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.

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 Avorgbedor, Ebun Abarshi. *Whipps Cross Hospital NHS Trust, Waltham Forest Primary Care*

10.1136/spcare-2023-PCC.35

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 a patient's 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 60–102years. 20 males. All potentially within their last 12 months. 9 e-discharges 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.

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

Chantal Meystre. *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.

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,