Methods Three PPM simulations were carried out in a general paediatric setting. Themes: acute presentation of a patient with no treatment ceiling decisions in place but parents not wishing for escalation of treatment; putting an advance care plan/DNACPR into place during acute presentation of a dying child and managing an expected death. Simulations were attended by medical and nursing staff with 2–3 staff actively participating and others observing. Two simulations were run with a high-fidelity mannequin and one with a low fidelity mannequin. Supporting items were used including DNACPR and EHCP (emergency health care plan) documentation, clinic letters/ward round entries and drug prescriptions.

All participants were asked to complete feedback at the end of each session and active participants were contacted following the session for further feedback. A five point Likert scale was used to rate enjoyment, organisation, quality and relevance of session and likelihood of attending further simulation teaching in PPM. A 10-point confidence scale was used to rate confidence in dealing with PPM scenarios and confidence in talking to families about death both before and after the scenario. Additional comments were also collected.

Ethical approval was not required.

Results Participants reported they enjoyed the sessions (mean score 4.7/5; range 0–5); felt they were well organised (4.7/5; 1–5) and of high quality (4.7/5; 1–5). They felt sessions were relevant to their training (4.5/5; 1–5) and that they would attend further simulation training in the area of PPM (mean 4.8/5; range 1–5). Confidence in managing PPM scenarios increased by a mean of 2.4 confidence points (range 0–5) and confidence in managing conversations around death increased 1.8 confidence points (range 0–5).

Conclusion Simulation training to teach PPM skills to the multi-disciplinary paediatric team was acceptable to participants and improved participants' confidence in managing PPM scenarios and conversations around death.

G363(P) SHARE OUR LEARNING EXPERIENCE AND APPROACH USED TO DEAL WITH A CHALLENGING COMPLEX CASE INCLUDING SAFEGUARDING CONCERNS AND ETHICAL ISSUES IN A COMMUNITY SETTING

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Aims Share our learning experience of dealing with a challenging complex case with life limiting condition called Canavans disease in a Community setting.

It was an acute life threatening safeguarding concern on background of long standing concerns by health professional on a 17 year old. He had complex health care needs including respiratory support and gastrostomy feeds. He is dependent on adults for all his care and administration of medications. He was on child in need plan due to long standing concerns.

Family suddenly expressed a wish to take him on a long haul flight to attend a family wedding to meet their own emotional and social needs.

Method Information gathering from varied professionals. Multi-agency meetings and sharing information transparently.

Presentation at Regional palliative care meeting, no consensus reached. Risks assessment completed and discussed with family about safety, dignity, pain relief and risk of deterioration on flight and empathised that despite efforts to mitigate concerns would not be in his best interest.

Family was not in agreement with decision of professionals

Escalated concerns with safeguarding lead and advice from legal team taken.

Best interest team meeting was arranged.

Result Decision in best interest of the young person not to fly as risks outweighed the benefits.

Young person was abandoned by family without appropriate carer to attend to his needs. He was then made ward of court and admitted in hospital till residential placement was arranged and transited to adult services.

Conclusion Despite adherence to principles of palliative care which was holistic, patient centred care and transition to adult services in a community setting, we are faced with ethical and legal challenges.

However, challenge was dealt with clinical leadership and team, effective communication skills and peer support and all having a common goal of compassion and ensuring safety of the young person.

This also prevented an impending safeguarding practice review

Recommendations Sharing of more such cases in a wider forum to develop better understanding for clinicians about what avenues are accessible. Having training days jointly organised by Paediatric palliative care with input from safeguarding leads would help clinicians acquire the needed skills for dealing with such complex ethical cases.

G364(P) WHAT SIGNS OR SYMPTOMS INDICATE A CHILD IS LIKELY TO DIE WITHIN MONTHS OR DAYS AND ARE THEY BEING USED WITHIN THIS HOSPITAL?

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Background Clinicians must be able to spot when children with life-limiting and life-threatening conditions might be approaching the last 6–12 months of life, to allow time for advance care planning to be put in place. As yet, no prognostic indicator tool exists for paediatric palliative care. The Chameleon children's end of life (EoL) care quality improvement project promoted the use of an EoL care prompt during 2018. The purpose of this audit was to then determine if the addition of prognostic indicators to the prompt tool may improve its use and thus the timely implementation of essential interventions.

Objectives To determine locally used prognostic indicators for the last 6–12 months of a child's life within this Children's Hospital. To retrospectively ascertain if they have been used and if appropriate interventions have been completed from the EoL care prompt.

