

concluded this is safe and effective.^{3,4} For patients using high doses of around-the-clock opioid it is hypothesised that proportional dosing may prevent dropout of participants during titration, due to lack of confidence of efficacy before maximal dose has been achieved.³

Methods We performed a systematic review of the literature for pharmacological and non-pharmacological management of breakthrough cancer pain. A survey of healthcare professionals working in specialist palliative care and multi-centre case-note review were performed analysing current management of breakthrough cancer pain.

Results 94 Healthcare professionals (HCP's) responded covering community, hospice and hospital settings. 57% prescribe transmucosal Fentanyl, with most initiating transmucosal Fentanyl every 2–3months. The main benefits are its' short duration of action and rapid onset of action. 73% found the greatest barrier is the titration schedule. 90% found heat and cold packs helpful. Davies⁵ also concluded heat, rest and positional change were most beneficial non-pharmacological options. 179 patient case notes were analysed. 56% of those prescribed transmucosal Fentanyl were using equivalent to 60mg morphine as background opioid, 34% were using less than equivalent 60mg morphine. 65% of cases had pain assessed using a tool, 74% of these used the Numeric rating scale. In 84% of patients the titration schedule was used. 83% of patients initiated on transmucosal Fentanyl continued to use it, discontinuation was most commonly due to entering the dying phase.

Conclusion Regional standards and guidelines have been updated following this review. There was consensus that under specialist palliative care guidance where patients are using the equivalent or higher than 60mg Morphine per 24hours it might be appropriate to consider starting transmucosal Fentanyl at higher doses than manufacturer recommendation.

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THE USE OF ALFENTANIL IN A SPECIALIST PALLIATIVE CARE INPATIENT UNIT

Helena Myles. *Millford Care Centre, Limerick Ireland*

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Background Alfentanil is a strong short acting synthetic opioid which is increasingly used in specialist palliative medicine. There is uncertainty and pragmatism in determining a conversion ratio from other strong opioids to alfentanil. Subcutaneous diamorphine: subcutaneous alfentanil 10:1 was initially used.¹ Recent retrospective chart reviews suggest that this conversion ratio is conservative, although there are conflicting

findings in the literature.^{2,3,4} These reviews have focused on converting to alfentanil from diamorphine rather than from opioids more commonly used in clinical practice. This retrospective chart review focuses on switching from oxycodone to alfentanil.

Method A retrospective chart review of consecutive hospice inpatients prescribed alfentanil via continuous subcutaneous infusion was undertaken. Patients were identified using controlled drug books. Data pertaining to demographics, primary diagnosis, renal function, indication for alfentanil rotation, opioid use in the 24 hours prior to rotation, initial alfentanil dose, subsequent dose escalation and reason for stopping alfentanil were collected. Ethical approval was obtained prior to commencement.

Results Data were collected for 20 consecutive inpatients. 90% (18/20) had a primary cancer diagnosis. 50% (10/20) had an eGFR <30mL/minute. As per available data, 83% (15/18) patients were prescribed a regular strong opioid prior to alfentanil switch. Of the 10 patients switched from oxycodone to alfentanil, a conversion ratio of oxycodone (subcutaneous): alfentanil (subcutaneous) of 10:1 was used for 6 patients to determine the initial alfentanil dose (Day 0). 5 of these patients required a dose increase on Day 2, as did the 1 patient with Day 2 data available for whom a conversion ratio of >10:1 was used. A ratio of <10mg:1mg was used for 2 patients, who also required increased doses on Day 2.

Conclusion These findings suggest that a conversion ratio of 10mg oxycodone (subcutaneous):1mg alfentanil may be conservative. This needs further evaluation.

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DRIVING COMMUNICATION FORWARD: IMPROVING COMMUNICATION FOR PALLIATIVE CARE PATIENTS AROUND DRIVING AND OPIOIDS – A QUALITY IMPROVEMENT REPORT

Seline Ismail-Callaghan, Megan Howarth, Rebecca Allan, Nicola Davey, Stephanie Meddick-Dyson. *University Hospitals Dorset, Quality Improvement Clinic Ltd, Leeds Teaching Hospitals Trust*

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Introduction The number of people requiring palliative care is increasing with an aging, co-morbid population. Pain is a prevalent symptom for palliative care patients and is often managed with opioids. Opioids reduce reaction time and can cause drowsiness and visual disturbance. Evidence recommends that driving should be avoided until a stable dose of opioids has been reached. It is vital for patient and public safety that these facts are communicated to patients who are prescribed opioids, as well as the legal consequences if guidance isn't followed. These discussions facilitate joint decisions, optimising patient freedom and quality of life. Surprisingly though these important discussions around driving and opioids don't always occur, and so this project sought to develop a systematic approach to integrating them into practice.

Design Retrospective case note analysis and prospective interventional quality improvement study.

Setting A 16 bedded specialist palliative care inpatient unit.

Population Hospice inpatients with an ECOG performance score of zero to three who had been prescribed opioids.

