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

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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

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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.