Mental Capacity and Safeguarding training is mandatory for most staff and yet human rights, which are the foundation for both, has been overlooked.

To meet this gap in practice, Sue Ryder worked with the British Institute of Human Rights to develop a Practitioners Guide. Following the learning from the demise of the Liverpool Care Pathway, a grant was secured from the Burdett Trust for Nursing to deliver a three year training programme.

Aim To educate and empower the workforce to feel more confident in embracing human rights as an integral component to end of life care, by building on existing knowledge and experience, increasing awareness of how human rights can be used to aid decision making and ensure human rights values are at the heart of personalised care.

Methods Sue Ryder is delivering a three tiered training programme: half day workshops for the non-registered workforce; 1 day workshops for the registered workforce; two-day workshops for train the trainers to enable sustainability. Nottingham Centre for the Advancement of Research in End of Life Care will evaluate the training using a longitudinal mixed methods design, using pre and post training confidence questionnaires and interviews.

Results We have delivered four workshops and educated 49 practitioners to May. A further 26 workshops are planned. We project to have educated 444 practitioners, including 24 trainers, by the end of 2017. Qualitative feedback has been overwhelmingly positive.

Conclusion Everyone working in end of life care should understand their human rights responsibilities in order to deliver personalised care. The Sue Ryder training programme will increase practitioners understanding and confidence to fulfil their duty.

P-152 THE LEGACY OF THE NORTHERN IRELAND CONFLICT IN PALLIATIVE CARE

Brendan O'Hara. *All Ireland Institute of Hospice and Palliative Care, Dublin, Ireland*

10.1136/bmjspcare-2017-hospice.177

Background Understanding the impact of the Northern Ireland 'Troubles'/conflict' on a particular area of health care – palliative care – which has received little, if any, previous research focus. The research was carried out for a dissertation submitted in partial fulfilment for the degree of Master of Philosophy.

Aim(s) To investigate how the legacy of the Northern Ireland conflict may be encountered by professionals providing palliative care – to those they are caring for who may have been directly/indirectly affected (victims/survivors) and those involved in inflicting damage, death and/or injury. To investigate how the distinct context of Northern Ireland has impacted on palliative care practice.

Method Interviews were carried out with nine professionals with experience and interest in the provision of support to people with palliative care needs. Participants reflected experience across a wide geography of Northern Ireland including the region's two major cities, four of the region's five health and social care trust areas, and four of the five inpatient hospice facilities. Participants included: three nurses; two doctors; a social worker; a chaplain; a complementary therapist and a welfare officer.

Results This research opened up a dialogue between the disciplines of peacebuilding and palliative care. The language of legacy, narrative, life story and peacebuilding is one which the palliative care community understands.

The impact of the Troubles has had an effect on the delivery of palliative care, through the attitudes and influences on those who provide the care and those they care for.

Conclusion The influences of the religious divide, the silencing, and the traumas of the past are not something that the care-giver is apart from – they are very much influenced by them. The sensitivities around the Catholic/Protestant divide, the silencing, and restricting opportunities to talk about 'Troubles'-related trauma, could prevent people from having appropriate palliative care.

P-153 STOPPING TRAFFIC

Beth Ward. *Demelza Hospice Care for Children, Sittingbourne, Kent, UK*

10.1136/bmjspcare-2017-hospice.178

The United Kingdom is one of the most prominent destination countries for people to be trafficked to in Europe. An estimated 20 000 people are trafficked into (and throughout) the UK every year, with the majority of victims coming from, arguably, the poorest countries. This presentation outlines the case of a baby (aged two days) who was referred to a children's hospice for end of life care. Within the context of the direct work, it became apparent that the mother had been trafficked into the UK and had experienced periods of homelessness. The children's hospice social work team worked intensively to seek support for this mother, but due to high service demand, and the mother's questionable residency status, no statutory organisation was willing to engage. The NSPCC helpline recommended the Salvation Army, a Christian church and registered charity and this partner charity offered an assessment visit by their Anti-Human Trafficking Team's First Responder Co-ordinator and plans were subsequently put in place for the team to take on the supporting role after the baby's death. As well as focusing on safeguarding this extremely vulnerable family unit, it was essential that this mother had the opportunity to bond with her baby and to, albeit briefly, positively experience motherhood. The baby died peacefully, aged seven weeks. Pre-death planning had clarified the family's customs and rituals, which dictated that the parents did not attend the funeral and therefore, two members of the children's hospice team, together with two representatives from the Salvation Army were present, as a mark of respect. A year on, the mother continues to receive concerted support from the partnership charity, enabling her to preserve her dignity, reflect, recover and rebuild her life.

P-154 THE VALUE OF SILENCE IN END-OF-LIFE SPIRITUAL CARE: CONNEXION, COMPANIONSHIP, POTENTIAL FOR CHANGE

Lynn Bassett, Amanda F Bingley, Sarah G Brearley. *Lancaster University, Lancaster, UK*

10.1136/bmjspcare-2017-hospice.179

Background At the end of life silence seems to take increasing prominence in encounters between professional caregivers, patients and their family members but its value as an element

of spiritual care has been little explored. Whilst silence lends itself to spiritual and existential dimensions of care, unfamiliarity with the phenomenon can lead to anxiety or avoidance. Greater understanding could support caregiving practice.

