

Aims To review the literature around ‘uncertainty’ in palliative care social work. To understand the perspectives of palliative care social workers, drawing on their experiences of dealing with uncertainty. Do they confidently hold positions of ‘safe uncertainty’ with patients and families? What are the benefits of doing so? Why is the pull of ‘safe certainty’ so strong and how can we overcome this as professionals?

Methods A mixed methods approach consisting of a literature review followed by a focus group (n=8) will be used to explore the shared views and experiences of palliative care social workers (May – June 2023). A reflexive thematic analysis (Braun, Victoria. Thematic analysis: a practical guide. 2021) will then be used to identify themes and patterns (July 2023).

Results The results of the literature review will be used to develop a set of focus group questions. Following the analysis stage, initial results will be shared with the participants so they can comment on their descriptive validity and reliability. Any feedback will be incorporated into the final write-up.

Conclusion It is hoped that the findings will help palliative care social workers to define their unique contribution to end-of-life care more accurately, to not only support their own sense of value and identity, but to help them share it with other members of the multidisciplinary team.

P-142 HOW MIGHT THE UNDERSTANDING AND PRACTICE OF SPIRITUAL INTELLIGENCE (SQ) IMPROVE HOLISTIC CARE?

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Background Spiritual intelligence (SQ) – ‘The intelligence with which we address and solve problems of meaning and value’ (Zohar & Marshall. *Spiritual Intelligence: the ultimate intelligence*. 2000). There is a growing awareness in the commercial world of the benefits of a spiritually intelligent workforce, and a number of training courses are now available. However, in a hospice setting SQ has yet to gain a wide understanding. Such an understanding can be useful in developing the health-care workforce (Price. *Nurs Manage*. 2008; 15(5): 28–33), help clinicians deliver good spiritual care (Karimi-Moonaghi, Gazerani, Vaghee et al. *Iran J Nurs Midwifery Res*. 2015;20(6):665–9), and enable leaders to take a soul-centred approach to their work, functioning from a sense of inner peace (Wright. *Nurs Stand*. 2012; 26(41):18–20). SQ has been shown to improve the efficiency of organisations and it is thought that, within a hospice, it has the potential to help the workforce focus on a shared purpose, bridge the clinical/non-clinical divide, improve job satisfaction (Heydari, Meshkinyazd, Soudmand. *Iran J Psychiatry*. 2017;12(2):128–133) and make burnout less likely (Khosravi, Nikmanesh. *Iran J Psychiatry Behav Sci*. 2014;8(4):52–6). Spiritual Intelligence could be seen as a reimagining for the twenty-first century of the spiritual roots of the hospice movement.

Aim To raise awareness of SQ and to grow a more spiritually intelligent workforce within a hospice setting.

Methods We have built the concept of SQ into our spiritual care training of staff and volunteers.

The Head of Spiritual Care uses the concept in inductions for staff.

Conclusions SQ has proved to be extremely helpful in explaining what spiritual care is, a notoriously difficult thing to define. Clinicians have grown in confidence in delivering spiritual care and in understanding distinctions between different support services. Referrals to the Spiritual Care Team come more regularly from those who have been exposed to the concept of SQ. SQ as a working model has improved the job satisfaction of the Spiritual Care Team enabling them to have more clarity about what they do.

P-143 IMPLEMENTATION OF THE RESPONDING TO URGENCY OF NEED IN PALLIATIVE CARE (RUN-PC) TOOL TO TRIAGE PATIENTS FOR HOSPICE INPATIENT BED

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It is estimated that there will be a shortfall of 40,000 nurses in the United Kingdom between 2023–24 (Nuffield Trust. *Closing the gap: Key areas for action on the health and care workforce*. 2019). Therefore it is imperative that the Right patient is admitted at the Right time in the Right environment. The hospice has 12 specialist beds, and they receive between 23–36 (median 29.5) referrals per month, admitting 14–22 (median 19) with length of stay between 1–51 (median 26) days. If all patients were admitted, we would need a total of 14 beds.

Aims To admit patients in a timely manner to the inpatient unit by the implementation of a triage tool. To triage patients based upon their symptom burden by incorporating the integrated palliative care outcome scale (IPOS) into the triage tool. To provide education to the two main hospice referrers to utilise the RUN-PC tool as part of their referral.

Jun. -Jul. 2022. Literatures search around hospice triage tools. Regular stakeholder meetings with hospice staff, board of trustees, community and hospital palliative care teams. Aug. 2022. Phase one of RUN-PC triage tool implemented. Sept. 2022. Phase two, incorporating IPOS into the RUN-PC tool. Monthly figures were collected based upon patients admitted to the IPU based upon the RUN-PC score.

