

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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**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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**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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**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

- Communication with relatives/professionals
- Advance Care Planning
- End-of-life care
- Overall assessment

Each domain was ranked from 1 (poor care) to 5 (excellent care), and key learning points discussed at a monthly meeting open to all clinical staff, and learning points later circulated. Questionnaires were given to staff at the final presentation.

**Results** Six reviews in total were possible (due to Covid-19 these were not possible every month). Questionnaire responses were overwhelming positive with 100% stating that it was useful to be able to review deaths in this format, written comments gained were positive (on poster). The monthly programme has now been taken on regularly at the hospice as a learning event.

**Conclusions** This has been a positive learning experience, for both individuals and at an organisational level. SJRs received overwhelmingly positive responses from staff and allow informal discussions which also help to ensure organisations effectively respond to and learn from deaths. This could be easily replicated at other hospices to support learning.

## Posters 57 – 81 | end of life care

### 57 COMMUNITY END-OF-LIFE ANTICIPATORY MEDICATION PRESCRIBING PRACTICE: RETROSPECTIVE MIXED METHODS OBSERVATIONAL STUDY

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**Background** Anticipatory medications (AMs) are injectable drugs prescribed to a named patient, ahead of possible need, for administration if distressing symptoms arise in the final days of life. Little is known about how and when drugs are prescribed in primary care.

**Aim** To investigate the frequency, timing and recorded circumstances of injectable end-of-life AMs prescribing decisions for patients living at home.

**Methods** Retrospective mixed methods observational study using GP and community nursing records for 329 deceased adult patients registered with 11 GP practices in two UK counties (30 most recent deaths per practice). Patients died between 2017 and 2019. Multivariable logistic regression models were built to detect key factors associated with AMs prescribing.

**Results** AMs were prescribed for 167/329 (50.8%) of patients, between 0 and 1212 days before death. The median prescribing timing was 17 days before death across all GP practices, with a range of median 3 to 33 days in individual GP practices. The likelihood of AMs prescribing was significantly higher for patients with a recorded preferred place of death (odds ratio [OR] 34; 95% CI 15–77;  $p < 0.001$ ) and specialist palliative care involvement (OR 7; 95% CI 3–19;  $p < 0.001$ ). AMs were typically prescribed (114/167, 68.3% patients) as part of one main end-of-life planning intervention when preferred place of death and/or Do Not attempt

Cardiopulmonary Resuscitation (DNACPR) discussions were also first recorded. Standardised prescribing of four drugs and doses was commonplace and prompted by primary care electronic end-of-life templates.

**Conclusion** Standardised AM prescribing patterns and variability in the timing of prescriptions highlight challenges in diagnosing dying, and the risks involved in prescribing far in advance of possible need. Our findings warn about the dangers of electronic end of life templates and the bureaucratisation and standardisation of end-of-life care planning interventions.

### 58 ANTICIPATORY PRESCRIBING FOR CONTINUOUS SUBCUTANEOUS INFUSION: FRIEND OR FOE?

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**Background** Anticipatory prescribing of ‘prn’ medication for symptom control is recommended for those approaching the last week-of-life however practices regarding anticipatory prescribing for continuous subcutaneous infusions (CSCI) varies widely. The Gosport Report highlighted risks associated with anticipatory prescribing for CSCI. The Association of Supportive & Palliative Care Pharmacy state the perceived benefit does not outweigh the risks.

**Methods** A network-wide cross-boundary audit was undertaken of the use of CSCIs in patients known to specialist palliative care services. A survey was completed by each service-lead and feedback collated following presentation of results.

**Results** 208 of 347 patients (174 hospital, 49 community, 124 hospice) prescribed medication via a CSCI were recognised as likely to be dying.

Drugs prescribed included strong opioids (286) anti-emetics (133), anxiolytics (89), anti-cholinergics (102), anticonvulsants (20) and steroids (6). Median doses of opioids and benzodiazepines were low (e.g, morphine 10 mg CSCI q24h)

The CSCI had been prescribed in anticipation in 1/5 of patients across all care settings (hospital 20, hospice 24, community 16). 58% of services/organisations responding to the survey allow prescribing for CSCI in anticipation.

Feedback following presentation of results and proposed guideline highlighted two conflicting sets of views and practices: anticipatory prescribing for CSCI as vital to ensure timely symptom control in the dying vs. the view it is unsafe practice, citing incidents/near-misses resulting from lack of clinical assessment of need at the time a CSCI is commenced. This audit reviewed current practice but is unlikely to capture such clinical incidents or ‘near-misses’ where drugs are administered without indication or at high doses.

**Conclusion** There is conflicting practice and opinion surrounding the risks and benefits of anticipatory prescribing for CSCI. This audit did not identify unsafe practice but will not reliably capture incidents or near-misses. Further evidence-based national guidance is required to guide safe practice.