Abstrats

**OA56** PERINATAL GRIEF AS A DEEPLY SOCIAL EXPERIENCE: PERSPECTIVES OF BEREAVED PARENTS

Joanne Clarke, University of Sydney, Australia

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**Background** Individual counselling and support groups are the most usual forms of support helping professions offer people who are bereaved. This can result in the rich social contexts of people’s lives being side-lined. Whilst the importance of social support is well acknowledged in the literature, it is frequently considered as axiomatic and not critically examined.

**Aim** This study explored how parents constructed their experiences of perinatal death and privileged their voices and perspectives.

**Method** Utilising a social constructionist, narrative approach, nineteen Australian women and men were interviewed within 4–24 months of the perinatal death of their baby. Participants were drawn from a community rather than clinical sample.

**Results** Bereaved parents clearly stated they required support from their social networks. However this was not always forthcoming. In the face of this, some turned to professionals and self help groups for support. Some found this helpful; many did not. Parents identified wanting support from their own parents, close family, friends and work colleagues. They wanted their social identity as parent affirmed and their experience acknowledged in everyday life.

**Conclusion** In addition to working individually with the bereaved when appropriate, professionals can contribute significantly to the wellbeing of bereaved parents by broadening their focus to providing support and education to their social systems: the ‘natural helpers’ in the parents’ social network. Shifting the gaze will in turn assist the social network to better offer support directly, something the bereaved state they want. It acknowledges that grief is a deeply social experience and not an individual one.

**OA57** THE DIGITALISATION OF DYING, LOSS AND GRIEF ON SOCIAL MEDIA CHANNELS

Mark Taubert, James Norris. Velindre NHS Trust, UK

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**Background** The internet and birth of social media channels have changed the way in which we deal with death, loss and grief forever. Our photo albums are now saved digitally and have changed the way in which we deal with death, loss and grief. Our photo albums are now saved digitally and have changed the way in which we deal with death, loss and grief.

**Aim** We will highlight how the digital landscape has changed to evoke thought and discussion around the subject of digitising death. They will explore the ethical and moral questions regarding end of life within the digital context. The role of the HCP will be examined in relation to social media and patient practice. All attendees will be provided with a number of simple tasks to carryout online. This will again provide a better understanding around the conversations that are occurring online and the digitisation of death.

**Method** An interactive 40 min workshop will be directed by us. This will conclude with a 20-minute discussion. Leaflets containing relevant tasks for HCPs to carryout online can be carried out after the workshop.

**Results**

- Understanding of the main social and digital channels that we (in the UK) use today.
- Understanding of how online channels have changed how we communicate and behave.
- The different ways grieving, remembering and mourning occurs online
- How death, grief and loss is different online
- Examination of how social media is breaking down the notion of death
- Reflect on how could/should HCPs and EOL professionals engage online in relation to EOL matters.
- Understanding how our digital footprint will ultimately become our digital legacy.

**Conclusion** Each participant/attendee will have a basic understanding of how death, grief and loss are addressed online within the UK. Examples of how different patients (especially children) are using social media in hospitals will be provided to help highlight the catalyst for change that social media has become.

**OA58** COMMUNITY CAPACITY DEVELOPMENT FOR ENHANCED HOSPICE PALLIATIVE CARE: EXPLORING THE VALUE OF COMMUNITY ENGAGEMENT

Kyle Whitfield, Martin LaBrie. University of Alberta, Faculty of Extension, Canada

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**Background** Over time, palliative care has become “professionalised”, placing a burden on health care systems to manage the suffering of individuals and families with advancing, life-limiting illness. The need to develop resources, infrastructure and policy to enhance the capacity for communities to facilitate and support individuals and families can add value to communities, enrich hospice-palliative care and reduce health care system burden.

**Aim** Few examples of communities developing such capacity exist, however, this oral presentation will describe the results of one study that examined, in one rural community in western Canada, key factors that influenced their ability to address their own hospice palliative care needs. We will report on factors that helped and factors that hindered them in their initial stages of planning for better care. A follow up study that is just at its initial stages (i.e. to start in Jan./Feb., 2015) will examine the value and outcomes of a model where communities collaborate with health care providers to strengthen their hospice palliative care community level capacities. In two rural communities in western Canada, such questions asked will be:

- What expertise and infrastructure is required to nurture community-based palliative care initiatives?
• What criteria constitute community engagement and leadership in hospice palliative care development?
• When using a model where communities collaborate with health care providers to strengthen their hospice palliative care, what are the direct outcomes? And are these of value, and if so, in what way, and if not why not?

Methods

The two studies use multiple research methods. Both use a case study approach and framework. Results are also generated from a systematic literature review; semi-structured key informant interviews and focus group interviews.

