

'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.

36 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.

37 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 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.

38 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

clinical and non-clinical skills after completing specialty training and the support available during the transition from trainee to consultant.

Method An online survey, using previous literature, pilot tested on multi-specialty consultants to test functionality. A five-point Likert scale to record various aspects of preparedness was used. The survey was distributed via the Association for Palliative Medicine email and social media. Ethics approval was obtained.

Results Forty-eight consultants completed the survey; 80% were female. 40% were in a consultant post for 1 year, 50% worked across multiple settings, 46% worked as a specialty doctor before training. The majority felt very or extremely prepared in clinical skills (71%), audit (84%), interaction with other colleagues (70%), time management (64%) and self-management (64%). 50% felt moderately prepared in Human Resources, 68% in organisation structure and 52% in leadership. The majority (70%) were not at all or slightly prepared in financial management. 50% reported being moderately and 43% slightly or not at all prepared in complaint management. Attendance at management and leadership course (68%) and management meetings (55%) were most useful to gain management experience. The majority (75%) found departmental colleagues gave the most support in stressful situations but only 7% had a formal mentor.

Conclusion Palliative Medicine consultants may require support with the non-clinical aspects of their role, such as management of complaints, finances and mentorship. This is consistent with findings from other specialties. Future research should identify how trainees should be supported in these areas, especially with changes to speciality training; 'Shape of training'.

39 DID YOU KNOW YOU COULD GIVE THE GIFT OF EYESIGHT? AN AUDIT OF CORNEAL DONATION DISCUSSION AT A PALLIATIVE CARE HOSPICE

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Background Currently in the United Kingdom there is a shortage of 500 corneal donors per year with a waiting list of 2 years. To address this, Sue Ryder St John's Hospice actively encourages all of its doctors to discuss with patients their views on corneal donation.

Aim The aim of the audit was to assess if all new inpatient admissions to the hospice were considered eligible for a discussion about corneal donation. A standard was also set for these discussions to occur within 72 hours of admission.

Method A review of electronic patient records for all admissions between January 1st 2022 to March 31st 2022.

Results There were 34 admissions to the hospice in this time. All admissions were considered for corneal donation discussion. Discussions were had with 79.4% (27/34) patients, all within the target time frame of 72 hours. Those not had were due to reasons such as confusion or rapid deterioration. Out of the discussions that occurred, 96.3% (26/27) of them were held by GP trainees. As a result of this developing trend, a concurrent survey was sent to all the GP trainees in February to indicate their confidence levels in this topic. Of the responses, 100% (4/4) of trainees had never had such discussions before with only 50% (2/4) of them having heard

about corneal donations prior to their palliative care placement. The change implemented was the creation of an informational leaflet about corneal donation which was distributed in March. This educational resource was also incorporated into the induction pack for future trainees. The leaflet was well received and data continued to be promising.

Conclusion This local hospice demonstrated a high rate of discussions about corneal donation. Fostering an awareness among all staff, like the GP trainees, was key to promoting this.

40 PHASE OF ILLNESS SURVEY

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Background Phase of Illness (POI) describes the current stage in the patient's illness and are classified according to the care needs of the patient. The phases are stable, unstable, deteriorating, and dying. POI are useful to prioritise interventions, manage caseloads and in handovers. POI is documented at every clinical contact by a range of healthcare professionals (HCP); therefore, consistency of assessment is important.

Aim To assess whether there is consistency across the organisation and clinical areas as to how to POI is being used and interpreted.

Method Clinical staff across the organisation were asked to complete two questionnaires. Two fictional patient scenarios were devised for the surveys. HCPs were asked to choose which POI best represented the patient's condition, which evolved over time, at each clinical contact by an HCP.

Results Thirty-five HCPs completed scenario 1, 29 completed scenario 2. The range of HCPs included nurses, doctors, physiotherapists, occupational therapists and patient and family services. Majority agreement across all POI assessments in scenario 1. Five of the seven questions having agreement of the phase by over 70%. Less agreement across the POI assessments of scenario 2. Only 2 questions showing agreement by over 70% of the respondents. This was in part due to disagreement when to change from unstable to another POI.

Conclusion POI assessments give a useful description of the patient and families' current care needs and whether an effective care plan is in place. This survey shows that there is mostly agreement of POI assessment across the multidisciplinary team. More work in terms of staff training and support is required to ensure the consistency of POI assessment across the hospice. The results of the survey have been disseminated to the hospice HCPs with a focus on when to change a POI.

41 FORTY YEARS OF PALLIATIVE AND END OF LIFE CARE TEACHING: A RETROSPECTIVE AND AN UPDATE

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Background Palliative and end of life care (PEOLC) is now a core competency for all UK graduating medical students. In 1983, a UK-wide survey investigated how PEOLC was being taught in medical schools. A similar survey has been