of life is diminished, and a reduced sense of spiritual peace ensues. Yet many healthcare professionals feel unprepared to appreciate, assess and tackle patients' spiritual issues.

Cheshire & Merseyside Palliative & End of Life Care Network has run the 'Opening the Spiritual Gate' course, across the UK for a number of years, to address this training need. This aims to increase awareness of spiritual and religious needs and facilitate recognition of spiritual distress.

Aim To explore participant perceptions of spiritual care and the impact of the training on their clinical roles after completing the course.

Methods A qualitative methodology was adopted, using digitally recorded semi-structured interviews. Purposive sampling of healthcare professionals who had undertaken the course, in either the North West or South West of England between 2015–2017, resulted in 21 participants. Data were subject to thematic analysis.

Results All participants reported on the value of the course and the impact on their clinical roles, including being better able to recognise when spiritual distress may be evident. Two main themes were identified; *recognising spirituality*, containing sub-themes of what spirituality means and what matters, and *supporting spiritual needs* with sub-themes of recognition of spiritual distress, communication skills, not having the answers and going beyond the physical.

Conclusions The course is clearly effective in preparing staff to recognise opportunities to provide individualistic spiritual care. Acknowledging that spiritual care is as important as physical care, and having the skills to address it, is vital for delivery of best holistic care.

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P-164 USING VIRTUAL REALITY IN PATIENTS WITH PALLIATIVE CARE NEEDS

Cecily Wright, Adarsh Babber, Sophie Price. *Thames Hospice, Windsor, UK*

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Background Virtual Reality (VR) is a 360° audio-visual simulation presented as reality to the user, allowing immersion and distraction from symptoms or treatments. There is some evidence based support for the use of VR technology to reduce symptoms including pain, anxiety and stress in patients with cancer, chronic pain and other conditions (Li, Montañó, Chen & Gold, 2011; Gorini, Pallavicini, Algeri, Repetto *et al.*, 2010; Oyama, 1998). The feasibility and impact of this technology was assessed in a hospice setting.

Method A pilot project for use of VR technology took place in a hospice inpatient and day unit over a four week period. Patients were assisted to use the technology by trained staff, with each session lasting approximately seven minutes. Patients chose their own 'experience' from a selection of options. A follow-up questionnaire on the experience, self-reported symptoms and any change in symptoms was completed by each patient.

Results A total of 14 sessions took place and each participant completed a questionnaire. All of the patients agreed they would use VR again and would recommend it to others. 75% of patients who reported pain felt they experienced some improvement following the session. Similarly, 50% of patients reporting breathlessness and 81% expressing anxiety, believed

they improved. Comments were generally positive, themed around 'immersion' and 'escapism'. The results were limited by the small number of participants and self-reported effect, but showed an overall improvement in symptoms.

Discussion This pilot study demonstrated VR technology to be a beneficial and well tolerated means of providing immersion and distraction therapy. Use was limited by the resources needed for the equipment, including cost, programmes available and trained staff. However, with rapidly emerging new technology and positive user feedback, VR is a viable non-invasive means for symptom management in palliative care.

P-165 OBSERVATIONS OF IMMERSIVE VIRTUAL REALITY SESSIONS IN A HOSPICE

Anna Lloyd, Erna Haraldsdottir. *St Columba's Hospice, Edinburgh, UK*

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Background Several studies have confirmed positive outcomes using virtual reality (VR) for clinical conditions such as anxiety disorders, phobias, post-traumatic stress syndrome, eating disorders and pain management. VR has also been employed to promote emotional wellbeing and induce positive emotions for people in hospital. Research into the clinical applicability of VR in health care settings is still in its infancy. Until now, little research has focused on VR in a hospice setting with one other hospice in the UK that has started a small research pilot. The aim of this study is to explore the feasibility, acceptability and potential benefits of using VR for people with incurable long term conditions in a hospice setting.

Methods This was a prospective observation and interview study of hospice patients' experiences of taking part in a 30 minute VR session where they were immersed in a virtual world.

Results Observational data of VR sessions with 20 patients showed that most people respond positively. Reactions were of joy, happiness and amazement or of feeling peaceful and calm. Some people voiced that they were able to forget symptoms. These participants valued being able to visit somewhere that they now never would while others were able to visit places, often from younger days, that they wished to see again, expressing that it allowed recourse to a happy time of life. Some participants' responses were more muted. Those participants would have preferred to have further opportunity to think about where they would like to visit having experienced a session. Some people, however, declined to take part stating that they saw no need for it, or that they felt that it was new and not for them.

Conclusion Preliminary findings are encouraging with VR well received by staff and patients alike. VR may best be targeted to people who are most likely to benefit from the technology.

P-166 INTRODUCING ACUPUNCTURE AS A NON-PHARMACOLOGICAL OPTION FOR PALLIATIVE CARE SYMPTOMS IN THE HOSPICE

Miriam Lemon. *Wirral Hospice St John's, Higher Bebington, UK*

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Background The evidence for acupuncture in a range of palliative symptoms is growing. Palliative patients are increasingly

interested in non-pharmacological therapies to symptoms (O'Regan & Filshie, 2010). Acupuncture offers relief from both physical and psychological symptoms often experienced in this patient group. Acupuncture was introduced to the hospice as a non-pharmacological option for both in-patients and outpatients in 2018.

