P-48 DEVELOPING AN EVIDENCE-BASED COMPASSIONATE EXTUBATION PROTOCOL IN AN ASIAN PAEDIATRIC INTENSIVE CARE UNIT

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Background Palliative Care in the Intensive Care Unit (ICU) is a new field, with significant advances being made in the past 15 years . These include the establishment of Compassionate Extubation (CE) guidelines, especially since the COVID-19 pandemic saw a surge in patients dying on a ventilator. Guidelines globally advocate for good and early communication, the use of opioids, benzodiazepines, and anticholinergic medications for symptom management, the discontinuation of non-comfort directed measures, and steroids to mitigate upper airway obstruction .

The majority of in-hospital pediatric deaths occur in the Pediatric ICU (PICU), with 70% following withdrawal/limitation of life-sustaining therapy . However, the available guidelines for CE in the PICU setting are limited. In a recent scoping review of Pediatric CE, only six studies were available with only 3 based in the PICU .

This study aimed to review the current landscape in Pediatric CE and identify gaps in care as well as recommendations for future research.

Methods A broad search using PubMed and Google Scholar to screen for existing guidelines on CE in the PICU was followed by consultation with regional and international experts in the field. Guidelines were chosen based on relevance to the aim of this study and individual guidelines were assessed and compared using the AGREE II tool.

Results Eleven guidelines were reviewed, with 7 excluded because they lacked specific recommendations for CE/symptom management. No guideline was of high quality globally, with the domain most lacking in quality being rigour of development. This was likely because evidence in Pediatrics is lacking, with significant extrapolation from the more established adult services. More studies are needed to assess symptom control after CE to guide management. An audit of cases using the protocols evaluated may also identify further room for quality improvement.

P-49 CANCER INDUCED BONE PAIN – THE USE OF EDMONTON CLASSIFICATION SYSTEM FOR CANCER PAIN AND MANAGEMENT OF REFRACTORY PAIN

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Purpose Cancer-induced bone pain (CIBP) affects a patient's functional capacity and quality of life, but there is limited evidence to guide opioid choice. We described the prevalence of the Edmonton Classification System for Cancer Pain (ECSCP) features in patients with bone metastases and assessed the possible efficacy of methadone rotation (MR) compared to other opioid rotations (OOR) in the cohort with refractory pain.

Methods Adults with bone metastases were assessed against ECS-CP features and those with worst pain intensity $\geq$4/10 and/or opioid toxicity graded $\geq$2 on the Common Terminology Criteria for Adverse Events (CTCAE) were randomised 1:1 to methadone or another opioid rotation. Standardised assessment tools were used at pre-defined study time points up to fourteen days.

Results From 147 eligible participants, 92.5% completed assessment. Mean participant age was 73.2 years. One or more ECS-CP features were present in 96.4% and CIBP in 75.7% of patients. Neuropathic pain was the most prevalent pain mechanism (45%) and was associated with breakthrough pain frequency, higher pain scores and background oral morphine equivalent daily dose (OMEDD). Of those with refractory CIBP, 38 (74.5%) consented, and 29 (76.3%, MR: 14, OOR: 15) completed the study. Both groups displayed significant reduction in pain intensities and total pain interference score. OMEDD reduced significantly in MR compared to OOR group (d= -0.8, p=0.05). There was no within group or between group differences in satisfaction with analgesia at the end of the study.

Conclusion Standardised assessment and classification of pain syndromes can assist in developing personalized pain interventions. This pilot study demonstrated that MR and OOR in patients with refractory CIBP are feasible, safe, and acceptable to patients. Appropriately powered multi-centre randomised controlled studies are needed to confirm the efficacy of MR and OOR in this cohort.

P-50 A CASE STUDY OF UTILISING A CLASS-BASED FORMAT FOR TRAINING NEWLY-HIRED NURSES IN A HOME HOSPICE SERVICE IN SINGAPORE

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Rationale This abstract describes postgraduate-level teaching for newly hired nurses at a community-based home hospice service in Singapore. This project is intended for the continuous professional development of in-service staff and faculty and is implemented during the probationary phase of employment for new staff.

Background Palliative home care nurses undertake the arduous responsibility of caring for the sick and the dying within the comfort of their own homes. The nature of the job necessitates healthcare providers to practice in a space outside their comfort zone, which adds to the already emotionally and mentally demanding work within the field of palliative care. New nurses joining a community-based hospice service require comprehensive and holistic training to face the challenges.

