

29 **LEAN IN, DON'T STEP BACK: THE VIEWS AND EXPERIENCES OF PEOPLE, AND THEIR CARERS, WITH MENTAL ILLNESSES AND INCURABLE PHYSICAL HEALTH CONDITIONS, OF PALLIATIVE AND END OF LIFE CARE**

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10.1136/spcare-2020-PCC.50

**Background** People with severe mental illness (SMI) have a life expectancy of up to twenty years less than the general population. They also experience poor physical health and higher rates of many life-limiting conditions. Research on the specific needs of people with SMI in palliative and end of life care is extremely limited and focuses on describing barriers to care from clinician's perspectives. The limited research that has been carried out originates outside the UK in the USA, Canada and New Zealand. The views of patients with both SMI and a life limiting and carers have not been included in previous research studies.

**Methods** Eight participants were interviewed using a semi-structured interview format. Five were patients with mental illnesses and incurable physical conditions and three were, or had been, carers of people with mental illness and incurable conditions. Interviews were transcribed and a reflexive thematic analysis carried out. A conceptual framework of themes was developed from the interview analysis and is presented in the paper.

**Results** Four overarching themes were developed from the analysis of the data.

1. Stigma and Prejudice – 'See me not my diagnosis'
2. Hesitancy and Avoidance – 'Treading on eggshells'
3. Collaborators in Care – 'the ignored experts' and
4. Connections 'Leaning in, not stepping back'.

Each will be discussed and illustrated with participant views.

**Conclusions** This study offers novel understanding of the views, experiences and expectations of a group of patients often marginalised and excluded from palliative and end of life care - people with SMI and terminal conditions. The themes developed from the interview data offer valuable insights into how access to, and quality of, palliative and end of life care can be improved for people with SMI. The findings are of interest to clinicians, policy makers, patients and carers.

30 **EXPERIENCES OF A PILOT COURSE FOR ADVANCED CARE PRACTITIONERS IN THE EMERGENCY DEPARTMENT TO SIGN DO NOT RESUSCITATE FORMS FOR PATIENTS APPROACHING THE END OF LIFE**

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10.1136/spcare-2020-PCC.51

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. The Royal College of Emergency Medicine's

guidelines suggests health care practitioners need the skills to talk to these patients. Within our department, we have advanced care practitioners (ACP) working as independent practitioners. These ACPs come from a nursing, paramedic or physiotherapy background. They have had further masters level training to do this role. Our department advocates early conversations with patients who have a frailty score of 7, 8 or 9 as per the Rockwood frailty score. With our hospital supporting the signing of do not resuscitate forms by ACPs, provided they have had sufficient training.

**Aims** We developed a full day course which is incorporates some lecture-based teaching and then in-situ simulation within the emergency department. Our aim was to gather feedback to see what educational benefit this brought to our ACPs.

**Methods** Following teaching around difficult conversations, do not attempt cardiopulmonary resuscitation and legal aspects we then gave the participants 4 in-situ simulations.

**Results** 9 participants completed the pilot course, none of which had, had formal training to have this type of conversation. This is despite these ACPs all having a minimum of 5 years post qualification. All felt their confidence had increased from no confidence to neutral or fairly confident. All felt this was useful for their training.

**Conclusion** This course has provided our ACPs skills to have the conversation with patients. We will look to gather feedback 1 month and 6 months following the course to see how and if this has influenced clinical practice.

31 **USING POINT OF CARE HIGH FIDELITY SIMULATION AS A TEACHING TOOL IN A HOSPICE SETTING**

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10.1136/spcare-2020-PCC.52

**Background** High-fidelity simulation uses computerised manikins that simulate scenarios with briefed facilitators who aid in delivering learning outcomes. Point of care simulation is the use of scenarios that are carried out within a clinical environment.

**Aim** To assess if using point of care high fidelity simulation within a hospice setting focussed on potential emergencies is a valuable learning experience for those that attend.

**Methods** A single afternoon educational session at Prospect Hospice. A high fidelity simulation mannequin was brought into a hospice side room where the scenarios took place.

4 doctors (x2 speciality doctors and x2 GP trainees), 1 trained nurse and 1 student nurse attended.

Four simulated scenarios were carried out including: acute breathlessness, opioid toxicity, anaphylaxis and communication with a relative about an error. Doctors and nurses were worked in a simulation in 'real time' within an environment that they would normally work. Prior to the session attendees had a rigorous pre-brief and introduction to simulation and a structured debrief following scenarios were carried out by trained facilitators. Feedback was collected after the session.

