DIGNITY BOXES: QUALITY CARE BEYOND DEATH
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10.1136/spcare-2023-HUNC.37

Background Care after death, for both the patient and their family is vital to maintain the same dignity and respect, observed whilst the patient was alive (Wilson, Laverty, Mann et al. Care after death. 2022, 4th ed.). This is something hospices do so well, however, there was one aspect where I felt we fell short of this. I and other nurses felt uncomfortable when returning belongings of loved ones to relatives, in a plastic bag. We felt both patients and relatives deserved a more dignified handover of patient property; herein formed the idea of cardboard dignity boxes. Researching online, I found evidence of relatives sharing the belongings in plastic bags as heart-breaking. Additionally, this concept aligns with the government pledge to tackle avoidable plastic waste by 2042 (GOV.UK, 2021). Worldwide plastic bag use totals 500 billion every year (World Health Organization: Regional Office for the Eastern Mediterranean, 2018).

Aim To introduce a presentation box for patients’ belongings returned to relatives, to maintain dignified care.

Method Online research was conducted to source suitable design, with several options sent out to all care team members to vote upon. All options were flat packed to facilitate ease of storage. The team majority chose a tasteful A4 box design with photo frame attachment and printed ribbon seal; this was sent to fundraising to acquire.

Conclusion We will now be able to continue to deliver respectful patient and family care, from the start of their journey with the hospice, to the end.

OUT OF THE COUNSELLING ROOM AND INTO THE FOREST. GROUP BEREAVEMENT FOREST THERAPY
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10.1136/spcare-2023-HUNC.38

Background Following COVID-19, there was no ‘rush’ as anticipated for indoor therapy groups. Face to face; one to one bereavement counselling was a preferred choice. The Bereavement Care Service Standards (Bereavement Services Association & Cruse Bereavement Care, 2014) highlight the importance of having plans in place to address clients’ bereavement needs appropriately. According to Cooley et al., mental health practitioners ‘have begun to harness nature’s restorative capacity by... taking talking therapies outdoors’ (Clin Psychol Rev. 2020; 77:101841). Research indicates the health benefits of forest therapy (Rajoo, Karam & Abdullah. Urban Forest & Urban Green. 2020; 54:126744). Spending time in nature can nurture our physical, emotional and spiritual existence (Conn. The Humanistic Psychologist. 1998; 26: 179–198).

Aims To pilot a small ‘walk and talk’ counselling therapy group (6–8 bereaved clients) in a local forest to establish if a therapeutic forest group is worth growing and developing.

Method Eight self-referred clients completed an initial consultation. Six were recruited. CORE-10 (Clinical Outcomes in Routine Evaluation) tool was used to assess clients’ general wellbeing pre and post intervention. Six clients attended the group; recently bereaved (3 months) to a longer time frame (3 years). All had close spousal or parental bereavements.

Six-weeks of group forest therapy, 1.5 hours duration, at the same time each week using a risk assessed route. Being within the forest plus contracted ‘conditions’ of therapy, held safe space, along with two experienced bereavement counsellors. Processing rich insights from mother nature’s metaphor aided and enabled clients’ unique understanding of grief. Immediately before and after the group activity took place, CORE-10 outcome measures were captured from clients. A feedback survey followed.

Results Six clients participated. Two completed the entire programme. Five attended most (five) sessions. Reduced CORE 10 scores demonstrated the group feeling an improvement by 36.8% compared with the outset. (Data gained from all but one client’s compatible scores). There were positive verbal ‘check outs’. Questionnaire analysis in progress.

Conclusion Positive feedback and early indications from the analysis suggest this pilot could be developed to benefit future counselling groups.

COMPASSIONATE NEIGHBOURS – SUPPORTING Bereavement THROUGH MUTUAL CONNECTIONS
Jon Devlin, Irene Baumgartl. Greenwich and Bexley Community Hospice, London, UK
10.1136/spcare-2023-HUNC.39

Background Greenwich & Bexley Community Hospice has been running a Compassionate Neighbours programme since 2018. Over the past five years, more than 270 people have been trained as Compassionate Neighbours; more than 430 ‘Community Members’ (CMs) have been referred for an introduction; and more than 250 pairs of people have been introduced to each other. Many of our volunteers continue their relationships with extended families or friends of the community member they visited after the death of their community member – which is supported and encouraged where it is wanted – and this is an area we have sought to understand further.