Methods 12 healthcare professionals were interviewed to find locally used prognostic indicators. Children who died an expected death as a result of either an oncological or

neurodisability disease from April 2017–September 2018 were identified for audit. Their medical records were reviewed to determine if these locally used prognostic indicators had been used and if appropriate interventions from the EoL care prompt had been recorded as completed.

Results 7 locally used prognostic indicators were determined from interviews. Each of the 20 patients identified for audit had evidence of at least 1 of these in their notes. Interventions from the EoL care prompt were completed best in the last few days of life, however only 1 patient met the standard of completion of all interventions across the 3 sections.

Conclusions Prognostic indicators are being used in the last few days of life, and these could be added to the EoL care prompt to improve its use. Despite this, not all interventions for EoL care are being completed. Further research is required to determine useful prognostic indicators and additionally to develop an effective Children's EoL care planning tool, which would be an exciting future for improving children's EoL care.

G365(P) IMPROVING PREPARATION AND SUPPORT FOR PARENTS WHO CARE FOR CHILDREN WITH MEDICAL COMPLEXITY AT HOME

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Aims There are increasing numbers of children who require complex medical care at home, (e.g. tube feeding and tracheostomy care). Parents, with the support of nurses and other carers, deliver the day-to-day care these children require. There are many benefits of care at home for the child and family but also some serious risks. The aim of this research is to investigate the problems occurring with complex care for children at home, and to develop interventions to help better prepare and support parents to provide safe medical care to their children.

Methods We are using a mixture of clinical and experimental studies to explore the safety problems, and to test and develop interventions. Methods include analysis of incident reports, thematic analysis of interviews and surveys with parents, and mixed-methods analysis of interventions.

Results The findings highlight a range of safety problems occurring with complex care at home, many of which can remain hidden from healthcare services. In interviews with parents, the key themes identified were responsibilities of the parents, impact on the family and change over time. Many parents reported feeling overwhelmed by their responsibilities. In our analysis of incident reports on feeding tube care and long-term ventilation at home, the most commonly reported concerns related to broken equipment and inadequate training for parents, nurses and carers. Experiments on feeding tube training suggest that training that is easy to understand may make parents over-confident and reduce the time they spend studying, leading to worst performance in a test of their knowledge. In a survey, parents indicated that simulation training and videos may be helpful methods of learning and we are exploring this further.

Implications This research shows that the provision of services to support parents caring for children with complex needs is highly variable. Good quality training for parents and carers is vital if these children are to be cared for safely at home. There needs to be more investment and system-wide changes to training and support for parents and carers who provide complex care at home.

G366(P) CHALLENGES AND FACILITATORS TO JOINT-WORKING AND REFERRAL TO PAEDIATRIC PALLIATIVE CARE: A HEALTHCARE PROFESSIONAL PERSPECTIVE

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Background Despite the National Institute of Clinical Excellence suggesting involvement of specialist paediatric palliative care (PPC) leads to better symptom control and 'total care' of patients/families for those with life-limited or life-threatening conditions, many of those eligible are not referred.

Aim To explore healthcare professionals views on challenges and facilitators for referral to PPC, in a tertiary hospital with no integrated palliative care team.

This research will help inform future quality improvement projects locally, to ensure more children's palliative care needs are met.

Methods Initial literature review to direct qualitative research: Medline search using terms associated with 'healthcare professionals', 'paediatric palliative care' and 'referral', screened for relevance.

Qualitative research Focus groups (approximately 5–8 healthcare professionals sufficiently senior to refer to PPC and voluntarily consenting to take part) will be held for each department area. Departments are grouped due to clinical cross-over and to ensure appropriately sized focus groups but aim to span the full spectrum of PPC needs, including neonatal, intensive care, general and community paediatrics and neurosurgery amongst other sub-specialties.

Participants' views, knowledge and current practices around referral to PPC will be explored, through fictitious case vignettes of children with different PPC needs.

Thematic analysis of recorded audio of earlier focus groups will inform approach/question style for subsequent. Differences between departments will also be compared.

Results Current literature is often US-based or uses oncology/intensive care cases, therefore not generalisable to UK-based children across the spectrum of PPC needs. Twamley et al (2014) had most relevance, however, leaves a gap in examining differences between sub-specialties and suggests 'deeply embedded attitudes' may be the reason for discordance between understanding and referral rates.

The qualitative research is currently being undertaken. We expect to present preliminary results from focus groups held from February 2020.

Conclusions The researchers hope to draw themes from the focus groups. We expect some overarching themes throughout all groups but others that may be more department specific. We are interested to see how health professionals perceive palliative care needs for case vignettes that are somewhat removed from their usual caseload.