DYING TO KNOW: A PILOT TO DELIVER PERSONAL DEVELOPMENT CURRICULUM ON DEATH AND BEREAVEMENT IN A SECONDARY SCHOOL IN GATESHEAD

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Introduction The aim of the Dying to Know project was to improve young people’s engagement with key issues surrounding death, dying and bereavement in order to better equip them to deal with life experiences. The Specialist Palliative Care Team (SPCT) at Gateshead Health NHS Foundation Trust collaborated with Emmanuel College in Gateshead to develop a personal development curriculum on the subject.

Methods Over a 6-month period in 2022, teachers and palliative care professionals delivered lectures and tutorials for 190 young people aged 14–16. Students and teachers were surveyed before and after the programme using free text responses and Likert scales.

Results The post-intervention survey was completed by 189 of the 190 pupils at the end of 2022. Of the 114 free text comments, 49% were positive, including the sessions being informative (43%) recognising the importance of talking about dying (12%) and increasing levels of comfort (4%). 31% of students disliked the title, 10% criticised the emotional response it caused, 10% were not interested in the programme and 5% did not like the lecture format. All teachers thought the programme should be continued.

Conclusions We successfully developed and delivered a teaching programme on death and dying to secondary school pupils. Based on feedback from students and teachers, we plan to revise some content and the name, then expand to other schools. Changing the lectures to video format will improve reproducibility and have less impact on SPCT time. Showing them to 3 different year groups will expand to other schools. Changing the lectures to video format will improve reproducibility and have less impact on SPCT time. Showing them to 3 different year groups will facilitate development and reinforce learning over time, supported by a drop in ‘any questions’ session by the SPCT during the same week. The schools will nominate a staff member to lead on this project and be a point of contact for a SPCT link nurse for each secondary school in the borough.

ADVANCED CARE PLANNING DOCUMENTATION IN A BUSY LONDON ACUTE MEDICAL UNIT: COMPARISON OF 2 RETROSPECTIVE AUDITS

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Background/Introduction An annual audit occurs at University College London Hospital (UCLH) revolving around the documentation of DNACPR, Treatment Escalation Plans (TEP) and mental capacity throughout the trust by the Transforming End of Life Care team. A deep dive into the potential barriers to improved documentation of these topics was carried out in the Acute medical unit (AMU) as this ward has a high turnover of patients and encounters patients early in their hospital journey.

Methods An audit of AMU was carried out assessing the rationale behind CPR status not being signed.

Results Pre intervention, 59.1% did not have a signed CPR decision at that point of admission. Post intervention 64% did not have a signed CPR decision. P-value of the observed difference was >0.05 and the CI covered the null hypothesis of 0. This suggests the change was due to chance. Pre intervention 53.8% of the unsigned patients warranted further discussion. Post intervention 9% of the unsigned patients warranted further discussion. P-value of the observed difference was <0.001 and the CI did not cover the null hypothesis. This suggests the change is not due to chance.

Conclusions Education around the importance of advanced care planning and recognition of the dying patient may improve documentation of CPR decisions and TEP. Targeting ‘front door’ teams may improve patients’ long term desired outcomes.

LONDON AMBULANCE SERVICE AND PALLIATIVE PARTNERS – INCREASING CONFIDENCE TO CARE FOR DYING PATIENTS AT HOME


Background The ECHO methodology is an international initiative aiming to cultivate communities of practice, with reciprocal knowledge and confidence transfer between a specialist hub and stakeholder teams. This project was established to enhance the confidence of London Ambulance Service clinicians who are increasingly required to attend dying patients, and manage them at home. The ‘stakeholders’ were all grades of ambulance clinicians. The hub consisted of a palliative physician and nurse, a care home matron, a GP plus two end of life leaders from London Ambulance Service (LAS) and an administrative partner (MHealth Hillingdon).

Method The curriculum was collaboratively agreed with LAS. Topics included understanding the palliative approach, ethical decision-making, symptom control for those patients who want to stay at home, emergencies at the end of life, communication challenges and family dynamics. Structure included brief didactic learning, real-time polls and case presentations by ambulance clinicians.

Results Engagement has been huge with over 200 ambulance clinicians engaging with the first three ECHO sessions. Initial themes from the contemporaneous realist evaluation using Slido demonstrate key changes in attitude, knowledge gaps, confidence and engagement.

