Radiotherapy completed and patient discharged home on hydromorphone and gabapentin.

Discussion Given the timing, and despite normal renal and liver function, we believe the oxycodone/naloxone to oxycodone switch contributed to the severity of opioid toxicity in this case. Other possible factors include infection and titration of pregabalin.

When repeated naloxone doses are required for toxicity, a continuous intravenous infusion often necessitates transfer to an acute hospital and may be avoided by administering a CSCI of naloxone. To the best of the authors' knowledge, this is the first case report of naloxone administered via CSCI for opioid toxicity.

Conclusion When switching preparations of oxycodone, specific patient factors and intra- and inter-patient variability should be considered and patients monitored carefully. CSCIs of naloxone for opioid toxicity should be considered if intravenous administration is not feasible.

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87 HOPE, COMFORT AND QUALITY OF LIFE OF PALLIATIVE PATIENTS: CORRELATION TO THE PLACE OF CARE

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Background Maintaining hope has been referred to as a way to endure suffering among people living with a life-limiting disease. Reports about comfort and well-being in palliative care have indicated that hope is an indicator of the quality of life (QoL) and the quality of dying. This study aimed to characterise hope, comfort and QoL of palliative patients, and correlate these variables to the place of care.

Methods A cross-sectional observational study was conducted to test the hypothesis that hope is positively correlated to comfort and QoL and that patients in palliative care units had higher levels of hope, comfort, and QoL than other settings. Participants were recruited from daycare hospital, palliative care units and community palliative care in Portugal. Patients answered the Portuguese versions of Herth Hope Index, McGill Quality of Life Questionnaire and Hospice Comfort Questionnaire, a VAS for pain, two-item screening for depression and socio-demographic information. All ethical procedures were considered according to the Helsinki declaration.

Results A total of 205 palliative patients participated in the study (mean age 64.5, range 28–89). Most patients were diagnosed with metastatic cancer (85.4%). Palliative care patients in the sample experienced good level of hope, comfort and QoL. A strong correlation was noted between hope and QoL (0.65; $p < 0.001$) and hope and comfort (0.58; $p < 0.001$). QoL of patients attending daycare unit were higher compared to other settings ($p < 0.05$). Patients experienced higher comfort at home ($p < 0.05$). There were no differences in hope regarding the place of care.

Conclusions Palliative patients reported good levels of hope, comfort and QoL. As hope is dynamic and correlated to comfort and QoL, hope fostering interventions should be implemented in palliative care settings to increase the QoL and quality of death. Further research should address the causative relations among these variables.

88 EXPLORING CONFIDENCE OF PALLIATIVE CARE PROFESSIONALS IN THE IDENTIFICATION AND ASSESSMENT OF MENTAL HEALTH PROBLEMS AND RISK

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Background Patients with life-limiting illnesses seen in palliative care commonly experience mental health problems and suicidal ideation. Mental health problems have a significant impact on quality of life emphasising the importance of assessment and psychological support in holistic palliative care. Practitioner confidence influences competence. This study assessed the confidence levels of palliative care professionals, across the West Midlands, in identifying and managing mental health problems and suicide risk.

Methods A cross-sectional survey comprising 16 points was disseminated via a regional research distribution list to palliative care professionals across the West Midlands. The survey was available online for 2 months and comprised of a variety of closed and open-ended questions (some with partial pre-coding), including Likert scales. Qualitative data was analysed thematically.

Results Responses were received from 154 professionals evenly spread across hospital, community and hospice settings. The aspect of assessment respondents felt most confident in was being able to differentiate a mental health problem from an appropriate response to illness (54.5%); least confident in completing a suicide risk assessment (34.4%). Confidence appeared to be greater in counsellors, psychologists and social workers. Other factors that increased confidence included 10 or more years experience in palliative care and experience in a mental health setting. Challenges highlighted included difficulties in accessing specialist psychiatric support; lack of experience or training (further training desired in 95%). Suggested training topics included communicating with, and optimising clinical assessment of, patients with mental health problems.

Conclusions Further training is strongly desired and should be incorporated into induction processes, curricula and education events. Team members with greater experience are well placed to support fellow team members in care for patients with mental health needs. Creating links with local mental health services, and further research focussed on the experiences of our patients are key priorities.

89 SO WHEN A WOMAN BECOMES ILL, THE TOTAL STRUCTURE OF THE FAMILY IS AFFECTED, THEY CAN'T DO ANYTHING, SO THE KIDS STUDIES WILL BE AFFECTED, HUSBAND'S WORK IS AFFECTED – VOICES FROM THE COMMUNITY ON WOMEN WITH BREAST CANCER IN LMIC; A QUALITATIVE FOCUS GROUP

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Background Psychological symptoms are common in women with breast cancer and profoundly affect their role in the

family and wider community, varying across cultural backgrounds. Breast cancer is becoming the most common cancer among women in India. We aimed to understand the cultural context within which Indian women with breast cancer living in India, experience psychological concerns.

