22.
- 93% of people who submitted an evaluation returned an improved rating.
- 100% of staff noticed a benefit to either the patient, a family member, themselves and/or other staff.

**Conclusion** This project has highlighted the considerable benefits of an evening complementary therapy service to patients, carers and staff. The majority of patients reported improved wellbeing, sleep and pain levels, with no negative impact on the ward routine reported.

#### P-153 CASE STUDY – HOSPICE INPATIENT UNIT

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**Background** Certain patient groups can struggle with equity of access to inpatient hospice care. This can include those with significant mental illness (Edwards, Ansley, Coffey, et al. *Palliat Med.* 2021; 35(10): 1747–1760; Sheridan. *The Lancet.* 2019; 4 (11) 545 –546).

We describe the case of a gentleman with a diagnosis of paranoid schizophrenia and likely autistic spectrum disorder who developed advanced colorectal cancer. He opted against treatment and was assessed as having capacity for this decision. With progression to subacute bowel obstruction, supported living became untenable. The major issue was declining personal care, on a background of longstanding self-neglect, compounded by worsening gastrointestinal symptoms. Upon reaching 'crisis point' hospice admission was offered.

**Methods** We were anxious we would fail to meet this gentleman's needs as reluctance for all care persisted. Assessing mental capacity for decision making was complex, we are used to considering this in cognitive impairment, rather than in the context of mental illness and autism. Shared working with the Mental Health Team (Edwards, et al., 2021; Valente, Saunders. *Am J Hospice Palliat Med.* 2010; 27: 24- 30), joint assessments of mental capacity for specific decisions and

interdisciplinary meetings ensured we were using correct legislation and least restrictive approaches (Regan, Sheehy. *Nurs Standard.* 2016; 31(14): 54–63). Involving his brother as an advocate was crucial, this also facilitated a visit after limited contact.

**Results** Breakthroughs occurred at unpredictable intervals with the respectful persistence of staff, building trust to accept basic care and medications (Pinto, Pereira, Chaves. *Nurs Care Open Access Journal.* 2017; 3(6): 331–333). The gentleman eventually commented that this is “*the best place he's ever been*”. Care was not always typical, with reluctance around some medications and administration routes, but it was individualised and improved symptom control.

**Conclusions** Hospices need training, integrated working with mental health services and an innovative approach to meet the needs of patients with significant mental illness. The key here was relationship building and there was a huge sense of pride for the team when gains were made (Pinto, et al., 2017). This case also highlights the value of inpatient hospice beds in supporting complex care.

#### P-154 AUDIT OF THE USE OF THE MALNUTRITION UNIVERSAL SCREENING TOOL (MUST) IN A HOSPICE INPATIENT UNIT

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The aim of the present audit was to review the use of the recently introduced Malnutrition Universal Screening Tool (MUST) within a hospice inpatient unit (IPU) setting.

**Method** We reviewed 57 records of patients who were admitted in the hospice IPU in November and December 2022. We looked at the MUST tool screening records which are part of the holistic nursing assessment.

**Results** 96% of patients were screened using the MUST tool. 90% of them scored as being at medium (9%) or high (81%) risk. Most of the patients (3 in 4) had had significant weight loss in the previous 3–6 months, although only 10% of them were underweight. Most patients' weight and height were estimated, hence the findings are an approximate.

**Discussion** This audit gives a snapshot of patients' estimated weight, BMI and MUST score. We have shown that, as expected, almost all patients were at risk of malnutrition. For that reason, our conclusion is that the MUST tool is irrelevant in a hospice setting. Malnutrition affects palliative care patients, due to various acute and chronic disease processes, with its prevalence increasing as the terminal phase approaches. If almost all palliative care patients are at risk of malnutrition, then what's the point of screening for it?

In this audit, most patients were not underweight, although they had experienced significant weight loss in the previous 3–6 months. This finding represents a big shift from the past, where the majority of palliative care patients were underweight. As most adults in the UK are nowadays overweight/obese, they can present at the end of their life with a normal body weight. The authors would like to propose an alternative approach to malnutrition screening, which involves nutritional assessment for symptoms that are associated with impaired nutrition intake and absorption, with an aim to provide symptom relief and perhaps improved nutritional status.