Results

Results from the first study reveal significant barriers to a community planning their hospice palliative care needs, such as: a lack of provincial guidelines or funds; unforeseen workload; community expectations for a hospice building versus improved care; and an overall fear of failure. Key factors supporting their planning were: improved community awareness; putting hospice palliative ‘on the map’ at a provincial level; substantial donations for new services etc. Although our second, follow study to determine more concrete outcomes to community leadership and collaboration with health care providers are unknown, we imagine results will speak to the need for specific and tangible resources, infrastructure and specific policy direction.

OA59 DEVELOPING AN INNOVATIVE MODEL OF PALLIATIVE CARE IN THE COMMUNITY IN BRAZIL

Santiago Rodríguez Corrêa, Carla Mazuko, Mauro Almeida, Raul Mendoza Sassi, Scott A Murray, Roberto Wern, Liliana De Lima, Geoffrey Mitchell, Graça Mota Figueiredo, Eduardo Yanneo. Faculdade de Medicina Da Universidade Federal Do Rio Grande–FAMED/FURG, Brazil

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Background

Despite a National Policy on Pain and Palliative Care (working since 2002) and the Family Health Strategy (primary care), Brazil does not have a strategy to integrate palliative care in primary care. The Atlas of Palliative Care in Latino America (ALCP-2013) did not find any team working with this mode: a primary care teach working.

Aim

Propose a model of palliative care in the Public Health Service of Brazil offered through the Primary Care to community.

Method

The Pilot Project is in the city of Rio Grande, south of Brazil, covering the area 29 with 3000 persons. This area has a team with a family physician, a nurse, a technical nurse and 6 Community Agents of Health (persons of area who work directly with population). The team has 3 aims 1) care: identification of possible patients (using the tracking and opinions of community health workers and the area diagnostics) > evaluation using PIG and SPCIT > care according to needs of these patients 2) awareness and needs assessment of the local/area community with ongoing monthly meetings and community engagement 3) awareness of management institutions in the city.

Results

The project started in November of 2014 and the first identification found 51 patients. Evaluation and assessment will begins and this number will be reduced. The first local meeting will happen in January/2015.

Conclusion

This project seeks to provide a proposal for palliative care offered through primary care in a public health service which does not exist in Brazil.

OA60 PUBLIC HEALTH AND PALLIATIVE CARE MIX; A CCPmedicine APPROACH TO REVERSE THE OVERGROWING BURDEN OF NON-COMMUNICABLE DISEASES IN TANZANIA

1Manase Frank, 2Joel Bwemero, 3Deborah Kalunga, 4Willy Sangu, 5Segella Semeni, 6Mavurahamisi Hamin, 7Muvakalege Julias. 1The Community Center for Preventive Medicine [CCPmedicine Medical Center] BOX 1024, Dar Es Salaam; 2Muhimbili National Hospital; 3Public Health Specialist Tanzania; 4Itala Municipality; 5Ocean Road Cancer Institute

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Outline of the Talk: The global prevalence of non-communicable diseases has increased persistently affecting developed and developing world. In 2008 alone 14 million premature deaths were reported globally and it is projected to reach 52 million by 2030.

Diagnosis of NCDs in many of the developing countries [including Tanzania] is often made late while the disease progression advances leaving a very limited chance for interventions to yield good health outcomes. A recent study [2011] conducted in Dar es Salaam, Tanzania on NCDs revealed that, around 16% of people admitted in referral hospitals had diabetes, and 88% had hypertension. The CCPmedicine is a community based private organisation that focuses on promoting healthy behaviour practices through prevention of non-communicable diseases in Tanzania by helping communities to take a leading role to promote their own health through health education, early detection of diseases, and facilitates timely disease interventions CCPmedicine approach to Public Health and Palliative Care mix in addressing the burden of NCDs in low resource countries like Tanzania has recently attracted policy makers, and practices to engage and support Palliative Care Services. In this paper we seek to share our experience of working with the private and public sectors to promote palliative care services in Tanzania.

Poster Abstracts

PA1 AN INTERNAL AUDIT INTO THE ADEQUACY OF PAIN ASSESSMENT IN A HOSPICE SETTING

Aditya Manna, SK Sarkar, UK Khana. Nankiveldaha Prayas, India

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Background

Pain is the most common presenting symptom of patients referred to palliative services. The effective management of pain is therefore paramount to any palliative service. The SOCRATES mnemonic is a pain assessment framework that is widely used by healthcare professionals to help them to remember to ask about key questions concerning a patient’s pain. The eight elements of this framework are Site, Onset, Character, Radiation, Associated Factors, Timing, Exacerbating and Relieving Factors and Severity.

Aim

To assess whether 100% of patients admitted to the hospice in a three month period with pain as a symptom were fully assessed using all elements of the SOCRATES mnemonic. Furthermore to ensure whether these patients were written up for regular and breakthrough analgesia medication.

Methods

New admissions from February to April were identified using SystmOne™ and their records searched for mention of