Abstracts

Background Working in a hospice setting can be difficult and emotionally challenging (Goodrich, Harrison, Cornwall. Resilience: A framework supporting hospice staff to flourish in stressful times. Hospice UK, 2015). Caring for patients on a daily basis who are dying or nearing end of life can lead to emotional distress, burnout and a high turnover of staff (Fetter. Clin J Oncol Nurs. 2012; 16(6):559–561). Data shows that over 40% of hospice workers are either thinking about or actively planning on leaving their role (Royal College of Nursing. RCN Employment Survey 2021). St Gemma’s Hospice currently offers individual supervision for all clinical staff, however, the uptake in some areas is poor.

Aims We aim to relaunch clinical supervision (CS) which embeds both Restorative Clinical Supervision (RCS) and Resilience based clinical supervision models (RBCS) by:

- Gaining an understanding of staff experience of supervision both as a supervisor and supervisee.
- Revise and implement a CS model based on current best evidence.
- Encourage staff to attend a minimum of quarterly.

Method The hospice Clinical Supervision Leads successfully completed the Professional Nurse Advocate (PNA) course in 2022. This was developed around the A-Equip model (McDonald. Bri J Midwifery. 2019;27(4): 258–264) which is a framework made of four distinct functions: Normative, formative, restorative and personal action for quality improvement. The model encourages staff to reflect on their own contribution to situations, building resilience which will empower them to make decisions independently. Training and supervisor support will integrate the new model into hospice provision using a flexible approach for staff to access either individual or group supervision.

Proposed results/conclusion Staff to feel supported to make thoughtful, reflective decisions which will enhance their resilience to cope. This will in time, lead to less staff sickness and reduced staff burnout. We will measure the response to the new model by using ‘check in’ scales before and after the sessions to gauge effectiveness. Measurable outcomes of the project will include attendance, absence management, staff feedback and retention.

Aim To demonstrate how the model of RBCS – known as Reflective Practice (RP) – was implemented and evaluated within the hospice. To evidence the impact it has made to clinical staff following attendance at RBCS/RP sessions.


Results Hospice UK baseline survey results – Response 25 out of 150 (16%).
- 16% – neutral or slightly negative perspective.
- 16% – positive perspective.

Nov. 2022: 152 sessions booked and 91 staff attended, = 61%.

Jan. 2023: 52% had attended RP.


Conclusion Evaluation of the RBCS/RP shows a positive contribution to the wellbeing of the clinical staff in the inpatient unit, hospice at home and children and young people’s teams. We have learnt that continual evaluation is essential to assess the impact of RBCS/RP for staff wellbeing.

P-240 IMPLEMENTING REFLECTIVE PRACTICE IN A HOSPICE USING THE RESILIENCE BASED CLINICAL SUPERVISION MODEL

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Background The COVID-19 pandemic highlighted the emotional burden and stress experienced by palliative care workers (Pastrana, De Lima, Pettus, Ramsey, et al. Palliat Support Care. 2021; 19(2):187–192). The charity identified that a sustainable model of clinical supervision was needed to support the wellbeing of clinical staff (Care Quality Commission. Supporting information and guidance: supporting effective clinical supervision. 2013). Two clinical staff were supported to participate in the Resilience Based Clinical Supervision (RBCS) Facilitators programme with the Foundation of Nursing Studies (FONS). Clinical supervision resources: What is Resilience-based Clinical Supervision? [Internet]), and Hospice UK between 2021 -2022.

Aims Our aim was to improve the experience of clinical supervision by increasing the tools and resources that supervisors could draw upon in their sessions. The particular components of the RBCS model would empower supervisees to build mindfulness techniques and reframing strategies, supporting their resilience and resulting in greater retention of skilled staff and a better quality of patient care.