Aims To monitor the effects of acupuncture on a range of palliative symptoms using visual analogue scales (VAS), patient satisfaction surveys and verbal feedback.

Methods Patients who may benefit from acupuncture for a variety of symptoms were identified by the multidisciplinary team. Acupuncture points were selected by an AACP trained physiotherapist following full assessment, health screen and written informed consent. Symptoms were monitored using VAS and feedback forms prior to each session of acupuncture with each patient.

Results 87% of patients who were identified by the MDT for acupuncture consented to trying this therapy in conjunction with other medical treatment. Positive results in reducing symptoms using VAS were shown in patients presenting with pain (mean VAS pre-treatment 8.7, mean VAS post-treatment 6.7) nausea (mean pre-treatment VAS 7.6, mean VAS, post-treatment 2.3) breathlessness (mean pre-treatment VAS 7.3, mean VAS, post-treatment 6.3) fatigue (mean pre-treatment VAS 8.6, mean VAS, post-treatment 6.3) and anxiety (mean pre-treatment VAS 7.6, mean VAS, post-treatment 3.6). Subjectively 70% of patients reported that acupuncture was a positive experience regardless of whether the primary symptom had improved. Patients reported feeling calmer and more relaxed during and after sessions.

Conclusion Acupuncture has proved to be a popular, safe and enjoyable adjunct to therapy intervention for patients with no adverse reactions or side effects of treatment. Early results have shown quantitative improvements in VAS as well as qualitative positive results for the use of acupuncture in patients' emotional and psychological wellbeing.

P-167 REFLEXOLOGY IN PALLIATIVE CARE: REMOVE THE PLACEBO EFFECT AND WHAT'S LEFT?

^{1,2}Simon Noble, ²Alana Douglas-Jones, ²Alice Dawson. ¹Marie Curie Palliative Care Research Centre, Cardiff, UK; ²Hospice of the Valleys, Ebbw Vale, UK

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Background The placebo effect may result in a 40% clinical improvement following administration of a non-active treatment. Complementary therapies such as reflexology are commonplace in palliative care services yet their evidence base is supported by poorly constructed research and subjective clinical outcomes. Cynics have attributed patient-reported responses to the placebo effect.

Method Retrospective data analysis of hospice patients' pre and post symptom-targeted reflexology using the palliative care outcome scale (POS-S) evaluation tool. Mean symptom difference (MSD) and percentage response (PR) were calculated for each symptom. Placebo adjusted response (PAR) was calculated (PR-40%) with PAR of 20% or above being considered significant.

Results 100 hospice patients received a total of 360 treatment sessions for eight symptoms. (See Abstract 167, Table 1).

Conclusion Adjusting patient-reported response for placebo effect suggests reflexology may have a positive effect on

Abstract P-167 Table 1

Symptom	MSD	PR	PAR
Pain	0.74	24%	<0
Constipation	1.5	80%	40
Insomnia	0.8	40%	0
Distress	0.8	47%	7
Neuropathy	0.8	47%	7
Fatigue	1.6	80%	40
Dyspnoea	0	0%	0
Poor appetite	0.25	17%	<0

constipation and fatigue. Constipation has long been reported to respond to reflexology and can be objectively evaluated with validated outcome tools. A feasibility study to conduct a randomised controlled trial to compare reflexology with placebo for constipation is in development.

P-168 THE RELAXATION REVOLUTION – A HOSPICE BASED RELAXATION GROUP TO SUPPORT PATIENTS WITH SOME 'R AND R'

Angeliki Panteli. St Wilfrid's Hospice, Eastbourne, UK

10.1136/bmjspcare-2019-HUKNC.190

Background There has been increased use of non-pharmacological treatments to support patients with life-limiting illness. Relaxation is now seen as a core component of interventions in hospice and palliative care (Miller & Hopkinson, 2008). The benefits have been well documented. A weekly hospice complementary therapist-led relaxation group was introduced and its impact evaluated.

Aim To evaluate the relaxation group and assess whether relaxation techniques help patients' symptoms and improve their sense of wellbeing.

Method Patients attended a six-week relaxation programme where they learnt techniques including breath-work, mindfulness meditations, guided visualisations and progressive muscle relaxation techniques. Referrals were received from within the hospice.

Using an adapted Visual Analogue Scale, each week patients were asked to identify their main symptom with a score from 0 (no symptom) to 10 (the worst it could be) pre- and post-intervention. Patients were also asked to rate their wellbeing on a scale from 0% (no sense of wellbeing) to 100% (the best they could feel) pre- and post-session. Results were further analysed to see which symptoms reported were related to an improvement in wellbeing.

Results Out of 121 patient contacts over 27 weeks, 113 (93%) reported an improvement in their symptoms. Overall mean before was 6.3 and post 3.5 (improvement of 2.8). Stress improved by a mean of 4.1; pain by 3.3; anxiety by 2.9 and Shortness of Breath (SOB) by 2.8.

A total of 98 (81%) reported an improvement in sense of wellbeing. Results were further analysed to see which symptoms reported had a correlated improvement in wellbeing. One example: patients citing SOB as main symptom felt their wellbeing improved by 20%.

Conclusion The relaxation group showed benefit to hospice patients and empowered them to use a holistic tool to manage