Learnings as the following:
‘Do no harm’ doesn’t just apply to the patient...are we also trying to consider family/ourselves/the wider healthcare system’
‘Dealing with different family opinions about whether hospital is appropriate’
‘Services available to avoid hospital admission for patient comfort’
‘Gives me a lot more confidence to have the challenging conversations with family if I recognise a patient is near end of life’

Conclusion The ECHO methodology, with a strap line ‘all teach, all learn’, is confirmed as a successful structured approach to cascade information in all directions to enhance practice and confidence for ambulance clinicians. Formal evaluation at the end of the first curriculum will take place, with a view to how to sustain ongoing learning.

COMPLAINT IMPLICATIVE SEQUENCES IN PALLIATIVE CARE CONSULTATIONS – AN EXPLORATORY OBSERVATIONAL STUDY USING CONVERSATION ANALYSIS

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Background ‘Patient safety’ is often seen as attainable through the application of and compliance with evidence-based guidelines and protocols. However, there is a difference between being safe and feeling safe. ‘Feeling safe’ in healthcare depends on the ongoing interactions of people with one another and their surroundings. This project, undertaken as part of MSc study, explores moments of clinician-patient interaction that are potentially ‘unsafe’ – where conversational activity can be described as complaint-implicative; that is, where there is some expression of discontent about some state of affairs for which responsibility can be attributed to ‘someone’.

Method Ethical permission was granted for access to a corpus of audiovisual recordings of naturally occurring clinical consultations between therapists (physiotherapists, occupational therapists), patients and carers in a hospice. Conversation Analysis (CA) was used to examine these interactions. A collection of episodes that appeared complaint implicative were transcribed according to Jeffersonian conventions and analysed, including in CA data sessions with other experienced scholars.

Results In this context, complaint can be intangible. Most episodes are ‘indirect’ complaints, where the target of the complaint is not the complaint recipient. I also identified a handful of ‘direct’ complaints, where the complaint recipient was made in some way personally accountable for a possible transgression. Therapists responded to direct complaints in ‘mid-range’ ways that were neither affiliating nor disaffiliating. Where such activity was not embedded in problem presentation, it delayed progression to a projected activity; participants worked to re-orient quickly to the clinical project at hand.

Conclusion Further research is required to determine whether these findings are typical in hospice consultation. Results of this initial exploratory project may add to the evidence that underpins communication skills training for clinicians working in palliative care.

RECOMMENDED SUMMARY PLAN FOR EMERGENCY CARE AND TREATMENT (RESPECT): A COLLABORATIVE MODEL GUIDING CARE CONVERSATIONS BETWEEN CARE RECIPIENTS, FAMILIES, & PROVIDERS

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Background Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is an interactive process guiding conversations about end-of-life care between a person, their family, and a health care professional. The ReSPECT process was developed to educate and train providers to ensure that decisions are made in advance and consistent with a person’s wishes. Launched in September 2021 across a multicultural conurbation in the West Midlands, instructors trained care professionals and facilitated the model in care homes, hospice and primary care settings. This paper analyses an audit of the ReSPECT model in care homes, offering suggestions for continued utilisation of the model.

Method Adapted to accommodate COVID-19 restrictions, ReSPECT training included face to face, virtual webinars, and regular ‘top tips’ communications. Third Quarter 2022, a single auditor assessed adherence to the ReSPECT model, quality of documents, and diversity of care homes/participants using a systematic chart review.

Results The auditor reviewed 1136 care plans, identifying 350 ReSPECT documents. For 30 audited care homes, 20–40% of residents had ReSPECT documentation, four homes achieved 64–87% completion rates. Medical conditions for 769 care recipients in the audit, in order of frequency, were dementia, frailty, hypertension, and diabetes. The quality of documentation and errors varied, e.g., 67% of recipients had charted mental capacity deficits, yet most lacked formal capacity assessments. Variation also existed across professional disciplines conducting the care planning session. Analysis did not reveal any significant demographic differences between care recipients, although smaller homes themselves were more diverse, larger homes more likely to successfully complete and document the ReSPECT process. The recommendations highlight the need for additional training at institutional and provider levels, particularly regarding capacity assessment.

Conclusion The ReSPECT model has potential to improve end-of-life planning and capturing the persons wishes, but additional training and validation is needed to assure consistent adherence.

SELF-PERCEIVED PREPAREDNESS OF NEW PALLIATIVE MEDICINE CONSULTANTS

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Background Specialty trainees are expected to achieve multiple skills during training in preparation for a consultant role. However, evidence from many other specialties suggests that new consultants are less prepared in non-clinical skills. Aim To identify if new UK palliative medicine consultants, within five years of their appointment, feel prepared in