A human feeling of connection was there. It was not just about one teaching another, it was about engaging, listening and understanding.

Conclusion By introducing harmony as a positive framework, HILDA can catalyse creative ideas for people to engage with living and dying, helping to overcome anxiety or fear of death.

P-163 DELIVERY OF GUIDED VISUALISATION SESSIONS FOR PATIENTS AND STAFF, USING A MIXED-FORMAT METHOD IN A HOSPICE SETTING

Angela Vigus. Birmingham Hospice, Birmingham, UK
10.1136/spcare-2023-HUNC.184

Background Guided visualisation (GV – meditation) has documented benefits for alleviation of stress and anxiety, in the context of palliative care (Coelho, Parola, Sandgren et al. J Hosp Palliat Nurs. 2018;20(4):392–399) and in the workplace (Carroll. J Interprofessional Educ Pract. 2022; 28: 100518). The outcome of preliminary satisfaction surveys and informal feedback formed the basis for the implementation of a hospice-wide complementary therapy service, featuring GV and made available to patients, their families and hospice staff.

Aims To implement and measure the uptake of a person-centred GV programme across the hospice using a mixed-format method and to evaluate its impact on physical and psychological symptom management (Goyal, Singh, Sibinga, et al. Agency for Healthcare Research and Quality. 2014. Report No.: 13(14)-EHC116-EF) in patients and improvements to staff wellbeing.

Methods April 2019 – design and delivery of GV as part of a 12-week programme for patients attending the Living Well centres. Sessions for staff provided by appointment. April 2020 – introduction of GV sessions to phone and virtual platform, continuing to support patients and staff during the COVID-19 pandemic. April 2021 onwards – adoption of a mixed-format method for GV delivery, driven by the service user. For all programmes, service evaluation included collection of data on attendance, outcomes from post-session surveys, formal and informal feedback.

Results

<table>
<thead>
<tr>
<th>Abstract P-163 Table 1</th>
<th>Recorded data of attendance at GV from April-March annually (2019–2022)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patients</td>
</tr>
<tr>
<td>April 2019-March 2020</td>
<td>640</td>
</tr>
<tr>
<td>April 2020-March 2021</td>
<td>335</td>
</tr>
<tr>
<td>April 2021-March 2022</td>
<td>531</td>
</tr>
<tr>
<td>April 2022-March 2023</td>
<td>645</td>
</tr>
</tbody>
</table>

Conclusion Social-distancing measures prompted transfer of GV delivery to a virtual platform which continued to be accessed by all service users. For both patients, their families and staff offering GV via face-to-face, phone and virtual sessions provided choice, enabled vital social connections to be sustained, created a safe space for service users to manage psychology and physical stress and promoted staff wellbeing.

P-164 EVALUATION OF A FATIGUE, ANXIETY AND BREATHLESSNESS (FAB) EDUCATION PROGRAMME IN A HOSPICE WELLBEING CENTRE

Katy Firth. Wirral Hospice St John’s, Bebington, UK
10.1136/spcare-2023-HUNC.185

Background Our wellbeing centre has included education groups for a number of years. We separated the therapy groups to increase the speed of access and reviewed their content.

Aims Determine patients’ knowledge about managing their fatigue, anxiety and breathlessness (FAB) pre and post group. Evaluate the effectiveness of the FAB group. Review whether the changes made reduced waiting times. Establish if attending the groups impacted upon IPOS (Integrated Palliative Care Outcome Scale) scores.

Methods We contacted hospices across the UK to determine if a standardised assessment tool to monitor the outcomes of their education groups was used. The majority of the hospices hadn’t used a standardised assessment tool. They had developed their own questionnaire using a Likert scale or visual analogue scale. We created a Likert scale questionnaire that patients would complete at the start and end of each session. We collected IPOS scores pre and post group. The IPOS questions we focused on were shortness of breath, weakness or lack of energy and have you being feeling worried or anxious about your illness or treatment.

Results The results from the questionnaires were positive. On average the post group questionnaire scores were all higher than the pre group scores. There was a significant reduction in waiting times from the date of referral to a person attending their first group by fourteen days. Over the data collection period similar numbers of patients were seen. There were small improvements in the average IPOS scores across all the groups.

Conclusion Attending the FAB group is improving patients’ knowledge around independent symptom management. Due to the nature of palliative conditions we wouldn’t necessarily expect to see a decrease in IPOS score for specific symptoms because symptoms are likely to fluctuate with ongoing treatment, illness or a deterioration in condition. Therefore, it is important that we continue to use non-standardised data collection methods alongside standardised outcome measures.

P-165 EVALUATING THE FEASIBILITY AND ACCEPTABILITY OF IMPLEMENTING A BREATHLESSNESS PROGRAMME IN A DAY THERAPY SETTING

Hayley Kidger, Nadine Graba. Hayward House, Nottingham University Hospitals, Nottingham, UK
10.1136/spcare-2023-HUNC.186

Background People with advanced disease often experience fatigue and breathlessness which impacts on their wellbeing (Gysels, Higginson. BMC Palliat Care. 2011; 10:15). Evidence-based, non-pharmacological, multidisciplinary breathlessness and fatigue management services have been found to...
improve quality of life (Booth. Prog Palliat Care. 2013; 21:4). They have not been developed or evaluated in the palliative day therapy setting.

**Aims** To explore the feasibility of implementing a breathlessness programme and evaluate patient experiences and outcomes.

