experiences/perceptions. This research was guided by Critical Realism philosophical approach, which helps to understand the causal mechanism of breathlessness in relation to complexity and stratified realities in study sample. Braun and Clarke’s reflective thematic analysis was used to frame study data.

Results Mean age was 56 (18–83). The sample consisted of 8 (40%) men and 12 (60%) women. Participants experienced daily breathlessness with exercise/basic activities. Fatigues, sleep problems, and stress/anxiety were other commonly reported symptoms associated with heart failure. Interconnected three themes were identified: Breathlessness evaluation (interconnected sub-themes: factor-related breathlessness, description, and impact of breathlessness), Breathlessness management (breathing exercise/resting, coping with emotional distress (to reduce stress), and retrospective/prospective life changes) and Needs for improving breathlessness management (psychological/emotional and family support).

Conclusion Breathlessness evaluation and management of participants vary by factor and its effects. Psychological support is needed for improving breathlessness management (psychological/emotional and family support).

Implications for practice/research Individual breathlessness (symptom) assessment is key to heart failure management to increase motivation for self-care continuity and reduce adverse outcomes.

170 CLINICAL CHARACTERISTICS AND RISK FACTORS FOR DISTRESS AMONGST HOSPICE INPATIENTS NEEDING PHENOBARBITAL FOR DEEP SEDATION AT THE END OF LIFE: A SINGLE-SITE SERVICE EVALUATION

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Background Terminal agitation is a common symptom in the last days of life which is usually manageable using standard measures. In rare circumstances, it’s necessary to use Phenobarbital. This service evaluation aimed to describe the characteristics of patients requiring Phenobarbital for management of terminal agitation in an inpatient palliative care unit between Nov 2019 and May 2022, with a specific focus on identifying potential risk factors for its use.

Methods Cases were identified by searching the unit’s controlled drug books for the selected period. Clinical notes were reviewed and relevant data entered onto a proforma. Risk factors for terminal distress were summarised numerically and thematically using accepted holistic assessment domains (physical, psychological, social/family and spiritual/existential) as a framework. For comparison, the clinical notes of a control sample (consecutive deaths where phenobarbital was not used from a random month in 2021) were also reviewed.

Results Phenobarbital was used in 21/813 deaths (2.6%), of which 20 sets of notes were reviewed. Mean (SD) age was 53.8 (15.1) in the Phenobarbital group compared to 73.9 (16.4) in the control group. 17/20 Phenobarbital cases (85%) had risk factors across 3 or more holistic domains compared to 4/30 controls (13%). Physical symptoms included refractory pain and breathlessness. Psychological factors included fear of dying or pain, severe anxiety and significant mental health comorbidities. Spiritual/existential factors included lack of acceptance of prognosis or engagement in advance care planning and being ‘too young to die’. Social factors included complex family dynamics, high levels of anxiety, unrealistic expectations in family members and having younger children.

Conclusions The frequency of Phenobarbital use was consistent with previous reports. Patients requiring it had multiple risk factors for distress in comparison with the control group. Prospective studies are needed to further examine this relationship.

171 SYMPTOMATIC IMPROVEMENT FOLLOWING INTRAVENOUS IRON IN MULTIMORBID PATIENTS WITH HEART FAILURE: OUTCOMES FROM AN INPATIENT HOSPICE

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Background Clinical trials have demonstrated the symptomatic benefit of intravenous (IV) iron in iron-deficient patients with Heart Failure reduced Ejection Fraction (HFREF) independent of haemoglobin. However, paucity in data exists regarding the optimal strategy and symptomatic benefit of IV iron in heart failure (HF) outside of trial settings in heterogeneous cohorts. We report our experience of IV iron in multimorbidity patients with end-stage HF.

Methods All patients receiving IV iron at our hospice between March 2020–June 2022 for HF were retrospectively identified. All HF subtypes were included. Data encompassing demographics, echocardiographic and haematological findings, medication history, symptomatology (NYHA Class and IPOS), and treatment were analysed in SPSS v28.

Results 13 patients (female:male 1:1.6, mean age 84.0±8.3 years) underwent IV iron infusion for NYHA Class II–IV HF. 5/13 (38.5%) had HFREF. All patients had at least two additional major comorbidities. The mean baseline haemoglobin was 110g/L (±18.5g/L) with a median baseline ferritin of 21.0ng/mL (range 7–66ng/mL). A significant rise in ferritin post-infusion was sustained to a median of 4.5 months (median post-infusion ferritin 104ng/mL (range 51–431ng/mL), p=0.012). Median pre-infusion IPOS scores were 3.0 for breathlessness and 3.0 for fatigue. Of the 8/13 patients who had received their infusion over six months ago, 4/8 (50%) had documented evidence of symptomatic benefit of whom 3/8 (37.5%) received a second infusion. There were no adverse events recorded.

Conclusion Although small, our experience highlights the symptomatic benefit and sustained effect of IV iron in a multimorbid palliative HF cohort, and the deliverability of this specific service in a real-world hospice setting.