induction to the hospice setting and creating a timetable of multidisciplinary activity, we can offer a positive and supportive environment for student nurses at all stages of their training.

**P-263 WHAT ARE THE BARRIERS AFFECTING THE FULL UTILISATION OF PARAMEDICS WITHIN HOSPICE CARE, IS A ROTATIONAL MODEL THE ANSWER?**

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10.1136/spcare-2023-HUNC.281

**Background** With increasing demand for community based palliative and end of life care, paramedics are being recognised as a potentially valuable asset to a multidisciplinary workforce (Lord, Andrew, Henderson, et al. Palliat Med. 2019; 33(4):445–51). But there are barriers that prevent paramedics from being routinely found within the multidisciplinary teams in hospices. These barriers include; lack of specialised training, lack of confidence in leaving dying patients at home (Blackmore. Palliat Med. 2022; 36(3): 402–404) and concerns of losing the unique acute skills gained in paramedicine.

**Aim** Can we combat the barriers hindering full utilisation of paramedics in palliative and end of life care by applying a rotational model where paramedics retain employment with the ambulance service and split their working hours between frontline ambulance shifts and integrating into a rapid response hospice team?

**Method** Four paramedics commenced a rotational role with East of England Ambulance Service and St Helena hospice SinglePoint team. We undertook a comprehensive training programme followed by a period of joint working with registered nurses (RNs) and non-medical prescribers (NMPs) leading to a blend of dual and autonomous rapid response visit and telephone triage, mainly focusing on presentations suggestive of reversible causes, chest pains, neurological symptoms and traumatic injuries from falls including wound closure.

**Outcomes** The application of a rotational model has allowed the paramedics to practise paramedicine in an acute setting ensuring they maintain their acute skills. The integrated working with the SinglePoint and training team has provided specialised training, increasing the paramedics’ skills and confidence in palliative care.

**Conclusion** A rotational model can help overcome some of the hurdles faced when integrating paramedics into hospice care and has additional positive outcomes in staff retention for the ambulance service, increased hospital avoidance, opportunities in disseminating learning to other frontline paramedics and providing specialist learning and development pathways. However, the pilot is in its infancy and development of the role should continue to evolve and be regularly evaluated.

**P-264 ROTATIONAL SPECIALIST PALLIATIVE CARE PARAMEDICS**

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**Background** The ambulance service was experiencing challenges retaining experienced paramedics, the hospice with recruiting experienced nurses. An opportunity for collaborative working, sharing skills and knowledge (Nolan, Nolan, Sinha. CMAJ. 2018; 190(21):E636-E637) was identified by both organisations.

**Aims** Improve recruitment and retention of experienced paramedics and nurses.

- Share the skill set between the hospice and ambulance service.
- Improving confidence and knowledge.
- Preventing skill fade.
- Increase the responsiveness of specialist palliative care in the community.
- Improve individualised care.

**Methods** Recruited four paramedics working alternate weeks between the hospice community team and ambulance service. Week one of a six-week induction – classroom based, focusing on core elements of palliative care:

- Holistic assessment of patient and carers.
- Symptom control.
- Care in the last days of life.
- Communication skills.

Each paramedic was allocated a non-medical prescriber mentor and shadowed the team during induction applying theory to practice. The paramedics:

- Triage phone calls.
- Attend crisis home visits, using their clinical assessment skills.
- Support with decisions regarding potential hospital admissions.
- Identify reversible causes in deteriorating patients.

When on ambulance service shifts the paramedics, identify patients who require palliative/end of life support and cascade specialist palliative care knowledge to their colleagues.

**Outcome** In the first quarter 82 patients were seen. A random audit of 40 cases showed, 37/40 patients remained out of hospital for 72 hours post paramedic intervention, 22 continued to remain out of hospital three months prior to death. One patient had an appropriate acute admission, one patient was admitted to a community hospital, and one to the hospice IPU. The paramedics are now fully embedded, we anticipate the data to show even greater outcomes.

Feedback received from colleagues in the hospice is 100% positive. Demonstrating that the MDT has benefited from the additional role, improving collaborative working and sharing expertise.

