Patients and their families often underestimate the severity of the disease and the risk of mortality (Elkington, 2005; Janssen, 2012). Given the disease trajectory, there is an important role for early advance care planning.

**Aim** To assess the effects of an educational intervention on the quality of generalist palliative care provided to patients with advanced COPD during an acute hospital admission.

**Methods** We reviewed the notes of patients admitted under the respiratory team at Hereford County Hospital with a COPD exacerbation and a background of at least one poor prognostic factor. These were assessed in the three months before and after an educational intervention. The notes were assessed for a range of quality outcomes in palliative and supportive care.

**Results** There were twenty-three patients who met the inclusion criteria pre-intervention, and nineteen patients’ post-intervention. Discussions with patients regarding their illness trajectory occurred more frequently post-intervention, in 42% of cases vs 17% of cases. Post-intervention, patients were more likely to have a Recommended Summary Plan for Emer- gency Care and Treatment (ReSPECT) with a documented ceiling of treatment, present in 95% of patients compared with 83% pre-intervention. Discussions surrounding prefer- red place of care and/or death took place in 26% of cases post- intervention vs 9% pre-intervention. Previously expressed future care wishes were reassessed more frequently post intervention, in 69% of cases compared to 54% pre-intervention. Discussions with patients regarding their illness trajectory occurred more frequently post-intervention, in 42% of cases vs 17% of cases. Post-intervention, patients were more likely to have a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) with a documented ceiling of treatment, present in 95% of patients compared with 83% pre-intervention. Discussions surrounding preferred place of care and/or death took place in 26% of cases post-intervention vs 9% pre-intervention. Previously expressed future care wishes were reassessed more frequently post intervention, in 69% of cases compared to 54% pre-intervention.

**Conclusions** Following an educational intervention, discussions around prognosis and future care planning took place more frequently in hospital inpatients with end-stage COPD. We are proposing an expanded educational programme with a focus on respiratory nurse specialists.

**REFERENCES**


**UTILISING THE ‘COGNITIVE CONSTRUCTIVISM’ EDUCATIONAL THEORY TO INFORM A LESSON PLAN FOR FINAL-YEAR MEDICAL STUDENTS ON THE MANAGEMENT OF TERMINAL AGITATION**

Anna Gray, Cardiff University

**Introduction** Foundation doctors are required to provide individualised care for dying patients and manage common symptoms, including terminal agitation. Education of final-year medical students on terminal agitation management is therefore important, but how should this be done? A lesson plan with an evidence-based design is required, such as the cognitive constructivism educational theory applied here.

**Aim** To incorporate cognitive constructivism into a lesson plan for final-year medical students on the management of terminal agitation.

**Methods** Lesson plan design took place in December 2022. Given its alignment with the constructivist approach, the ASSURE model was chosen (Analyse; Standards and objectives; Select and Utilise strategy, technology, media, and materials; Require learner participation; and Evaluation and revise.) The students’ learning needs were identified from the Foundation Programme curriculum. The revised Bloom’s Taxonomy was also used to write learning outcomes. The cognitive constructivism theories by Dewey and Piaget informed appropriate lesson activities that help achieve learning outcomes.

**Results** Three domains of the revised Bloom’s Taxonomy (‘remember’, ‘understand’ and ‘apply’) were used to formulate five learning outcomes relating to the identification of reversible causes of, and management of, terminal agitation. Cognitive constructivist approaches were embedded in the lesson plan design by use of suitable learning activities for students to participate in. Theory-based learning preceded problem-based learning, thereby applying Piaget’s concept of ‘schema’. Further, to include Dewey’s principle of collaborative working on real-world problems, the activities of case-based discussions and communication skills role play were included. Finally, a class quiz was used to establish if learning outcomes were met.

**Conclusion** This lesson plan aims to support medical students in preparing to care for dying patients when qualified as foundation doctors. Lesson activities align with theoretical principles from Dewey and Piaget which appropriately challenge the students’ clinical knowledge, judgement, and reasoning through participating in realistic learning activities.

**STRENGTHENING THE LOCAL INTERPROFESSIONAL LUNCHEON TIME PALLIATIVE CARE TEACHING PROGRAMME AND PROVIDING A SAFE SPACE FOR LEARNING TOGETHER**

Anneka Burge, Sabrina Vitello, Armita Jamali. Royal Marsden Hospital

**Background** Local departmental teaching programmes provide opportunities for learning and developing teaching skills. Our hospital multi-professional palliative care team’s (PCT) teaching programme consisted of two lunchtime sessions a week: knowledge-based sessions delivered by a PCT doctor or external speaker, and ‘journal club’ delivered by a PCT member. Often sessions were cancelled due to lack of speaker availability, or by the timetabled PCT presenter. Informal conversations with colleagues within the PCT revealed apprehension about delivering sessions due to their formal format or lack of time to prepare. The aim was to redesign the programme to provide a safer space not only for learning, but for teaching and reflecting.

**Methods** We redesigned the teaching format and proposed different teaching styles. There were five different session types: Knowledge-based delivered internally, Knowledge-based delivered by an external speaker, Reflective Cases, Journal Club, and Private Study.

We proposed sessions could be delivered in pairs, with no powerpoint expectation and with the aim of generating group discussion. We emailed the PCT and spoke through the programme virtually explaining the above. We piloted the new format from May 2022 to October 2022 and evaluated this using an online survey.

