uncertain. However, caregivers from both family and care-home settings were predominantly attuned to the person and skilled in effortlessly supporting them through the care activity.

Conclusions: Findings provide real-world empirical evidence which reenergises the concept of person-centredness in dementia care. Personal care activities typically created opportunities of engagement, rather than sites of conflict, for people with advanced dementia. The findings provide much needed insight into ways to improve care experiences for people with advanced dementia. Appropriate training/guidance for care-home staff and family carers could support more engaged and pleasurable care experiences for people with dementia.

References

Camp, C.J., Skrajner, M.J., Gorzelle, G.J., 2015. Engagement in Dementia, in Volicer, L., Hurley, A.C., Assessment Scales for Advanced Dementia. Health Professions Press, London.

Mahoney, E.K., 2015. Rejection of Care in Dementia. in Volicer L, Hurley AC. eds 2015 Assessment Scales for Advanced Dementia. Health Professions Press, London.

P193: Participation of faith-based organizations in the secular health- and welfare- care system for the older people in Japan: evidence and challenges

Authors: Tsuyoshi Okamura, Chiaki Ura, Ryosho Shoji, Akinori Takase, Yukan Ogawa

Objective: Due to longevity, universal health coverage, declining population, and a stable society, it is estimated that the number of people with dementia will reach 10 million by the mid-21st century, accounting for 10% of the total population in Japan. To move toward a dementia-friendly community, it is essential to develop innovative and effective dementia care. However, human and economic resources are limited. Therefore, we focused on traditional Buddhist denominations that have organizations, educational systems, human resources, networks, and care venues. The fundamental question of this study is: Japanese Buddhism has created basis for mindfulness-based cognitive therapy, but is it also innovative in the care of older people?

Methods: We looked for papers that 1) were written in a medical rather than a religious context, 2) were written in English, and 3) dealt with the care of the older people in Japan.

Results: 1) Institutional care workers' need for Buddhist priests for helping anxiety of older residents was reported. 2) Effectiveness of community cafés for the family caregivers of people with dementia in the Buddhist temples were reported. 3) Potentials of monthly visit to bereaved families, Buddhist priests' tradition, as the outreach of grief care was suggested. 4) Care workers' own ideas about death after working in the landscape of dying and death was reported by the interview which used Buddhist priests as the interviewers.

Conclusion: Participation of Buddhist priests as 1) spiritual cares for the residents in the institutions, 2) carers for the family carers in the community, 3) carers of the bereaved families in the outreach activity, and 4) carers for the care workers, were reported. However, robust evidence was not enough. From the standpoint of Japanese clinicians, there are too few papers compared to the actual contributions. More studies should be done which might also work as external monitoring. Traditional Buddhism in Japan has a closed membership system which is based on the family gravesite system and is generally not enthusiastic about propagation, which would also be compatible with a secular care system.

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