

procedures to make accessing support easier for employees, including updating our guidance following a bereavement.

What difference have we seen? Feedback from employees has been positive and employees are coming forward to let us know that they have additional responsibilities outside of work.

Managers have said they feel more confident in having conversations with employees about the support they might need following a bereavement.

P-236 EXPLORING THE EXPERIENCE OF HEALTHCARE PRACTITIONERS PROVIDING COMMUNITY PALLIATIVE CARE OUT-OF-HOURS

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10.1136/spcare-2023-HUNC.256

Background Community palliative care outside normal working hours is provided by both specialist palliative care professionals and primary/community health professionals. Understanding their experience of delivering care is important, not least in terms of impact on the quality of patient care (Maben, et al. Patients' experiences of care and the influence of staff motivation, affect and wellbeing. Final report. NIHR Service Delivery and Organisation programme; 2012).

Aim To explore the experiences of professionals delivering community palliative care out-of-hours.

Methods Qualitative interviews were conducted with professionals providing community palliative care, purposively sampled by discipline, specialist/primary, and model of care. Data analysis used reflexive thematic analysis.

Results 28 interviews undertaken with 39 participants including specialist palliative care (n=21), primary/community care (n=15). Three main themes were: (1) staff distress, (2) over-stretched resources (3) moral comfort. Most examples of distress were in the context of struggling with over-stretched and limited resources, and being unable to provide the care that aligned with their professional values. When expressing satisfaction that care had been provided well (moral comfort) it was in relation to going 'above and beyond', or where they had more control over time spent with patients, and could deliver the care needed.

Discussion Professionals providing palliative care may have good strategies to deal with the distressing nature of their work, but organisational factors can increase distress (Goodrich, Harrison. Resilience: a framework enabling hospice staff to flourish in stressful times. Hospice UK, 2015), especially when resources (time, capacity, personnel) are insufficient. This constitutes 'moral distress' (being in a situation in which one is constrained from acting on what one knows to be right – Jameton. *AMA J Ethics*. 2017; 19(6): 617–628).

Conclusion Most experiences of moral distress for professionals stemmed from insufficient healthcare resources to manage care needs at the end of life. This was most evident for district nursing services. Service leads and commissioners must listen carefully to experiences of professionals trying to provide high quality care, as well as patients and families.

Funder: Marie Curie Research Grant MCRGS-20171219–8011

P-237 ABSTRACT WITHDRAWN

P-238 ESTABLISHING SUPERVISION FOR ALL STAFF AND VOLUNTEERS IN A HOSPICE

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10.1136/spcare-2023-HUNC.257

Background Regular supervision has been shown to increase the level of satisfaction of staff within their work environment, through increased job satisfaction and wellbeing (Bégar, Severinsson. *J Nurs Manag*. 2006; 14(8): 610–616). It is recommended by the Care Quality Commission (CQC. Supporting information and guidance: supporting effective clinical supervision. 2013) and the Nursing & Midwifery Council (NMC. Clinical supervision for registered nurses. 2008). Supervision is not always practised in a planned and supportive manner (Turner, Hill. *Ment Health Nurs*. 2011; 31(3): 8–12), particularly in non-clinical areas (Rothwell, Kehoe, Farook, et al. *BMJ Open*. 2021; 11(9):e052929).

Aims To introduce a robust system of supervision encompassing all staff and volunteers within the organisation. We recognise that this may involve different models of supervision, but sessions should take place at least quarterly, be appropriately recorded, and auditable.

Method A baseline survey was carried out to establish the current level of supervision taking place. A supervision policy was developed, and education supporting this was provided, as well as education for potential supervisors. Implementation planned in three stages, to clinical staff, non-clinical staff, and volunteers. An audit was planned for three months after implementation, to check that staff have a named supervisor and to measure the take-up of supervision. A second audit, to evaluate the quality of the supervision, will take place six months later.

Results The baseline audit showed that 13% of clinical staff rarely or never had supervision. Notes were taken in 50% of cases. The most common topics discussed were around wellbeing and development. The first post-implementation audit is underway. A stratified random sample of staff are being contacted to see evidence of supervision having taken place. Supervision trees will be examined to ensure that all staff have named mentors. A second post-implementation audit is planned for November. This will focus on the quality of supervision taking place.

Conclusions Our baseline audit demonstrated that most clinical staff have some form of supervision, although it is often irregular and varying in quality. Most clinical staff see the value of more regular supervision. We have now implemented a more robust system for supervision, which is currently being audited.

P-239 EMBEDDING THE ROLE OF THE PROFESSIONAL NURSE ADVOCATE (PNA) INTO THE HOSPICE ENVIRONMENT

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10.1136/spcare-2023-HUNC.258