Results

Abstract P-143 Table 1

Month	Number referred	Number admitted	Mean Length of time on hospice Waiting list (days)	Admitted within RUN PC target times	Percentage Target met within RUN PC times
January 2022	29	13	4.84	-	-
February 2022	28	15	3.06	-	-
March 2022	27	16	5.86	-	-
January 2023	28	20	3.05	12	60%
February 2023	23	17	2.25	14	65%
March 2023	28	22	2.68	20	68%

Conclusion Implementation of the RUN PC tool utilising the patients' IPOS scores demonstrates that patients are waiting on the hospice waiting list for a shorter period of time. The RUN-PC allows us to identify the patients with the greatest urgency and we can respond accordingly to their need.

P-144 TO ADMIT OR NOT TO ADMIT, THAT IS THE QUESTION – DEVELOPING A HOSPICE INPATIENT UNIT NURSING ACUITY SCORE TO GUIDE SAFER ADMISSION DECISIONS

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Background Twice daily admissions meetings at 9am and 3pm are held between the inpatient, community nursing and medical teams at our hospice. To date, the decision to admit is based on bed availability alongside staffing numbers. However, the complexity of the current inpatients is not always objectively considered, and on occasion challenges relationships between the teams. A literature search was carried out to explore current use of acuity/dependency scores and identified an Australasian hospice nursing acuity tool. This was subsequently adapted for our unit.

Aims To create a tool which gives an objective view of the complexity of the patients in a hospice inpatient unit. To use this tool in admissions meetings to aid communication and decision making around capacity to admit. To evaluate the use of this tool after a pilot. To review our inpatient admission guidelines accordingly.

Method Each morning before 9am and each afternoon before 3pm, the complexity score will be calculated by the nurse in charge of the inpatient unit using the acuity tool. This score will then be shared in the admissions meeting, alongside bed and staffing status. It is anticipated that this score will be most useful in the decision of whether or not to admit emergency same day inpatient requests, which understandably cause heightened concern amongst staff. The complexity score will be an objective measure of whether the admission can be achieved safely.

After three months of using this in the admissions meeting, a survey will be sent to staff members involved in the admissions process to understand whether this has been helpful in understanding the ward complexities and aiding decision making in admissions meetings.

Results Interim informal feedback from staff is positive.

P-145 SAFE STAFFING IN A HOSPICE INPATIENT UNIT

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Background Despite the NHS having safe staffing reporting requirements in place since 2014 (NHS England. How to ensure the right people, with the right skills, are in the right place at the right time: a guide to nursing, midwifery and care staffing capacity and capability [Internet] 2013; Francis. The Mid Staffordshire NHS Foundation Trust Public Inquiry [Internet] 2013), this has not been applied to hospices. There are also no specific staffing standards for hospice inpatient units.

Aims To provide quality assurance on staffing levels within the hospice inpatient unit. To obtain intelligence on bed occupancy, demand, and capacity, and our ability to support the wider health and care system in relation to specialist palliative and end-of-life care.

Method A retrospective audit was performed over 6 months (Nov. 2022 to Mar. 2023) collecting actual nursing and health care assistant staffing numbers against planned staffing levels. This was reviewed against numbers of patients and the standard calculation for Care Hours Per Patient Day (CHPPD) was applied.

Results We were safely staffed within our budgeted staffing establishment for registered and unregistered workforce, and expectations on hours filled. Nights were better staffed than days due to more set patterns of working for that group of staff. There was an average of 16 CHPPD received by patients and their families. Lower staffing levels aligned with lower bed occupancy, suggesting we flexed our staffing to meet clinical need and demand on services. There was no impact on our ability to achieve other deliverables, including time from referral to admission.

Staffing levels demonstrate that we could have potentially taken more admissions on occasions, had the demand for inpatient beds been present showing we can support the systems in which we operate.

Discussion We recognise that safe staffing is only a tool, and for it to be fully effective (Royal College of Nursing. Impact of staffing levels on safe and effective patient care: literature review [Internet] 2023), it needs to be reviewed alongside additional information such as adapted dependency tools (NHS England. Safer nursing care tool [Internet] (no date)) and capacity and demand information. We have committed to continuing to review this information, including an annual report, and will adapt other national tools for our use as they become available.

P-146 RELEASING TIME TO CARE IN A PALLIATIVE CARE TEAM: A TIME AND MOTION STUDY

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Background Like many areas, COVID-19 had a heavy impact on our inpatient and community services (Cross Party Group on Hospice and Palliative Care. Inquiry: Experiences of palliative and end of life care in the community during the COVID-19 pandemic. 2023). With increasing numbers of referrals, complex patients and recruitment challenges we needed to consider how we could work effectively and to release time to care and be fit for the future (Warren. The health and care workforce: planning for a sustainable future. King's Fund. [Internet]; [posted 2023 November 24].

Aims To understand how the hospice palliative care multidisciplinary teams utilise their clinical time with a focus on identifying any inefficiencies and to evaluate time currently spent on direct patient care.

Methods Activities were self-reported by members of the clinical teams either manually or electronically using a Paper Time Study Worksheet (Institute for Healthcare Improvement. Paper Time Study Workshop [Internet]). Data was collated and themes analysed by the Clinical Quality Team.