meeting the specialist needs for Tier 3 competencies (Health Education England & Skills For Health. Common core principles and competences for social care and health workers working with adults at the end of life. 2017), aimed at enhancing confidence. Assumptions lead to lack of confidence and barriers in effective communication (Royal College Physicians. Talking about dying: how to begin honest conversations about what lies ahead. 2021; General Medical Council. Understanding communication failures involving doctors. 2019). The impact of using CA to embed the learning of micro skills within ACST was explored and evaluated.

Aims To evaluate our ACST courses, delivered over a 12 month period to multiprofessional groups, via a blended approach with RealTalk and authentic clinical scenarios, using the adapted EMET (Whittaker, Parry, Bird, et al. BMJ Support Palliat Care. 2018; 8(4):439–446) capturing (a) pre and post evaluation of confidence/competence, and (b) the impact of CA evidence base RealTalk on learning.

Methods Addition of CA evidence base to ACST April 2022-March 2023: pre and post evaluation using EMET (Whittaker, Parry, Bird, et al., 2018); adaption of pre course preparation based on stakeholder feedback; data collected from EMET and goal setting returning to practice; data on impact of RealTalk on learning; data collected on professional demographics.

Results EMET has shown increases in confidence of the nuances and tacit skills that can be taught (Land, Parry, Pino, et al. Patient Educ Couns. 2019; 102(4): 670–679), enhancing professional behaviours. Post learning questionnaire showed 97.3% of delegates feel confident to listen to and talk with a dying person about issues surrounding their death. 100% feel competent in recognising a person’s cues. Demographics: Doctor, 53%; ELOC facilitator, 4%; ACP, 14%; Therapist, 3%; CNS, 25%; Other, 1%.

100% agreed that they felt safe in the learning environment, the course met their needs and they would recommend the course to colleagues.

Conclusion Having adapted ACST, RealTalk has added the next step in widening the dissemination of talk as action in clinical practice, confidence has increased following the embedding of basic principles that underpin a range of complex communication skills. Practitioners can draw on these to facilitate compassionate conversations role modelling into clinical practice.

**P-82 IMPROVING CONFIDENCE AMONGST COMMUNITY-BASED HEALTHCARE PROFESSIONALS IN HAVING CONVERSATIONS REGARDING RESUSCITATION STATUS**

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Aim To deliver a training programme to enable senior practitioners from the wider community team to complete DNACPR (‘Do Not Attempt Cardio-Pulmonary Resuscitation’) forms.

Background It is well documented that practitioners find initiating DNACPR discussions with patients difficult due to fear of causing distress, time constraints, as well as fear of complaints (Perkins, Griffiths, Slowther. NIHR Journals Library. 2016). The Institute of Medicine recommends that improved education around end-of-life care planning will help communication between the patient, family and care provider allowing for a more dignified death and limiting unnecessary suffering (Dobbins. Nurse Pract. 2016; 41(9):26–34). A systematic review of advance care plan training facilitation showed that role play is an effective pedagogy to help enhance practitioner confidence when initiating these conversations (Chan, Ng, Chan, et al. BMC Health Serv Res. 2019; 19(1):362).

Method A half-day training programme was developed by the palliative care team which incorporated advanced communication skills, legal and professional accountability, mental capacity assessment, discussion and role play to explore the complexities and importance of advance care planning conversations. A total of 16 senior practitioners including community nurses, physiotherapists and paramedics attended. The sessions were interactive and used a range of materials including recordings, presentations and simulation training. The practitioners were given the opportunity to practice complex scenarios in a safe environment to help develop their confidence within this area. Following the course, a competency document was completed, and an Observed Structured Clinical Examination performed to determine safety and expertise. Once successfully completed, this then allowed for the senior practitioners to complete DNACPR forms in the community.

Results This training session gained excellent feedback and was highly recommended by all the participants.

Conclusion By sharing expertise with community-based colleagues, trusting relationships between teams were built, enhancing patient care to be delivered within the wider community.

**P-83 WHAT MATTERS TO YOU TODAY? DOCUMENTING PATIENTS’ GOALS IN THE LAST DAYS OF LIFE**

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10.1136/spcare-2023-HUNC.104

Background The Respite and Response team at Ayrshire Hospice supports people to be cared for and die at home, if that is their choice. The team also aims to prevent unnecessary hospital admissions, and provides respite for carers. During 2021/22, 167 people were supported by the team to achieve their preferred place of death at home. Short-term goals are discussed at every visit (when appropriate), with the team aiming to help the patient realise their goal, or facilitate an adapted version wherever possible.

