

18 EXPERIENCES OF DEVELOPING IN-SITU PALLIATIVE SIMULATIONS IN THE EMERGENCY DEPARTMENT

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Aims/Objectives/Background Emergency Medicine (EM) is a unique speciality often meeting people at the worse moments of their life. Death is an everyday occurrence, and with that comes the skills needed to talk to patients and families about when their end of life may be nearing, what treatments may or may not be beneficial and whether cardio pulmonary resuscitation is suitable. These conversations can be very challenging for all concerned, including junior doctors. The Royal College of Emergency Medicine's guidelines suggest doctors need to have the skills to talk to these patients. Therefore, we felt we needed to develop a series of realistic EM in-situ simulations for our staff to learn and practice on.

Methods/Design We created 3 simulations designed to enable junior doctors to have difficult conversations with patients who are approaching the end of life in the ED. Scenario 1 was the end of life patient with COPD who was not for further interventions. Scenario 2 is of a very frail patient with multiple comorbidities with another pneumonia. Scenario 3 revolved around a massive upper gastro intestinal bleed with known oesophageal cancer. These simulations were tested in-situ in the ED over several months and the feedback collected from all team members.

Results/Conclusions These simulations were trailed over January – March 2019 as part of our weekly in-situ simulation. 20 people took part in the above simulations. All had a doctor plus nursing support. Feedback data was pooled from all the simulation sessions. 80% of people moved from being not confident or lacking in confidence to fairly confident or confident after doing the simulations. All participants felt their knowledge had increased significantly following the simulations. Positives described by participants include 'Learning to recognise when CPR may be futile in patients and balancing delivering treatment and assessing futility of discussing of patients'.

19 INVOLVEMENT OF PALLIATIVE CARE LINK NURSES TO LEVERAGE PALLIATIVE CARE DELIVERY – CASE OF KIBAGABAGA HOSPITAL, RWANDA

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Palliative Care Association of Rwanda (PCAR) implemented a one-year project involving Palliative Care Link Nurses (PCLNs) to leverage PC service delivery. Through trained PCLNs the project attempted to i) promote best practices through education, clinical procedures ii) follow up patients by health center staff, CHW cell coordinators and CHWs at village level to improve on continuum of care.

Justification Rwanda government has put into integration of PC in both public Hospital system and availability of strong pain management drugs (Opioid) the need for essential PC package still unmet, still huge gaps in patient care outside hospital ward (home based)

Key Results Twenty-seven (30) link nurses (20 female and 10 male Nurses) from different hospital wards were trained with one Doctor. Follow-up meetings at the hospital and health center levels were organized. Patient follow up meetings with 73 CHW cell coordinators were conducted. In 3 months after the training, nine (11) patients with cancer were discharged to be followed at home. Two (2) patients who had been abandoned at the hospital for 3 years were reunited with their families. Hospital staff were enlightened on the importance of working as a team to provide holistic care to patients.

Main lessons PC is not yet on hospital structure which makes the staff consider it as additional responsibility. Follow up meetings at the hospital have many disruptions because the nurses are on duty and patients are waiting. Some nurses work during the night shift and therefore difficult to meet during the day.

Key recommendations Ministry of Health should include PC in job description of the staff trained. PC advocacy is needed in top government policy makers as well as in all stakeholders involved in universal health coverage as it a new concept to many.

20 ASSESSING THE IMPACT OF PLACEMENTS IN PALLIATIVE MEDICINE FOR CORE MEDICAL TRAINEES (CMT)

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Introduction With nearly half of UK deaths occurring in hospital it is almost inevitable that doctors will be involved in the management of dying patients. The importance of good end-of-life care is well documented, however junior doctors feel unprepared for this in clinical practice. After identifying that few CMT Programmes included Palliative Medicine, we established a four month hospice post as part of the local hospital's CMT rotation. Fifteen trainees have rotated through this post over the past five years.

Method Trainees were sent a survey to assess how they felt the rotation had impacted on their skills and career choices.

Results Ten trainees replied, three now work in palliative care, the remainder in various fields of medicine, anaesthetics or general practice. 80% had actively sought a CMT job with a palliative care, as they wanted experience in this, 80% felt the rotation had affected their future career choice. Respondents indicated the placement had increased their knowledge and confidence in end-of-life care, strengthened their communication skills, and positively impacted on their work now, regardless of current speciality.

Conclusions Overall the placement was well evaluated. It improved trainee's knowledge and strengthened valuable skills that are transferrable to other specialities within medicine.