Summary of Work We developed a novel training programme that emphasised person-centred learning, anchored on the relational elements of learning. In a job that mostly sees nurses independently visiting and managing patients alone, we focused on building a strong sense of community within our new hires to guard against the solitude of independent practice. A group-based training format was developed, with regular in-person sessions, and new staff were encouraged to share their struggles and successes for advice and affirmation accordingly. This allowed for mentorship beyond the traditional preceptorship model of nursing education. It gave new nurses access to a multidisciplinary team of seniors they could turn to, focusing on sharing narratives from daily practice to demonstrate and affirm each nurse's learning and progression. Specific aspects of mindfulness in the workplace are deliberately introduced as part of the training sessions to foster a culture

of open communication and to establish a psychologically safe space. Key elements of mindfulness, such as non-attachment, equanimity and non-reactivity, are referenced and modelled during class discussions, as these have been observed to be particularly relevant to the field of palliative care, where burnout and empathy fatigue can be particularly challenging and intimidating to new hires.

Summary of Results The feedback received from our new hires was overwhelmingly positive in favour of the group-based training format. Cultivating a safe space wherein new nurses could bring their doubts and queries was a clear positive point, with some stating that it was less stressful than having to report all activities to a single mentor. Multiple new hires reported that the prospect of having a safe space to return to regularly, during the transition from supervised to independent practice, was validating and reassuring.

Discussion and Conclusion The group-based discussion uses tools similar to those employed in group therapy. It has proven useful in allowing individuals to better reflect on their learning and to process issues specific to palliative care, such as transference from a grieving caregiver or empathy fatigue.

Take-Home Message The challenges of home hospice care are manifold, and the training of new staff must include holistic development of the person alongside their clinical skills. Employing a group-based format cultivates a strong sense of belonging and trust that facilitates reflective and collaborative learning. Creating a workplace culture that normalises staff learning from each other, given the heterogeneity of our training backgrounds and experiences, improves the tendency for prosocial thinking and behaviours and fosters open communication and interpersonal respect at work.

P-51 BLOOD TRANSFUSION DEPENDENCE & FUTILITY – A CASE DISCUSSION

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Introduction The decision to deliver transfusions to patients who are receiving palliative care is complex, where they may be of variable benefit especially towards the end of life. We describe a case of a gentleman with metastatic castrate resistant prostate cancer presenting with non-resolving active bleeding gastrointestinal tract, and discuss the ethical considerations attached to the issue of continued blood transfusions in the palliative setting.

Case Report Mr W is a 67-year-old Chinese male with CRPC that progressed despite anti-androgen therapy, bilateral orchidectomy and radiotherapy. He presented with melena and a haemoglobin level of 3.9g/dL. He was started on proton-pump inhibitors and red blood cells transfusions. He remained comfortable throughout his admission. His condition was complicated by a NSTEMI, urinary tract infection and acute kidney injury. He was reviewed by Cardiology who deemed him not a suitable candidate for cardiac interventions nor anti platelet therapy in view of his active BGIT.

His echocardiography revealed a reduced ejection fraction of 37%; he developed fluid overload and required intravenous diuresis. He was assessed to be a high risk for esophagogastroduodenoscopy considering his NSTEMI. He remained ambivalent when broached about continuation of blood transfusions, while his family felt that withholding transfusions was akin to 'giving up'. Mr W continued to have daily melena and was

MEDICAL INDICATIONS	PATIENT PREFERENCES
Beneficence and Nonmaleficence • What is the patient's medical problem? History? Diagnosis? Prognosis? • Is the problem acute? Chronic? Critical? Emergent? Reversible? • What are the goals of treatment? • What are the probabilities of success? • What are the plans in case of therapeutic failure? • In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided?	**Respect for Patient Autonomy** • Is the patient mentally capable and legally competent? Is there evidence of capacity? • If competent, what is the patient stating about preferences for treatment? • Has the patient been informed of benefits and risks, understood this information, and given consent? • If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making? • Has the patient expressed prior preferences (eg, advance directives)? • Is the patient unwilling or unable to cooperate with medical treatment? If so, why? • In sum, is the patient's right to choose being respected to the extent possible in ethics and law?
QUALITY OF LIFE	**CONTEXTUAL FEATURES**
Beneficence, Nonmaleficence, and Respect for Patient Autonomy • What are the prospects, with or without treatment, for a return to normal life? • What physical, mental, and social deficits is the patient likely to experience if treatment succeeds? • Are there biases that might prejudice the provider's evaluation of the patient's quality of life? • Is the patient's present or future condition such that his or her continued life might be judged as undesirable? • Is there any plan and rationale to forgo treatment? • Are there plans for comfort and palliative care?	**Loyalty and Fairness** • Are there family issues that might influence treatment decisions? • Are there provider (physician, nurse) issues that might influence treatment decisions? • Are there financial and economic factors? • Are there religious or cultural factors? • Are there limits on confidentiality? • Are there problems of allocation of resources? • How does the law affect treatment decisions? • Is clinical research or teaching involved? • Is there any conflict of interest on the part of the providers or the institution?

Abstract P-51 Figure 1