

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

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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

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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