**Method** The Cambridge Breathlessness Intervention Service study day was attended by a specialist palliative care physiotherapist and occupational therapist, to consolidate existing knowledge and understand the Breathing, Thinking, Functioning model (Spathis, Booth, Moffat, et al. Prim Care Resp Med. 2017; 27(1):27). A six-week group programme was designed and implemented covering breathing techniques, staying active, stress and anxiety, fatigue management, living well whilst planning for the future and guided relaxation. This took place weekly, in four hour sessions. The programme was delivered by a physiotherapist and occupational therapist, with support from nursing and medical colleagues. Demographic data and patient feedback were collected, with the Chronic Respiratory Questionnaire- Self Reported (CRQ-SR), (Williams, Singh, Sewell, et al. Thorax. 2001; 56(12): 954–9) completed at weeks one and six.

**Results** 44 patients were referred to the programme. 47% had a cancer diagnosis, 30% a respiratory condition, 10% cardiac failure and 13% a mixed cancer/respiratory pathology. 14 patients attended the group, over three different cohorts. 7 patients completed the entire programme and completed the PROMs. 9 patients died after referral, 4 after starting the group. The 21 referrals who did not start a group either declined the group or were not appropriate for a variety of reasons. The mean number of sessions attended was 3.5. Of those that completed the programme, CRQ-SR score had a mean improvement of 10.7 points, with the Mastery domain demonstrating a mean improvement of 3.28, where 2.0 is considered significant (Morgan, Respiratory Med. 1991; 85:23–24).

**Conclusion** An informal group in a day therapy setting can be an effective, acceptable and feasible method of delivering a breathlessness and fatigue management programme. This project can offer learning to those in similar settings.

**THE CREATION OF A HOSPICE BASED PALLIATIVE BREATHLESSNESS REHABILITATION GROUP: ‘TAKE A BREATH’**

Sarah Sharp, Sue Ryder: Leckhampton Court Hospice, Cheltenham, UK

10.1136/spcare-2023-HUNC.187

**Background** Respiratory disease affects 1 in 5 people and is the third biggest cause of death in England. Both British Thoracic Society (BTS, 2013) and NICE guidelines advocate the use of pulmonary rehabilitation. However, research shows that those people with advanced disease struggle to complete pulmonary rehabilitation despite evidence confirming significant benefits. The Breathlessness Service at this hospice regularly encountered patients with end stage disease who either declined or were unable to access NHS pulmonary rehabilitation. Despite a high symptom burden, patients with respiratory disease remain under-represented in palliative care. Research suggests that by integrating pulmonary rehabilitation with palliative care, symptom burden can effectively be addressed in a holistic, patient centered manner.

**Aim** To set up a hospice-based breathlessness rehabilitation service which will provide patients with advanced disease a supportive environment in which to exercise and learn self-management techniques.

**Methods** A literature search was conducted confirming the evidence base for a palliative pulmonary rehabilitation group. Using BTS and NICE guidance, a 6 week programme of 2 hour sessions was devised consisting of circuit based exercises, education topics and relaxation sessions. Using an existing cohort of patients, a pilot group was formed, completing the first ‘Take a Breath’ course in February.

**Results** Patients demonstrated improvements both subjectively and objectively. Data was collected using a modified Chronic Respiratory Questionnaire (CRQ), Phase of Illness, Karnofsky Performance Scale, Timed Up and Go and a patient feedback questionnaire.

**Conclusions** This course is an effective example of rehabilitative palliative care, and also importantly provides an introduction and route into hospice care. For many of these patients, ‘Take a Breath’ has been their first experience of hospice care and has allowed them to go and make further links with the wider hospice MDT. Further audit into the longer term benefits would be beneficial, in terms of symptom control, self-management and also ongoing engagement with palliative care services.

**POST PANDEMIC IMPLEMENTATION OF A HOSPICE-BASED REHABILITATION PROGRAMME**

Nikki Reed, Sophie Boyle, Lisa Shyamalan. Marie Curie Hospice West Midlands, Solihull, UK

10.1136/spcare-2023-HUNC.188

**Background** In March 2020 the community focused day services at our hospice were stopped overnight as the UK went into national lockdown due to the pandemic. In April 2022 it was acknowledged, that whilst still balancing Infection Prevention & Control measures (IPC), it was important to re-establish community focused day services within the hospice.

A literature review highlighted:

1. Rehabilitative palliative care has the potential to reduce disability and reduce dependence on families, health, and social care services.
2. Prolonged periods of social isolation reduce quality of life.

**Aim** To implement a rehabilitation programme at our hospice.

**Methods** A small project group generated: Inclusion/exclusion criteria; Standard Operating Procedure; Project management documentation; Risk assessments; Agreed validated outcome measures.

An eight-week rehabilitation programme was commenced in April 2022. Initial assessment with both a physiotherapist and occupational therapist, to consolidate existing education topics and relaxation sessions. Using BTS and NICE guidance, a 6 week programme of 2 hour sessions was devised consisting of circuit based exercises, education topics and relaxation sessions. Using an existing cohort of patients, a pilot group was formed, completing the first ‘Take a Breath’ course in February.

**Results** Patients demonstrated improvements both subjectively and objectively. Data was collected using a modified Chronic Respiratory Questionnaire (CRQ), Phase of Illness, Karnofsky Performance Scale, Timed Up and Go and a patient feedback questionnaire.

**Conclusions** This course is an effective example of rehabilitative palliative care, and also importantly provides an introduction and route into hospice care. For many of these patients, ‘Take a Breath’ has been their first experience of hospice care and has allowed them to go and make further links with the wider hospice MDT. Further audit into the longer term benefits would be beneficial, in terms of symptom control, self-management and also ongoing engagement with palliative care services.