conversation, checking the recipient's welfare, and how to open and close the conversations.

Conclusion The unique feedback from the simulated relative's perspective has enabled us to deliver a learning package that helps to prepare learners to deliver unwelcome news over the telephone in time critical situations. Further work will look at the clinical impact of this project.

51 INTRODUCTION OF THE ROLE OF ASSISTANT PRACTITIONER IN A PALLIATIVE CARE SETTING

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10.1136/spcare-2021-PCC-70

Introduction The role of Assistant Practitioner (AP) was first formally defined in 2002 and is widely considered a pioneering role able to work semi-autonomously across various health and social care settings. Although not registered to a formal body, an AP's accountability comes through locally agreed and defined protocols. Health Care Assistants (HCA) can progress to AP by successfully completing a 2-year Foundation Degree in Health and Social Care. In 2015 Marie Curie Hospice Liverpool introduced the role of AP to work across all patient-facing areas and two individuals were identified to attend university one day a week while spending 4 days per week in practice developing new skills.

Methods Due to the role being new to the charity, there was opportunity for the AP to co-create the job specification and identify, with the help of the wider multi-disciplinary team (MDT), tasks which would be beneficial to the team for the AP to carry out. The AP would continue to carry out many of the tasks usually delegated to the HCA, while also developing new skills to support the registered nurse.

Results Both APs successfully completed the Foundation Degree and continued to develop the role and their skills. New opportunities to develop the role are continuously sought although there have been some barriers to development due to not being registered to a formal body; mainly around medication checking and administration. Nevertheless, venepuncture, assessing new patients, handover of patients to the MDT and assisting in the application of topical medications have become key skills within the role of AP.

Conclusion Although the introduction and implementation of the role has been somewhat successful, there are areas of the journey of the development of the role that have been identified that could have been improved on and role distinction is still unclear to a certain degree.

52 A VIRTUAL MULTIDISCIPLINARY JOURNAL CLUB

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Background Research is essential in enabling practitioners to deliver evidence-based treatment and care.¹ A journal club has been identified as a way to encourage a research culture by engaging staff to build evidence of best practice.² Since January 2019 Marie Curie Hospice Liverpool have developed a unique multi-disciplinary approach to journal club, which has recently been impacted by the COVID19 pandemic. We

recognised the importance of re-instating these sessions in order to continue learning and development of a research culture in our hospice.

Methods Our journal club is held fortnightly and is co-ordinated by the research nurse and speciality doctor with support from our research lead. Following the height of the COVID19 pandemic, meetings resumed and were encouraged to utilise Microsoft teams in order to maintain social distancing in meeting rooms. This provided us with a unique opportunity to expand our journal club outside of the hospice and invite healthcare professionals from external organisations (including acute hospital trusts and other local hospices) to join these meetings.

Results To date we have held a total of 22 meetings. Healthcare professionals attending the meetings have generated 109 research questions relevant to palliative care. Feedback from external organisations has been positive, and these healthcare professionals report being grateful for the opportunity to attend a journal club. We are currently working on developing a structure for a quality improvement project which will allow members of the MDT to come together and answer one of our generated questions.

Conclusions Our MDT journal club model has proved to be successful, and with the support of technology has allowed us to share our learning outside of the hospice. Attendance and engagement across disciplines has made our staff research aware, creating a culture of enquiry and an eagerness to provide evidence-based care.

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53 AN AUDIT INVESTIGATING THE ROLE OF NASAL HIGH FLOW OXYGEN THERAPY IN ONCOLOGY PATIENTS – IS IT DELAYING APPROPRIATE PALLIATION?

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10.1136/spcare-2021-PCC-71

Introduction High-flow nasal oxygen (HFNO) is increasingly used as part of ward-based treatment, especially for oncology patients with respiratory failure that is either directly due to the underlying malignancy or secondary to anti-cancer drugs or radiotherapy-induced pneumonitis. Patient selection is paramount to its success, as unsuitable selection can result in delays in appropriate palliation, leading to unrealistic expectations for relatives.

Methods We performed a retrospective audit of 40 patients across both Gloucester Royal and Cheltenham General Hospitals, who received HFNO on the respiratory wards over July–December 2019.

Results The average age for patients receiving HFNO was 74 years with mortality rates being the highest at 80% in the 80–89 years age group. Interestingly, 81% of patients with HFNO as their ceiling of treatment died and only 10% of patients deemed for full escalation of treatment died. The majority of referrals were from medical specialities, closely followed by oncology. The oncology patients did show the highest mortality rates. The majority of patients referred for

NHFO were those deemed not to be appropriate for escalation to ITU.

