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.

Poster Nos 85–89: Psychosocial

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.

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...
Improving role clarity and collaborative clinician-interpreter training may alleviate negative emotional effects. Evidence limited by rapid nature of review and location/heterogeneity of studies.

**LIVING WITH ILLNESS GROUP – IPOS DATA ANALYSIS**

Joanna Vriens, Suzy Williams, Joan Williams. Phyllis Tuckwell Hospice

To date, research has demonstrated the high rates of caregiver burden, anxiety and depression but offers little evidence of how best to ameliorate these issues. The aim of this study was to identify the psychological needs of caregivers of PWD at EOL.

**Method** A systematic review adhering to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines and narrative synthesis were conducted. Population: adult (aged >18 years) informal caregivers of a formally-diagnosed PWD. Inclusion: English-language studies of psychological needs of caregivers of PWD at EOL. The electronic databases searched were APA PsychINFO, Ovid AMED, CINAHL by EBSCO, Cochrane Database, Ovid EMBASE, Ovid EMCARE and Ovid MEDLINE.

**Results** Eleven studies met the inclusion criteria; ten qualitative studies and one mixed-methods study. These studies captured the experiences of 356 caregivers. Data extraction identified 80 findings and data synthesis resulted in 22 categories of psychological needs. A narrative synthesis found six key themes: i) relationship-orientated psychological needs; ii) support needs; iii) information needs to support psychological wellbeing; iv) care of the caregiver and the need to maintain caregiver wellbeing; v) the need for role recognition and an identity outside of the caregiving role and vi) psychological security.

**Conclusion(s)** Elucidating the psychological needs of caregivers of PWD at EOL is the first-step in being able to improve the quality of life of caregivers of PWD by identifying targets for the help and support they need when providing care for PWD at EOL. Future research should focus on interventions that might address these needs.

**WHAT ARE THE PSYCHOLOGICAL NEEDS OF CAREGIVERS OF PEOPLE WITH DEMENTIA AT THE END OF LIFE?**

Juliette Lewis, Dylan Harms. Cardiff University

Background The WHO recognises dementia as a global health priority. The incidence and prevalence of dementia is increasing exponentially and neither health nor social care services are able to meet the needs of people with dementia (PWD) at the end of life (EOL) without the help of informal caregivers.

**Method** The assessment involved 16 patients attending the Living with Illness group. Tools used were IPOS (Integrated Palliative Care Outcome Scale) tool at the beginning and then repeated 8 weeks later at completion.

AKPS (Australia modified Karnofsky performance scale); to measure overall performance status and ability to perform activities of daily living.

Phase of Illness (POI); to assess whether current care plan was meeting needs.

**Results** Patients functionally deteriorated (AKPS scores) over the course of the group. Fewer patients were categorised as stable (POI) at the end. Total IPOS scores (high scores indicating more distress) were calculated for 11 patients with two fully completed IPOS’. At the end of the programme the scores/distress were reduced for six patients, stable for two and a minimal increase of one point for one individual. Four patients didn’t complete the programme two were due to worsening health.

**Conclusions** Despite functional deterioration, IPOS scores improved for most patients attending the group. Some of the greatest improvements were psychological scores; patients feeling more at peace, less depressed or anxious. Of the 11 patients with complete datasets six had a reduction in total IPOS scores equating to reduced overall distress; three had no change or minimal increase of one point. Only two patients had a larger increase in scores. This is despite ongoing deterioration in their health due to their underlying illness.