Aims To explore the extent to which Compassionate Neighbours provide elements of informal therapeutic support to those who have been bereaved – an extension to the programme’s focus of supporting those at risk of loneliness/social isolation – and the extent to which this complements our existing bereavement support offer.
Method Focused interviews with: Compassionate Neighbours; People who knew the person who died; Health and social care professionals who refer. Analysis of: programme referral data, and hospice’s EPR (SystmOne) data.

Results The relationship between a Compassionate Neighbour, the person they were connected with and their wider support network can provide a unique way to support bereavement. Evidence of need for less ‘formal’ counselling support for some people. Evidence of appropriate signposting to bereavement services for those who may not otherwise have accessed support.

Conclusion Compassionate Neighbours are in a unique position to provide support due to their personal relationship with the deceased. CNs can be especially effective when referrals target those with pre-bereavement risk assessment needs. Compassionate Neighbours are a resource to increase the hospice’s bereavement capacity. The programme has developed a community-led response to supporting those at the end of life, as well as the recently bereaved.

P-18 HOW COMPASSIONATE IS YOUR WORKPLACE? SUPPORTING LOCAL BUSINESSES TO BE COMPASSIONATE WORKPLACES

Jenni Homewood. St Helena Hospice, Colchester, UK

Background The impact of the COVID-19 pandemic highlighted that many organisations needed to review their practices to support their workforce facing loss, grief and bereavement. The Chartered Institute of Personnel and Development states ‘A compassionate approach is vital to remain connected, mentally healthy, and productive while we battle through the challenges we face at work and beyond’ (The role of compassion in the workplace. 2020). Research highlights the importance of compassion in the workplace following a bereavement to ensure retention of staff and healthy mental wellbeing (Marie Curie, 2021; Hospice UK. Compassionate Employers workplace support [online]). It was recognised that developing training would be beneficial for organisations to support compassion in their workplace.

Aims To develop a training session that engages employers to support and guide their workforce during life’s most difficult moments. To deliver the training to external organisations and businesses. To support a compassionate communities approach to improve end of life care and support to all.

Methods Training was developed using a multi-disciplinary approach, specifically to support and guide local business workforces by:

- Providing a framework to understand loss, grief, and the impact of bereavement.
- Developing empathetic conversations.
- Improving management of staff and colleagues with kindness.
- Promoting compassionate leadership culture.
- Providing resources for policies, wellbeing, and guidance.

Results Training is being delivered to a range of organisations. The responses and feedback provided after attending this has been very positive:

- 100% of participants agreed their understanding of a compassionate approach in the workplace has increased.
- 100% of participants recommended that other organisations attend this training.

Conclusion 85 attendees from at least ten different workplaces have completed the training so far, with the unanimous message being that all workplaces should implement a compassionate approach to grief and bereavement. The outcome shows that hospices can effectively influence the workplace culture to become compassionate workplaces.

P-19 ABSTRACT WITHDRAWN

P-20 EYE MOVEMENT DESENSITISATION AND REPROCESSING

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10.1136/spcare-2023-HUNC.41

Background Traumatic and sudden loss can result in trauma symptoms such as nightmares, flashbacks and avoidance. These symptoms can disrupt natural grief processes (Murray. J EMDR Pract Res. 2012, 6(4):187–91). Eye Movement Desensitisation and Reprocessing (EMDR) is an 8-phase evidence based therapy that addresses the past, present and future impact of traumatic memories (Shapiro. Eye movement desensitization and reprocessing (EMDR) therapy: basic principles, protocols, and procedures. 2018.) The Family Support Team regularly see clients with bereavement related trauma symptoms. NHS mental health services may be unable to respond in a timely way (Royal College of Psychiatry, 2020).

Aims To explore the provision of EMDR within a hospice setting.


Results Since February 2022, 17 clients were assessed for EMDR. Ten completed active trauma processing (phases 1–8). Four are currently in phases 1–2 (history taking and preparation) and are likely to proceed to Phases 3–8, active trauma processing. Further, we have identified four clients with high levels of dissociation (Leeds, Madere, Coy. J EMDR Pract Res. 2022, 16(1):2022). In total 15 memories were processed with an average Subjective Unit of Disturbance (SUD) of 7.4 (On a scale of 0–10 where 10 is the highest disturbance possible). After EMDR processing this came down to an average of 0.7.

Conclusion Evaluation of EMDR shows a significant positive contribution to the wellbeing of bereaved clients. Client feedback was universally positive; “It really works doesn’t it?” (Client, Jun. 2022). This was the case even where EMDR could not be delivered in time limited setting due to the presence of a high degree of dissociative symptoms. Systematic use of outcome measures and a planned piece of research would strengthen the evidence for the provision of EMDR.