8 A QUALITATIVE INVESTIGATION OF PATIENT AND CAREGIVER RECIPROCAL SUPPORT IN SPECIALIST PALLIATIVE CARE

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10.1136/spcare-2024-PCC.8

Background Patients and caregivers in palliative care have capacity to support one another and cope with advanced illness. Joint adaptation to changing roles and mutual recognition of the challenges they face are reciprocal dimensions of support provision between patients and caregivers in palliative care.[1] However, few studies have explained how patients with advanced illness and caregivers are mutually supportive in palliative care. We aimed to identify processes of reciprocal support among patients and caregivers in palliative care.

Methods A qualitative study using the grounded theory method[2] was conducted with 15 patients and 21 caregivers recruited from a regional specialist palliative care service comprising two hospice sites. Sampling was purposive and theoretical. Data comprised a total of 30 semi-structured interviews using an interview schedule formulated for data collection. The data were analysed using grounded theory coding procedures and analytical memos were compiled to support the analysis.

Results Patient and caregiver reciprocal support manifested primarily in the form of emotional support. Caregivers provided emotional support to assist the patient cope with distress. Patients provided emotional support to alleviate caregiver strain, and particularly when they felt unable to reciprocate beyond emotional support. Patient and caregiver reciprocation in emotional support comprised mutual expression of affection and optimism, mutual disclosure about concerns, mutual effort to maintain constancy and normalcy, and mutual obligation to accommodate each other's preferences for care. However, obligation to accommodate each other's preferences resulted in patients and caregivers also concealing their distress from each other and in some cases, feeling constrained by one another when discussing treatment and care with healthcare professionals.

Conclusions Reciprocal support among patients and caregivers in specialist palliative care involves both disclosure and concealment. Healthcare professionals need to be alert to the impact of both disclosure and concealment in the decision-making process for treatment and care.

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9 THE USE OF IMMERSIVE VIRTUAL-REALITY INTERVENTIONS TO IMPROVE PSYCHOLOGICAL WELL-BEING IN ADULT CHRONIC PHYSICAL ILLNESS

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10.1136/spcare-2024-PCC.9

Background Despite the negative psychological sequelae associated with chronic illness, psychological wellbeing is commonly overlooked in palliative care. Immersive virtual reality (VR) is a novel treatment that may improve psychological outcomes and ameliorate quality of life in adults living with chronic physical illness (ACPI). The aim of the study was to systematically review literature to:

1. Explore the psychotherapeutic applications of immersive VR in ACPI
2. Assess the effect of immersive VR interventions on the psychological welfare of ACPI

Methods A systematic literature review and meta-analysis were conducted. Database searches of Ovid MEDLINE/PubMed, Web of Science, PsycINFO, Embase and Scopus included literature published between July 1993 to March 2023. Given the paucity and heterogeneity of study design and interventions, narrative synthesis was conducted.

Results Out of 12811 texts screened; 31 studies were included. In these studies, 75% of participants were female, and the median age of participants was 50.8 years. Most of the texts included were feasibility or pilot studies. Immersive VR interventions focusing on relaxation and participant engagement demonstrated high acceptability and feasibility when adopted to patient populations dealing with cancer, kidney disease, dementia, cardiovascular disease, and multiple sclerosis. Results indicate that immersive VR can alleviate pain and reduce anticipatory anxiety, particularly in oncological settings.

Conclusions There are notable positive effects associated with immersive VR promoting environment-based and game-based relaxation, amongst people with cancer as well as other restricting chronic physical conditions. Further research on long-term benefits of VR, in wider population groups, is recommended.

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10 AN EXPLORATION OF CORNEAL DONATION WITHIN A HOSPICE INPATIENT UNIT (IPU)

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10.1136/spcare-2024-PCC.10

Background Having a certain illness or health condition does not necessarily prevent a patient from becoming an organ donor and it is possible that palliative care patients dying in hospice setting may still be eligible to donate their corneas. In line with the organ donation law in England, patients are asked about their organ donation wishes. Should a patient choose to become a cornea donor when they die, IPU staff will endeavour to fulfil patient's wish.

Methods An audit was undertaken to examine the documentation on corneal donations among inpatients who were admitted to IPU between January and March 2023. The nursing team also learned from past cases to avoid missing prospective corneal donations. Additional supporting information was sought from local eye bank to compare the regional corneal donation statistics and ascertain the outcome of retrieved corneas.

Results Results provided by the eye bank confirmed that we have been consistently the second biggest contributor to the

corneal donations among hospices in Southeast England and 26 patients have been benefitted since 2022. The audit identified that four patients had their corneas donated but two were not recorded in the notes, and six patient records lacked accurate records of patients' wishes regarding corneal donation. As a result, the electronic Advance Care Planning template, Verification of Expected Death (VoED) form and daily nursing handover sheet have been amended to track and record patient's decisions and the liaison with the eye bank if appropriate.