**Results** 9 colleagues responded; 100% preferred the current format, the majority had attended most of the different session types and every person found each session type ‘very
useful’ or ‘quite useful’. There was a mixed response regarding which session type colleagues wanted more or less of. 100% felt comfortable delivering a session. Free text comments confirmed the informal teaching increased enthusiasm to teach and many expressed particular enthusiasm for the structured space to reflect, and private study.

**Conclusion** The redesign of the teaching programme has created new learning methods for the team, more opportunities to share experiences and learn from, with and about each other, whilst developing teaching skills.

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**Abstracts**

**15** TO IMPROVE THE QUALITY OF E-DISCHARGE SUMMARIES FOR PATIENTS POTENTIALLY IN THEIR LAST 12 MONTHS OF LIFE USING THE G.R.E.A.T TOOL

Bavan Seelan, Andrew Butler, Syed Burney, Johra Alam, Rea Downes, Shanthini Avorbedor, Ebun Abarshi. Whipp Cross Hospital NHS Trust, Waltham Forest Primary Care

**Introduction** Concise e-discharge summaries undoubtedly support seamless transition to enable clear treatment plans and ensure that patient preferences considered wherever possible. ‘Ambitions-for-Palliative-and-End-of-Life-Care’ national guidelines emphasise the importance of well-coordinated care; a concise summary will enable this ambition to be fulfilled. Now, discharge summaries fall under the purview of the medical team and serve as primary documents for communicating care plan between settings. While sifting through patient records, doctors need to know which information to include, to ensure excellent follow-up.

**Setting** Margaret Centre (MC) is an 11-bed specialist inpatient palliative care unit. In its 2021/22 annual report, 1 in 3 of all admissions were discharged to the community. The centre’s vision is to provide ‘specialist services without walls’, achievable through healthy partnerships and collaborations at various levels.

**Method** As part of the Gold standard formwork, we examined e-discharge summaries for all discharges from 1st January to 30th September 2022. We used the G.R.E.A.T tool, adapted from Dudley Group NHS.

G.R.E.A.T is an acronym for G- GSF Code; R- resuscitation status; E- End-of-life care (EOLC) medications; A-Advance Care Planning (ACP) including the Urgent Care Plan (previously Coordinate-My-Care); and T – treatment escalation plan (TEP).

**Results** Patients aged 60–102 years. 20 males. All potentially within their last 12 months. 9 e-discharge summaries were for Medical Outliers. These were excluded. 32 discharges from MC were to: nursing home (44%), home (38%), acute ward (9%), hospice (6%), and interim placement (3%). 4 discharges had no e-discharge summary.

Of 28 patients with summaries: Patient GSF-code was recorded 36% summaries; resuscitation status 43%; present/absent EOLC medications 61%; inpatient ACP discussions 54%; TEP 50%. All five elements of G.R.E.A.T. present in only 25% of e-discharge summaries.

**Conclusion** A quarter of e-discharge summaries on patients within the last 12 months of life, did not include any information regarding G.R.E.A.T. Junior doctors can be supported in this respect.

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**16** IS CONTEMPLATION OF PERSONAL MORTALITY HELPFUL FOR CONFIDENCE IN END OF LIFE DISCUSSIONS?

Chantal Mestyre. The Omega Course

10.1136/spcare-2023-PCC.36

**Background** The Royal College of Physicians ‘Talking About Dying’ report 2018 demonstrated that trained medical professionals find initiating End of Life conversations difficult due to culture, confidence and practicalities. Clinicians and patients find confronting their own mortality challenging and the inaccuracy of prognosis compounds the reluctance to address end of life discussions. The Omega Course was designed for the pre-morbid lay population to increase death literacy, then teach skills required for a compassionate community, including communication skills by role play. We trialed an abbreviated OmegaPro one day course to assess if the same curriculum, starting with contemplation of one’s own mortality and end of life care planning, was beneficial to senior clinicians with communication and advance care planning.

**Methods** The 14 hour Omega Course was condensed into 6 hours for professionals, as some of the material would be familiar. The focus on universal and personal mortality, end of life wishes and communication role plays was purposely retained. Pre and post-course questionnaires, using quantitative and qualitative questions were performed (n=24).

**Results** Statistically highly significant paired t-test results (p<0.001) demonstrated increased confidence at the end of the day in:

- Thinking about my own death
- Listening to patient concerns
- Responding to patient concerns

**Best part** o Role play scenarios 11
  o All of it 9
  o Relaxed discussion and sharing 3
  o Exploring own death in order to understand patients 3

**Most challenging part** o Thinking about own death 9
  o Role play 7

**Comment for course marketing** o Do it! 18
  o Educational 6
  o Makes you think 6

**Conclusion** Clinical training is depersonalised for professionalism and psychological coping. This can obstruct communication with dying patients. The challenge of contemplating personal mortality pre communication training was appreciated and effective but if death is more personally acknowledged debriefing in supervision will be important.

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**17** PASSING THE BATON OF CARE: TRAINING ON TREATMENT ESCALATIONS PLANNING, DECISIONS MAKING CARDIO PULMONARY RESUSCITATION AND ANTICIPATORY CLINICAL MANAGEMENT PLANNING IN AN ACUTE HOSPITAL

Clare Finnegan, Craig Rimmer, Ella Sykes. Southport and Ormskirk Hospital NHS Trust

10.1136/spcare-2023-PCC.37

**Background** Making clinical decisions when recovery is uncertain can be challenging for clinicians working within the acute hospital. Recognising the possibility of uncertain recovery facilitates honest and sensitive conversations about patients wishes,