Methods A prospective, observational survey of language used in multi-disciplinary meetings over a two-week period across three hospices. Participants were blinded to data collection which was performed anonymously by one staff member on each site. The proportion of euphemisms were compared to 'd-words'.

Results Multidisciplinary teams were more likely to use the 'd words' (76%; n: 241) than euphemisms (24%; n: 75). There was variation between the hospices: 39% (n:50) compared with 17% (n:20) and 7% (n:5). This could be due to differences in staff or interpretation during data collection.

Conclusion Considering specialists in palliative care are heavily involved in discussions around death, it is unclear why 24% would opt to use euphemisms. Does this suggest fear within some professionals of talking about death openly? Are staff who use euphemisms amongst themselves more likely to use them with patients? Or by their use are staff exhibiting a sensitive approach to difficult issues? Further investigation is required to evaluate the use of euphemisms with patients and relatives and to compare across other healthcare settings.

P-43 EMPOWERING PARENTS OF CHILDREN TO BECOME A THERAPEUTIC AGENT OF CHANGE

Jolanta Martis. *ellenor, Northfleet, UK*

10.1136/spcare-2021-Hospice.63

Background During lockdown parents who have children suffering with life-limiting illness or who experienced grief had considerably reduced access to professionals and face-to-face working. Hospices were challenged to adapt a new way of working. Momentous events that so fundamentally impact our entire society lead us to re-examine our belief structures and ways of working.

Aim To provide parents with the tools to enable them to feel more in control when everything else seems without control. To help create emotional openings, paths to their child's world.

Methods Parents were asked to attend a block of 10 online sessions to help them strengthen the relationship by using 30-minutes structured playtime once a week, using a kit of carefully selected toys in their own home. Parents were provided with the guidance to help build the child's self-esteem, help the child learn self-control and responsibility. Providing dialogue, the parents were empowered to be a therapeutic agent of change for their child.

Results Written and verbal feedback indicated that parents felt more equipped to support and improve their parent/child relationship. The results support that the benefits of Child Parent Relationship Therapy (CPRT) may extend to the family system. They became more in control and prepared for the future on how to support their children. The parents valued flexibility in the approach.

Conclusions Our daily practices feel right and true to us, regardless of whether they have evolved to keep up with the pace of change. To initiate a new approach to current conditions, based on our experiences of COVID-19 and re-direction of support has been highly valued by patients and their families. However, they are not about making incremental changes that lead to new ways of doing things based on old beliefs. They are geared instead toward causing a total shift of perceptions, beliefs and thought process.

P-44 ABSTRACT WITHDRAWN

P-45 THE LIFE AND DEATH PODCAST

Helen Furnivall. *Ashgate Hospicecare, Chesterfield, UK*

10.1136/spcare-2021-Hospice.64

Background During the pandemic, the humanity of death has often been lost. In October 2020, Ashgate Hospicecare launched The Life and Death Podcast to humanise the process of dying by telling universal stories through local voices.

Aims To open up conversations around death, hospice care and what 'dying well' really means.

Methods We brought together givers and receivers of end-of-life care to have honest conversations around the importance of a dignified death. In each episode, we met a different pair connected by Ashgate as they reflected on their unique relationships and the reality of end-of-life care. We worked closely with Reform Radio, a non-profit community production company, to record and edit the series which launched during Hospice Care Week.

Results *'This morning I watched the funeral of a dear friend being streamed. Tonight, I was sent this podcast and it has helped calm my scrambled thoughts.'* This review, left during a national lockdown, demonstrates just how impactful this series has been. Another listener wrote, *'These are exactly the kinds of conversations we need to be having with each other, in order to become a society who can support each other through death and dying.'* Unbelievably, the series reached the top 100 charts on Apple Podcasts, has received over 100 5* reviews and 3,800 listens. The podcast's release also attracted local press coverage, including The Derbyshire Times, Hasland Magazine, Destination Chesterfield, Imagine Radio and BBC Radio Sheffield. The podcast has been so successful that we have launched a second series, featuring Kathryn Mannix and other special guests.

Conclusions The Life and Death Podcast has opened up conversations that many find difficult, highlighted the importance of good quality end-of-life care and brought comfort to listeners across the country and beyond.

P-46 BARRIERS TOWARDS PROVIDING EFFECTIVE SPIRITUAL CARE TO PALLIATIVE CARE PATIENTS

Syed Qamar Abbas. *St Clare Hospice, Harlow, UK*

10.1136/spcare-2021-Hospice.65

Introduction Spiritual care is an integral part of palliative care. However, there is evidence that providing effective spiritual care is not achieved in most settings (O'Brien, Kinloch, Groves, et al., 2019; Harrad, Cosentino, Keasley, et al., 2019). Spiritual care means different themes for different people. These can be related to the need for meaning and purpose, to love and feel loved, the need to feel a sense of belonging and the need to feel hope, peace and gratitude. For some people, it can be related to their faith. There are still data to indicate that patients with some faiths are not served by hospices as per their population ratio (Public Health England, 2016; Ahmed & Siddiqi, 2015; Currow, Ward, Plummer, et al., 2008).