Conclusion The latest corneal donation audit and subsequent implementations have tightened the documentation practice and will enable the IPU staff to support patients' organ donation wishes more accurately. The encouraging outcomes demonstrated the great joint effort and perseverance by the nursing team and medical team, and the results will be made publicly available to patients, hospice visitors and staff.

11 A PILOT QUALITY IMPROVEMENT PROJECT IN OPTIMISING THE ASSESSMENT AND MANAGEMENT OF PATIENTS AT RISK OF CATASTROPHIC HAEMORRHAGE

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10.1136/spcare-2024-PCC.11

Introduction Catastrophic haemorrhage is a rare palliative care emergency that can profoundly impact patients and carers. When caring for at-risk patients, particularly those receiving community care, there are ethical and practical challenges. It should be recognised that: terminal bleeding may not materialise; if bleeding occurs the burden of care often falls on carers, including administering anxiolytics; anxiolytics can unintentionally cause respiratory depression.

Expert opinion in the form of guidelines is available to help specialists navigate challenges, though little evidence exists.

Methods Recommendations from E.Ubogagu and DG.Harris' guidelines (2018) were collated into eight best practice criteria: (1) an MDT approach, (2) recognising and assessing bleeding risk, (3) risk mitigation (4) considering social circumstances, (5) anxiolytic prescribing decisions, (6) sensitively explaining bleeding risk, (7) introducing crisis-packs and (8) preparing carers. DG.Harris and SIR.Noble's systematic review (2009) reports midazolam is most established, despite variations in anxiolytic prescribing. At Royal Oldham Hospital (ROH) buccal midazolam is preferred.

At-risk patients, with malignant and non-malignant disease, were identified from ROH palliative care records for referred patients who died March-September 2023. Their documented bleeding risk assessment and management was compared against best practice criteria.

Results ROH at-risk patients accounted for 5.6% of all patients, with those receiving community care accounting for 2.8% (n=9). On average, 29.9% of criteria were met. Highest performing criteria were recognising and assessing bleeding risk (77.8%) and risk mitigation (72.2%). There were no discussions to explain bleeding risk nor prepare carers. Two patients received intramuscular midazolam (11.1%), but no buccal midazolam was prescribed.

Conclusions A pilot project aims to improve practice by creating a new hospital Standard Operating Procedure that includes: (a) a flowchart to assess and mitigate bleeding risk, consider social circumstances and buccal midazolam; (b) advice on explaining bleeding risk; and (c) an ABCDE algorithm and information leaflets to prepare carers.

12 CANCER CACHEXIA: A MULTIDISCIPLINARY APPROACH TO EXPLORE THE PREVALENCE OF CACHEXIA

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10.1136/spcare-2024-PCC.12

With a breadth of literature relating to background, prevalence and impact of cancer cachexia, there remains a gap in incorporating theory into practice, with cachexia being underdiagnosed and undertreated. The importance of having a multidisciplinary team to build a cachexia clinic has been acknowledged.[1] This gave inspiration to the exploratory work conducted in Gateshead.

We aimed to identify cachexia prevalence within an upper GI cohort, to identify the demand for a multidisciplinary clinic. For newly diagnosed Upper GI oncology patients, a retrospective audit over a four month period was completed - collecting data including; weight parameters, appetite, nutritional risk, malnutrition diagnosis/severity using GLIM criteria[2] and identification of inflammation using Modified Glasgow Prognostic score. Defining cachexia as disease related malnutrition based on the GLIM definition and presence of inflammation is recommended.[1] Additionally, we attempted to identify stage of cachexia where inflammation was present using criteria by Fearon.[3]

In total 31 patient notes were analysed, 22 male and 9 female. The average age range was 46–89 years (mean 71 years).

13 patients (41.9%) were diagnosed with malnutrition using GLIM, 8 moderately and 5 severely malnourished. Eleven (35.4%) also had presence of inflammation and cachexia. Using classification by Fearon as a grading rather than diagnostic method, 5 were found to have refractory cachexia (3 severe malnutrition, 2 moderate), whilst 5 had cachexia (1 severe malnutrition, 4 moderate). One had pre-cachexia (with moderate malnutrition).

When using Fearon classification to diagnose cachexia without a positive GLIM diagnosis, 6 patients had pre cachexia, although no diagnosis of malnutrition.

We have found GLIM to be useful in identifying malnutrition and inflammation, with severe malnutrition more prevalent in refractory cachexia and moderate malnutrition most prevalent in cachexia. Fearon classification is useful to detect pre cachexia with no malnutrition diagnosis and a limited loss in weight.

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