**Results** All attendees reported the simulation was a useful and novel experience that aided their learning and was relevant to their work in the hospice. 6 out of 7 attendees strongly agreed that the simulation was useful for developing their

clinical skills e.g. airway adjuncts and managing emergencies as a team in the hospice. The session also highlighted other aspects of emergency care that would benefit from review, such as practical access to guidelines and emergency drug use. **Conclusions** High fidelity point of care simulation is a useful tool in palliative care MDT teaching in the hospice. It benefits those attending on a personal level and provides insight and safe 'real-time' practice for possible emergencies and can lead to positive changes to these systems.

### 32 OPIOID CALCULATIONS VIA BISCUITS

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10.1136/spcare-2020-PCC.53

**Background** Specialist Palliative Care practitioners tend to have a familiarity with the mental gymnastics to calculate equipotent doses of analgesia and ensuring safe calculations is critical to medicines safety. All healthcare colleagues who manage medications should be aware of the relative strengths of strong opioids but achieving this with a wide range of learning styles can be a challenge. A hands on education module with a more visual component was developed to address aspects of the VARK learning styles for both district nurses and specialist colleagues.

**Methods** To develop practical and memorable education in opioid relative strengths a 'biscuit equivalence unit of 5 mg oral morphine' was used. Commonly used opioids were identified and given to attendees in pairs to calculate how many 'biscuit equivalent units' the medication total daily dose represented. Actual wrapped biscuits were utilised (and eaten during the session) to show the relative strengths of common opioids ie morphine orally and via CSCI, fentanyl and buprenorphine patches and oxycodone.

**Results** The educational session has to-date been run 2 out of a planned 3 sessions with requests to provide at additional locations. All attendees have provided positive feedback and reflected that it was a novel way of understanding relative strengths of opioids. It provided the opportunity to rediscuss opioid strengths and the visual pile of biscuits, in particular for fentanyl patches, provided a very memorable point of reference.

**Conclusion** Understanding opioid doses and relative strengths of medications is a central aspect of safe medication management. Ways of making this more memorable for practitioners will improve their familiarity and safety in using these medications and supporting patients and families in their safe use. We often say that a cup of tea and a biscuit go a long way in conversation, their use in education may be just as effective.

### 33 THE KNOWLEDGE, CONCERNS AND ATTITUDES OF PALLIATIVE HEALTH CARE PRACTITIONERS IN TREATING PATIENTS WITH SUBSTANCE USE DISORDER

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10.1136/spcare-2020-PCC.54

**Background** In the UK, we are seeing an increase in the number of older drug users including those accessing drug

treatment services. Because harm reduction interventions have resulted in more older drug users dying of non-drug related causes, studies suggest that they are likely to have a higher morbidity than the general population. Serving the palliative needs of those with substance use disorder (SUD) is often difficult due to the complexities of symptoms, their social circumstances and health care practitioner (HCP) understanding. A rapid evidence assessment in 2019 revealed limited inquiry into the experiences and attitudes of service providers.

**Aim** To evaluate the knowledge, concerns and attitudes of palliative HCP's (doctors, nurses and healthcare assistants) working in a range of clinical environments in treating patients with SUD in the Mid-Essex region.

**Methods** A mixed methods approach was carried out using an online survey tool. Quantitative evaluation of knowledge was measured using a 10-item true/false questionnaire. Confidence in managing patients with SUD was investigated using a Likert scale. Concerns relating to management were collated with a qualitative approach and interpreted by emergent coding analysis.

**Results** 40 health care practitioners (HCPs) working in the community, hospice inpatient unit or hospital completed the survey. 82% had experience in managing patients with SUD. Knowledge about medicine management and pain control was varied across the three roles. Although the majority felt confident in assessing pain in SUD, over 70% lacked confidence in managing opioid substitution therapies. Confidence in planning discharge was also low. Frequently expressed concerns included tolerance to analgesia, unpredictable behaviour and safe drug storage.

**Conclusions** Despite the increasing palliative needs in SUD, there appear to be gaps in knowledge and low confidence towards management amongst HCP's. More support through education and policy is required at a local level.

### 34 THE EDUCATION AND PRACTICE OF SELF-CARE IN PALLIATIVE MEDICINE TRAINEES, A QUALITATIVE STUDY

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10.1136/spcare-2020-PCC.55

**Context** The emotional burden of regularly confronting suffering when caring for dying patients can affect the well-being of palliative care clinicians. Experienced clinicians recommend self-care strategies as a way of sustaining this work. There is increasing evidence for the effective use of self-care strategies in other caring professions who face similar challenges. Little is known about how doctors-in-training learn such skills. The aim of this study was to explore how trainees in palliative medicine learn and practice self-care strategies.

**Methods** Eight palliative trainees in one region in England participated in a qualitative study using semi-structured interviews. An inductive thematic approach was used to analyse the data.

**Results** Five closely linked themes are described detailing the perspectives of the trainees. Self-care was recognised as being integral to their identity as a palliative medicine clinician, even though it was not openly discussed. Trainees were keen