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the home, but little is known about how anticipatory prescribing impacts on them.

Method Semi-structured interviews were undertaken with bereaved carers to explore their experiences, feelings and perspectives relating to when a family member was prescribed anticipatory medications at home. Interviews were conducted throughout the Covid pandemic with changing restrictions, such that the last interviews were conducted in December 2020. Eight participants were recruited in liaison with the community palliative care team; their views about how the medications were introduced and used were recorded. Three interviews were via video-consultation, the others in person. Recruitment was terminated when data saturation was achieved, and transcripts were reviewed using thematic content analysis.

Results Three main themes were identified. 1) Anticipatory medications were accepted in the home (despite inadequate explanation) because symptoms or suffering were expected. 2) Medications did not have the presumed effect (with a perception of lack of benefit and harm). 3) Emotional burden on carers (dealing with death alongside feelings of loss of control and being unheard).

Conclusion This study suggests a mismatch between the intended benefits and actual contribution of anticipatory prescribing to end of life care at home. Perceptive explanation, accounting for distressing circumstances, needs to be provided to carers when these medications are introduced, including expected benefits and limitations. Such prescribing should not be a surrogate for naming dying. The interviews reinforced the inequality between hospice care and dying at home, particularly in the out of hours setting. Hospice at home care positively influences carers' experiences. The Covid pandemic changed the approach to dying. Visiting restrictions in hospices became a determinant to die at home, but fewer health-care professionals made home visits.

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82 PUBLIC UNDERSTANDINGS OF PALLIATIVE CARE IN THREE SETTINGS: HOME, HOSPICE, HOSPITAL

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Introduction Both professional and public misperceptions about palliative care are common and may contribute to poor access to palliative care in different settings globally. We sought to synthesise the published literature to better understand public perceptions of palliative care in different healthcare settings.

Methods Non-medical subject headings (Non-MeSH) for palliative care and perceptions were used to search for relevant quantitative, qualitative and mixed-methods studies in MEDLINE, EMBASE, PsycINFO, CINAHL and, Web of Science Social Science Citations Index Expanded and Conference Proceedings Citation Index from 1 Jan 2002 to 31 May 2020. Search results were screened against a priori inclusion criteria, data extracted and quality appraised by two independent researchers. Data were analysed using critical interpretive synthesis.

Results 48 of 33985 studies from Europe, North America, Asia and Australasia were included (32 quantitative, 9 qualitative, 7 mixed methods). This represented 32585 members of the public (aged 18 to 101 years; 54% women). Synthesis found considerable differences in public perception of where palliative care can be accessed. Some understood palliative care to be available in a hospice institution but less so at home. Levels of knowledge about hospice access was low and thought to be available only to those living near a hospice. Availability of palliative care in hospital was variably known, with some, viewing palliative care as only available in hospital, and that once receiving hospice care, further admissions to hospital were precluded; this likely reflects the particular use of the two terms (palliative care, hospice) in the US.

Conclusion In the context of poor understanding of palliative care, public perceptions of where care is available are mixed. Terminology appears to add to the confusion. Better public understanding of where palliative care is offered may improve access to this care, improve quality of life and reduce health-care costs.

83 ADDRESSING SPIRITUAL NEEDS, FACILITIES AND BARRIERS IN PORTUGUESE PALLIATIVE CARE: A CROSS-SECTIONAL SURVEY

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Background Spiritual care is an essential component of Palliative Care (PC) and a dimension of holistic care that preserves dignity and helps sick people to find meaning in suffering and in life. The knowledge about its implementation is still scarce in the Portuguese context. This study aimed to evaluate the facilities, barriers and needs for spiritual care in PC.

Method We conducted a descriptive cross-sectional survey of 180 health professionals in the period November 2018 to September 2019 at PC units. The data were collected through an online questionnaire published on social networks, after approval by an Ethics Committee. Sociodemographic and professional data, spiritual beliefs and knowledge about the objectives and purposes of PCs were collected. These were evaluated using an instrument consisting of 26 statements of dichotomous response (true/false).

Results The average age of participants was 42.42 years (SD=11.35), most are female (82.2%), nurses (43.9%), and 70% work in the health field. The total sample has worked on average for 15.67 ± 10.28 years and more than half (58.9%) perform functions in palliative care. Most identify with a religious belief (87.8%), attaching great importance to spiritual/religious conviction (45% of participants). The results suggest that empathy and the therapeutic use of silence (82.2%) are facilitators of spiritual care. The key barriers refer to the lack of expert professionals and the organization of care (36.1%). The results also highlight the need for specific training in the area of spirituality, hope and intervention strategies (53.9%).

Conclusion This study has provided insight into spiritual care in PC in Portugal. Future studies are necessary to investigate the effects of spiritual care more fully, and to develop outcome measurements that appropriately capture the effects of the variety of spiritual care practices.