Methods We held a seminar with the topic of 'Faith at the end of life', where we held focus groups with two questions: (1) What prevents healthcare professionals in providing effective spiritual care? (2) What can we do to change that?

Analysis and Results 63 healthcare professionals attended. They were from medical, nursing, spiritual care, social care and allied healthcare professional backgrounds. They were divided in to six groups and discussion was facilitated by an experienced professional. Themes about barriers were: lack of knowledge, lack of time and right environment, not having confidence in team members, lack of language, 'death denying culture', confusion between religion and spirituality, difficulty having an answer leading to avoidance, fear of offending, fear of communicating poor prognosis, communication skills and fear of own emotions. Themes to bring about changes were: training; identifying own spiritual needs; developing right language and communication skills; raising the profile of spiritual care; developing resources and websites, and regular reflection and support.

Conclusion Despite long-standing effort from the hospice movement, healthcare staff still struggle with the concept of spiritual care needs. Hospices need to develop targeted training programmes and reflection for staff and support non-hospice staff with resources and training.

P-47 'HOPE' – MAKING SPIRITUAL ASSESSMENT MORE MEANINGFUL

Mark Pringle, Gill Harvey. *Woodlands Hospice Charitable Trust, Liverpool, UK*

10.1136/spcare-2021-Hospice.66

Background On admission to Woodlands Hospice's inpatient ward, every patient has an initial assessment carried out by a nurse. A section of this assessment includes a psychosocial and spiritual component but this component was often not fully completed, sometimes resulting in delays to accessing appropriate personalised support for the patient. Our Pastoral Support Worker met with nursing colleagues and members of the Quality and Improvement team to discuss potential ideas for improving the assessment. They agreed we needed to look again at the process for assessing patients' spiritual needs and the supporting documentation.

Aims

- To support patients to identify what gives their lives meaning and purpose.
- To enhance each patient's experience of the admission process.
- Further develop holistic therapeutic intervention, individualised to each patient's needs.
- Support the improvement of mental health and wellbeing for every patient.

Methods

- Conducted a baseline of the original 'Psychosocial and Spiritual Assessment'.
- Spoke with patients and staff about how the assessment could be improved.
- Piloted a draft, patient-centred, inclusive spirituality assessment.
- Developed a spirituality care plan that reflected the needs of the patient, identified during the nurse admission assessment.
- Developed an e-learning module to support training for relevant staff.

- Re-audited the use of the revised spirituality assessment.

Results Following the results of the baseline audit which highlighted areas for improvement, we developed the 'HOPE' assessment model and accompanying care plan. The HOPE approach allows for an open-ended exploration of an individual's spiritual resources including their belief in organised religion, personal spirituality and beliefs, and their effects and subsequent evaluation.

Conclusion Supporting each patient's individual spirituality practice can be beneficial to their overall experience. The HOPE approach is particularly useful and important to understanding a patient's spiritual needs, enhancing their experience and can support the development of a personalised care plan.

P-48 INCLUSIVE SPIRITUAL CARE FOR ALL PEOPLE RECEIVING HOSPICE CARE

Martin Hill, Channele Wilson. *Havens Hospices, Essex, UK*

10.1136/spcare-2021-Hospice.67

Introduction The modern hospice movement was founded by Dame Cicely Saunders with a Christian religious ethos. Our spiritual care review showed society has changed while hospices remained mostly static. The review uncovered the following:

- Misconceptions about who hospice care is for, leading to inequalities in access.
- Belief, for many people, is something deeply personal and not dependant on religion.
- To avoid neglecting personal spirituality, hospice and spiritual care should be inclusive and proactive.
- Spiritual care was offered through a Christian Chaplaincy model. Patients declined with limited information about the alternative provision.

Aims

- Transition hospice spiritual care from a chaplaincy model to one inclusive of all religious and no religious beliefs.
- Clearly communicate inclusivity of spiritual care throughout the hospice to gain consistency in understanding.
- Present proactive inclusivity of spiritual care for all patients, family members, volunteers, and staff in the diversity of spiritualities today.
- Preserve formative values and ethos, from the Christian foundations of Havens Hospices.

Methods

- Be, speak, live spiritual care message in person and through communications.
- Produce policy and procedure for the breadth of the organisation.
- Recruit and train volunteers from diverse religious, spiritual and no affiliation.
- Listen and respond positively to people of all beliefs and none.
- Data analysis – demographic of patient intake compared against local census demographics.
- Self-audit against best practice guidance.
- Robust spiritual care review leading to spiritual care strategy.

Results

- Inclusive spiritual care increased through staff awareness.