Parallel session 3.1 – Workforce spotlight; upskilling and resourcing
(Tuesday 7 November 2023, 10:45 – 12:00)

**0-09 WHEN LESS IS MORE – THE POSITIVE IMPACT OF LOW-FIDELITY SIMULATION IN A HOSPICE SETTING**

Vikki Rata. Sarah Ireland, St Margaret’s Hospice, Taunton/Yeovil, UK
10.1136/spcare-2023-HUNC.9

**Background** Simulation is considered a mainstay methodology for healthcare education (Jeffries. Simulation in nursing education: From conceptualization to evaluation. 2020), however, it has been under-utilised in end of life care (Bassah, Seymour, Cox. BMC Palliat Care. 2014; 13(1):1–0). Challenges exist surrounding the design of end of life simulations in non-traditional environments who lack ultramodern equipment and space to run high fidelity simulations. High fidelity simulation is often pursued by the simulation community in the belief that it leads to greater learning (Carey & Rossler. The how when why of high-fidelity simulation.) Simulation, however, is a technique not a technology (Gaba. BMJ Qual Saf. 2004; 13(S1): i2–10), and there is significant evidence to suggest that low fidelity simulation may be superior (Massoth, Röder, Ohlenburg, et al. BMC Medical Educ. 2019; 19:1–8) as it is less anxiety-provoking and leads to a less burdensome cognitive load for participants (Lapière, Arbour, Maheu-Cadotte, et al. Simulation & Gaming. 2022; 53(5):338–63).

**Aims** To design and deliver a low-fidelity simulation programme for roll out across the hospice, with relevant subject matter that engages both our clinical and non-clinical teams across the organisation, leading to clear learning.

**Methods** A rolling simulation programme with sessions at least twice a month was run from March 2022 to Dec. 2022. Our sample was 160 participants who took part in 29 simulations. Prior to the beginning of the simulation programme, baseline data was collected via questionnaire. After 10 months of simulation implementation, the questionnaire was repeated to analyse the impact of low- fidelity simulation on the organisation.

**Results** Baseline questionnaires showed 35% of the organisation had never heard the term ‘simulation’, and over 40% felt anxious around simulation. Following participation in simulations, the repeat questionnaire showed awareness of simulation within the organisation had increased to over 90%. Anxiety around simulation participation dropped by 10%, and we saw a 30% increase in the confidence of staff to undertake challenging conversations. Based on our significant findings, we also developed Cards against Calamity – an end of life simulation game – and began to share this with other hospices.

**Conclusion** Low-fidelity end of life simulation can be used with positive effect for clinical and non-clinical staff in the hospice setting.

**0-10 EMBEDDING PALLIATIVE EDUCATION AND LEARNING INTO CARE HOMES: A PROSPECTIVE PILOT STUDY OF OBSERVATIONAL FEEDBACK AND ROLE MODELLING**

Wendy Freeman, Nicky Wood. Isabel Hospice, Welwyn Garden City, UK
10.1136/spcare-2023-HUNC.10

**Background** The Ambitions for Palliative and End of Life Care (2021) highlight the need for all staff to be prepared to care. This includes ensuring staff working in care homes can support their patients’ palliative care needs. Palliative education is a good first step to ensure this quality care and prevent inappropriate admissions to hospital from care homes echoed in a report by Public Health England (2014) which noted increases in care home deaths and called for training in end of life care recognition. But how do we guarantee this education is embedded? Bandura’s social learning model (1986) highlights the importance of learning within the care setting.

**Aims** This pilot study aims to harness an educational approach which will consist of observational feedback and role modelling. Intention is to give real time education that will be embedded.

**Methods** A pilot has been designed taking place from May 2023 to June 2023. The care home educator gained agreement of two homes to deliver this pilot over two sessions. The educator will create a transparent real-time observational and role modelling approach. Feedback will be offered to individuals and overall, to the care home. Consent has been obtained from both homes to conduct this pilot. All learning will be documented within an observational template collating evidence of observations and resulting learning. Embedding of learning will be monitored on subsequent sessions. This evidence will be reviewed to highlight themes and findings. All evidence will be anonymised.

**Conclusion** A observational and role modelling approach could allow embedding of real time learning into practice. The aim is to ensure all care home staff are prepared to give high quality palliative care to their residents. This pilot aims to provide evidence to allow further such initiatives within other care homes.

**0-11 FUTURE-PROOFING THE PALLIATIVE CARE CLINICAL NURSE SPECIALIST WORKFORCE**

Sue Griffith, Alison Gray. Farleigh Hospice, Chelmsford, UK
10.1136/spcare-2023-HUNC.11

**Background** The shortfall in health care professionals at all levels has been accentuated in the specialist palliative care workforce recently (Buchanan & Campbell. BMJ. 2013; 347: f6201). Internationally, this is described as reaching a ‘crisis’ (Mahase. BMJ. 2023; 380: 713), whilst simultaneously, the population needing palliative care is increasing (Sleeman, de Brito, Etkind, et al. Lancet Glob Health. 2019; 7:e883–92). Retirement of Clinical Nurse Specialists (CNSs) led to unfilled