Aim To gain deeper understanding of silence as an element of palliative spiritual caregiving.

Methods A two-phase phenomenological approach, using heuristic inquiry and hermeneutic phenomenology. Data were gathered through self-inquiry and unstructured interviews with 15 palliative care chaplains. A descriptive and hermeneutic analysis facilitated explication of the lived experience to produce an interpretation of the nature, meaning and value of silence in end-of-life care.

Results 'Spiritual caregiving silence' emerged as a way of being with another person, complementary to speech and non-verbal communication, in which the caregiver takes both an active and participative role. This demands engagement and commitment. It evokes a sense of companionship and connexion and creates accompanied space that allows the other person to be with themselves in a way that they may not be able to be alone. It provides a means of and a medium for communication that is beyond the capacity of words and a supportive environment when words fail. Silence has the potential to enable change by creating opportunity for acknowledgment, expression and articulation of truth. Chaplains observed outcomes of acceptance, restoration and peace.

Conclusions Spiritual caregiving silence is a person-centred phenomenon that supports the wellbeing of patients at the end of life and their family members. Understanding has been deepened through the interpretive and reflexive phenomenological process drawing upon cross-disciplinary knowledge and specialist experience. Findings may find resonance with other caregivers, to stimulate further reflection and discussion and support clinical practice.

P-155 SILENT VOICES: BARRIERS AND SOLUTIONS TO MEN ENGAGING IN PALLIATIVE CARE GROUP SUPPORT

Matt Jackson, Sarah Popplestone-Helm. *St Richard's Hospice, Worcester, UK*

10.1136/bmjspcare-2017-hospice.180

The hospice supports patients and families through a variety of group work programmes. However, engaging men in groups has proved challenging. A common trend was that males were uncomfortable and unwilling to participate in support if they felt under pressure to talk about their thoughts and feelings.

To increase male engagement, a gardening group was set up at the hospice in partnership with Prostate Cancer UK. Male patients met weekly in the hospice gardens, participating in light gardening whilst taking time out and sharing their experiences.

The group has grown and evolved over two years to twenty-five men attending weekly. They have developed a close bond, an ethos of care and support and a sense of fun, humour and enjoyment. One member described the group as 'my opportunity to be with my friends, I can share anything, laugh, cry, be silent, be silly, we understand each other.' The group evolved to include trips out, guest speakers and recently members have visited other groups and organisations sharing their experience of their group. A day is planned for the

summer for men with life-limiting illnesses, encouraging new members to engage in palliative care group support.

The success of this men's group has led the hospice to consider why it has succeeded where others have not. Interviews and questionnaires with the members of this group, has enabled a greater understanding of barriers and concerns preventing men from engaging in group support. The group is self-directed and passionate; these men are articulate and passionate, willing to speak at national level to encourage others to participate in group support. They are determined to ensure longevity for the men who come after them, to be a voice for and to encourage 'the silent men', offering opportunity and durability for male groups such as theirs.

P-156 DEVELOPMENTS IN PRESSURE ULCER MANAGEMENT AND PREVENTION

Wendy Green, Kevin Thompson, Miranda Fairhurst. *The North London Hospice, London, UK*

10.1136/bmjspcare-2017-hospice.181

Despite the risk assessment and care planning systems and processes in place on our In Patient Unit (IPU) pressure damage is the cause of approximately 53% of incidents reported each month.

National benchmarking data suggests we may admit more patients with pressure ulcers and also acquire more pressure ulcers than other hospices of a similar size, but this observation warrants further investigation. It is possible we admit more patients for end of life care than other similar sized hospices and this would make patients more susceptible to the development of pressure ulcers.

The majority of acquired pressure ulcers are categorised as unavoidable.

Aims

- Ensure best practice is followed
- Ensure comprehensive implementation of recommendations arising from root cause analysis investigations
- Eliminate the incidence of avoidable acquired pressure ulcers on IPU.

Approach Since March 2016 we have improved oversight and reporting of pressure ulcers and recognised that this area of practice required improvement. In January 2017 we recruited a senior registered nurse to work two days a week on IPU as Tissue Viability Nurse. His priorities are to:

- mentor the IPU team
- develop links with tissue viability nurses in the community
- undertake baseline pressure ulcer management audit using Hospice UK tool.

Evaluation Results from the baseline audit indicate good levels of compliance with the existing risk assessment and care planning processes, but scope for development in terms of the assessment of risk factors relating to nutrition, cognitive impairment and sensory loss. There is also a need for an appropriate patient information leaflet.

Conclusion Review and analysis of pressure ulcer incidents will continue on a monthly basis. The Tissue Viability Nurse will develop the risk assessment process further and design and introduce an appropriate patient leaflet.