‘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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10.1136/spcare-2023-PCC.56

**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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10.1136/spcare-2023-PCC.57

**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 participants 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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10.1136/spcare-2023-PCC.58

**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