Methods Five focus groups were conducted in South India (clinicians[2], lay-public [3]). A topic guide explored: understanding of breast cancer, experiences of patients with regards to diagnosis and treatment, and psychological impact. Groups were audio-recorded and verbatim transcribed. Lay groups were conducted in Malayalam with translation and back-translation. Transcripts were subjected to thematic analysis in English.

Results Forty five (oncologists [5], nurses [10], church members [16] and community volunteers working in a palliative care unit [14]) participated. Three major themes (Psychosocial impact of diagnosis, Psychosocial impact of cancer treatment and Coping with diagnosis and treatment) and nine subthemes emerged from the two groups. All described psychological impact on women with breast cancer including body image, change of family role and their need for support. Family and faith were recognised as the major framework providing key support but also significant stress - particularly where there was poor involvement in treatment decisions. Clinicians were also concerned about financial implications and issues around early cancer detection. Lay people and nurses also commented that poor communication and lack of empathy from doctors, aggravated distress.

Conclusion Clinical and lay communities were aware of widespread psychological impact affecting women with breast cancer. Family and faith provided both a strong support structure, but also could be a cause of distress as roles and expectations were challenged by the disease and its effects.

Funding Self-funded

Posters 90 – 119 | service development

90 EVALUATING THE USE OF DIGITAL COMMUNICATION TECHNOLOGY IN A HOSPITAL SPECIALIST PALLIATIVE CARE TEAM DURING THE COVID-19 PANDEMIC

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Background Healthcare professionals' use of technology-enabled communication has increased during the COVID19 pandemic, due to social distancing restrictions. Currently, there is little published data about the experience of specialist palliative care teams using this technology, or how these tools can help to support care beyond the pandemic. This project aimed to evaluate the implementation of digital communication technology, in a hospital specialist palliative care team, during the COVID-19 pandemic.

Method During the months of September and October 2020, an online survey was distributed to staff in the specialist palliative care team at the Royal Liverpool University Hospitals. The following information was collected: purpose, scope, location of use of technological tools, barriers, and future opportunities.

Results The survey was completed by 14 healthcare professionals. Microsoft Teams and Zoom were the most commonly used tools, with team updates (n= 14, 100%), multidisciplinary team meetings (n=14, 100%), education (n=12, 85.7%) and cross-site working (n=9, 64.3%) identified as the most common reasons for use. All participants used the tools on-site (n=14, 100%) with some also connecting at home (n=8, 57.1%) or at an alternative work location (n=2, 14.3%). Twelve (85.7%) reported that meetings were abandoned due to technical barriers. These barriers included: problems with logging in (n=12, 85.7%), connectivity issues (n=12, 85.7%), video/audio quality (n=8, 57.1%) and lack of training (n=8, 57.1%). Identified opportunities included the potential to use technology to support integrated palliative care, by improving communication between hospital and community teams and education. These findings have been used to identify local practice recommendations.

Conclusion Technology has the potential to improve specialist palliative care delivery; however, it is important to identify, and address, several issues (technical, process, and training) in order to overcome barriers to adoption in clinical practice.

91 ENHANCING THE QUALITY OF OUT OF HOURS TELEPHONE ADVICE: A DECISION SUPPORT TOOL FOR NURSING STAFF

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10.1136/spcare-2021-PCC.109

Background The majority of hours in the week fall outside of '9 to 5' working hours and it is well recognised that all branches of care need to develop out of hours (OOH) services. The Ambitions for Palliative and End of Life Care Framework suggest that services should offer 24/7 access to their users and provide specialist advice day or night. This poses a challenge for many centres across the UK with currently no standardised approach. Reviewing OOH telephone calls received by our inpatient unit over two months identified a need to streamline and standardise specialist advice and improve staff confidence in managing these calls. This issue is relevant to all palliative care services.

Method An established triage tool previously developed by the Gippsland Region Palliative Care Consortium was analysed. Differences in pathways of care or clinical approach were identified and addressed in light of both our national and local service. Interactive, small group education was provided to teach staff about the triage tool.

Results Phase 1 - triage tool adapted and tailored to the specific set-up of our local service

Phase 2 - Pre- and post-education questionnaires demonstrated increased confidence among all attendees

Phase 3 - Next step to evaluate clinical impact

Conclusion This work demonstrates a positive change achieved by adapting and modifying processes from other healthcare settings and is applicable to any specialist palliative care service where inpatient nurses provide OOH telephone advice. Further work is required, ideally as a multi-centre collaboration, to evaluate the clinical impact of the triage tool in ensuring access to specialist palliative care advice in accordance with the Ambitions for Palliative and End of Life Care Framework.