**P-265 SUPPORTING PARAMEDICS WITH END OF LIFE DECISIONS**

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10.1136/spcare-2023-HUNC.283

**Background** At the end of 2022 Mountbatten Hampshire met with the South Central Ambulance Service (SCAS) to discuss how the two organisations could work collaboratively to
improve patient care and outcomes. As a result of this meeting it was clear that there was a lack of understanding of what Mountbatten and indeed hospices can offer and how they can support paramedics in their role. It was agreed that Mountbatten would facilitate awareness training sessions for SCAS employees.

**Aims** The aim of the sessions has been to give a potted history of the hospice sector, provide a clear picture of Mountbatten’s strategy and communicate how Mountbatten can support paramedics in the roles through Mountbatten’s 24/7 Coordination Centre and rapid response service. It is hoped this will assist paramedics when out in the community to know they can call Mountbatten in order to make the right decisions for the patient they have been called to.

**Method** It was felt that it was imperative that paramedics attend sessions at the hospice to help break down some of the perceptions of what a hospice is and also provide an opportunity to meet with the teams at the hospice. Training sessions have been held with each team of paramedics, each team consists of 20–25 members.

**Results** To date over 100 paramedics have attended the session and the feedback has been incredible. All groups so far have stated that end of life was the one area they had the least confidence in and we know Mountbatten has now given great assurance.

**Conclusion** The sessions started six months ago, with six teams attending the training so far, with another scheduled. Mountbatten will also be holding the same sessions for the Isle of Wight Ambulance Service during May and June.

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**P-266 COLLABORATIVE WORKING TO SUPPORT THE DEVELOPMENT OF SIMULATION TRAINING IN PALLIATIVE CARE**

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**Background/aims** Simulation training has become widely recognised as a tool for educating health care staff in a variety of contexts (General Medical Council. Promoting excellence: standards for medical education and training. [Internet], 2015; Nursing & Midwifery Council. Realising professionalism. Standards for education and training Part 1. [Internet], 2018), but use in palliative care settings is limited (Renton, Quinton, Mayer. BMJ Support Palliat Care. 2017; 7(1):88–93). A quality improvement project undertaken at a children’s hospice last year demonstrated the potential value of simulation training in this field and interest was expressed in upscaling the programme. This project is to develop an e-learning train-the-trainer programme for educators in palliative care settings.

**Method** A special interest group formed of UK-based paediatric palliative care educators identified that educators needed support and advice about how to plan and deliver high fidelity simulation training. University funding was obtained to produce an e-learning package for palliative care educators to support the provision of high-quality simulation training. Supported by a UK university’s e-development team, this project is a collaboration between a lead lecturer in simulation, a children’s hospice education team, and a specialist palliative care doctor. The package is a ‘getting started’ guide to simulation for palliative care.

**Results** The e-learning package will be advertised to palliative care team educators in the UK and available to buy on a cost per user basis. The anticipated result is that an increased number of simulation training courses will be developed and implemented in various settings where palliative care is provided. Success will be measured via a questionnaire sent to those who completed the package regarding the perceived usefulness of the package and its impact on training development.

**Conclusion** High fidelity simulation training has been employed sparingly in palliative care settings, but recent work has generated interest. An e-learning package is being produced to equip palliative care educators to facilitate high quality simulation training.

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**P-267 BENEFITS AND CHALLENGES OF IMPLEMENTING A HOSPICE SIMULATION-BASED EDUCATION PROGRAMME**

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**Methods** Simulations were designed following a Learning Needs Analysis to meet individual and organisational needs. Topics have included sepsis and acute deterioration, care after death, advance care planning, communication, seizures, delivering symptom management in community settings and emergency tracheostomy management. Simulations were prepared with key learning outcomes identified, candidate and facilitator information briefs and set-ups required. Simulation sessions include a 10-minute pre-brief, 15 minutes simulated scenario and 30 minutes debrief with refreshments. Each session is delivered by 2 facilitators for 4 staff members. Quantitative and qualitative feedback was gathered using a 5-point Likert scale and free text questions. Facilitators have reflected on the process.

**Results** Challenges. Few staff within the hospice had formal training in, or previous experience of, delivering simulation teaching debrief sessions. Participants’ anxiety pre and during simulation and anxiety from doctors who were called by participants during scenarios. Little evidence of paediatric palliative care simulations so innovation needed. Low-fidelity equipment in hospice due to cost of high-fidelity equipment. Balancing acute clinical care learning needs with palliative care learning needs.

Benefits. Empowering staff. Well received by staff. Developing clinical skills and leadership. Improved safety. Identifies ongoing training needs. Extended into non-clinical training for