

**P-151 EMBEDDING DIGNITY INTO PRACTICE**Emily Dobson. *Saint Michael's Hospice, Harrogate, UK*

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**Introduction** The national commitments framework focussed on six key themes. Within these we decided to work on one 'maximising comfort and wellbeing' through the lens of dignity. We undertook a scoping exercise where we reviewed ten different patient notes to look at what we understand dignity to be and how this may be translated for patients, relatives, friends and carers. We identified that there were six tenets which relate to a person's feeling of dignity in the inpatient unit:

- Pain and symptom control;
- Loved ones cared for;
- Pragmatic concerns taken care of e.g. housing;
- Place of care established – often in line with preferred place of death;
- Control – being able to exercise choices made;
- Respect for choices made.

We identified that these six tenets working in tandem enabled a person to consider that they have dignity at the end of their life. Based on the identification of these six tenets we drew together a project.

**Objectives**

- value the uniqueness of every individual;
- uphold the responsibility to shape care around each individual;
- value communicating with individuals that are meaningful to them;
- recognise and respect how an individual's dignity may be affected when supported with their personal care;
- recognise that that an individual's surroundings and environment are important to their sense of dignity;
- value workplace cultures that actively promote the dignity of everybody;
- recognise the need to challenge care that may reduce the dignity of the individual.

**Current workplans**

- Adapting our care plans;
- To disseminate training on Transactional Analysis;
- To create a policy/procedure around challenging dignity which would allow care plans to be challenged where they do not feed into the established six tenets identified above.

**P-152 PERSON-CENTRED CARE: FEASIBILITY AND ACCEPTABILITY OF THE SUPPORT NEEDS APPROACH FOR PATIENTS (SNAP)**<sup>1</sup>Carole Gardener, <sup>1</sup>Gail Ewing, <sup>2</sup>Morag Farquhar. <sup>1</sup>University of Cambridge, Cambridge, UK; <sup>2</sup>University of East Anglia, Norwich, UK

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**Introduction** The Support Needs Approach for Patients (SNAP) is a complex intervention to facilitate delivery of person-centred care in progressive conditions, such as chronic obstructive pulmonary disease (COPD). SNAP consists of:

1. The SNAP tool: designed for purpose (Gardener, Ewing, & Farquhar, 2019; Gardener, Ewing, Kuhn & Farquhar, 2018);

Gardener, Ewing & Farquhar, 2018) comprising 15 evidence-based validated questions to help patients consider areas where they may need more support;

2. The SNAP approach: a needs-led conversation between the patient and healthcare professional (HCP) to express, prioritise and address unmet support needs identified through the patient-completed tool.

Feasibility and acceptability of the SNAP intervention now needs exploring in clinical practice.

**Methods** HCPs from three care settings (primary, community and secondary) were recruited to the SNAP pilot in the East of England. SNAP-trained HCPs implemented SNAP with patients with COPD (n=56) over a four month period and participated in monthly qualitative interviews to monitor tool use and identify modifiable barriers to SNAP delivery. Purposively sampled patients (n=20) who received the intervention were interviewed about their experience. End of pilot focus groups with participating HCPs explored barriers and facilitators to delivering SNAP in clinical practice. Normalisation Process Theory (May & Finch, 2009) guided data collection and analysis.

**Results** SNAP was considered acceptable and feasible by HCPs and acceptable to patients with COPD, with some variation by setting. This variation may relate to the nature of the setting and/or HCP investment in SNAP which may compromise intervention fidelity. HCPs identified three challenges for implementation: 1) limited consultation time, 2) delivering SNAP to non-English speakers, and 3) belief amongst some HCPs that they 'already do this.' SNAP enabled new needs-led conversations (including future care conversations) and consequent actions, even where patient-HCP relationships were well-established.

**Conclusion** SNAP appears acceptable and feasible for use in practice with potential benefits to patients with COPD across a range of care settings. Findings are informing SNAP training refinement and indicate that formal evaluation of SNAP is warranted.

**P-153 A HOSPICE-WIDE PROJECT TO DEVELOP AND SUPPORT MULTI-PROFESSIONAL PARTICIPATION IN CLINICAL AUDIT**Jean Levy, Rosie Chester, Chris Doyle, Gordon Glen, Joy Ross. *St Christopher's Hospice, London, UK*

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**Background** Clinical audit within the organisation was perceived as piecemeal and lacking focus: staff lacked motivation and/or confidence to carry out audits. A new programme was devised to inspire and enthuse staff to examine areas of interest, encourage ownership of improvement activities, build staff skills in audit, and to boost multi-professional team working. A project was established, involving clinical, managerial and other staff, focusing on a particular area (discharge).

**Aim** The project aimed to achieve:

- Greater staff involvement in clinical audit;
- A training programme to improve staff knowledge of and interest in clinical audit, and address the organisation's audit priorities;
- Identification of other priorities for quality improvement projects;