P-241 IMPLEMENTING THE RESILIENCE BASED CLINICAL SUPERVISION MODEL INTO AN EXISTING SUPERVISION FRAMEWORK

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Background Clinical supervision has existed in healthcare since the 1990s but implementation has been inconsistent, with some believing it to be a management monitoring tool (Sloan, Watson. Nurs Standard. 2002;17(4):41–46; Nugent, Nanda, Hitchcock. BMJ Support Palliat Care. 2022;12:A3-A4). Recent data shows a high percentage (91%) of clinical hospice staff at our workplace have access to clinical supervision and it is valued highly, illustrated by its inclusion in local policies and induction procedures, as well as its inclusion in national policy. In 2021, we were invited to participate in a Hospice UK project to introduce Resilience Based Clinical Supervision (RBCS) to our hospice and this presentation describes our journey with implementing this model (Stacey, Cook, Aubeluck, et al. Nurse Educ Today. 2020;94: 104564; Stacey, Aubeluck, Cook, et al. Int Pract Develop J. 2017;7(2):5).

Aims Our aim was to improve the experience of clinical supervision by increasing the tools and resources that supervisors could draw upon in their sessions. The particular components of the RBCS model would empower supervisees to build mindfulness techniques and reframing strategies, supporting their resilience and resulting in greater retention of skilled staff and a better quality of patient care.
Methods Two clinical supervisors learned how to facilitate the RBCS model and cascaded this learning to two further supervisors. Following a pre-implementation baseline audit, the model is being trialled with selected small supervision groups who have consistent membership and regular attendance. After 6 sessions the group participants will be evaluated to assess the impact of the model.

Results Supervisors’ feedback is yet to be evaluated but supervisors report feeling empowered by having a structure to frame their sessions and are building confidence in the model.

Conclusion After some initial supervisor resistance to the RBCS model, supervisees have responded very positively and this in turn has built confidence in supervisors. We plan to build our pool of RBCS trained supervisors so that as an organisation we have a wider range of strategies and tools to offer to our colleagues in clinical supervision.

P-243 SUSTAINABLE EDUCATION IN A MULTI-SITE CHARITY: CHALLENGES AND SOLUTIONS
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Background A restructure of the education team within a multi-site national charity delivering palliative and neurological care provided the opportunity to develop a programme of education that met learning needs for the whole organisation, in particular, specialist education in palliative and end of life care.

Aim To ensure our non-medical clinical colleagues have the education to deliver palliative and end of life care with confidence in any of the organisation’s settings.

Method The Health Education England (HEE) (2019) learning outcomes for end of life care were accessed and mapped to each clinical role within the organisation, enabling the identification of learning that could be addressed with in-house programmes. An in-house palliative and end of life care programme was designed, to include a 5 ½ day course for colleagues new to palliative care. A pilot of the 5 ½ day course was launched, with 12 participants from 3 sites booked. The materials were designed to be quality-assured so that specialists and educators could deliver them at each site.

ResultsColleagues were keen for such a course and specialist colleagues supported its production and delivery. Evaluations of the days delivered have been positive, and include increases in confidence levels based on learning outcomes of each day (Royal College of Nursing. RCN Quality Assurance Framework: Evaluation Model of Education, Learning and Development. 2022). A half-day virtual session to be held after three months will require the participants to report back on the results of making a pledge to improve practice, with the potential to demonstrate theory improving practice. Participants from hospice and neurological care included nurses, healthcare assistants and an occupational therapist in a mix provided fertile learning in itself (Cust. Nurs Times. 2021 Apr. 27). The course is designed to be interactive and most participants engaged fully.

Conclusion Colleagues are keen to have learning opportunities to develop their ability to support service users. Developing a course that can be replicated throughout the organisation enables greater equity for staff and service users.

P-244 UTILISING A QUALITY IMPROVEMENT APPROACH TO DEVELOP A NATIONAL CLINICAL INDUCTION PROGRAMME
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Sue Ryder has multiple clinical services offering palliative, neurological and bereavement care. The strategic aim is to create