Conclusion Our experience demonstrates that the mortality of oncology patients on HFNO is high. Although starting HFNO in these patient groups might be appropriate if we can demonstrate evidence of reversible pathology, care needs to be taken in managing the expectations of patients and their families, and where relevant, appropriate palliative input sought.

54 BUSTING SOME MYTHS OF ONLINE DELIVERY OF PALLIATIVE CARE EDUCATION

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10.1136/spcare-2021-PCC.72

Background/Introduction There is an urgent need to continue palliative care professional development (CPD) for all those delivering health care, especially in view of health needs of the population currently affected by the Covid-19 pandemic. Face to face teaching, whilst preferable to date, has not been possible. The face to face interaction at the start of a Masters course in Palliative medicine was transitioned to virtual learning. We explored the impact of using technology on the learning experience of participants both in terms of comfort with the virtual environment and its impact on their learning

Methods Prospective evaluation of a redesigned face to face teaching programme. Participants were asked if the virtual learning environment or technology had impacted on their learning using a 5 point scale for each of the sessions. A further delayed evaluation is underway, to explore the continued impact of the sessions.

Results 13 sessions forming a 3 day programme were evaluated. 252 responses were received (45% response rate) 223/252 responded that all was well, 18/252 mentioned some technical difficulties but with no negative impact on learning, 8 mentioned technical issues which did impact on learning, 2 mentioned being uncomfortable with the virtual learning environment with no impact on learning and 1 person described being uncomfortable with negative impact. Results to date of the delayed evaluation have been received from 16 participants (response rate of 32%).

Conclusions Enabling virtual CPD to continue to skill and enable the health care workforce to deliver palliative care to patients is paramount, especially while Covid-19 restrictions to face to face gatherings continue. With attention to teaching techniques (delivery style, focused content and use of interaction), neither the technology or a virtual learning environment, negatively impact learning for the majority of students. Further exploration of prospective data is underway.

55 THE USE OF BREAKOUT ROOMS AND INTERACTION TO CREATE A COMMUNITY OF PRACTICE IN A VIRTUAL LEARNING ENVIRONMENT

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10.1136/spcare-2021-PCC.73

Background/Introduction Interaction and a community of practice are integral to postgraduate education. Previously, face to face (F2F) teaching allowed an opportunity for these factors to evolve naturally. Due to Covid -19 restrictions, this interaction needed to transition to virtual learning for a Palliative Medicine MSc. We explored the use of breakout room and use of a 'chat' function on a virtual learning platform to stimulate interaction and create a community of practice. These features were used within sessions for case based discussions, team building activities and immediate whole group responses to particular palliative care issues and challenges, enabling the cohort of students to build on each other's comments.

Methods Participants were invited to send immediate free-text evaluation of the sessions. These results were screened for comment on breakout rooms, and thematic analysis used to explore feelings towards this teaching strategy.

Results 252 responses were received across all sessions (45% response rate). Results were screened for reference to breakout rooms and use of the chat function. Thematic analysis revealed that these were positively received ('More breakout rooms', 'really good'), and gave rise to an opportunity for people to interact within a virtual learning environment. Additional unsolicited feedback to the course team indicated satisfaction with the delivery style 'I felt like there was still a really nice feeling of camaraderie, and that I got to know a lot of the others with the breakout rooms. I also felt much less inhibited using the chat function than I would putting my hand up in a lecture'

Conclusions Breakout rooms, and the use of the 'chat' function, were found to be an excellent medium with which to facilitate interaction and develop a community of practice. Using all aspects of technology to successfully support delivery of palliative care education can enhance palliative care knowledge during this time when F2F education is not possible.

56 LEARNING FROM DEATHS: THE STRUCTURED JUDGMENT REVIEW

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10.1136/spcare-2021-PCC.74

Background Most acute trusts have systems in place to review hospital deaths to identify areas that could be improved and areas of good practice. Following on from the National Mortality Case Record Review, the Learning From Deaths Guidance published in 2017 sets key requirements to ensure organisations effectively respond to and learn from deaths. This includes introduction of structured case record reviews when reviewing deaths. Following this guidance, we set up a monthly educational programme at Woking and Sam Beare Hospice from November 2019-September 2020, including monthly adapted 'Structured Judgment Reviews' (SJR) of nominated deaths.

Methods Each month a patient death was selected from a list that teams felt further discussion would be beneficial. An 'independent reviewer', not directly involved in the care, would objectively review the notes. The phases of care focused on were:

- First assessment
- Ongoing care