

P-35 **NIV WITHDRAWAL DURING THE COVID-19 PANDEMIC: A PALLIATIVE CARE TEAM'S EXPERIENCE**

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Background The COVID-19 pandemic required clinical teams to rapidly adapt to emerging healthcare challenges.¹ Non-invasive ventilation (NIV) has a key role in managing respiratory failure secondary to COVID-19,² but mortality remains high.³ There was a lack of national guidance on managing deteriorating patients where NIV was the ceiling of treatment.⁴ The Royal Wolverhampton NHS Trust's Palliative Care and Respiratory teams developed local guidelines to provide high-quality symptom control and end-of-life care for these patients. An audit was conducted to assess the effects of implementing this protocol during the pandemic's second wave.

Methods A retrospective case note review was conducted on all patients who received NIV on the acute Respiratory ward during 01/08/2020–31/03/2021. Data was collected on initiation and duration of NIV support, Palliative Care input, reasons for and medications used during NIV withdrawal, and provision of holistic care.

Results 588 COVID-19 patients were admitted during this time. 239 received NIV, and 136 died during this admission. The Palliative Care team were involved in 63 of 293 patients who received NIV. NIV was withdrawn in 82.5% (n=52) of patients known to Palliative Care, most frequently due to clinical deterioration (60.0%, n=31). All patients known to Palliative Care were prescribed anticipatory medications; 71.4% (n=45) were commenced on a continuous subcutaneous infusion (CSCI). In all Palliative-Care-led NIV withdrawals (n=24), symptoms were managed effectively with PRN opioids/benzodiazepines. Patients remained comfortable at the time of death, and no concerns were raised by patients, families or clinical teams regarding the decisions or process of NIV withdrawal. 11 remained on NIV until death due to several reasons, including patient request.

Conclusions Local guidelines were adhered to during NIV withdrawal and provided a clear strategy for symptom management in critically unwell COVID-19 patients. Early involvement of Palliative Care team allowed a holistic and proactive approach in complex cases.

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P-36 **INTRODUCING A PALLIATIVE CARE SIMULATION DAY FOR FINAL YEAR MEDICAL STUDENTS**

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Background Simulation-based medical education recreates challenging end-of-life scenarios to teach key palliative medicine skills, enhance patient safety and promote participant psychological safety. A palliative medicine week for Queen's University Belfast final year medical students was designed to support application of the palliative medicine undergraduate curriculum, incorporating blended learning of communication skills, simulation, and clinical immersion.

Methods A multidisciplinary teaching faculty of consultants, registrars and specialist nurses developed four simulation scenarios on opioid toxicity, breathlessness, constipation, and agitation. Learning outcomes were mapped to Outcomes for Graduates (General Medical Council, 2018) and the Palliative Medicine Curriculum for Undergraduate Medical Education (Association for Palliative Medicine, 2014). Facilitators received simulation instruction and ran practice sessions with volunteer simulation staff and students. Each scenario includes a debrief and opportunity for repeat simulation, reinforcing skills and boosting confidence. The simulation session is delivered using high quality manikins on simulated wards and contemporaneous feedback is collated.

Results Expert advice, scenario practice and volunteer feedback enhanced scenario development, identifying a key focus for each, therefore spotlighting main learning outcomes and maximising impact. Early qualitative feedback has been unanimously positive. Students identified that scenario complexity and novelty increased value and engagement. Students felt facilitators were supportive, the feedback mechanism was safe, and multidisciplinary input added benefit. Facilitators found the students enthused and engaged. The opportunity to repeat challenging simulations saw students develop confidence and skill in palliative care competencies.

Conclusions Expert advice and trialling scenarios enhance simulation development and promote alignment with student expectations and priorities. Facilitator training, especially debriefing, and opportunities to repeat simulations maximise the learning experience and may be particularly important in palliative care simulation. A multidisciplinary approach highlights the significance of effective interprofessional competency and collaboration. Feedback is crucial in enriching the quality of palliative care simulation in education.

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