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BUILDING THE EVIDENCE BASE FOR COMPLEMENTARY THERAPY IN HOSPICES

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Background Complementary Therapy (CT) is widely used in hospices; however the backing research on its efficacy has been somewhat limited. CT can be understood as the bridge between the medical model and alternative therapies. Yet this profession has struggled to gain respect in modern medicine and it is debatable whether Complementary Therapists are seen as equal to other MDT members. Against this background a team of hospice Complementary Therapists have been gathering evidence of their clinical input with a view to assessing and demonstrating its efficacy.

Aims To conduct a wide scale evaluation of CT treatments provided across all services to assess the impact on patient care and for a range of symptoms. Results to guide future evidence based treatment management (the right treatment at the right time).

Methods Patients, using an adapted visual analogue scale, rated their symptoms pre and post CT input. Results, separated into symptom categories, were analysed over a three year period.

Results 1321 patient reported outcomes were collected. After data cleansing, 1217 treatment episodes were reviewed

On average, patient symptoms improved by 2.13 on the 10 point adapted VAS scale which is statistically significant

Pain, breathlessness, anxiety and nausea gained the highest score and were perceived to have the most benefit by patients

Constipation, fatigue, insomnia and appetite had very poor outcomes.

Conclusions We believe the above results demonstrate that CT can indeed provide statistically significant results in a palliative setting. Of particular interest has been the emerging evidence with regards to particular efficacy for particular symptoms. These results can guide other clinicians when referring to the CT team more appropriately therefore meaning patients receive the most suitable treatment for their needs. Such evidence helps with improving the recognition of the role of Complementary Therapy in the hospice setting.

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SPECIALIST PALLIATIVE CARE INPUT IN PATIENTS WITH PARKINSON'S DISEASE

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Background Parkinson's disease (PD) is a common, chronic, progressive neurological condition (NICE, 2006). Its prevalence rate in 2009 was calculated as 27.4/10,000 and is predicted to increase by 28% by 2020 (Parkinson's UK). NICE guidance for PD recommend that palliative care should be considered throughout all phases of the illness (NICE, 2006).

Methodology The audit reviewed all patients over a three-year period who were referred to St Gemma's Palliative Care Services between October 2013 and October 2016. The computer database SystmOne was used to capture patients who had a coded diagnosis of PD.

Results A total of 38 patients were referred to Palliative Care Services, of whom 20 were still alive at point of collection. There were equal numbers of male and female patients referred and the mean age at referral was 78 years. The mean average documented time from diagnosis to death was 8 years. The average time from referral to death was 6.419 months. However, to specifically focus on the 18 patients who died, eight were referred to palliative care services within the last one month of life and four were referred within the last week. The most common referral reasons to palliative care services were request for help with advance care planning (ACP), marked decline in physical function and dysphagia. Of the patients that were referred, 76% (29/38) had documentation of ACP and 63% (24/38) had documentation of DNACPR decision and Gold Standard Framework recommendations. 15/18 patients of those who died had documentation of ACP.

Discussion Patients with PD are much more likely to be referred to specialist palliative care services in the last phases of their illnesses despite NICE guidance. Despite good working relationships with the PD Nurse Specialists, the subgroup of patients referred is a much smaller cohort in comparison to the incidence of PD throughout Leeds.

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ABSTRACT WITHDRAWN

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TAKING THE RIGHT STEPS TO THE MANAGEMENT OF DELIRIUM AND AGITATION

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In 2016 The Cheshire and Merseyside Palliative and End of Life Care Audit Group conducted an audit of the management of delirium in palliative care patients across settings. Willowbrook Hospice (a 12-bedded specialist palliative care unit) took part in this audit. The audit found that benzodiazepines were often used first line for the management of delirium which is not supported by the evidence from the literature. This was felt to be because some staff do not distinguish between agitation and delirium in the dying person. The audit group produced guidelines for the recognition, assessment and management of delirium and recommended the use of the Confusion Assessment Method as an assessment tool.

In response Willowbrook have developed a THINK DELIRIUM policy and accompanying Quick Reference Guide which takes a stepwise approach (similar to the WHO analgesic ladder) to delirium and agitation recognition, assessment and management. In addition we developed a teaching tool that could be delivered easily 1:1 or at daily handovers. All staff were updated over a period of a few weeks. Staff now report increased understanding of the differences between delirium and agitation and confidence in management. We are planning a second audit over the next few months.

This poster describes the THINK DELIRIUM project and the stepped approach to management including the outcome of further audit and a survey of the confidence of staff in

recognising and management of delirium and agitation after the educational intervention

P-96 **DIAGNOSIS AND ASSESSMENT OF DELIRIUM IN HOSPICE INPATIENTS**

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10.1136/bmjspcare-2017-hospice.122

Background Delirium may be reversible in up to 50% of patients with advanced cancer and the majority of patients who recover from delirium recall it as highly distressing.

