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

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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.

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

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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 specialties, 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.

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**Abstracts**

**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.

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**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