Aim Documentation in the patient record did not accurately reflect the person-centred care carried out. An initiative was launched by a team member to improve practice – specifically regarding documentation of patients’ goals. The aim being that 95% of Respite and Response patients will have up-to-date person-centred goals documented by June 2023.

Methods The project lead presented to colleagues on the importance of discussing and documenting goals (Boa, Wyke, Duncan et al. BMJ Support Palliat Care. 2012;2:A9-A10) during a team development day. The team also linked with a local representative from The Care Inspectorate, responsible for regulating the service. A baseline audit was completed, looking at the level of personalisation and frequency with which goal setting was recorded. A run chart was displayed within the team office, with percentage compliance plotted at fortnightly intervals.
Results The project is ongoing at the time of writing, however, initial results are positive, with an increase in individualised goals being documented at each visit from 65% to 90% in the first month of the project. This will continue to be monitored to ensure practice is embedded.

Conclusion This project, being driven by a team member passionate about goal-setting with patients, coupled with explaining why the practice is important from the perspective of the regulator, have helped to achieve buy-in from the team.

Background Hospital re-admissions often contribute to unnecessary suffering and decreased quality of life for palliative care patients and their family members, particularly those approaching the end of life. Discharge summaries provide vital information to support healthcare professionals when making decisions about care settings and whether patients should be re-admitted to hospital. A baseline audit of hospice discharge summaries conducted between October 2022 and March 2023 found only 15% of discharge summaries contained information regarding patients’ preferences for hospice or hospital readmission.

Aim To improve communication between healthcare professionals regarding patients’ preferences for place and ceilings of care.

Methods A quality improvement project was conducted. The hospice discharge summary template was updated to include a specific section on ‘patient’s preferences regarding hospital admission’. Medical staff were updated about the changes and teaching provided to key members of staff regularly involved in writing discharge letters. A review of discharge summaries between April 2023 and May 2023 evaluated the impact of these changes.

Results Documentation of patients’ preferences for hospital admission improved 56% (15% (3/20) to 71% (5/7)) following the changes implemented. Information included in the most recent discharge summaries were that two patients would be for hospital admission, two were not for readmission and one patient had declined to discuss admission.

Conclusion We found an improvement in the documentation of patients’ preferences for hospital admission following changes made to our discharge template document. Reviewing and changing template documents can have important effects of the quality of information provided between care settings. Further audit and quality improvement cycles are planned.

Background Accurate and timely communication between primary and secondary care is essential for delivering high-quality patient care (Dinsdale, Hannigan, O’Connor et al. Fam Pract. 2020; 37(1):63–68). Communication and collaboration between primary care and palliative care providers is needed to deliver complex care management and to coordinate care, and letters form an important modality for this (Professional Record Standards Body. Outpatient letter v2.1. [internet]). There is increasing evidence that GPs prefer to receive structured clinic letters from specialists, with clearly communicated problem lists and outcomes.

Aims To assess the effectiveness of GP update letters in communicating key messages and outcomes of a patient encounter with the specialist community palliative care team.

Methods To evaluate our template based GP update letters over a period of two months, assessing accuracy, timeliness, and clear conveyance of key messages including recording:

- Specific problem(s) for which the specialist team are offering advice.
- Investigations and change of management plan.
- Rationale for medication changes and prescription requests.
- Controlled medication requests given specific doses.
- Actions requested of General Practitioners in clear courteous manner, including urgency of action.

Results Interim data at two weeks: 37 letters sent. 86% sent same day. 100% recorded primary diagnoses. 37% recorded secondary diagnoses. 89% clearly outline relevant problems. 87% made a clear prescription request. 19% of letters requesting controlled medications did not specify doses.

Conclusion Interim analysis shows GP update letters were sent within 48 hours. Areas of improvement could include recording secondary diagnoses, further clarity around specific problems such as problem listing, and prescription requests, which for controlled drugs suggest doses. This ongoing audit is concurrent with further enquiry of the GP view via survey, and assessing an opportunity for letter writing training for the wider multi-disciplinary team, also by survey of confidence. Adding to the template format may assist these improvements.

Digital ways of working

Background Research, using design and digital methods, can potentially help patients and caregivers to manage their digital legacy (the digital information available about someone following their death – Coop, Marlow. Palliat Med. 2019;33 (1):114–15). However, there is a lack of multi-disciplinary partnerships needed to conduct digital legacy research in palliative care (Nwosu, McGlinchey, Sanders, et al. JMIR Aging.