Aims To retrospectively identify episodes of delirium in hospice inpatients and explore practice around consideration and management of potentially reversible causes.

Methods A retrospective review of all patients who were inpatients in the hospice during a two-week period was performed by searching electronic records for use of descriptors agreed by a group of healthcare professionals to be reasonable proxy terms for delirium. For each delirium episode the following were considered:

- Whether a diagnosis of delirium was made
- Whether the most likely cause was identified and addressed where appropriate.

Results 28 patients were included in the project with 38 episodes of delirium identified in total. A diagnosis of 'delirium' was made in 13 of these 38 episodes. In 23 of the 38 episodes a most likely cause was identified. An attempt was made to address the documented most likely cause in 16/23 cases. In seven this was either not possible or thought to be inappropriate due to the patient's condition.

Discussion Proxy descriptors were used to identify delirium episodes. The use of proxy descriptors is likely to underestimate hypoactive delirium which is thought to represent the majority of delirium seen in hospice populations. It was more difficult to assess from descriptors of hypoactive delirium e.g., drowsy or sleepy if symptoms are related to delirium or to disease progression. A quality improvement project has been established to improve recognition and assessment of delirium. A validated screening tool has been introduced. Education has focused on prompt identification and active consideration of possible causes of delirium, and whether it is possible and appropriate to reverse these.

P-97 **AN AUDIT OF THE ASSESSMENT OF DELIRIUM IN HOSPICE ADMISSIONS THROUGH THE INTRODUCTION OF THE 4AT**

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10.1136/bmjspcare-2017-hospice.123

Background Delirium is a significant problem in the palliative care setting, with incidence of delirium ranging from 5%–45% of inpatients (Hosie et al., 2013). In Scotland there has been development of a new management pathway for delirium by Healthcare Improvement Scotland and the Scottish Delirium Association (2016). This recommends the use of the 4AT to help diagnose delirium.

Aims This is an audit to review the practice of screening for delirium in the hospice setting. The aim of the audit is to

ensure delirium assessment in the hospice is in line with current guideline. The standard is that 100% of patients over the age of 65 should have a documented cognitive screen on admission.

Methods Notes from patients admitted from 19 June to 19 November 2015 were retrospectively reviewed to assess for formal documentation of delirium screening and also the incidence of delirium in this population. Patients over the age of 65 were included and patients that were admitted for care in the last days of life were excluded from the data. Stage two involved the introduction of the 4AT in the above inpatient population. The use of the 4AT was then re-audited in patients who were admitted to the hospice in the following six months.

Results Prior to the intervention only three out of 38 patients had formal assessment of delirium on admission. Post intervention 26/29 patients had formal assessment with the use of the 4AT. 58% patients who were admitted over this year period and fitted the inclusion criteria developed a delirium during their stay.

Conclusion This audit has shown that education and introduction of simple routine assessment can increase the recognition of delirium in a palliative care setting, potentially improving levels of care for patients.

P-98 **PALLIATIVE CARE AND DEMENTIA COLLABORATION PROJECT**

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10.1136/bmjspcare-2017-hospice.124

Background There are unmet palliative care needs in dementia (Van der Steen et al., 2013; Dempsey et al., 2015). The number of people dying with dementia is rapidly increasing (Etkind et al., 2017). Choice in end of life care is a national priority (National Palliative & End of Life Care Partnership, 2015; Department of Health, 2015). NICE Guidance recommends a palliative care approach from point of diagnosis and equitable access to services based on need (NICE clinical guideline reviewed, 2016; Dixon et al., 2015). Electronic care registers (My Care Choices Register in North East Essex) enables recording and sharing of care preferences (Wee, 2015; Department of Health, 2015). Hospices have a pivotal role in sharing palliative care expertise and enabling other teams to incorporate palliative care principles and practices into their work (Calanzani et al., 2013; Hospice UK., 2015). Palliative care teams also need to develop skills in dementia (Van der Steen et al., 2013; Hospice UK., 2015). We therefore developed the Palliative Care and Dementia Project in September 2016.

Aims 1) Develop collaborative working between Palliative Care and Mental Health.

2) Identify unmet palliative care needs in advanced dementia.

3) Increase number of referrals for Dementia patients.

4) Establish use of My Care Choices Register.

Methods Senior Palliative Doctor providing weekly direct support to two Acute Dementia wards over six months. Baseline and subsequent audit of My Care Choices Register registration and hospice referrals. Use of SPICT (10) – Supportive and