Intervention Three Plan-Do-Study-Act (PDSA) cycles were performed. Firstly, the issue was discussed in the daily multidisciplinary team meeting (MDT) to raise awareness, secondly a prompt was added to a pre-existing clerking proforma. Finally, a reminder poster was placed in the ward office to promote discussion prior to discharge.

Outcome Measures Primary measures were the proportion of patients with the presence of documented driving status, and the presence of a documented discussion surrounding driving and opioids.

Results Baseline data found that 11.5% of patients had a documented driving status and 11.5% had a documented discussion surrounding driving and opioids. Over the course of the study the proportion improved to 65.2% and 60.9% respectively.

Conclusion Use of Quality improvement change methods have resulted in the successful integration of new interventions to increase discussions around driving when prescribed opioids. A previously overlooked issue in this facility, thus improving clinical and patient information sharing, and patient empowerment to take charge of their own health.

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THE PREVALENCE AND IMPACT OF CHRONIC BREATHLESSNESS IN AN OLDER, FRAIL POPULATION IN PRIMARY CARE

Helene Elliott-Button, Miriam Johnson, Alan Rigby, Joseph Clark. *Hull York Medical School, University of Hull*

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Background Chronic breathlessness is a debilitating symptom with major adverse impact on those involved. Little is known about prevalence and impact of breathlessness in community-dwelling older, frail adults.

Methods Mixed-methods study. Cross-sectional survey of 249 adults at risk of severe frailty (living in own homes; ≥ 65 years, eFrailty Index >0.36) to determine i) prevalence (self-reported breathlessness most days/past month), ii) impact of chronic breathlessness (questions about mental health, activities, care from healthcare practitioners (HCPs), and iii) associated clinical factors. Qualitative interviews explored psychological impact and experiences of breathlessness care in primary care for: patients ($n=20$), carers ($n=5$), and HCPs ($n=10$). Quantitative analysis used descriptive and inferential statistics (odds ratios); qualitative data were subjected to thematic analysis. Findings were synthesised using modified Critical Interpretative Synthesis.

Results 99/249 (40%) participants (median age 80 years, 61% women) reported chronic breathlessness. Breathlessness was associated with worse psychological outcomes: higher odds of anxiety (OR 2.2; 95%CI 1.29–3.85), family anxiety (OR 2.0; 95%CI 1.20–3.41), and depression (OR 1.9; 95%CI 1.12–3.39) (measured on Integrated Palliative care Outcome Scale), and poorer quality of life (QoL): higher odds of significant

problems with usual activities (OR 1.78; 95%CI 1.06–2.96) (measured on EQ-5D-5L). People with chronic breathlessness give up activities because of their breathlessness which they conflate with underlying disease. Breathlessness is ‘one of many’ symptoms and in context of ‘one appointment, one problem’, is not recognised as therapeutic target by patients or HCPs, remaining invisible and unmanaged. HCPs can feel helpless and do not routinely ask about impact of breathlessness.

Conclusions Over one-third of older, frail adults live with chronic breathlessness with major detrimental impact. Lack of routine assessment in primary care means they may not access evidence-based symptom-targeted interventions. Systematic identification, assessment, and management in primary care may help improve psychological health, QoL, and overall wellbeing.

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THE EMOTIONAL IMPACT ON PROFESSIONAL HEALTHCARE INTERPRETERS OF INTERPRETING PALLIATIVE CARE CONVERSATIONS FOR ADULT PATIENTS: A RAPID REVIEW

Jennifer Hancox, Clare McKiernan, Alice Martin, Jon Tomas, John MacArtney. *University Hospitals Birmingham, Birmingham St Mary's Hospice, University Hospitals of Coventry and Warwickshire, University of Warwick*

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Background Professional healthcare interpreters improve patient outcomes for patients with Limited English Proficiency, both in and outside of palliative care. Healthcare professionals working within palliative care are at risk of psychological distress with exposure to often challenging conversations, but the impact on interpreters working in this setting is insufficiently explored. We aimed to synthesise existing findings into the emotional effects of conducting palliative care conversations on this core member of the healthcare team.

Methods A rapid review of five electronic databases was conducted in December 2021. Studies available in English identifying emotional effects on professional healthcare interpreters of interpreting common palliative care conversations for adult patients, were searched for inclusion. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework guided the review. Quality appraisal was performed using CASP checklists. Thematic analysis was conducted using NVivo. Quotes were utilised to illustrate themes.

Results 11 articles were included for analysis from the USA(5), Australia(3), Canada(2) and the UK(1). 8 interview-based, 2 online surveys and 1 quality improvement project. From the reviewed papers, themes were identified under three categories. (1) Emotional effects: including stress, discomfort, loneliness, guilt. (2) Factors Influencing Emotional Effects: moral conflicts and the role of the interpreter, perceived clinician communication, barriers to seeking support, relational and interpreter factors. (3) Recommendations to mitigate negative emotional effects: pre-briefing, debriefing and interpreter/provider training.

Conclusion Interpreters experience a range of emotional responses to palliative care conversations. Moral conflict resulted when expectations of the interpreter's role were unclear; when interpreting verbatim (acting as a neutral conduit) clashed with the desire to deliver information in a